



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

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

(Summary Report)

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**DECLARATION:**

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



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## INTRODUCTION

The summary report is based on the main report of a qualitative research on the role of community spaces and mechanisms in health promotion amongst the poor communities in rural Pakistan<sup>1</sup>. The study was conducted by the Rural Support Programmes Network (RSPN) with support from the Maternal and Newborn Health Programme - Research and Advocacy Fund (RAF).

## BACKGROUND

The national indicators of Pakistan are far from meeting the targets set for the Millennium Development Goals (MDGs) 3, 4 and 5. Women living in rural areas are at a higher risk of dying from pregnancy related causes than those from urban areas (319 vs. 175 per 100,000 live births) (National Institute of Population Studies and Macro International Inc., 2008). Neonatal mortality is about 55% higher for the poorest 20% households as compared to the richest 20% (Alam, Nishtar, Amjaz, & Bile, 2010). The national health policies and the National Maternal and Child Health Policy and Strategic Framework, 2005-2015 have recognised the importance of equitable distribution of health services and have committed to tackling the broader gender, social exclusion and poverty (GSEP) issues (Siddiqui, Haq, & Mahaini, 2004; Jaferey, Kamal, Qureshi, & Fikree, 2008; Government of Pakistan, 2005). Several government programmes and non-government donor funded projects have endeavoured to promote maternal, newborn and child health (MNCH) by facilitating positive behaviour change through creation of dialogic spaces meant to engage local people in health groups, committees or organisations (RAF, n.d). However, the role, effectiveness and sustainability of MNCH programme strategies in empowering the poor and marginalised has not been studied or measured.

This study contends that community spaces, which may be formal and created by the MNCH programmes and/or exist as informal indigenous mechanisms of interaction, are the loci for enactment of power that indirectly effects health. The study aims to identify the different kinds of community spaces and explores if and how these spaces have included or excluded the poor and marginalised and contributed to their empowerment and health promotion. The findings and recommendations from the study can be utilised by decision makers at the policymaking, programme design and implementation levels in the health and development sector in designing reform strategies for MNCH promotion.

## OBJECTIVES

- To identify the type of community spaces available for maternal, newborn and child health promotion
- To understand the role of community spaces as loci for

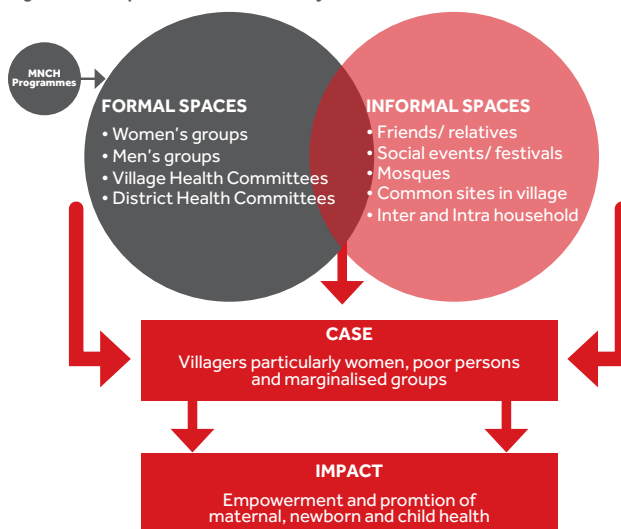
empowering women, poor persons and marginalised groups

- To suggest ways in which community spaces can be used more effectively for maternal, newborn and child health promotion.

## METHODOLOGY

The study used a qualitative case study design and an action-oriented approach. Three of the most socially and economically deprived districts of Sindh (District Thatta), Punjab (District Rajanpur) and Gilgit-Baltistan (District Ghizer) were purposively selected as study sites keeping in mind the geographical diversity of Pakistan and the deprivation ranking of districts. As the study design considered the community people, particularly women, poor persons and marginalised groups as the case, and studied the effect of informal and formal spaces on the empowerment and promotion of their MNCH (see Figure 1), one village in each selected district was chosen as the study site. Data of MNCH programmes was gathered by conducting a document review and twenty five (25) key-informant interviews (KIIs) of management and field staff of the National Programme for Family Planning and Primary Healthcare; the Population Welfare Department; the Maternal Newborn and Child Health Programme; the Maternal and Child Nutrition Programme of the Lodhran Pilot Project; the Maternal and Child Health Programme of Merlin and the Aga Khan Health Services of Pakistan. Information from the community women and men

