ENHANCING REPRODUCTIVE HEALTH SERVICES USE BY MARRIED ADOLESCENT GIRLS AND YOUNG WOMEN - ROLE OF COMMUNITY WOMEN VOLUNTEERS

REPORT
POTENTIAL OF COMMUNITY WOMEN VOLUNTEERS FOR FILLING SERVICES DELIVERY GAPS IN FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES DELIVERY IN THE COMMUNITY

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LIST OF ABBREVIATIONS

CBWs	Community-Based Workers
CPR	Contraceptive Preventive Rate
CWVs	Community Women Volunteers
PHC	Primary Health Care
LHWs	Lady Health Workers
FMST	Field Monitoring and Supervisory Teams
FP	Family Planning
FPRH	Family Planning and Reproductive Health
IUDs	Intra Uterine Devices
LHS	Lady Health Supervisors
IRMNCH&N	Integrated Reproductive Maternal Neonatal Child Health & Nutrition
MCH	Maternal and Child Health
NCRP	Nur Center for Research and Policy
PDHS	Pakistan Demographic and Health Survey
PEER	Partnership for Enhanced Engagement in Research
QDA	Qualitative Data Analyst
RH	Reproductive Health

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Executive Summary

The term "volunteer" is currently used across a wide range of settings to denote unpaid and un-coerced service. As compared to paid employees, volunteers have been reported to be more motivated by social interaction with others and by the opportunity to contribute toward achieving the missions of their recruiting organizations. Volunteers are increasingly being found to be necessary and helpful for a healthy community. Social services provider organizations who mobilize community resources and expand capacity through volunteers enhance their general profiles, and thereby attract more volunteers, program participants, and funds. Other potential benefits of using volunteers include an increased ability to serve clients and respond to the needs of the community (e.g., increased services, expanded hours of operation, shorter wait times); greater staff diversity (e.g., age, race, social background, income, education); increased skill set and expanded community support.

Pakistan's health sector suffers from severe financial and crisis level human resources shortages.[1] The country's national health programs are under performing as is evident from its stagnating health indicators and failure to achieve national and international health goals. Fresh initiatives are needed to invigorate the programs and enhance their impact. The Primary Health Care (PHC) and reproductive health programs have a special need for volunteers mobilized from within the community to support and facilitate the work of their services providers. The research team at Nur Center for Research and Policy (NCRP) Lahore in collaboration with George Washington University Milken Institute of Public Health, undertook a study to test the innovative strategy of enhancing access of LHWs to married adolescent girls and young women (aged 15-24 years) for Family Planning and Reproductive Health (FPRH) counselling through community-based women volunteers.

Objectives

1. To document the socio- demographic profiles and FPRH knowledge, beliefs and practices of Community Women Volunteers (CWVs);
2. To record the CWVs perspectives on volunteering and their experiences of working as volunteers.

Study Participants and Methods

Our study site was Nishtar Town, Lahore. Permission for the study was taken from Punjab Provincial Health Department and Lahore District Integrated Reproductive Maternal Neonatal Child Health & Nutrition (IRMNCH&N) office. Two hundred and twenty-five (225) LHWs working in Nishtar Town gave their informed consent for participating in the study. We selected the quasi experimental 'Before and After' study design to test our study intervention. The participating LHWs selected 900 CWVs from among their family members, friends, social circles and client women and trained them on FPRH Counselling in informal interactions with them

[1] WHO World Health Report 2006

before launching them in the community to create awareness about the services the LHWs provide and FP messages for families of married adolescent girls and young women on delaying of first births and adequate birth spacing. Our intervention-testing phase was interrupted by the COVID-19 Pandemic. We had completed a Baseline survey and 225 participating LHWs had selected and trained their CWVs who had started conveying the messages given to them by the LHWs when lockdowns for containing the COVID-19 pandemic started to be imposed in our study area. While we were not able to complete our intervention testing, in our revised study methodology, we undertook a survey of the recruited CWVs and the participating LHWs and their supervisors (LHS) to record the profiles of the volunteers and their motivation for volunteering and get feedback from the LHWs and LHSs on their experience with mobilizing volunteers and the effectiveness of the later in the facilitation of their work.

Study Key Findings

1. CWVs Profiles

The age of the volunteers ranged from 18 – 65 years with mean age of 34.35 ± 8.4 years. With respect to their education level, 20.3 percent had primary and 35 percent secondary school level education and 29.56 percent had no formal education. Higher secondary and college education had been received by 8.45 and 6.64 percent respectively. In terms of employment, 78.4 percent were not doing any paid job while 18.7 percent had low paid jobs. About one third lived in joint families.

2. CWVs Reproductive Health Knowledge and Practice

The age at first pregnancy of the volunteer women ranged from 15-34 years with a mean of 20.68 years. Their number of pregnancies ranged from 1 – 14 with a mean of 4.15 and number of live children ranged from 1 – 10 with a mean of 3.5.
Ninety eight percent good knowledge of reproductive health needs of women and available reproductive health services and 96.8 were familiar with most FPRH services provided by LHWs. Over 87 percent had utilized LHWs services during their last pregnancy and delivery.

3. CWVs Family Planning (FP) Knowledge and Practice

Almost all the CWVs (99.6 percent) believed in planned families. The ideal family size was 3-4 children for 65 percent and 1-2 for 32.68 percent. While 86.69 percent favored the use of modern contraceptives, 11.5 percent preferred traditional methods. Among modern contraceptives 80.67 percent preferred condoms and 28.44 percent IUDs.
With regards to FP practices, 91.4 percent had used FP themselves. Among these 70.56 percent had used condoms and 23 percent IUDs. The 51.22 percent who were not using contraceptives at the time of interview due to various reasons intended to use them.

4. CWVs Reasons for Volunteering

Most of the volunteers greatly appreciated the work done by LHWs and had good relationship with them which is why they agreed to help them. Some had done volunteer work with LHWs previously as vaccinators and polio workers, therefore they volunteered for the project. Other

reasons given included pleasing God, spare time availability for volunteer work, increasing their interaction with the community, increasing their knowledge of FPRH and sharing their knowledge with others.
There were a few who said they expected to be paid and that they and their families were disappointed for not being paid anything for their work. There were others who knew they will not get any payment but had volunteered in the hope of getting paid employment later.

5. **Knowledge CWVs had gained through the project**

Some volunteers said that they were not aware of the range of services the LHWs provided other than just contraceptives before working for the project. Others had gained knowledge related to how much gap between pregnancies is actually necessary, and what adverse effects on health can happen if there is no adequate birth spacing. Many respondents said they did not know that the capsule is put in the arm and they gained this information through helping the LHWs.

6. **CWVs perceptions about community acceptance of their services and their satisfaction with the services they had provided.**

Most CWVs were happy with the response of the community to the counselling messages they discussed with them. Some reported getting scolding from mothers- in- law and some being made fun of because they had not borne any children themselves. The remark of one CWV sums up the experience of the volunteers with the community:

"Yes, I faced some problems like in some houses some women didn't cooperate because of their backward mentality and in some houses mothers-in-law and husbands also didn't allow them to interact with us. But there are still some people who appreciate our work and follow our advice."

Discussion

Our study has demonstrated the availability of volunteers for promotion of the services of LHWs and spreading FPRH counseling messages in the community, even in economically challenged communities. The study has demonstrated the potential of volunteers from the community for filling health human resources gaps in these programs.

Scalability and sustainability of intervention is a concern in all new initiatives. In our study these were the essential focus in our conceptualization of volunteers. LHWs and other community-based workers (CBWs) are widely deployed in Pakistan and no new cadres are proposed to be introduced. In this initiative LHWs/CBWs have been empowered to recruit volunteers with no interferences from officials. No qualifications or other specific particulars are required for recruitment. No specific time duration is needed for the volunteers to serve. No monetary incentives are paid to the volunteers which could burden the cash-strapped programs or lead to other evils like political influence and favoritism in recruitment.

There is however a need for replication of our study in rural areas since our study was done in a highly urbanized area of Lahore district and monitoring and supervision by the program managers

and supervisors was done to keep track of volunteers recruited and do trouble shooting as and when required. Another action which can ensure sustainability further is award of certificates to the volunteers for providing services beyond a specified period of time (3 months or 6 months) and to the LHWs for the number and diversity of volunteers they recruit.

