

SUMMARY REPORT

Care-Plus Delivery of MNH Services in Conflict Areas of KP, Balochistan and FATA

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Declaration

"I have read the report titled "Care-Plus Delivery of MNH Services in Conflict Areas of KP, Balochistan and FATA" and acknowledge and agree with the information, data and findings contained".

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Introduction

Pakistan in recent years has faced ongoing conflict and insurgency in the provinces of Khyber Pakhtunkhwa (KP), Balochistan, and the Federally Administered Tribal Areas (FATA). Hence, access to social services, including Maternal and Newborn Health (MNH) services was significantly reduced in the conflict areas.

This qualitative research study, was undertaken both at the demand and supply sides of the governance equation. On the demand side, the research assessed the influence of patriarchal power dynamics operating at the household level on decision making with regard to accessing MNH services in conflict areas and identifying factors which can be mitigated to bring about a change. The study also aimed to explore socio-cultural patterns at the community level to evaluate the indirect impact, if any, on MNH services. On the supply side, the study explored the availability and utilisation of MNH services at various levels in the supply chain system, the quality of services, the attitude and behaviour of the providers and responsiveness to consumer needs. The supply side analysis helped in discovering the key areas that need to be improved to better respond to the consumer needs.

Study Design and Methodology

The research study was conducted to (i) assess maternal and newborn health situation and identify factors that are detrimental to access to and utilisation of MNH services, specifically those belonging to marginalised population groups; and (ii) capture the perspectives of under-served populations, care providers and managers about the gaps in the current level of MNH services, and how these services can be timely made available in conflict areas.

Twelve conflict districts / agencies were selected from Balochistan (Dera Bugti, Qilla Abdullah, Pishin, and Quetta), KP (Lower Dir, Upper Dir, Swat, Buner and Dera Ismail Khan) and FATA (Bajour, North Waziristan, and Khyber agencies) having highest security risks.

Two qualitative research tools were used to collect primary data, comprising: (i) 167 in-depth Interviews (IDIs) with health managers, some categories of MNH services providers and mothers; and (ii) 108 Focus Group Discussions (FGDs) with MNH service providers, mothers and community influencers. The study tools were pre-tested in the non-sample areas and results of the pre-test were incorporated into the final tools and discussion guides.

The higher level study team comprised of a Team Leader, an Anthropologist and a Project Manager. The field teams comprised of provincial and district coordinators, social mobilisers, moderators and note takers.

Two workshops were conducted for training in IDIs and FGDs. In both workshops, trainees were given a session on the goals and objectives of the study followed by sessions on the logic of qualitative research. The participants were made to practice using mock interviews and 'role play'. Both workshops had a component of one day field application of tools/guidelines in a group similar to the target group in terms of study characteristics, followed by sharing feedback from the field with the team.

The provincial and district level supervisors regularly monitored the fieldwork to ensure data quality, resolution of any problem encountered, in addition to dispatching transcripts to SoSec office, Islamabad. Regular telephonic link and communication between field teams and Team Leader /

Anthropologist / Provincial Coordinators had a positive impact on field activity. The Programme Coordinator also supervised the fieldwork, and sought clarification wherever needed about the data received from the field.

Four senior researchers holding Ph.D. and M.Sc. degree in Anthropology/ Social Sciences were selected as Data Analysts. The Data Analysts managed the data systematically by assigning a unique identification number to each transcript received from the field. Data analysis was done manually using matrices developed in Microsoft Excel. The Anthropologist supervised the data management and data analysis.

Study Findings

The qualitative research study explored five key thematic areas in nine districts and three FATA agencies. The themes explored include: existing MNH Services; access to available MNH services; referral linkages to higher level health facilities; perceptions and expectations of users and providers; and how communities and providers can participate in the delivery of services.

a. Existing MNH Services

The public health sector has a three-tiered health delivery system: lady health workers (LHWs) at community level and community midwives (CMWs) in some area, lady health visitors (LHVs) and doctors in primary healthcare (PHC) facilities, and specialists at hospitals. The private sector also provides MNH services, especially in the urban areas.

LHWs play a significant role in community level MNH services but are less active in FATA and Balochistan province due to higher security threats from militants and limited provision of supplies. Traditional Birth Attendants (TBAs) are also important service providers. Khyber Pakhtunkhwa and Balochistan provinces have trained some TBAs in the recent past.

MNH services at PHC facilities, managed by LHVs and doctors, are facing a series of problems, like: shortage of female staff, absenteeism, insufficient equipment and medicines, poorly maintained infrastructure and inappropriate location at some places. The services at the secondary hospitals are much better and comprehensive (except in Dera Bugti district), but over-crowded with users.