Figure 1: Conceptual Framework of Study



was collected through thirty seven (37) focus group discussions (FGDs) based on participatory rural appraisal (PRA) tools that included transect walk, social mapping, network diagram and cause and effect diagram. Some women who had faced significant MNCH issues and

<sup>1</sup> The main report titled 'The Role of Community Spaces and Mechanisms in Health Promotion amongst the Poor Communities in Rural Pakistan' is available at <http://www.rafpakistan.org/raf/contents/Research-Reports-By-Raf/61.html> and <http://www.rspn.org/index.php/publications/assessments-evaluations/>

some men were selected for in-depth interviews (IDIs) to document their case studies.

## FINDINGS

### Types of Formal Community Spaces

We identified different kinds of formal community spaces and categorised them into following four types:

1. The facility based fixed spaces
2. The small transitory spaces that were formed during door to door visits of healthcare workers
3. The large transitory spaces that were formed when and where awareness raising sessions were conducted by healthcare workers
4. The emerging institutional spaces that were created as meetings of health groups and/or committees were convened by healthcare workers

Figure 2: Types of Formal Spaces

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

● Fully Functional ● Partially Functional ● Non-Functional

Source: Created on the basis of findings from this study

Together the four types of formal spaces have contributed a great deal to raising awareness about MNCH issues like nutrition and hygiene, antenatal care, birth spacing and family planning, immunisation and improved healthcare seeking behaviours in all the three study sites. However, the MNCH programmes are not geared towards empowering the poor and marginalised. As shown in Figure 2, none of the MNCH programmes create or facilitate all four types of formal community spaces. Most MNCH programmes focus on creating large transitory and emerging institutional spaces that do not have a well-defined structure, membership criteria and functional mechanisms for including the poor and marginalised.

### Types of Informal Community Spaces

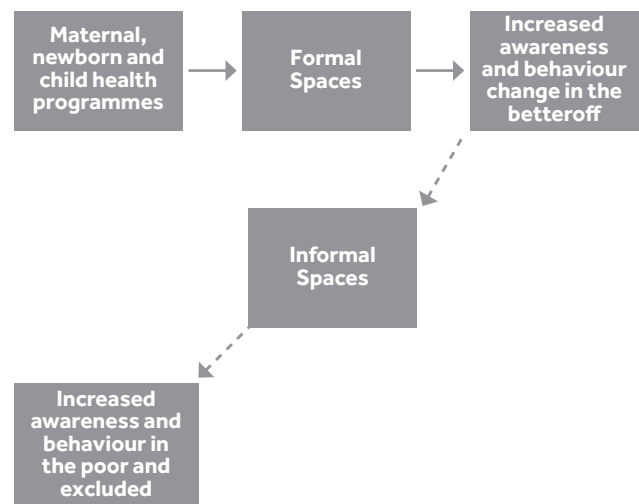
The informal spaces can be categorised into public and

private spaces. The public informal spaces were heavily gendered as men claimed a larger share of them, while women occupied them rather transiently as they went out to fetch drinking water, wash clothes and work in agricultural fields. Most public informal spaces occupied by men like the mosques, shops, agricultural fields, Jamat Khanas, shade of old trees, and road sides provided opportunities for the men to interact within (bonding) and across (bridging) their castes and class. Therefore, men's access to information and opportunities was far more than that of women, whose interactions were usually limited within their own families and castes. Women's solidarity could be differentiated by socio-economic boundaries as the poorer women shared their problems openly and helped each other in resolving them. They helped in each other in deliveries, arranging transportation and accompanying each other to healthcare facilities. On the other hand, the social capital of the women from the better-off castes was quite limited as they stayed in their own houses and usually interacted with their own family and friends. Besides the households, there were very few informal spaces where men and women intermingled and had the opportunity to discuss MNCH related issues.

