

# Mobilization for Empowerment (MORE) Program

## Preliminary Results from the Endline Survey

The central objective of community driven development projects is to build citizenship, enhance community capacity for collective action and build livelihood opportunities for the most disadvantaged. The MORE Program in Pakistan organized households into community organizations (COs) and in some villages introduced an inclusion mandate, where 50% of individuals organized had to be women and / or from poor households. One or two members from each CO formed the village support organization (VSO) that decided how to allocate a village-level grant through the village development plan (VDP), a list of community infrastructure projects, asset transfers and/or vocational trainings. Preliminary analysis suggests that the intervention achieved some of these objectives, especially in villages with the inclusion mandate.

### **Capacity for Collective Action**

An index collective action (including questions on purchasing inputs collectively or organizing villages for a common purpose) is higher for individuals from treatment villages. Within treatment villages, a higher proportion of households are organized in inclusion villages (63%) compared to non-inclusion villages (57%). Also, a higher proportion of the population are CO members – 24% in inclusion villages compared to 19% in non-inclusion villages. These differences in participation are persistent as they can be observed both at midline (3 years later) and endline (6 years later).

Inclusion villages are also more likely to have women as leaders in VSOs (23% vs. 13%). In addition, female VSO members in inclusion villages are more likely to have schooling compared to female VSO members in non-inclusion villages. There are no differences among female members based on treatment status when looking at employment, knowledge about law or financial literacy. The ability of VSO members to organize community members and interact with government has improved significantly over time: 51% of VSO members organized members to approach government officials for village related problems at the endline vs. 26% at

midline. Similarly, 45 percent of VSO members helped government target beneficiaries of government programs such as BISP or Zakat at endline compared to 26 percent at midline.

### **Livelihood Opportunities for the Disadvantaged**

Developing rural economies are often characterized by entrenched local power, exclusion of minorities and low accountability of government and poor service delivery. Preferences of residents in inclusion villages are better reflected in the VDPs compared to non-inclusion villages. Income generating assets that were given out as part of asset transfers in VDPs are *well targeted* to poor individuals. In inclusion villages, there are more beneficiaries and are *more* likely to receive income generating assets. In general, however, women are *less* likely to be beneficiaries of income generating assets. Women are also more likely to have been visited by a politician during the recent local government elections in treatment villages relative to women in control villages. Women in treatment villages have a higher knowledge about the law (measured via an index of several questions) relative to men in treatment villages. Based on the poverty scorecard, households in treatment villages that were poor at baseline were also less likely to be poor at endline thanks to the higher probability of receiving a latrine.

### **Political Participation**

Even though there is no differential treatment effect for the political participation index<sup>1</sup>, we find that there is higher political competition in the local government elections in treatment villages as more candidates stood for the 2015 local government elections. The candidates from treatment villages are more likely to come from households that have participated in community development activities in their village in the past and tend to have better quality housing (proxy for economic well-being). We also find that female and male voter turnout for the 2013 National Assembly Election<sup>2</sup> was higher in inclusion villages - 57% in inclusion villages vs. 46% in control villages for females and 70% in inclusion villages vs. 66% in control villages for males.

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<sup>1</sup> There are four sub-components of the Political Participation Index: Did you attend any political rallies in/near your village?, Do you know the name of the Union Council Nazim?, Do you know the name of the Union Council Naib Nazim?, Number of political party signs correctly associated with party name/party leadership.

<sup>2</sup> This analysis is based on 66 (46 treatment and 20 control) of the 150 study villages.

### **Aspirations for Children**

Men in treatment villages have a higher index of aspirations<sup>3</sup> for their daughter relative to men in control villages. This effect can be found in both inclusion and non-inclusion villages relative to control villages. However, there is no treatment effect in aspirations for their son, perhaps because aspirations were already high.

### **Dispute Resolution**

Men in treatment villages are more likely to use formal mechanisms for dispute resolution related to village development and village investment issues. The community mobilization efforts in treatment villages can potentially have led to higher interaction with formal authority and therefore greater ease in dealing with them in case disputes arise. Almost a third of women prefer resolving disputes within their family or zaat group (32 percent) or by approaching a village influential (34 percent) rather than using a more formal mechanism like approaching the police, court or the Panchayat. There are no differences between women in treatment and control villages.

### **Dietary Diversity**

Women report consuming fewer meals a day compared to men, but there is no differential effect by treatment status. Women also have a less diverse diet compared to men but again there are no differences by treatment status. In contrast, female adolescents do not report consuming fewer meals per day and also do not have a less diverse diet compared to male adolescents.

