



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

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“Care-plus: Delivery of Maternal and Newborn Health (MNH) Services in Conflict Areas of Khyber Pakhtunkhwa (KP), Baluchistan and Federally Administered Tribal Areas (FATA)” is a study funded by the Maternal and Newborn Health Programme - Research and Advocacy Fund (RAF), and has been implemented by SoSec Consulting Services, Pakistan.

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We hope that the findings of this study will help the MNCH Programmes in KP, Balochistan and FATA in improving the factors that are detrimental for access to and utilization of MNH services in the conflict areas of their respective provinces.

Disclaimer

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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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# Table of Contents

Table of Contents.....	ii
List of Abbreviation.....	vi
Executive Summery.....	vii
<b>CHAPTER 1.....</b>	<b>1</b>
INTRODUCTION.....	1
Background.....	1
Rationale of the Study.....	1
Study Design and Methodology.....	2
Study Objectives.....	2
Research Questions.....	2
Study Tools.....	2
Mapping of MNH Services, Programmes and Initiatives.....	3
Selection of Target Districts.....	3
Selection of Study Subjects.....	3
Development of Research Tools.....	4
Field Testing of Research Tools/Guidelines.....	4
Selection of Field Researchers.....	5
Training of the Field Researchers.....	5
Supervision of Fieldwork.....	5
Strategy for Data Collection.....	5
Ethical Considerations.....	6
Selection and Orientation of Data Analysts.....	6
Challenges in Implementing the Study.....	6
Layout of Research Report.....	6
<b>CHAPTER 2.....</b>	<b>7</b>
EXISTING MATERNAL AND NEWBORN HEALTH (MNH) SERVICES .....	7
Introduction.....	7
Khyber Pakhtunkhwa Province.....	8
Providers Perspective.....	8
Users Perspective.....	11
Federally Administered Tribal Areas.....	11
Providers Perspective.....	12
Users Perspective.....	13

Balochistan Province .....	13
Providers Perspective .....	13
Users Perspective .....	17
Summary of findings and Conclusions.....	18
<b>CHAPTER 3.....</b>	<b>19</b>
ACCESS TO AVAILABLE MATERNAL AND NEWBORN HEALTH (MNH)	
SERVICES KEEPING IN VIEW SECURITY SITUATION.....	19
Introduction.....	19
Khyber Pakhtunkhwa Province and Federally Administered Tribal Areas.....	19
Perspective of Users and Providers.....	19
Balochistan Province.....	23
Summary of findings and Conclusions.....	26
<b>CHAPTER 4.....</b>	<b>28</b>
REFERRAL LINKAGES TO HIGHER LEVEL HEALTH FACILITIES.....	28
Introduction.....	28
Khyber Pakhtunkhwa Province.....	28
Providers Perspective.....	28
Users Perspective.....	30
Federally Administered Tribal Areas.....	31
Providers Perspective.....	32
Users Perspective.....	33
Balochistan Province.....	34
Providers Perspective.....	34
Users Perspective.....	36
Summary of findings and conclusions.....	38
<b>CHAPTER 5.....</b>	<b>40</b>
PERCEPTIONS AND EXPECTATIONS OF USERS AND PROVIDERS TO THEIR	
MATERNAL AND NEWBORN HEALTH (MNH) NEEDS.....	40
Introduction.....	40
Khyber Pakhtunkhwa Province .....	40
Providers Perspective.....	40
Users Perspective.....	43
Federally Administered Tribal Areas.....	45
Providers Perspective.....	45

Users Perspective.....46

Balochistan Province.....48

Providers Perspective.....48

Users Perspective.....50

Summary of findings and conclusions.....52

**CHAPTER 6.....54**

HOW COMMUNITIES AND PROVIDERS CAN PARTICIPATE IN SERVICE DELIVERY.....54

Introduction.....54

Khyber Pakhtunkhwa Province.....54

Providers Perspective.....54

Users Perspective.....56

Federally Administered Tribal Areas.....58

Providers Perspective.....58

Users Perspective.....59

Balochistan province.....61

Providers Perspective.....61

Users Perspective.....63

Summary of findings and conclusions.....64

**CHAPTER 7.....65**

FINDINGS, DISCUSSION AND PROPOSED WAY FORWARD.....65

Existing Maternal and Newborn Health (MNH) services.....65

Access to available MNH services keeping in view security situation.....66

Referral linkages to higher level health facilities.....66

Perceptions and expectations of users and providers to their MNH needs.....67

How Communities and providers can participate in service delivery.....67

Discussion .....67

Proposed way forward.....70

**ANNEXURE.....73**

**ANNEX 1.....74**

PROJECT CORE TEAM.....74

**ANNEX 2.....76**

GUIDELINES FOR IN-DEPTH INTERVIEWS AND FOCUS GROUP DISCUSSIONS.....76

Guidelines for IDIs with Public Health Managers at District and Provincial level.....76