### Information Flow from Formal to Informal Spaces

Sometimes, the poor women visited the better-off women and/or worked in their households. During these transitory transactional interactions, the better-off women who participated in the formal spaces or had familial relations

Figure 3: Information Flow from Formal to Informal Spaces



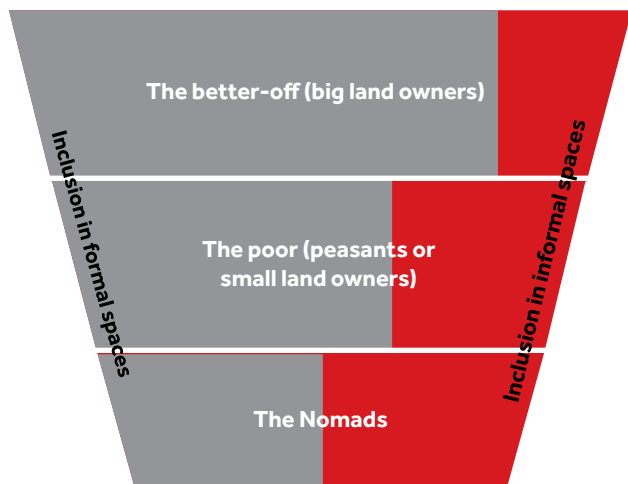
with the healthcare workers shared some of the information gained from the formal spaces with the poor women. The same was true for women's segregated gatherings at event celebrations and while visiting religious shrines and/or Jamat Khanas as these were spaces where they interacted irrespective of socio-economic stratification. This infiltration

of information from the formal community spaces through the informal ones is illustrated in Figure 3.

### Inclusion and Exclusion in Formal and Informal Spaces

Socio-economic class determined people’s participation in both formal and informal community spaces. The informal spaces were mostly occupied by the poor and marginalised groups, while the formal spaces were dominated by the better-off. The relationship between the socio-economic class and participation of people in the formal and informal community spaces is shown in Figure 4. Social and economic class stratification was found to vary by context and affected the mechanisms of inclusion and exclusion in both the formal and informal spaces. In Thatta and Rajanpur, social stratification was based mainly on land ownership, caste, economic class, occupation and pattern of settlement, while in Ghizer the society was stratified mainly on the basis of religious sect. Exclusion of the poor and marginalised groups from the formal community spaces was due to MNCH programme design and implementation strategies and behaviour of the community people. We found that the MNCH programmes registered people as clients only if they had been living in an area for more than six months, thereby excluding those who followed a nomadic pattern of settlement. The MNCH programme guidelines mandated the inclusion of notables, literate people, and health workers in the transitory large and emerging institutional spaces, while no such specifications were made for inclusion of the excluded. This reinforced the power and social influence of the notables. The MNCH programme facilitators were selected on the basis of their educational level and belonged to the better-off castes, therefore in the formal spaces they tended to associate with their relatives or friends and continued to carry their prejudices against the poor and marginalised groups. Lack of resources in the MNCH programmes also limited activities that were meant to reach out to the poor and marginalised communities who usually lived in remote

Figure 4: Social Inclusion and Exclusion in Formal and Informal Spaces



areas. The limited inclusion of the poor in the formal spaces had to be sanctioned by the better-off who were the primary stakeholders of formal spaces and did not feel very comfortable in intermingling with the poor. The participation of the poor in the formal spaces was also found to be either consultative or passive as they could barely understand the language and/or use the information given to them by the healthcare workers. The poor and the marginalised excluded themselves from the formal spaces as they remained heavily engaged in earning their livelihood and they gave little value to maternal health. In the informal spaces, the poor were able to set their own agenda for dialogue. The men usually gathered to resolve community disputes or problems related to their livelihood, while the women helped each other in fulfilling responsibilities and at times in accessing healthcare facilities.