### **Maternal and Child Health**

Literature suggests potentially positive impacts of CDD interventions on health outcomes, especially on maternal and child health outcomes. Gine, Khalid and Mansuri (2017) find some evidence of improved provision of postnatal care as well as better performance of LHW in providing antenatal care and well-baby visits in treatment villages. Their analysis is based on the data from the midline survey that was done in 2013. This section extends their results to the endline survey conducted 3 years later (and 6 years after the start of the intervention) to see if the

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<sup>3</sup> Aspirations Index Work – There are three sub-components: Would you let your daughter/Son work?, Would you let your daughter work in an NGO?, Would you let your daughter contest elections?

positive outcomes observed at midline have persisted. It should be noted that the endline results are based on data from 139 villages (95 treatment and 44 control villages) from 4 districts in rural Pakistan. The district of Nowshera is excluded from the endline analysis because data collection could not be carried out due to security concerns.

The first set of outcomes in Table 1 refer to the overall incidence of illness in the past month. The incidence of illness is lower among households in treatment villages relative to those in control villages, but insignificant. In the event of an illness, over 90% of the individuals report seeking consultations. There are no differences by treatment status in the number of health providers approached for consultation. However, the likelihood of utilizing a government health service provider is higher among households in treatment villages.

There is a relatively small sample of respondent who provide information on BHU utilization and performance because only 20% of the consultations are made to government service providers. Table 2 looks at the differences in the experiences of households utilizing services at the BHU based on treatment status. Even though the signs of all the coefficients point towards a story of better experiences of households from treatment villages, none of the indicators show statistically significant improvement. Consequently, the BHU index, which combines all the measures of BHU performance reported in Table 2 has a positive but insignificant coefficient.

Tables 3 and 4 refer to the quality of maternal care and pregnancy history. Overall, there is no change in the incidence of pregnancy between treatment and control villages, which suggests that the results that follow are driven by changes in utilization and provision of maternal care and not changes in underlying rates of pregnancy. There is statistically significant improvement in the likelihood of a pregnancy being registered as well as receiving antenatal care among households in treatment villages. Subsequently, the Pre-Pregnancy index is positive and statistically significant. Similarly, there is a higher provision of postnatal care in treatment villages. However, the odds of a birth of a child being registered as well as that of a child's weight being recorded are statistically insignificant. Overall, Post Pregnancy index is positive and significant. These results suggest improvements in maternal health care provision both prior to and following the delivery of the child.

Table 5 looks at whether assignment to treatment has an effect on health service provision by the Lady Health Worker (LHW). Column 1 suggests that even though there is a higher likelihood of a LHW visiting a pregnant woman in treatment villages, it is statistically insignificant. There is a higher likelihood of pregnant woman receiving antenatal care from LHWs as well as receive well-baby visits for providing vaccinations/immunizations in treatment villages. However, even though the odds of receiving postnatal care from a LHW and well-baby visits for checking height have positive coefficients, they are insignificant. Overall, the LHW index, which combines the maternal health care provisions measures in the table, is positive and statistically significant for treatment villages.

These outcomes are also tested for a sub-sample of women who report having children who are 0-18 months old at endline, since they are most likely to have given birth during a time period when all mobilization activities were closer to completion and therefore treatment effects would be stronger. As can be seen from the results reported in tables 10 to 12, the coefficient estimates are more or less stable and as expected, the treatment effects are significant and stronger both for pre and post delivery maternal health provision as well as the role of the LHW as a provider of these services.

The survey also collects information on health outcomes of infants and children less than 3 years of age at endline. Even though there is a lower likelihood of children with incomplete immunization and a higher likelihood of them having immunization cards in treatment villages, the coefficients for both these indicators are statistically insignificant (Table 6). There are no significant differences in diarrhea incidence or the incidence of stunting in children 5 years and under between treatment and control villages (Table 7).

Next we look at the perceptions regarding the LHW. Table 8 shows that even though there is a higher likelihood of women in treatment villages reporting the presence of a LHW in their village, the coefficient is not significant. The results are analogous when looking at the sub-sample of women who were pregnant in the last three years. This is in contrast to the results obtained at the midline in Gine, Khalid and Mansuri (2017). The difference in results can potentially be explained by a spillover of improved provision of maternal health services by

LHWs in control villages. There is evidence that suggests that this hypothesis may be true. The percentage of women from control villages reporting that a LHW was assigned to their village has increased from 62% at midline to 76% at endline. Looking at the same indicator for the sub-sample of women who were pregnant in the last three years, the percentage of women from control villages has increased 60% at midline to 81% at endline. Similarly, women report a higher but statistically insignificant frequency of LHW visits in treatment villages. However, this indicator is positive and significant for the sub-sample of women pregnant in the last three years. The coefficients on the likelihood that women (both all and those pregnant in the last three years) are satisfied with the services/advice provided by the LHW are negative but insignificant.

