



POLICY BRIEF

RE-THINKING COMMUNITY SPACES FOR MATERNAL, NEWBORN AND CHILD HEALTH PROMOTION

BACKGROUND: Despite the policy commitments and struggle of numerous government and non-government health programmes for several decades, mothers, newborns and children continue to die at high rates in Pakistan. The maternal and child health indicators are considerably worse among women living at the economic and social margins of the society. To understand the root causes of inequities, especially why participatory approaches used by MNCH programmes have been unsuccessful and how class and gender influences maternal and child health care programme design and delivery, the Rural Support Programmes Network (RSPN) with funding from the Maternal and Newborn Health Programme – Research and Advocacy Fund (RAF) conducted a qualitative case study in Pakistan. Based on the study, this policy brief presents the key issues, findings, and recommendations for policy makers to support healthcare policy and practice to achieve the MDGs with greater emphasis on reducing inequities in maternal healthcare in Pakistan.

CONTEXT: The study was conducted in three selected villages of districts Thatta, Rajanpur and Ghizer. Data from 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 was collected. The findings suggest ways for better utilisation of community spaces.

THE ISSUE

- Pakistan has not met the targets set for the Millennium Development Goals (MDGs) 3, 4, and 5 (UNDP, 2012).
- A mother dies every 20 minutes as a result of giving birth, and rural women bear a higher risk (Jaffrey, Kamal, Qureshi and Fikree, 2008; PDHS, 2008).
- Neonatal mortality is about 55% higher for the poorest 20% households (Alam, Nishtar, Amjaz and Bile, 2010).
- Empowerment of the women, poor and marginalised can no more be ignored.

KEY FINDINGS

MNCH programmes and Empowerment: MNCH programmes have improved awareness, contraceptive usage and healthcare seeking behaviours through creation of spaces like facility - based care provision, door to door visits, group awareness sessions, and formal groups and committees. However, the functionality of these spaces varies. The monitoring indicators of these groups and committees is also limited to the number of groups formed and the number of participants rather than on the functioning of the groups/committees and who participates in them. Empowerment and social organisation for collective action is not the agenda of MNCH programmes.

Social Exclusion in MNCH Programme Spaces: Social exclusion of the poor and marginalised from the formal community spaces (facility-based care, door to door visits, group awareness sessions, and formal groups and committees) was prominent in all research sites and it adversely affected their health. Major reasons for this exclusion are:

- Guidelines that mandate the selection of community influentials in awareness sessions and groups/health committees.
- Criteria that prevent the registration of nomadic groups as eligible clients.
- Healthcare providers and facilitators usually belonged to the better-off castes and they carried their prejudices that led them

to ignore and mistreat the poor and marginalised.

Indigenous Spaces and their Interaction with MNCH Programme Spaces: Public and private indigenous community spaces (households, events celebrations, water collection and laundry points, agricultural fields, educational and religious settings) where people got together and had conversations, were found in all research sites. These spaces were more inclusive for community participation as they allowed transitory interaction across socio-economic class, through which some MNCH information imparted in formal spaces trickled down to the poor and excluded women.

KEY RECOMMENDATIONS

1. Health promotion strategies that promote social organisation and empowerment should be adopted in future MNCH programmes. A move from awareness raising and behaviour change to promotion of citizen-state interaction for local accountability and social organisation for rights and entitlements of the women, poor and marginalised groups is essential.
2. The objectives, roles, structures, operating procedures, and monitoring systems of MNCH programmes and their formal community spaces should be reviewed with explicit consideration of existing social and power structures. These should be made more inclusive and representative of all socio-economic strata in the community, and monitored accordingly.
3. The programmatic criteria for registering nomadic population groups as clients should be reviewed and mechanisms for addressing their healthcare needs should be developed.
4. The training curriculum of MNCH programme facilitators and local healthcare providers should include developing an understanding of social mobilisation and empowerment process, existing MNCH programme and indigenous spaces, and overcoming of socially constructed biases.
5. The indigenous spaces where community people participate irrespective of their socio-economic strata should be frequently utilised by the MNCH programmes for health promotion activities.

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