Guidelines for IDIs with Private Health Managers.....78

Guidelines for FGDs with Lady Health Visitors/ Midwives.....80

Guidelines for IDIs with Mothers.....82

Guidelines for FGDs with Lady Health Workers.....85

Guidelines for FGDs with TBAs.....87

Guidelines for FGDs with Pregnant mothers.....89

Guidelines for FGDs with Mothers having Child <1year.....91

Guidelines for FGDs with Husbands.....93

Guidelines for FGDs with Mothers/ Mothers-in-law.....95

Guidelines for FGDs with Fathers/ Fathers-in-law.....97

Guidelines for FGDs with Community Influential.....99

References.....101



LIST OF ABBREVIATIONS

AHQ	Agency Headquarters Hospital
BCC	Behaviour Change Communication
BHU	Basic Health Unit
CBO	Community Based Organisation
CD	Civil Dispensary
CME	Continuing Medical Education
CMW	Community Midwife
DG Khan	Dera Ghazi Khan
DHO	District Health Officer
DHQ	District Headquarters Hospital
DI Khan	Dera Ismail Khan
DoH	Department of Health
DPWO	District Population Welfare Officer
EDO	Executive District Officer
EDOH	Executive District Officer Health
EmONC	Emergency Obstetric and Neonatal Care
FATA	Federally Administered Tribal Areas
FGD	Focus Group Discussion
FMO	Female Medical Officer
FP	Family Planning
HHR	Health human resource
IDI	In-depth Interview
IDPs	Internally Displaced Persons
KP	Khyber Pakhtunkhwa
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Newborn/Neonatal Health
MO	Medical Officer
MSF	Medecins Sans Frontieres
NATO	North Atlantic Treaty Organisation
NGO	Non- governmental Organisation
NP	National Programme
NWA	North Waziristan Agency
OB/GYN	Obstetrics and Gynaecology
ORS	Oral Rehydration Salt
OT	Operation Theatre
PHC	Primary Healthcare
PHM	Public Health Manager
PHP	Public Healthcare Provider
PMA	Pakistan Medical Association
PPL	Pakistan Petroleum Limited
QR	Qualitative Research
RAF	Research and Advocacy Fund
RHC	Rural Health Centre
SBA	Skilled Birth Attendant
SOP	Standard Operating Procedure
TBA	Traditional Birth Attendant
THQ	Tehsil Headquarters Hospital
UC	Union Council
WC	Women having <1 Year Child
WHO	World Health Organisation
WMO	Woman Medical Officer

Executive Summary

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 have been significantly reduced in the conflict areas, a crisis which has been further compounded by floods in the recent past.

The objectives of this qualitative research study are to: assess MNH situation in the conflict areas of Pakistan; and identify factors that are detrimental for access to and utilisation of MNH services, especially for the most marginalised populations groups. Focus Group Discussions (FGDs) and In-depth Interviews (IDIs) were conducted with users and providers of MNH services to scrutinise both the demand and supply sides of the governance equation. The study also aimed to explore socio-cultural patterns at the community level to evaluate their impact, if any, on the MNH services.

The qualitative research study explored five key thematic areas in nine districts and three FATA agencies. The themes explored included: existing MNH Services; access to the 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.

Findings of the Study

The acts of terrorism and militancy have adversely affected the MNH services. During attacks, roads get blocked, public transport disappears and both health providers and patients find it difficult to reach the health facilities. Insecurity, threats by Taliban, fear of militancy and target killing have also had a negative impact on the overall socio-economic conditions and socio-psychological environment, resulting in major damage to the social fabric of the society. Most of the families and health workers have left the conflict areas and moved to safer places.

The quality, access and utilization of MNH services in the security-affected areas are compromised for a variety of reasons. The public sector staffing issues stand out prominently, such as the shortage of female health providers, absenteeism and political interference in staff recruitment and posting. Another key challenge is the deficiencies in health infrastructure such as the lack of repair and maintenance of buildings, and absence or uninhabitable residential quarters affecting the working environment. The limited availability of utility services further compromises of the provision of services, e.g. shortage of electricity, gas and water supply. Staff in the public sector complained of low salaries as compared to the private sector and even DoH employees in the Punjab province. Equal wages for working in both unaffected and security risk areas was also stated as an unjust decision.

The users also face problems in access to and utilization of services due to short supply of medicines, lack of or worn out equipment, indifferent staff behaviour, short working hours of health facilities, insufficient or remote location of many primary healthcare (PHC) facilities, and lack of an organised transport system for referral services. The dominance of elders and/or male members of the family further restrict the mothers in timely seeking MNH services. Hence, poor and marginalised families generally depend on traditional birth attendants (TBAs) while well off families prefer better equipped private sector facilities. The aforementioned challenges are generally common to all areas, but are much more severe in FATA and Balochistan.