Finally, Table 9 we measure the changes in WASH indicators as a result of assignment to a treatment village. There are no significant differences in the usage of soap but a weak higher likelihood of soap availability in households in treatment villages. There are no differences between households in treatment and control villages when comparing the likelihood of barefoot walking of adults or children.

## References

Giné, Xavier, Salma Khalid and Ghazala Mansuri. 2017. "The Impact of Social Mobilization on Health: Evidence from Rural Pakistan" World Bank, mimeo.

Table 1: Illness Incidence

	(1)	(2)	(3)
	Incidence of Illness	No. of consults	Govt. provider consulted
Treated Village	-0.009 (0.011)	-0.015 (0.017)	0.061** (0.027)
N	34878	9223	8356
R-squared	.0535	.0292	.0302
Dep Var Mean	.277	.963	.155

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 2: Utilization of Basic Health Unit (BHU)

	(1)	(2)	(3)	(4)	(5)
	Wait Time BHU	Consult Fee BHU	Convey Concerns	Treated well	BHU Index
Treated Village	-1.217 (2.633)	-6.271 (12.337)	0.022 (0.025)	0.018 (0.037)	0.062 (0.058)
N	674	674	674	674	674
R-squared	.0696	.0196	.132	.0107	.0359
Dep Var Mean	22.7	38.2	.911	.911	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.



Table 3: Maternal Health - Pre Delivery

	(1)	(2)	(3)	(4)
	Pregnancy	Pregnancy Registered	Antenatal Care	Pre-Preg Index
Treated Village	0.013 (0.018)	0.071** (0.027)	0.097*** (0.030)	0.201*** (0.059)
N	4435	2036	2036	2036
R-squared	.0109	.121	.415	.337
Dep Var Mean	.479	.144	.371	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 4: Maternal Health - Post Delivery

	(1)	(2)	(3)	(4)
	Post Natal Care	Birth Registered	Weight Recorded	Post-Preg Index
Treated Village	0.052** (0.026)	0.032 (0.023)	0.002 (0.005)	0.070** (0.035)
N	1987	1987	1987	1987
R-squared	.316	.583	.0159	.455
Dep Var Mean	.277	.326	.00648	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 5: Lady Health Worker (LHW) Health Service Provision

	(1)	(2)	(3)	(4)	(5)	(6)
	LHW Visit during Preg	LHW Antenatal	LHW Post Natal	LHW Height Visit	LHW Vacc Visit	LHW Index
Treated Village	0.026 (0.037)	0.096*** (0.024)	0.029 (0.021)	0.008 (0.023)	0.065** (0.032)	0.124*** (0.047)
N	2036	2036	1987	1987	1987	2036
R-squared	.247	.19	.123	.0323	.331	.348
Dep Var Mean	.387	.107	.0762	.136	.34	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 6: Immunization Outcomes (Children 3 years and Under)

	(1)	(2)
	Incomplete Immunization	Immunization Card
Treated Village	-0.037 (0.030)	0.030 (0.020)
N	3024	3024
R-squared	.125	.342
Dep Var Mean	.435	.22

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 7: Diarrhea and Nutritional Outcomes

	(1)	(2)
	Diarrhea Incidence	Stunting Incidence
Treated Village	0.029 (0.025)	0.003 (0.023)
N	4724	3424
R-squared	0.093	.00892
Dep Var Mean	0.286	.52

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 8: Perception of LHW

	(1)	(2)	(3)	(4)	(5)	(6)
	LHW Assigned	All Women LHW Frequency	LHW Satisfied	LHW Assigned	Women Pregnant in Last 3 years LHW Frequency	LHW Satisfied
Treated Village	0.034 (0.041)	0.049 (0.041)	-0.017 (0.025)	0.018 (0.055)	0.160*** (0.046)	-0.029 (0.042)
N	4672	3629	3686	1036	851	853
R-squared	.0341	.0143	.0277	.0123	.0181	.0422
Dep Var Mean	.764	.984	.744	.806	.941	.759