Conclusions

LHWs can mobilize volunteers to facilitate them in the delivery of counseling services and awareness creation in the community about the services they provide.
Volunteers are available in economically challenged communities to provide services without cash incentives.
Volunteers have the potential to fill the long -standing gaps of deficient health human resources and community participation in the delivery of community-based services.
The volunteers' intervention is scalable and sustainable where LHWs are deployed.
Further research studies are needed in rural and far -flung area to study the applicability of the model in those areas.

1 - INTRODUCTION

Volunteerism, defined as a social phenomenon of unpaid care and citizen participation in society, is being increasingly harnessed to address the financial shortfalls faced by Human Services Organizations as a fallout of conservative political philosophy of governments since the 1980s.[2] The term "volunteer" is currently used across a wide range of settings to denote unpaid and un-coerced service. The different definitions of volunteerism have five elements in common: (1) free choice; (2) unpaid service (not monetary donation); (3) a formal commitment to assist (i.e., excluding informal familial or neighborly support); (4) the volunteer is not the intended beneficiary of the service, and (5) an action of deliberated (as opposed to spontaneous) nature. A unique difference between volunteers and paid employees is that volunteers do not receive monetary compensation and organizations lack the formal reward and power structures to influence their behavior. Organizations therefore have to rely on the 'rewarding experience of volunteering' to enhance the motivation of volunteers. As compared to paid employees, volunteers have been reported to be more motivated by social interaction with others and by the opportunity to contribute toward achieving the missions of their recruiting. [3,4]

Volunteers are increasingly being found to be necessary and helpful for a healthy community. Social services provider organizations who, mobilize community resources and expand capacity through volunteers enhance their general profiles, and thereby attract more volunteers, program participants, and funds. [5] Other potential benefits of using volunteers include an increased ability to serve clients and respond to the needs of the community (e.g., increased services, expanded hours of operation, shorter wait times) ; greater staff diversity (e.g., age, race, social background, income, education); increased skill set and expanded community support.[1] In the democratic societies of the developed countries where freedom of choice is valued, volunteerism is viewed as both a means and an expression of this freedom. As mentioned above, budgetary constraints and human resources shortages have led to more and more reliance on volunteer services worldwide. Critical questions regarding capability of volunteers and sufficiency of numbers have yet to be fully explored but the need for their services has become well established.

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[2] Ascoli, U., & Cnaan, R. A. (1997). Volunteering for Human Service Provisions: Lessons from Italy and the U.S.A.. Retrieved from http://repository.upenn.edu/spp_papers/10

[3] Kerstin Alfes, Bethania Antunes & Amanda D. Shantz (2017) The management of volunteers – what can human resources do? A review and research agenda, The International Journal of Human Resource Management, 28:1, 62-97, DOI: 10.1080/09585192.2016.1242508

[4] Pearce, J. L. (1983). Job attitude and motivation differences between volunteers and employees from comparable organizations. *Journal of Applied Psychology, 68*, 646–652.10.1037/0021-9010.68.4.646

[5] Successful Strategies for Recruiting, Training, and Utilizing Volunteers. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatmenthttps://www.samhsa.gov/sites/default/files/volunteer_handbook.pdf

Pakistan's health sector suffers from severe financial and crisis level human resources shortages.[6] The country's national health programs are under performing as is evident from its stagnating health indicators and failure to achieve national and international health goals.[7] Fresh initiatives are needed to invigorate the programs and enhance their impact. The health programs have not explored the role of volunteers in overcoming barriers they face like health workers shortages and mitigation of socio-cultural factors limiting the outcomes and impact of their interventions. The PHC and reproductive health programs have a special need for volunteers mobilized from within the community to support and facilitate the work of their services providers. The country's largest community-based PHC and FP program popularly called the Lady Health Workers (LHWs) Program, is providing services at the household level to predominantly the underserved and marginalized populations of the country. The program is being implemented since the early nineties but has had limited impact particularly on increasing Contraceptive Prevalence Rate (CPR) and utilization of reproductive health services.[8, 9] Under-utilization of LHWs services has been reported. Our study on the nutrition and health status of adolescent girls, found restricted access of LHWs to married adolescent girls for FPRH counseling.[10] The CPR in this age group and married young women up to 24 years age is 20 % as compared to the 39-40 % for women of child bearing age.[11] Low social status of these women due to deeply entrenched cultural factors is mostly responsible for their disempowerment and marginalization.

Nur Center for Research and Policy (NCRP), Lahore in collaboration with George Washington University Milken Institute of Public Health, undertook a study to test innovative strategy of enhancing access of LHWs to married adolescent girls and young women (aged 15-24 years) for FPRH counselling through community-based women volunteers. Our study concept was derived from the Care Group experience of using volunteers to motivate mothers to adopt key Maternal and Child Health (MCH) behaviors.[12]

2 – OBJECTIVES of CWVs Survey

2.1.To document the socio-demographic profiles and FPRH knowledge, beliefs and practices of

[6] WHO World Health Report 2006

[7] Pakistan MDGs Report

[8] Z Mumtaz, S Salway, C Nykiforuk, A Bhatti, A Ataullahjan, B Ayyalasomayajula.The role of social geography on lady health workers' mobility and effectiveness in Pakistan. Soc Sci Med, 91 (2013), pp. 48-57

[9] Rose Zulliger, PAKISTAN'S LADY HEALTH WORKER PROGRAM. https://chwcentral.org/pakistans-lady-health-worker-program

[10] Snapshot of poor adolescent girls' nutrition and health. Technical Report

[11] PDHS 2017-18

[12] Perry H., Morrow M., Borger S., Weiss J., De Coster M., Davis T., & Ernst P. (2015). Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings. *Global health, science and practice*, *3*(3), 358–369. https://doi.org/10.9745/GHSP-D-15-00051the study participating 225

CWVs participating in the project;

2.2. To record the CWVs' perspectives on volunteering and their experiences of working as volunteers.

The purpose of the survey was to generate evidence for advocating the need and feasibility of mobilizing the services of volunteers to address the human resources shortages and negative socio-cultural beliefs limiting the impact of FPRH and MNCH services being provided by community-based programs like the IRMNCH&N.

3– PARTICIPANTS AND METHOD

Our original PEER (Partnership for Enhanced Engagement in Research) funded project was a sequential mixed methods With Focus group Discussion (FGDs) with community groups preceding the impletion of our intervention-testing qasi experimental 'Before and After' study The study included selection of CWVs by LHWs from among their family members, friends and social circles and client women, a manageable workload for the volunteers and at least monthly contact between the LHW and her selected group of volunteers for feedback on how their work was going on and any issues they were facing. During these meetings the messages the volunteers were passing on to the target age group women and their families were refreshed and new messages were added. The LHWs provided monthly feedback on the progress of the intervention-testing to our study Field Supervisory Team. Our intervention-testing phase was interrupted by the COVID-19 pandemic. We had completed a Baseline Survey and the 225 participating LHWs had selected and trained 900 CWVs who had started conveying the messages given to them by the LHWs. While we were not able to complete our intervention testing, under our revised study methodology, we undertook a survey of the recruited CWVs and the participating LHWs and their supervisors (LHS) to record the profiles of the volunteers and their perspectives on volunteering, motivation and experience gained during the project and to get feedback from the LHWs and LHSs on their experience with mobilizing volunteers and the later contribution to the facilitation of their work.

The project was being carried out in Nishtar Town of Lahore City District. At the time of its discontinuation, the project had recruited 225 LHWs and they in turn had mobilized the support of a total of 900 CWVs. During the pandemic the NCRP team had remained in touch and as soon as the lockdown was lifted and approval for our proposed revised methodology had been received from PEER, interviews were organized with the following respondents:

- The 600 CWVs who agreed to give interviews.
- The 225 LHWs participating in the study: The data collected from them included their background information, their own FPRH practices and experience of working with CWVs they had recruited for the project and views and suggestions for institutionalizing CWVs support for the promotion of their work in the community in the IRMNCH&N program.
- The 14 LHSs who were supervising the work of the participating LHWs in the study area. Similar data to LHWs was collected from them.