Most of the consumers appear dissatisfied with the public sector services and criticised the quality of care. According to them, private hospitals are mostly better equipped, provide better quality of care and staff behaviour is sympathetic. However, private sector charges heavy fees thus crowding out poor and the marginalised. The poor people, on the other hand, stated to prefer public sector facilities if medicines were available. However, in case of emergency, poor try to avail services both in public and private sector and even might sell their movable assets to meet the treatment costs.

Public sector staff was dissatisfied with low salary which is not compatible with that offered by the private sector and the Government of Punjab. Equal wage for working in the normal and security risk areas was stated as an unjust decision. Further, public sector staff was mostly engaged in private practice on the pretext of low salary, particularly the LHVs.

Lack of awareness among users about the importance of MNH services was also identified as a reason for low utilisation of services. This situation is further precipitated by low status accorded to women's health in the local culture.

b. Access to available MNH services

Dera Bugti district in Balochistan province and North Waziristan Agency (NWA) in FATA are classified as areas with chronic conflict. Insecurity, threats by Taliban, fear of militancy and target killing have caused a negative impact on the overall socioeconomic conditions and socio-psychological environment, resulting in major damage to the social fabric of the society. Most of the families who could afford and health workers have left the conflict areas and moved to safer places.

The violence has also adversely affected the local job opportunities and business with consequent increase in the already high levels of poverty in these areas. The continuing security issues have created many challenges for the local population, especially access to education and health services.

The acts of terrorism and militancy have also adversely affected the MNH services. During the attacks, the roads get blocked, public transport disappears and both the health providers and patients find it difficult to reach the health facilities. During acute episodes of insurgency either the staff is not available at the health facility or there is lack of transport for travel to the health facility. In such situations, many a times the result is the death of the mother or the baby or both.

c. Referral linkages to higher level health facilities

Considerable delays have been observed in making decision to avail the referral services and in search of a suitable transport to carry the pregnant mother to the referral facility, especially in the rural, far flung and mountainous areas. The quality of services at the referral hospitals is found compromised because of the absence of referral procedures or protocols, shortage of female staff and specialists, and shortage of supplies and medicines, more so in FATA agencies and Balochistan province (except Quetta district). In some situations, emergencies have to be carried to the tertiary hospitals in Peshawar city (in KP), Quetta city (in Balochistan), and referral hospitals in Punjab province from Dera Bugti district.

The issue of referral is further complicated because of local customs and traditions restricting the movement of females without purdah and male escort, especially in FATA and rural Pashtun communities residing in KP and Balochistan provinces. Further, permission of elders is also required for seeking care at secondary hospitals, especially in FATA and rural areas of KP and Balochistan provinces.

Security concerns and poor road infrastructure further handicap the poor referral system. Users and providers face major threats from militants while on the road, more so at night and especially in FATA agencies and Dera Bugti districts of Balochistan.

d. Perceptions and expectations of users and providers

The perceptions and expectations of the providers and users paint a very gloomy picture of MNH services in the security compromised areas, especially for the mothers residing in the remote rural and mountainous areas. The quality, access and utilisation of MNH services are compromised for a variety of reasons. The public sector staffing issues stand out prominently, like the shortage of female health providers as stated earlier, absenteeism and political interference in staff recruitment and posting. The other challenge is the deficiencies in the health infrastructure like the lack of repair and maintenance of buildings, and absence or non-availability of residential quarters affecting the working environment. The limited availability of utility services further compromises the provision of services, e.g. electricity,

gas and water supply. Providers in the security compromised areas are also not happy with their present wage.

The users also face problems in access to and utilisation of services due to reasons explained above besides indifferent staff behaviour, short working hours of health facilities, inappropriate or remote location of many PHC facilities, and lack of an organised transport system for referral services. The dominance of elders and or male members of the family further restricts the mothers in timely seeking the MNH services. Poor and marginalised families thus generally depend on TBAs while well off families prefer better equipped private sector facilities. The above challenges are generally common to all areas, but more severe in FATA and Balochistan province.

e. How communities and providers can participate in the delivery of services

Services providers and users suggested a number of interventions for increasing access to and utilization of MNH services. There was consensus on establishing facility level health committee and women group. Recommendations were also made on the tasks to be assigned to the health committees like institutionalising the local transport system for referrals, facility oversight, monitoring staff presence, pursue DoH to fill-in vacant posts and meet infrastructure and supplies deficiencies, and encourage families for savings to meet MNH needs. Local communities can play a vital role in ensuring the safety of the healthcare providers through the involvement of health committees, tribal elders, Jirgas and Sardars.

Various options were identified to manage referrals and comprised: motivation of communities to organise village level transport system, government to provide ambulance at selected locations - a suggestion from Balochistan, and set a revolving fund at village level. Health Committees and tribal elders (in case of FATA) were identified as the institutions to support in both establishing the local transport system and its smooth functioning.

Providers and users stressed for reinforcing awareness raising campaign, with more focus on men in FATA, for enhancing utilisation of MNH services. Meeting the shortage of female health staff by the DoH was another suggestion to increase the access and utilisation of MNH services. Users from FATA also stressed the need to provide CMWs, both to expand the services as well as to meet local customs restricting the mobility of mothers.