Most of the users were not satisfied 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 cordial. However, the private sector charges heavy fees and thereby crowding out the poor and the marginalised. Resultantly, poor people prefer public sector facilities if medicines are available. Nonetheless, in case of emergency, the poor try to avail services both in public and private sector and might even sell their assets to meet the treatment costs.

Security concerns and poor road infrastructure also affected referral services. Users and providers face major threats while on the road, more so at night and especially in FATA agencies and Dera Bugti district of Balochistan. This security situation is causing considerable delays in decision making with regards to availing the referral services. The referral is also delayed in finding suitable transport to carry the mothers to the referral facility, especially in the rural and far flung and mountainous areas.

The quality of services at the referral hospitals are also compromised due to multiple reasons including the absence of referral procedures or protocols, shortage of female staff and specialists, and shortage of supplies and medicines. These constraints are present throughout FATA agencies and Balochistan with the exception of Quetta. In some situations, the emergencies have to be carried to far located tertiary hospitals.

The issue of referral is also complicated because of local customs and traditions restricting the movement of females without Purdah and male escort, especially in FATA, and within rural Pakhtun communities residing in KP and Balochistan provinces. The process further becomes complex because permission of elders is also required for seeking care at referral hospitals.

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

Various options were identified to manage referrals and these comprised of: motivating communities to organise village level transport system, pushing for the government to provide ambulances at selected locations (a suggestion from Balochistan) and to set a revolving fund at the village level.

Providers and users stressed for reinforcing awareness raising campaign with more focus on men in FATA in order to enhance the utilisation of MNH services. Meeting the shortage of female staff by the DoH was another suggestion. Users from FATA also stressed the need to provide community midwives (CMWs), both to expand the services and to meet local customs restricting mobility of women.

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 Pakistan Medical Association (PMA), counselling of patients and monthly continuing medical education (CME) sessions of private providers on MNH.

## Discussion

The study areas have been in the grip of an ongoing militancy since over 10 years. Militants have destroyed many girls' schools and PHC facilities. Mobility for women in these areas is restricted due to strict practice of Purdah and the requirement for them to be accompanied by male escort. These barriers are further increasing as the insurgents are ideologically opposed to female empowerment.

The obstacles to seeking MNH services are due to a number of factors. These include risks to life during travel, health human resource (HHM) issues, short working hours of health facilities, stockouts 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. These steps could include higher pay package, posting staff in their domicile districts, adequate supply of essential medicines and supplies, proper upkeep of physical infrastructure of health facilities and Behaviour Change Communication (BCC).

Failure to tackle Health Human Resource (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 offer 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 which leads to low utilisation of services. An appropriate BCC strategy could help in improving utilisation of MNH services modifying traditions restricting movement of females.

## Proposed way forward

There is 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, adequately enhance the salary package of the staff serving in the high-risk areas. Provincial DoHs may also consider expanding training activities such as developing case management protocols and training of providers, retaining of Traditional Birth Attendants (TBAs) and training and deployment of Community Midwives (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 circumvent constraints emerging from socio-cultural restrictions imposed on mobility of women.

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. The model should be studied for expansion.

Introduction of BCC should also be considered to apprise the users of the consequences of irrational practices and for improving their ability to recognise danger signs. Most of the stakeholders were in favour of establishing facility level Health Committee; a concept that has already 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 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 community by renting out and renovating suitable houses.

The study findings and recommendations, reinforced with literature review, have proposed an agenda for action. The proposed agenda needs further analysis and unfolding into Strategic Plan for each study district. It is quite likely that a donor will pick up the bill for the development and may be the implementation of district specific strategic plans, without directly involving itself in implementation like this qualitative study.



### Background

Out of the 1.3 billion poor people around the world, 70% are reported to be women; therefore, giving poverty a female face. While as a result of being poor, women rights are more likely to be violated through the Feminisation of Poverty, particularly in times of emergencies and conflict [1]. As a result, women are unable to access, and afford basic amenities and services such as health, education and nutrition, to name a few. Although, the past century witnessed a revolution in healthcare, yet millions of women still endure the risks of antenatal, natal and postnatal complications. Improvements have been witnessed over time but in low-income countries, including Pakistan, these have occurred at a slower pace. The target for Millennium Development Goal (MDG) 5 is to reduce by three-quarters, between 1990 and 2015, the maternal mortality. Two indicators to measure the target include maternal mortality ratio and proportion of births attended by skilled health personnel. Pakistan is a signatory to achieving the eight MDGs including MDGs 4 and 5.

Every year approximately 350,000 women die while pregnant or giving birth, up to 2 million newborns die within the first 24 hours of life, and there are 2.6 million stillbirths around the world. About 15% are complicated births [2]. The overwhelming majority of these deaths occur in low-income countries and conflict areas. Most of them could be prevented. These deaths occur because women (usually the poor and marginalised and those in security risk areas) have limited access to functioning health facilities or qualified health professionals.