Semi-structured questionnaires were developed and pilot tested. A new team of female interviewers was recruited and trained by the Project Manager and briefed by the PI. They got further hands-on training in the field during the pilot testing of the questionnaires. Interviews started on September 11, 2020 and were completed on November 25, 2020. A total of 833 interviews were done. During data cleaning 104 questionnaires were discarded owing to being incomplete or inconsistent data. A total of 729 questionnaires were analyzed.

3.1. Monitoring of Data Collection and Data Entry

Three female interviewers collected the data. A Field Supervisor was attached with them who helped them in contacting LHS and LHWs participating in the study. The LHS and LHWs in turn connected them to their respective CWVs.

The interviewers translated the filled questionnaires in Urdu and then back into English. This exercise enhanced their understanding of the questions including what responses to expect. The per day target for each interviewer was 5 translated interviews which they uploaded on to G-Drive in their respective folders. The Project Associate scrutinized the data received from the field, reviewed the uploaded English transcripts by the interviewers for completeness and corroborated them with the Urdu versions. She communicated the mistakes detected to respective interviewers who corrected them where possible.

3.2. Qualitative and Quantitative Data Entry

- Owing to a large qualitative data component in the questionnaire a qualitative Data Analyst familiar with the use of qualitative data software (MaxQDA) was recruited. He gave training to the project field manager, supervisors and interviewers. The training included interviews techniques, coding and use of MaxQDA. The data collected was uploaded by the Project Associate and then coded in MAXQDA software for qualitative analysis by the Qualitative Data Analyst (QDA) and two Research Analysts at NCRP.

- The quantitative data was entered in coded form in excel according to the template created and guided by the Data Analyst.

The hard form data was segregated area-wise, indexed in the respective files and has been stored securely under the custody of Manager Operations, NCRP.

4 - RESULTS

4.1. Community Women Volunteers (CWVs) Background Data

The age of the CWVs (will be also referred to as volunteers) ranged from 18 – 65 years with mean age of 34.35 ± 8.4 years (CI 33.61-35.10). Their mean age at first pregnancy was 20.67± 3.9 years (20.38-20.97) with a wide range of 15 –34 years. This reflects high rate of teenage marriages in the community. Their husband's ages ranged from 19-80 years with a mean of 38.57 ±9.04 years.

Most of the respondents had primary (20.32 percent) and secondary school level education (35 percent) with 29.56 percent illiterate and 6.64 percent with a college education. These rates are better than those reported in Pakistan Demographic and Health Survey (PDHS) 2017-18, indicating better education levels of women in the area. About a third were living in joint families (32.7 percent). Family size ranged between 1 -30 members with a mean of 7.6, which is about the same as reported by most national and Punjab province surveys. Employment wise most were housewives (76.66 percent) and most of those employed were working in low paid jobs (18.71 percent) (Table-1).

Respondents Current Age (Years)			
N	**Range**	**Mean (SD)/N**	**95% Confidence Interval**
511	18 - 65	34.35 (8.54)	33.61- 35.10
Age at First Pregnancy			
486	15 - 34	20.67 (3.29)	20.38- 20.97
Husband's Age			
484	19 - 80	38.57 (9.04)	37.76 – 39.37
Family Size			
511	1 - 30	7.61 (4.26)	7.24 – 7.98
Household Type			
511	Joint	N =167	32.7%
	Nuclear	N = 344	67.3%
Educational Attainment			
497	None	29.58%	25.60-33.60
	Primary	20.32%	16.80-23.90
	Secondary	35.01%	30.80-39.20
	Higher Secondary	8.45%	6.00-10.90
	College	6.64%	4.50-8.80
Employment Status			
497	Housewife	79.48%	72.90-80.40
	Irregular Employment	0.20%	0.00-0.60
	Low Paid job*	18.71%	15.30-22.10
	Mid Paid job**	1.61%	0.50-2.70
	High Paid job***	0.00%	0.00-0.00

***<=30,000, **31,000-50,000, *** >50,000**

Table-1: CWVs Background Data

Reasons for not enrolling in school or incomplete education

Many questions were asked to understand the reasons for not enrolling in school or incomplete education of the respondents. It was found that girls' education is firmly grounded in the gender role assigned to women as producers and nurtures of children and home-makers. The dominant belief in the respondents' families about girls' education (as reported by the respondent) was that their essential responsibility is to look after children and their marital homes after marriage therefore they don't need education or more than primary or school level education. A number of the respondents who were receiving education before they got married would have liked to complete their education before marriage or continue after marriage but religious/conservative backgrounds, long distances of schools from their homes and refusal of permission from in-laws, prevented them from doing so. Table-2 lists the reasons given by the respondents who had no education, incomplete education and those who couldn't complete their education after marriage.

No or incomplete Education	**Reasons given by Respondents**
1. No Education	*"In our family, educating a girl is considered unnecessary as looking after kids and household chores is considered her only responsibility."*
	"Due to household responsibilities, I could not even think of getting any sort of education."
	"My grandfather did not allow girls of the family to leave the house for any kind of activity, not even for education. He was of the view that going to school/college would ruin a girl's reputation in the society"
	"I was not interested, and also there is no trend to educate girls, so I never tried or thought of getting an education."
2. Incomplete Education	*"I never paid attention to getting an education after matriculation, as girls of our family were not allowed to study further"*
	"I was told by my family that it is sufficient if I can read/write my name, further education is not necessary."
	"My father asked me to stay at home and to offer prayers only. According to him further education was not needed"
	"My father's reaction was not supportive at all, he was of the view that the school environment was not suitable for girls
3. Education after Marriage	*"My husband allowed me to study, but I did not get the opportunity because of children and household chores."*
	"Due to household responsibilities I could not even think of getting any sort of education."
	"I was advised by my mother- in- law that looking after the house and children should be my only focus. I was not allowed to get enrolled in

	any school/college.
	"I was told that a married woman should not get herself busy in getting education.
	"I was pregnant soon after I got married, I didn't find time to study"

Table-2: Gender Role Assignment as a Reason for Girls no or Limited Education

Poverty was mentioned as a reason for not enrolling in school or incomplete education by a number of respondents. In the words of one with no education, *"The situation of my home was not good. We were hardly meeting our basic needs of food and clothes-we could never even think of getting an education"* Another who couldn't complete her education also gave poverty as a reason, *"Circumstances of my house were very difficult, there was no money to fulfill the expenses of the household that's why I never tried to continue my education."*

Reasons given by some who wished to continue their education in preference to getting married included lack of education facilities and long distance of schools from their homes like, *"I used to live in a village and there were no schools nearby"* and *"At that time, there were no schools in our village so I couldn't continue my studies"*; and fathers' negative attitude to education, *"My father asked me to stay at home and to offer prayers only. According to him further education was not needed"* and *"My father's reaction (to the respondent wish to continue her education) was not supportive at all, he was of a view that the school environment was not suitable for girls"*

Empowerment Status

We used consent at marriage, education status, employment status, control over spending of own income, decision-making about own health as indicators of empowerment. Over 80 percent scored low (Table-3). Never-the-less they made their own decisions for becoming volunteers for supporting and promoting the FPRH counseling work of LHWs.

	Empowerment status	**Score**	**N**	**%age (%)**	**95% Confidence Interval (%)**
1	Not empowered	0 - 6	406	81.69%	78.30-85.10
2	Partially Empowered	7 - 11	91	18.31%	14.90-21.70
3	Fully Empowered	12 - 13	0	0.0%	0.00-0.00

Table-3: CWVs Empowerment Status

Consent for marriage was one of the criteria for assessing the empowerment status of the respondents. Early marriages and marriages without taking consent from the girls is a well-known practice in the community and the responses of our study CWVs to the question whether their consent was sought at the time of marriage confirm this observation (Table-7). From the responses it is apparent that they were accustomed to relying on their elders (usually parents/father) for the decision of their marriage and that there was no tradition in most families of taking consent from girls at the time of marriage. Some were of the view that trends are changing.