### DISCUSSION AND RECOMMENDATIONS

#### Redefining the Agenda and Design of MNCH Programme Spaces

The participatory and empowering approaches have been recognised for their particular relevance and effectiveness in dealing with MNCH issues that are marked with inequitable service distribution, delays in healthcare seeking behaviours and demand and supply side barriers in the healthcare system (Mu shi, Mpembeni, & Albrecht, 2010; Ogwang, Najjemba, Tumwesigye, & Orach, 2012). While empowering participation has been found to have a positive effect on the health of the vulnerable, it emphasises upon community development by engagement of people in deliberative discourse to promote voice, choices and local accountability (World Health Organization, February 2006; Mansuri & Rao, 2013). The different types of formal spaces created or facilitated by different MNCH programmes have contributed to an overall increase in awareness and positive behaviour change. However, empowerment and collective action for social change is not the agenda of MNCH programmes and the functionality of their formal spaces is also limited. The critical choice that health and related development programmes in Pakistan will have to make is with respect to defining their political position as providing or increasing healthcare access of the vulnerable population will require taking their side and redefining programme structures and strategies in their favour (Schaffer & Lamb, 1981). Drawing upon the five approaches and radical discourse of health promotion (World Health Organization, 1986; Laverack & Labonte, 2000), we propose that formal spaces which encourage participation and empowerment of the poor and marginalised are important for improving quality of life and equitable access to healthcare. Therefore, it is recommended that:

1. To improve the MNCH indicators it is important to address the health needs and empower the poor and marginalised. A move from awareness raising on health issues and

availability of healthcare services to mobilisation for rights and entitlements and citizen-state interaction for local accountability is necessary. The radical discourse of health promotion that favours social justice and empowerment should be adopted as the agenda of MNCH programmes. This means that the purpose and strategies of formal spaces of MNCH programmes should be critically reviewed and aligned with the agenda of health promotion and empowerment.

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

### Ensuring Inclusiveness in MNCH Programme Spaces

The MNCH programmes reinforced the power of the community notables by focusing on their inclusion in awareness sessions and health groups/committees. The client registration criteria, attitude of healthcare workers, and the inadequacy of resources for outreach activities were other mechanisms by which the poor and marginalised were excluded from MNCH programme spaces. To ensure inclusiveness in MNCH programme spaces, it is recommended that:

1. The programmatic criteria for registering nomadic population groups as clients should be reviewed and mechanisms for their inclusion need to be developed.
2. The objectives, roles, structure, and operating procedures of the formal community spaces should be reviewed with explicit consideration of existing social and power structures. The objective of this should be to find ways to improve these institutions and make them more inclusive and representative of the whole community, and not merely limited to the inclusion of notables.
3. Monitoring systems of MNCH programmes should ensure inclusion of all vulnerable groups.
4. The training curriculum of MNCH programme facilitators and local healthcare providers should include overcoming of socially constructed biases, understanding social mobilisation and empowerment processes, and understanding the existing informal and formal spaces and their utilisation for better health outcomes.

### Proper Utilisation of Informal Community Spaces

In some informal spaces, especially religious gatherings, celebrations, and events the community people participated irrespective of their social stratification. In others, the poor women had transitory transactional interactions with the

better-off women and this made way for the infiltration of information imparted in formal spaces to the excluded. The informal spaces also provided ground for the solidarity of the poor and marginalised where they helped each other in livelihood activities and accessing healthcare services. Narayan (1999) has provided a framework and emphasised the role of the state in encouraging cross-cutting social ties between different community groups as well as institutional actors (Narayan D. , August 1999). This implies that an interactive relationship exists between the informal and formal spaces, and warrants a comprehensive understanding of both for addressing community development and MNCH issues. Therefore, it is recommended that:

1. The informal spaces where community people participate irrespective of their social strata should be frequently utilised by the MNCH programmes for health promotion and empowerment of the poor and marginalised.
2. The informal spaces that are occupied exclusively by the women, poor people or marginalised groups should be outreach sites for MNCH programme activities geared towards encouraging equity in healthcare services. Specific modules should be designed to train the healthcare workers in engaging the excluded without exploiting them.
3. The MNCH programme design should encourage their facilitators to develop understanding of the existing informal spaces and their interaction with formal spaces.

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