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 9: WASH Outcomes

	(1)	(2)	(3)	(4)
	Use Soap	Saw Soap	Adults Barefoot	Children Barefoot
Treated Village	-0.003 (0.010)	0.043* (0.024)	-0.025 (0.021)	-0.009 (0.025)
N	4672	4672	4672	3874
R-squared	.0419	.224	.0566	.064
Dep Var Mean	.297	.267	.207	.444

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 10: Maternal Health - Pre Delivery (Women with children 0-18 months)

	(1)	(2)	(3)	(4)
	Pregnancy	Pregnancy Registered	Antenatal Care	Pre-Preg Index
Treated Village	-0.001 (0.014)	0.100*** (0.030)	0.111*** (0.035)	0.257*** (0.064)
N	1080	1030	1030	1030
R-squared	.00787	.121	.415	.331
Dep Var Mean	.954	.138	.413	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.



Table 11: Maternal Health - Post Delivery (Women with children 0-18 months)

	(1)	(2)	(3)	(4)
	Post Natal Care	Birth Registered	Weight Recorded	Post-Preg Index
Treated Village	0.056* (0.032)	0.055** (0.025)	0.002 (0.007)	0.086** (0.039)
N	1024	1024	1024	1024
R-squared	.305	.597	.0185	.474
Dep Var Mean	.301	.353	.00971	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 12: Lady Health Worker (LHW) Health Service Provision (Women with children 0-18 months)

	(1)	(2)	(3)	(4)	(5)	(6)
	LHW Visit during Preg	LHW Antenatal	LHW Post Natal	LHW Height Visit	LHW Vacc Visit	LHW Index
Treated Village	0.037 (0.048)	0.128*** (0.028)	0.046* (0.026)	0.008 (0.025)	0.094*** (0.032)	0.176*** (0.053)
N	1030	1030	1024	1024	1024	1030
R-squared	.242	.193	.121	.0419	.345	.357
Dep Var Mean	.417	.112	.0841	.133	.34	

Note: The symbols \*, \*\*, \*\*\* represent significance at the 10, 5 and 1 percent respectively. Standard errors are reported in parentheses below the coefficient and are clustered at the village level. All specifications include social mobilization team effects. Variables are defined in Table 13.

Table 13: Defintion of Variables

Variable Name	Description
Incidence of Illness	Did you fall ill in past month
Consultation Made	(If sick) Did you consult a health care provider for illness
No. of consults	(If sick) How many health care providers did you consult for illness
Govt. provider consulted	(If sick) Did you utilize a govt. health care provider for your illness
Wait time BHU	(If used BHU) How long was the wait time at the BHU
Consult Fee BHU	(If used BHU) How much consultation fee did you pay at BHU
Convey concerns	(If used BHU) Were you able to convey your concerns to the service provider
Treated well	(If used BHU) Were you treated well by the service provider
BHU index	Index combining Wait time, Consult Fee , Convey concerns and Treated well
Pregnancy	Have you been pregnant in the past 3 years
Pregnancy Registered	(If pregnant) Was your pregnancy registered with the BHU
Antenatal Care	(If pregnant) Have you received antenatal care during this pregnancy
Pre-Preg Index	Index combining Pregnancy registered and Antenatal Care
Postnatal Care	Have you received postnatal care following delivery
Birth Registered	Was the child registered at BHU after delivery
Weight recorded	Was the child weighed at birth
Post-Preg Index	Index combining Post Natal care, Birth registered, Weight recorded
LHW visit during preg	Did the LHW visit you during this pregnancy?
LHW antenatal care	Was antenatal care received from the LHW
LHW postnatal care	Was postnatal care received from the LHW
LHW Height visit	Did you receive well-baby visits for checking height/weight of baby
LHW Vacc visit	Did you receive well-baby visits for vaccination/immunization help
LHW index	Index of LHW visit, Antenatal care, Postnatal care, Height visit, Vacc visit
Incomplete Immunization	Child not fully immunized against Polio, BCG, Measles or DPT
Immunization Card	Do you have an immunization card for the child
Diarrhea incidence	(For all children 0-5 years) Did the child have diarrhea in the last 6 months
Stunting Incidence	Does the height of the child indicate stunted linear growth
LHW Assigned	Does HH report that an LHW is assigned to their village
LHW Frequency	(If LHW assigned) How frequently does the LHW visit in a month (Recall period: Last 3 months)
LHW Satisfied	(If LHW assigned) Are you satisfied with the services/advice provided by the LHW
Use Soap	Self-report of whether soap is used for washing hands
Saw Soap	Enumerator could verify presence of soap in household
Adults Barefoot	Do adults in HH walk barefoot in the settlement
Children Barefoot	Do children in the HH walk barefoot in the settlement