No tradition of taking consent in the past but changing of tradition now	*"There was no such culture in the past to ask for a girls approval regarding marriage The decision of marriage was made only by the parents and the elders of the house."* *"Even today, decision for marriage are only taken by parents or elders of the family. Families are of the view that their children are immature and cannot take such decision on their own."* *"There was no trend of asking consent from anyone at the time when I got married. Parents married me by their own choice."* *"During my time, consent was not taken from girls. But now trends have changed, now our parents and elders do consider girls' and boys' consent."*
Consent not considered mandatory for marriages committed to in childhood.	*"Everyone and even I knew that I would get married to my cousin since childhood and I had no issue"* *"I was engaged to him when I was very young and even started liking him so parents didn't feel the need to ask for my consent".*
Marriage of children/girls is a responsibility of parents/guardians and has to be fulfilled by them.	*"My father died soon when I was young, since then my uncle is my guardian and he just wanted to get over with his responsibility, so consent before my marriage didn't matter to him"*

Table-4: CWVs' Families' Perspectives on Taking of Consent for Marriage from Girls

4.2. CWVs' FPRH Knowledge and Practices

Among the criteria used by LHWs for the selection of CWVs were knowledge of FPRH and good FPRH practices. We assessed the CWVs understanding of Reproductive Health and their utilization of available RH services during their last pregnancy and delivery. Almost all (98.04 percent) knew about RH services available at the community level. Maternal health counseling, antenatal care, supplements, Tetanus immunization, delivery services were mentioned by over 90 % of the respondents. Postnatal care was mentioned by 81.84 percent. LHWs topped the list when respondents were asked to list RH services providers. Over 98 percent mentioned them. The other providers listed were doctors (71.40 percent) Lady Health Visitors (6.47 percent)), Dais and Hakims by 8.5% each.

Consistent with their RH knowledge, over 90 percent had antenatal care, taken iron and folic acid supplements and had Tetanus Toxoid immunization during pregnancy and their delivery had been attended by skilled birth attendants. LHWs had provided services to 87.4 percent and doctors to 71.4 percent.

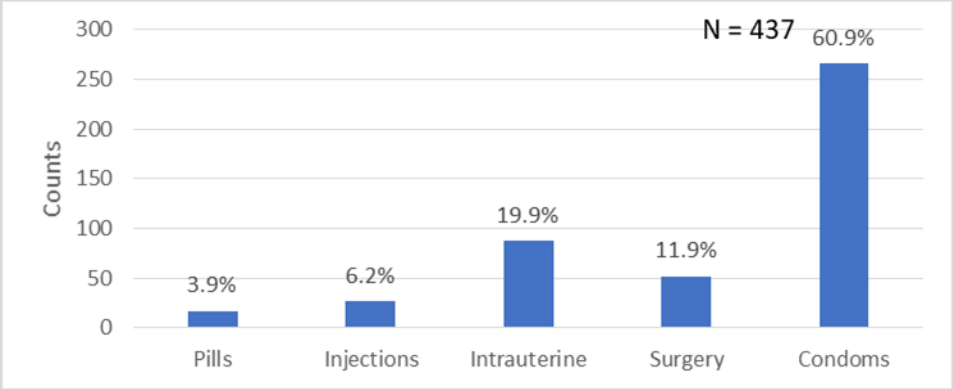
N	Variable	Response	N (%)	95% Confidence Interval
CWVs Knowledge about available RH services				
511	Knew about available RH services	Yes	501 (98.04%)	96.84-99.24%
		No	10 (1.96%)	0.76-3.16%
501	Available RH services mentioned	Maternal Health Counseling	484(96.61%)	95.02-98.19%
		Antenatal Care	473(94.41%)	92.40-96.42%
		Supplements	496(99.00%)	98.13-99.87%

		Tetanus Immunization	471(94.01%)	91.93-96.09%
		Delivery services	453(90.42%)	87.84-93.00%
		Postnatal Care	410(81.84%)	78.46-85.21%
		Others	17(3.39%)	1.81-4.98%
501	Providers of RH Services mentioned	Family	41(8.56%)	6.05-11.06%
		Dai	41(8.56%)	6.05-11.06%
		Hakims	45(9.39%)	6.78-12.01%
		LHW	419(87.47%)	84.51-90.44%
		LHV	31(6.47%)	4.27-8.68%
		Doctors	342(71.40%)	67.35-75.45%
CWVs RH Services Utilization during last pregnancy				
479	Services utilized during last pregnancy	Antenatal Care	452(94.36%)	92.30%-96.43%
		Supplements	450(93.95%)	91.81%-96.08%
		Immunization	448(93.53%)	91.32%-95.73%
		Skilled Birth Delivery Attendant	449(93.74%)	91.57%-95.91%
		Postnatal Care	340(70.98%)	66.92%-75.05%
		FP Advice after Delivery	383(79.96%)	76.37%-83.54%
479	Providers of services	Family	41(8.56%)	6.05%-11.06%
		Dai	45(9.39%)	6.78%-12.01%
		LHW	419(87.47%)	84.51%-90.44%
		LHV	31(6.47%)	4.27%-8.68%
		Doctor	342(71.40%)	67.35%-75.45%

Table-5: CWVs Reproductive Health (RH) Knowledge and Practices during Last Pregnancy

The CWVs FP knowledge was comparable to their RH knowledge and practice. Aside from the 65 percent who considered 3-4 children as the ideal number and 11.5 percent who had used traditional methods of contraception, 99.6 % believed in planned births. Among modern methods, condoms were the preferred method of contraception for 80.6percent. Intra Uterine Devices (IUDs) were preferred by 28.5 percent and pills and injections by 10 percent each. Five percent had gone for surgery (Table-6).

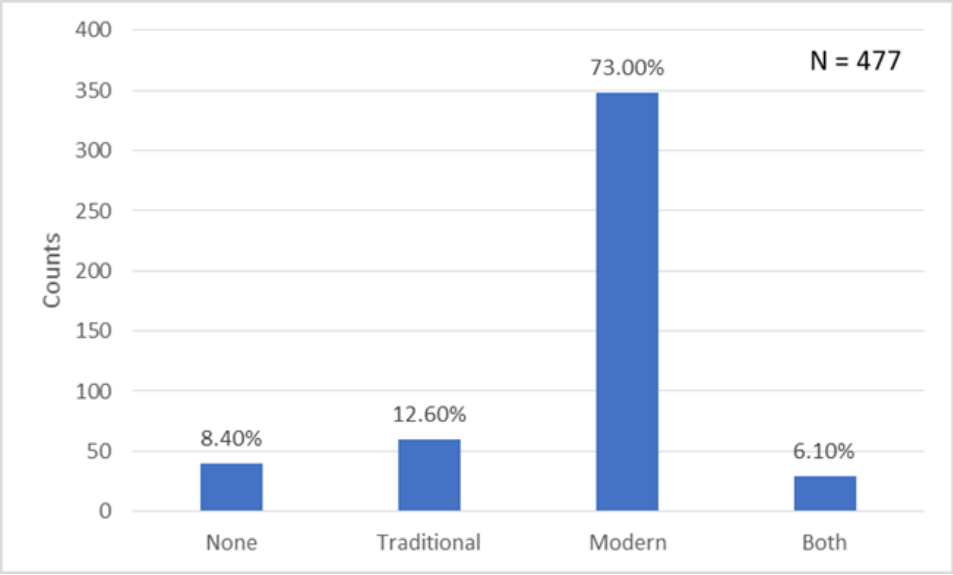
N	**Variable**	**Response**	**N (%)**	**Confidence Interval**
511	Ideal Number of Children	1-2	167(32.68%)	28.61%-36.75%
		3-4	333(65.17%)	61.04%-69.30%
		5-6	3(0.59%)	0.00%-1.25%
		As Allah Wills	8(1.57%)	0.49%-2.64%
511	Belief in planned births	No	2(0.39%)	0.00%-0.93%
		Yes	509(99.61%)	99.07%-100.15%
511	FP Method Used	NA	2(0.39%)	0.00%-0.93%
		Traditional	59(11.55%)	8.78%-14.32%
		Modern	443(86.69%)	83.75%-89.64%
		Both	7(1.37%)	0.36%-2.38%
450	Modern Methods used	Pills	45(10.00%)	7.23%-12.77%
		Injections	45(10.00%)	7.23%-12.77%
		IUD	128(28.44%)	24.28%-32.61%



		Surgery	23(5.11%)	3.08%-7.15%
		Condoms	363(80.67%)	77.02%-84.32%

Table-6: CWVs FP Knowledge and Practices

The contraceptive methods preferences of current users are presented in Fig-1 and Fig-2. Seventy



three percent were using modern methods, 12 percent traditional methods and 6 percent both methods. Among modern methods 69.9 percent were using condoms, 19 percent, IUDs, 6.2 and 3.9 percent injections and pills respectively. The users of surgery had gone up to 11.9 percent in this group.