A number of suggestions were also made for improvements in the private health sector, e.g. NGOs to organise ambulance service, supervision of private health facilities by PMA, adjust price list of all laboratory tests, counselling of patients and monthly CME sessions of private providers on MNH.

Discussion

The study areas are in the grip of an ongoing militancy since more than 10 years. Militants have destroyed many girls' schools and PHC facilities. This is because the insurgents are against female empowerment and their mobility without Purdah and a male escort.

The obstacles to seeking MNH services are due to a variety factors like risk to life during travel, health human resource (HHR) issues, keeping the facilities open for service, stock outs of medicines, local culture and traditions, lack of awareness about MNH issues, distance to health facility and the cost of treatment. The Provincial DoHs will have to think out-of-the-box and take appropriate steps so that the provision of health services is less disrupted, such as higher pay package, posting staff in their

domicile district, adequate provision of essential medicines and supplies, proper upkeep of physical infrastructure of health facilities, BCC.

Failure to tackle HHR issues has devastating effects on the health and survival of mothers and infants. The formulation and implementation of health policy and strategy, including the health human resource, is a provincial subject under the Constitution. The inaction on the part of Provincial DoHs has led to enormous brain drain from the security compromised areas. Special measures need to be taken that enhance access to both routine and EmONC services. Research in other countries shows a correlation between the availability of HHR, quality of care and health outcomes, and this is particularly relevant to re-establishing the health services in conflict affected areas.

Remedial measures at DoH level could take many shapes like encouraging community elders, Jirgahs and Sardars negotiating with militants to exempt health staff from kidnapping/ransom/killing; posting staff to their home district; organising local health committees to keep a bridge between the users and providers; institutionalising local transport system for timely evacuating emergency patients; expansion of community level MNH services providers; paying more for work in the security compromised areas and etc. To deal with stock-outs of essential drugs, the DoHs will have to review the drugs allocation quota policy.

In general, low status is accorded to women's health in the local culture. Further, there is lack of awareness about the importance of MNH issues leading to low utilisation of services. An appropriate Behaviour Change Communication (BCC) campaign could help in improving the utilisation of MNH services by modifying traditions restricting the movement of females.

Proposed way forward

There is a need to map out vacancies in the conflict affected districts. Staff domiciled from conflict districts should be encouraged to move to their home district. In parallel, the salary package of the staff serving in the high-risk areas should be adequately enhanced. Provincial DoHs may also consider expanding training activities like: developing case management protocols and training of providers, retaining of TBAs, and expanding the training and deployment of CMWs. This strategy is not only the least cost solution but will also generate local level self employment opportunities, meet the technical criteria as well as socio-cultural restrictions imposed on mobility of mothers.

Good experience of coordination and monitoring MNH services at community level has been reported in Swat district where working relations between TBAs, LHWs and CMWs have been strengthened, and Lady Health Supervisor (LHS) is providing monitoring support with regular linkages with the nearest health facility. This model should be studied for implementation in other districts.

Introduction of BCC should also be considered to apprise the users of the consequences of irrational practices and for improving their ability to recognise the danger signs. Most of the stakeholders were in favour of establishing facility level Health Committee and this concept has also been applied in some of the developing countries. The functioning Health Committees in LHW catchment areas have also been reported in the conflict affected areas of Swat district.

It may be worthwhile to establish referral procedures and protocols. This task could be divided into two parts, i.e. developing referral procedures and SOPs, and staff training.

The provincial DoHs should give priority for improving infrastructure of existing health facilities,

especially those located in rural and far flung areas, so that the staff feels comfortable in working and residing in the facilities. Consideration should also be given to relocate irrationally located PHC facilities within the communities by renting out and renovating suitable houses.

How to make a beginning? The study findings and the "way forward" based on suggestions made by the providers and users, and reinforced by inputs from literature review, have proposed an agenda for action. This needs further unfolding through detailed discussion with the health offices of each conflict affected district/agency and the respective provincial Departments of Health to quantify the gaps in various areas identified under the way forward, assessing the feasibilities of interventions required to meet the deficiencies, the timeframe for improving the quality of and access to MNH services, and the estimates of needed resource envelope.

The more opposite approach to move from status quo would be to assign the task of developing "Strategic Plan" for each conflict affected district on the basis of area specific challenges and tailoring interventions that are situation specific. The task of developing district specific Strategic Plans may assigned to local experts in consultation with relevant provincial stakeholders. The final product of the proposed TA would be a "medium term District Strategic Plans" backed by activity scheduling, the resources needed for each activity and the monitoring indicators to chase the progress. It is quite likely that a donor will pick up the bill of developing the district specific strategic plans along with commitment to finance key implementation areas, without directly involving itself in implementation.