Fig-1: Preferred FP Methods of Current Users of Contraceptives

Fig-2-: Modern Methods of FP Preferences of Current Users of Contraceptives

4.3. CWVs Perspectives on FP

The emergent dominant belief among the volunteers was that owing to poverty and high cost of living, couples should have the number of children they can afford to provide a good quality of life. Beside the affordability of children, the child and mothers' health were repeatedly referred to as a reason for small family size. However, by small family most of the respondents meant 3-4 children. Few appeared to favor 1-2 children as according to one respondent, "*Children should be paired (2 sons and 2 daughters) so that no child would face the feeling of loneliness because in our society if you want to be stronger than you must have a strong family background*." *(Table-7a*)

1. Overall view on number of children	• "Inflation is so high, resources are limited and there is only one earner at *home, so there should be fewer children"*
2. 3-4 children	• *"There should be 3-4 children so that they can support each other after the death of their parents because parents can't stay forever"* • *"Children should be paired (2 sons and 2 daughters) so that no child would face the feeling of loneliness because in our society if you want to be stronger than you must have a stronger family background"*
3. 1-2 children	• *"If there is only one child, he feels lonely and the children become the support of the parents, so there should be 3 or 4 children"* • *"Inflation is at its peak nowadays and in these circumstances having three children is too much. Expenses cannot be met properly and children face hard times as their basic needs are not fulfilled"* • *"Nowadays two children are enough, so that parents could educate them from a well reputed school and as a result they would get many job opportunities"* • *"Children should be less in number because raising them is not an easy task nowadays. It is difficult to provide them proper food and education. It is important to keep a small number of children so that parents can take good care of their family."*
4. Will of God	• *"HE gives money and children as much as HE desires"*

Table-7a: CMVs Views on Number of Children per Couple

The CWVs opinions on births planning and spacing were consistent with their views on the number of children a couple should have. Mother's and child health and reduced expenditures were given as reasons for spacing births. Most favored more than 3 years' intervals between births. The ones who preferred shorter intervals gave two reasons; one that the mother will free herself of child-

bearing early and give attention to other needs of her household; and two that longer spacing can lead to complications like birth of premature babies (Table-7b).

1. Positive opinions on planned births	• "*Expenses are less, both (mother &child) enjoy good health, a small family seems to be good and helps in a peaceful life"* • *"There are so many household issues. It affects the health of the mother and the child. She won't be able to give proper time to her kids and to her house, if she does not adopt child spacing"* • *"There should be FP so that mother and child can stay healthy and it will be easier to raise the children if there is a gap between children."* • *"If child spacing is not considered, then the health of the mother will deteriorate, as a result she will not be able to take care of herself as well as the baby"*
2. Supportive of long birth spacing	• *"There must be a space of 4 to 5 years in between children for the good health of children and their mother."* • *"There should be 3-4 years of child spacing, this would allow the mother to develop a bond with her present child and it will prepare her for the next child"*
3. **No birth spacing**	• *"There is no point in taking a break from children. I think all children should be born without any break so that mother can get free. After completing the responsibility of having children, a woman can also focus on household chores"* • *"There should be space of two years in between children and not more than this because so much space can create medical complications, as for one of my friend; child spacing of almost four years led to birth of premature baby.*

Table-7b: CWVs Opinions on Birth Planning

To compare their beliefs with their own practices of FP the reasons for their practicing and not practicing of FP were explored. Among those of child-bearing age who were not single, widowed, and pregnant or given birth recently, most were found to be practicing FP. Completion of their families was the main reason for practicing FP and as per their views on the number of children had stopped conceiving children when the number reached four or more.

The few who were not using contraceptives had both delays and difficulties in conceiving children or were afraid of the side effects of modern contraceptive. The later however were using traditional methods instead which they considered safer than modern contraceptives.

1. Reasons for	• *"I am doing it because I already have 7 children and we can't*

practicing FP herself	*afford to have more"* • *"I have two children and I just want two more. I took a break two years ago and I'm still taking a break because I think it is necessary for a woman's health as well as babies health and I use a condom for it"* • *"My daughter is 2 months old right now, and I want to nourish her in a proper way. When she will reach 2 year of age then I will think about my second child so that my children would be healthy and well."* • *"My family is complete and I don't want more children that's why I am using contraceptives. At this age, husband and wife need each other's attention rather than planning for the next child."* • *"It is happening with the consent of my husband and it is also important for my own health."* • *"I don't want more kids. My health no longer allows me to have children. I have weakness and body aches. I can't even perform household chores"* • *"We have got a child, and its already difficult to manage; in order to make both ends meet - we need to plan our family"*
2. Reasons for not practicing FP	• *"I want a baby but am not conceiving from a long time (5 years). I haven't conceived another baby after the birth of my son. That is why I am not using anything. After baby I will use condom as it doesn't have any side effects."* • *"I am not using any FP method as I usually conceive late, I have already lost my three babies."* • *"I am afraid of using any kind of contraceptives, I have heard from a relative that they have side effects"* • *"I am using traditional method because I think that's the most secure way to do FP. I am doing this with my own will (goliyan jism ko phula daiti hain-The body swells with pills)"* • *"My husband is not comfortable using modern methods (condoms), I am only doing traditional method for child spacing"* • *"When I was married there was no concept of FP and we did not have access to all these modern methods of FP; I wish we were aware of this concept as we are facing issues because of our family size"*

Table-7c: CWVs Reasons for Practicing FP Themselves

4.4 CWVS Reasons for Volunteering for the Project

We asked the CWVs to give their reasons for volunteering for our project. Most knew the LHW they were working and said that they had immense respect for her and her work. Some had worked with her on other projects as volunteer vaccinators or polio workers and that was the reason for their volunteering for this project. Others took volunteering as the opportunity to help others spend their free time productively, to please God or increase their knowledge of FPRH. A few were

disappointed for not getting any payment for their services but some among these were hopeful that this service will help in getting paid employment in future. (Table-8)

Reasons for volunteering in the past	
• **Free time** • **On request of LHWs** • **To render social service** • **To please Allah**	*"I was free so I joined lady health worker to assist her"* *"When the LHW requested, I joined the polio campaign as a volunteer"* *"I was working as a vaccinator with Lady Health worker, I could manage it with my daily routine"* *"I joined them as a social worker for the good will of my community"* *"I was a school principal and very socially active member of the community; I have always encouraged activities to help mankind"* *"I work to please Allah. I can't afford to help others financially, so I help by involving myself in such activities"*
Reasons for Volunteering for the PEER project	
1. Appreciation of LHWs and their work	• "*Our lady health workers support us a lot. If they help us then we should also pay them back by helping them out. Anyway, this work is very good and it is beneficial for people."* • *"Health workers have very good manners. I did this job to help them because I like the fact that they take good care of us and take care of our children's health. Therefore, it was my responsibility to help them."*
2. To help increase understanding of FPRH and prevent others from making t mistakes they made because they had no knowledge when they needed it	• *"I agreed to be a part of this project because I wanted people to know that planned births are necessary. People are very poor and cannot handle more children efficiently because they don't know anything about FP, that's why they keep on giving birth."* • *"I joined this project for my own personal will. Before I joined this project, I observed women were unaware of these issues and were living pathetic lives. So, I joined this project so that I could be a part of the effort to make women aware about these private topics."* • *"I only did this work because there was no one to tell me about the pros and cons but if someone will be benefitted by me, it would be better."* • *"I could not let anyone else make that same mistakes I made; There would be nothing better than I using my knowledge to educate people about FP."*
3. Spend free time productively	• *"I want to do this work because I am free at home and have nothing much to do. My children go to school and they all are grown up now. So, I had nothing to do and started this work to help others."* • *"I started this project because I was free at home and all my kids are grown up so I thought I should help other people out. The LHW came to my house and requested me to help her and I couldn't say no to her because she has always helped me out in my time of need."* • *"I like to meet people and I feel happy to help them. LHW guided me about*

	FP and now I go and tell people so that they can do FP. I also help my family and guide them."
4. Increase their own knowledge about FPRH	• *"I did this project because I had many misconceptions related to FP services but when the LHW cleared all my misunderstandings, I really wanted to remove others' confusion as well."* • *"To help LHWs and to spend some good time. It feels good to meet people as it increases my knowledge. People talk about FP issues that I solve with the help of LHW."*
5. Personal relationship with LHWs	• *"The lady health worker is my mother-in-law so it is my duty to obey her. She explained everything to me and said that I should also tell my friends about FPRH as many of them have just gotten married."* • *"I know the LHW, she lives very near to my house and has always helped me out when I needed it. So, I thought I should help her too."*
6. Please Allah	• *"The Health Worker is a very good friend of mine. I loved her job from the beginning because she helps people a lot. So, I wanted to do this job too and it is a service to the people. By doing this job, I can also please Allah."* • *"Everything should not be done for the sake of money. I have only done this work for Allah's will and for the peace of my inner self."* • *"To please Allah. "People give their valuable prayers to LHW, If I do this work then I might get their valuable prayers as well."* • *"It's charity work "Sadqa Jariya" and to help others. It also helps LHW and its good work that's why I am doing it."*
7. Increase prospects for paid employment	• *"I thought that I have enough experience so I should use my services to educate people and also I thought I would receive more money after doing this work."* • *"I joined LHW to get an experience of this work. I was expecting a job at the end of this project that's why I joined LHW."*

Table-8: CWVs Reasons for Volunteering

Some were disappointed for not being paid anything for their work; *"We don't get paid to do this work though we are investing our time on it so our family speaks against it. They say if you're not getting anything then why are you doing this?"*

Another volunteer mentioned, *"I was expecting monetary benefits out of this project that's why volunteered for it. I was also working with LHW on the polio project.*

4.5 Barriers faced by the CWVs in the delivery of services

Most of the respondents reported not facing major issues due to their standing within the community and a reputation that they had built by being associated with the much-respected LHWs. The issues reported by some of them included not getting paid, not having a supportive

family, social barriers, certain households not respecting them and dealing with difficult husbands and mothers-in-law.

Some mentioned that since they did not have to go any extra miles for this and just had to speak to people when they met, it did not require much effort on their part so it was easy for them to do. Whilst some thought it was easier to tell those close to them only because of the private nature of the topic.

The overall experience of the CWVs in the conduct of their work is summed up in the remarks of one of them,

> ***"Yes, I faced some problems like in some houses some women didn't cooperate because of their backward mentality and in some houses mothers-in-law and husbands also didn't allow them to interact with us. But there are still some people who appreciate our work and follow our advice."***

Remarks of those who had faced no barriers	
1. Support of LHWs	• *"Most mentioned that because they were working with the LHW, it automatically earned them the respect of people that they show to the LHW."* • *"Most of the women do listen to me; I have not faced any hindrance. I also refer women to consult LHW. They haven't refused to listen to me either."*
2. Given respect because of their age and familiarity with the community	• *"I talk about those things which benefit women in their personal lives. Women listen to me attentively as I am talking about good things in life. Also, I am an aged woman, this is one of the reasons that many of the women don't argue with me due to the respect factor of my age."* • *"No, I didn't face any problem because I don't go out much as I am aged and can't go door to door so I just guide people at social gatherings and my known fellows. They all respect me and follow my advice as I am a senior one."*
3. People know them therefore listened to them	• *"There was not much difficulty because people know me and LHWs as well and it is for the benefit of all people then why would anyone say any negative things? That's why I have never faced any kind of difficulty or any hindrance."*
4. Respect for peoples' privacy and avoiding of home visiting	• *"I have not had any difficulty in doing this work. Everyone understands me very easily and I do not go to anyone's house for this work. Whenever a woman comes to meet me somewhere, I try to make her understand,"* • *"No, I only recommend it to my close friends who recently got*

5. Restricting themselves to family and friends	*married, that's why I did not face any kind of difficulty."*
Reported issues faced by some CWVs	
1. Personal and family issues due to not being paid	• *"We are not getting any money for this work so my mother- in-law got angry and also cursed me by saying that why am I doing this and why am I going to anyone's house without any reason. This is the big barrier for me."* • *"We don't get paid for this work, we have to give our full time and nothing comes from it and we can't leave our children alone at home."*
2. Time constraint: Didn't have enough time for the extra work	• *"Due to less or limited time we can't inform many of them and my university fellows point out that what have you started and why are you ditching your studies. Parents also complain that I should concentrate on my studies, it's no use doing it without money. Time wastage."* • *"Sometimes there is a problem because of my kids. I also have to spend time at home. The only problem in the community is that if I don't provide timely medicine at home, women get pregnant."*
3. Mothers- in- law didn't allow access to their daughters in law	• *"It was very difficult in the beginning. People did not listen easily. I told them about FP methods and that taking gap between babies is very important as it is very beneficial for the health of the mother and child otherwise mother will fall weak before her actual time. Sometimes mothers- in- laws don't allow us to talk to their daughters- in- law which creates a problem."* • *"Occasionally, some mother-s in- law scolded us badly, they argued that why do you wander from street to street they call us 'Awara'. They say that you will make my daughter- in- law just like you are 'Awara'."* • *"Sometimes people's mothers-in-law get angry. She doesn't like FP methods. According to her, children are the will of Allah, so a woman should not use anything. I also guide such women that gaps are necessary for their daughters-in-law. They will be fine and people agreed with me."*
4. Found convincing people on FP difficult.	• *"Some people still did not believe me, they considered FP as a taboo. These kinds of people did not believe in our messages. It is a very difficult task to convince them."* • *"Most of the women are conservative and feel shy when talking on these topics. They consider this topic a matter of shame for them that's why it is not easy to talk upon these topics so normally."*

5. Shyness and not liking hurtful remarks about their own infertility **6. Miscellaneous issues**	• *"As such nothing happened as a problem but people often demanded condoms from us and we did not have them with us and this made people feel uncomfortable."* • *"I don't feel comfortable doing it because my family doesn't like it. And some of them also taunt me that why am I guiding others because I never conceived a baby and it hurts my feelings."* • *"I feel very strange and feel shy because this is actually a private topic."* • *"These are the topics of shame and privacy. I am not an educated woman. I feel shy and hesitant to discuss these things. Some women are amused and make fun of me, which makes me feel reluctant."* • *"I didn't go out in the community. I just shared it (the messages given by LHW) among my family members at social gatherings but they all discouraged me that I shouldn't guide someone because I am not in a position to do that as I never conceived a baby and they consider me 'barren'."*

Table-9: Issues and Barriers Faced by the CWVs

4.6. CWVs feedback on Community perceptions and impact of their work

We wanted to know the CWVs own views on how the community perceived them and their work. We found a general trend of reporting of respectful behavior towards them where people listened to them and cooperated with them. This was described by some of them with examples of how they had been able to convince at least one person close to them on changing their FPRH practice.

The majority view was that because people were already respectful towards the LHWs, they were accepting of the volunteers too and they were very cooperative. Some of the volunteers said that they were already known in the community which is why the community was very welcoming towards them when they started volunteering with the LHW.

Get respect because of working with the LHW	
• *"People accepted us very quickly in society because we already have personal relationships with them. They know us and the Lady Health Worker very well and they know the work of the Lady Health Worker so it's not hard for us to work with them because they respect us and follow our advice."*	• *"Everyone in the community knows me. They listen to me and trust me as well. I give women contraceptives and guide them in their health. If a woman has some serious problems, I ask help from LHW. She guides them well with regard to FP."*
• *"Doing this work only benefits people, it improves their own health, so whenever we tell people something they are very happy and they know*	• *"People already knew that I am working with LHW so they listened to my advice and also acted on my word. People do demand condoms from me but as I do not have them with me, it*

that we are working together with LHW. They also give us a lot of respect."	*puts a negative impact on them and they feel bad when we return them back empty handed."*

Table-10: The CWVs perceptions on the community acceptance of their services

4.7. CWVs individual success stories

When asked to give some specific examples of having successfully counseled women themselves to use contraceptives or of family members who were persuaded to allow the use of contraceptives, experiences with a wide range of users and their family members were recounted. Some had been able to convince strict mothers- in- law and husbands to let their daughters in law/wives use contraceptives. Others mentioned how they were able to convince women who were continuously bearing children and hadn't thought of stopping, to start using contraceptives. One was able to prevent early marriage of an adolescent girl and another in persuading a just married teenager to delay her first pregnancy. A very heartening story was of a CWV reaching out to a Christian woman and persuading her to use contraceptive to stop having more children (Table-11).

1. Overcoming mothers-in-law's objections	
• *"I convinced the mother- in- law of a woman with the help of the LHW to allow her to use contraceptive. I counseled the woman that she is not mature enough to handle kids that's why she should use condoms, The LHW provided her condoms but the girl didn't even know what a condom is and how to use it, so we helped her out from her confusion."*	• *"Sumaya lives in my neighborhood. She has five children and she wants to stop her pregnancy but her mother-in-law does not allow it. She says children are a blessing from Allah and doesn't allow her daughter- in- law any medicine to stop pregnancy. Sumaya talked to me about her problem so I consulted the LHW and after that I gave her a condom and she is very happy about it."*
2. Successful counseling of relatives	
• *"On my advice, my elder sister -in -law has used Copper T, she has 4 children but she did not know about Copper T. Even I came to know this from the LHW. When I told her about this procedure she agreed, then we visited General Hospital and she kept Copper T."*	• *"My sister- in- law has five children, she also did not apply a birth gap, I made her understand that it is a perfect time for her to have a birth gap. She tried Copper T on my advice and now she is satisfied and happy."* • *"I asked my sister- in- law to use a condom because taking a gap was very important for her as she feels very weak after delivery. Condoms don't have any side effects while copper T doesn't suit everyone.*

3. Counseling Neighbours	
• *"I helped a woman in my community who used to get pregnant without any gap and she didn't take any advice from LHW. Her husband and mother- in- law also didn't allow her to use any contraceptives. Her family doesn't know much about me that I am also providing services like LHW, so, I secretly gave her pills for delaying of next pregnancy gap. Now she has a gap of 1 and half years."*	• *"One of my neighbours is Bushra, she is 35 years old. She has 5 children. Her husband is a drug addict. She doesn't want to have another baby. I suggested her to use modern method, she listened to me."*
4. Delaying early marriage and early pregnancy	
• *"I persuaded a girl's parents who wanted to marry their daughter in her teenage and she had not become an adult yet. I told them to educate her instead so that she could handle and run her family and household responsibilities in a more precise way in the future."*	• *"A girl was married at the age of 16. I counseled her about FP. I told her to conceive at the age of 18 not before that and she followed my advice. I have asked her to use a condom so that she won't conceive before 18."*
5. Reaching out to minority population	
• *"There is a family in my street. They are Christian. I had no relationship with them before. They also lived far down from me. But one day there was a Milad in the neighborhood, I also invited her to come and join us. She came and I started trying to convince her that she shouldn't have children anymore- she had five children. She got angry and left but then I started going to her house and explained to her and finally she agreed and now she is using Copper T."*	

Table 11: Some Success Stories recounted by the CWVs

4.8. CWVs' own feelings about the work they were engaged in

The general feedback from across the volunteers was a feeling of satisfaction, spiritual and moral uplifting and an overall good feeling associated with the work they were doing. Some respondents informed that they enjoyed this work because it gave them an opportunity to get away from the worries of their homes, interact with people and help them, which in turn made them feel good.

Most of the respondents felt satisfied emotionally and spiritually. They also felt that the work was rewarding socially. The reasons for these were that they felt this work was benefiting people, it is a good deed and helping others will not only earn them respect in the community but also gain them blessings from God. (Table-12).

1. Positive feelings

• *"It makes me feel good - it's a bit of a personal issue. But it (FP) is important for them to do because they have to feed all the children. They don't have proper food for themselves then how will they provide it to others."* • *"When people do listen to me silently, admit to my word and because of me take care of their health and their infants, I am pleased and satisfied. Because children are meant to be everything for their mothers, they are the whole world to their mothers, so they should be healthy."* • *"I like helping people. Because of me if someone gets help, my heart feels calm. Even if my sister-in-law needs counselling about FP then I help her with the help of LHW. I also like to meet people."*	• *"I like to help women. I get peace of mind. I work as a midwife in the community, so people ask me to come to their home. So, I guide them about FP and reproductive health."* • *"I feel very happy when I help others. It is my life's goal to help others. "God helps people from above, my wish is to help people from here below in whatever way possible for me"* • *"I feel good as it is very satisfying to help people on something life changing. I wish, I had been more educated so that I could help people a lot."* • *"I feel very relaxed and satisfied while doing this because I did this to please Allah, I am helping people so in reward people will remember me in their prayers so it is enough for my peace."* • *"I work for the pleasure of Allah. I feel happiness in my heart by helping others. If someone benefits because of me, then it's a work of reward."*
2. Negative feelings	
"I don't feel comfortable doing it because my family doesn't like it. And some of them also taunt me that why am I guiding someone because I never conceived a baby and it hurt my feelings."	• *"I feel very strange and feel shy because this is actually a private topic."* • *"These are the topics of shame and privacy. I am not an educated woman even. I feel shy and sometimes feel disappointed to discuss on these things. Women take it funny which makes me feel reluctant."*

Table- 12: What did the CWVs feel about the work they were doing?

4.9. Had working for the project changed the CWVs views about LHWs services and work?

We explored the CWVs knowledge and views on the services the LHWs provide and the way they work before they were recruited for our project. Since the CWVs were selected by the LHWs themselves and most had agreed to work with them (the LHWs) because they knew them, it was not unexpected that most respondents had great respect and admiration for the LHWs at the start of their work for the project. Most of the respondents felt that LHWs provide great service and help many people, that their (LHWs) work greatly benefits the community and that people really rely on them for FPRH services. They believed that the LHWs had a good standing in the community, people love them, respect them.

However what was really interesting was the responses of the ones who didn't know the LHWs from before and had no knowledge or negative perception about the services LHWs provided. While among this group of respondents these negative perceptions were few but are nevertheless important because they reflect the views of the community in general who are not familiar with LHWs. Both the positive and negative perceptions of the CWVs are listed in Table-13

1. LHWs Perceived as hard working providers of good FPRH services around the clock

• *"They have helped a lot of people. People understand when they listen to them. They guide people about FP. They provide contraceptives and give women health counselling before and after delivery."* • *"We respect them a lot because they are like our mother. They give us so much comfort that our baby is born in better conditions and they take care of us (mother and the baby) at that time with great love…."* • *"They are very nice. They are very hard-working and do a lot. They provide medicine and contraceptives for FP. Some people come to get condoms from them late at night as their husbands feel shy to buy condoms from the market."*	• *"I was very inspired by them. When they came to my home for polio duty, I asked them if I could join them and they allowed me."* • *"I knew them already because they regularly visited my home in the past and they solved the delivery case of my elder sister in law. If they had failed to help at that time, then there were chances of abortion. They help us in every thick and thin and because of LHW, we have not consulted a doctor for a long time……."*
2. Doing a tough job lovingly and caringly as providers of Primary Health Care (PHC)	
• *"I have very positive views of LHWs. This is because she helped me and other children in the neighborhood, when we got sick or suffered cough. They provide us with medicines, and also referred to the doctor and even sometimes went with us, if needed."*	• *"The job of a LHW is very tough because she has to go to every single house and inform the people, which is very tough. It also affects their health but it is very beneficial for the people of society."* • *"Their work is very difficult; they have to do a lot of difficult work – they also do work in extreme seasons like rain and storms etc."*
3. No knowledge of LHWs work or LHWs viewed as Polio workers or negatively viewed	
• *"I had very varying perceptions of LHW as I used to think on one hand that these are not morally good women of the society but on the other hand, I used to think that they help people with medicines."* • *"I didn't know what they did before this and I never asked others about them."*	• *"I had really bad views on lady health workers as I used to think that these women wander here and there with no reason and no work."* • *"I used to think that these females are polio worker and visiting people door-to-door."* • *"I used to make fun of these women that why did they give funny things to other women but after marriage, I came to know more about lady Health workers and their nature of work."*

Table-13: CWVs Views on the Services and Work of LHWs

Table-14 presents the gain in knowledge about LHWs work and change in views of CWVs about the work the LHWs do. A number of CWVs, including those who knew them from before, found out the details of services provided by the LHW including accompanying women to hospitals even at midnight, taking them for procedures such as IUD, surgery etc. and provision of free medicines and contraceptives, their involvement in Polio vaccination campaigns and the services they provide for the control of Dengue fever in the community. Gain in knowledge about the benefits of birth spacing for mother and child was also mentioned and some had increased their knowledge of contraceptives.

1. Gain in knowledge about the nature of LHWs FPRH services and services in other fields	
• *"I found out later that LHW also goes with pregnant women for their delivery even at midnight. They are always ready to help others."* • *"The health worker is a nice woman of the area. She visits homes and tells people about contraceptives. I came to know about pills, IUD, and condoms through her. She also tells us about the COVID precautions and childcare."*	• *"I came to know about women's health and the ways of FP, they are also involved in women delivery, they provide free medicine and condoms to people and are also involved in polio vaccination."* • *"They work for dengue fever as well. I hadn't heard about this before."*
2. Increase in their knowledge about the importance of birth spacing	
• *"Yes, I found out about contraceptives and how much gap is required to have the next baby. I also found out how often pregnant women should go to the doctor."* • *"I got to know that gap is important for the health of the mother. I asked women to use Copper T for the gap and they agreed with me that taking advice from others on FP is very important."*	• *"I have found that taking a gap between pregnancies can improve the health of the baby as well as the health of the mother. I have also received information about the supplements which should be given to pregnant women."*
3. Increase in knowledge about modern contraceptives	
• *"I learned about the capsules that are inserted in the arms and what is the benefit of keeping copper T and how long a woman should avoid pregnancy."*	• *"I learnt about the capsules in the arm and the copper T used for FP."*

Table-14: CWVs Gain of Knowledge and Change of Views about LHWs' Services and Work

4.10. CWVs intentions about continuing their work after the project closure

Most of the respondents intended to continue their work. As stated by one of them:

"I want others to be benefitted just like we did and they can help the women around them by counselling them about their health."

This remark embodies the multiplier effect of seeding knowledge within the community through informal channels.

The few who said they would not be able to continue gave time constraints and their timidity about discussing intimate issues with others as their reasons for not continuing.

Intention of continuing their work	
• *"Yes, every woman should know about the basics and procedures of FP. Know about gap (between pregnancies) how much necessary for the health of both mother and her infant. That's why I used to tell different people to convey and share this information with others."* • *"Yes definitely. I will tell them that it is very important to take a gap between babies and always refer to the hospital for delivery------."*	• *"I want others to be benefitted just like we did and they can help the women around them by counselling them about their health."* • *"I tell everyone that whenever you meet someone, explain about FP and health issues to them so that every woman knows how to take care of her health and everyone stays healthy."* • *"Yes, I do share it with others whenever we meet in gatherings or while purchasing vegetables on streets."*
Inability to continue	
• *"I am doing a polio job and have a small family with less number of members; I am the only sister in my home. These topics are a matter of shame but yes whenever, I get a chance I guide and refer to LHW for help."*	• *"Neither do most of the time females ask me about these things nor do I discuss these things intentionally."*

Table-15: CWVs Expressed Intentions about Continuing their Work after Project Closure

5 – DISCUSSION

Our study has demonstrated that volunteers are available even in our economically challenged communities, to work with and support community health workers without any financial incentives. While in the developed countries, volunteers have been recruited and their services effectively utilized in diverse fields for over a hundred years, in the developing countries finding

and motivating volunteers to provide services without incentives has been difficult.[13,14] The results of our study show that our differing economic conditions and socio-cultural environments are not real barriers to volunteerism, particularly in the urban/semi urban areas in which our study was undertaken. Our study proved wrong the apprehensions of some of the LHWs about finding volunteers who would agree to work without incentives. The 225 LHWs participating in the study managed to recruit 900 volunteers to carry and spread their FP counselling messages in the community. The multiplier effect of the seeding of FP knowledge in the community through volunteers can be expected to lead to the creation of increased demand for contraceptives, which some of the participants of our study results dissemination webinars thought would create problems for the LHWs who complain of supply shortages. However, it can also be expected that demand created by knowledge seeded through peers will motivate people to get their own supplies and not depend on government entirely. This needs to be looked into since the community has developed the belief that provision of preventive care technologies like contraceptives, nutritional supplements and vaccines is the responsibility of government and they need not spend their money on them. Peer counselling may prove to be more effective than the off and on counselling by health care providers in convincing the community of the importance of preventive care.

The reasons the volunteer gave for their willingness to work without monetary incentives were similar to those previously reported.[15] Of special note however is the volunteers' recognition of LHWs' services and appreciation of her work. Most of the volunteers expressed their admiration for the services provided by LHWs who had recruited them and stated that they volunteered because they were inspired by her. This indicates that community health workers generate goodwill in the community and can mobilize community support and facilitation for her services. This form of community mobilization and participation has many positive implications for the LHWs, the program and the community. Currently LHWs are reported to be performing about 25 tasks in addition to their primary responsibility of providing PHC and FPRH services. Help from community volunteers is likely to relieve their stress from overwork and improve their PHC and FPRH services delivery especially in the areas of FPRH counseling and awareness creation. For the program, effective community mobilization and participation are long standing challenges. These gaps in program implementation have reduced the role of community to that of a passive consumer of services.[16,17] Active community participation in the form of volunteers is likely to develop a sense of responsibility and ownership in the community for the program. As the LHWs' enhance their capability and experience of working with volunteers, they are likely to reach across sectors for recruiting volunteers and thereby address the elusive challenge of inter-sectoral coordination in the delivery of community-based services.

[13] Barbir F (2010) Challenges in Planning and Implementing Community-Based Health Interventions: Training Female Community Health Volunteers with the Bedouin Communities in the Bekaa Valley of Lebanon. *International Journal of Migration, Health and Social Care* 36–41

[14] Chatio S. and Akweongo P. Retention and sustainability of community-based health volunteers' activities: A qualitative study in rural Northern Ghana. Published online 2017 Mar 15. PLoS One. 2017; 12(3): e0174002.

[15] https://www.ncvo.org.uk/ncvo-volunteering/why-volunteer

[16] Akhtar, T., Khan, Z and Raoof, S.(2014) Community participation eludes Pakistan's maternal, newborn and child health programmes. EMHJ, Vol. 20, No. 1.

[17] Rosato, M., Laverack, G., Grabman, L., Tripathy, P., Nair, N., et al. (2008). Community participation: lessons for maternal, newborn, and child health. Lancet, 372(9642): 962–971.

Scalability and sustainability of the volunteers' intervention was the essential focus in our conceptualization of volunteers. Our concept of community volunteers empowers the LHWs and other community-based workers (CBWs) to recruit volunteers with no interferences from officials. No qualifications or other specific particulars constrain their recruitment. No specific time duration is needed for the volunteers to serve. When one volunteer leaves, the LHW can replace her with another. No monetary incentives are needed to be paid to the volunteers which could burden the cash-strapped program or lead to other evils like political influence and favoritism in recruitment. This makes the intervention both scalable and sustainable. Another action which can add to sustainability is award of certificates to the volunteers for providing services beyond a specified period (3 months and 6 months) and to the LHWs for the number and diversity of volunteers they recruit. There is however a need for replication of our study in rural areas since our study was done in a semi- urban area of Lahore district where access to a wide range of services was available, the women were better educated and likely more empowered than rural women.

6 - CONCLUSIONS

Community Volunteers willing to work with health workers without monetary incentives are available and LHW can mobilize them.
Volunteers have the potential to fill the long -standing gaps of human resources shortages, community participation and inter-sectoral coordination in the delivery of community-based Services.
The volunteers' intervention is scalable and sustainable where LHWs are deployed.
Some further research studies are need in rural and far-flung areas to study the applicability of the model in those area and develop specific models for those areas.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