Pakistan has a high Maternal Mortality Ratio where one out of every 89 women will die of maternal causes during her life time, compared to one per 8,000 in the developed world [3]. Moreover, every day more than 500 newborns die in Pakistan and every year an estimated 216,000 Pakistani babies die before they reach their first month of age [4]. According to World Health Organisation (WHO), MNH indicators are worse in rural areas, where out of 64 percent births reported, only 30 percent of the deliveries were assisted by Skilled Birth Attendants (SBAs) [5]. Access to healthcare for women and children in Pakistan is the lowest amongst 'poor' (at 24.7 percent) and 'poorest' (at 10.1 percent) [4] while conflict situations further breed poverty, and create social and physical barriers to access MNH services.

### Rationale of the Study

Pakistan in recent years faced various emergencies including the ongoing conflict and insurgency in the provinces of Khyber Pakhtunkhwa (KP) and Balochistan, and Federally Administered Tribal Areas (FATA). As the war in Afghanistan intensified, militants were pushed into these regions of Pakistan and they established themselves as a local power in collaboration with indigenous partners to retaliate against foreign invasion in Afghanistan and also to enforce their own version of Islam in Pakistan. As a result of the conflict that ensued thereafter, the access to existing social services, including MNH services was significantly reduced in many areas. Floods in parts of KP and Balochistan provinces further aggravated the situation.

The conflict has also significantly damaged physical infrastructure of social services and in many places, complete cessation of social services while displacing large sections of the populations. The damage to physical infrastructure of public sector social services institutions by the militants was partly to push their demand opposing foreign invasion in Afghanistan and partly to resist women education and provision of other social services including health services. In 2009, approximately 3.6 million people and 0.531 million households were displaced in KP and FATA [6]. The crisis affected not only the Internally Displaced Persons (IDPs) but also those who stayed behind, some of whom being just as poor and vulnerable as the IDPs.

It is generally believed that the delivery of health services, including MNH services, has deteriorated in conflict areas with consequent worsening of MNH indicators. The available information points out that access to MNH services is limited in conflict areas of Pakistan owing to numerous factors like social barriers; women's dependence on men to access health services; limited physical access to providers or lack of transport to reach them; lack of knowledge about the service providers; internal displacement; damage to functioning health facilities; absence of health staff, especially females, due to security reasons; deteriorating poverty status of

households and unaffordable informal user charges or cost of service charges by the private providers. Therefore, there was an urgent need to undertake research in order to understand the dynamics of conflict areas, especially in poverty stricken pockets, limiting the access to and utilisation of MNH services.

### Study Design and Methodology

This qualitative research study was undertaken to scrutinise MNH services, 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 consumer needs.

### Study Objectives

The specific objectives of the qualitative study were to:

- Assess the maternal and new born health situation in the conflict affected areas of Pakistan
- Identify factors that are detrimental for access to and utilisation of MNH services, especially for the poorest quintile, the socially excluded and displaced populations, and vulnerable groups in conflict areas

### Research Questions

Primary Research Question: To assess the maternal and new born health situation and identify factors that are detrimental to the access and utilisation of MNH services, specifically those belonging to the poorest quintile, the socially excluded and displaced populations, and vulnerable groups in the conflict areas of KP, Balochistan and FATA agencies.

Secondary Research Question: What are the perspectives of under-served populations, care providers and managers about the current level of MNH services and gaps, and how can maternal and new born health services be made available in conflict areas?

### Study Tools

The following study tools were used to collect qualitative data:

In-depth Interviews (IDIs): The IDIs of selected managers, supervisors and technical staff assisted the study team in capturing their experiences, views and perceptions about: (i) the design and capacity of the ongoing programmes to reach the users in conflict areas, (ii) likely contribution of these programmes in improving the key indicators of MNH and ways to measure the contribution at the local level, (iii) any difference in the programme scope and its outreach in urban and rural areas in security risk districts, (iv) social and poverty impact of the ongoing Maternal, Neonatal and Child Health (MNCH) programmes, (v) health and non-health factors either constraining or contributing positively, and (vi) suggestions to improve the programme policies and services to ensure an easy access to the users in the security risk areas, especially the poor.

Focus Group Discussions (FGDs): The findings of the IDIs were further probed through FGDs to attain more collective opinions of specific segments of society i.e. users' of services, their family members and providers of services. The FGDs conducted amongst various provider and user groups thus allowed an interactive debate for a more multi-faceted analysis of the core issues surrounding the equitable access to MNH services in conflict areas, from the perspective of both demand and supply sides.

Mapping of MNH Services, Programmes and Initiatives

As part of preparation for a detailed qualitative assessment, a mapping exercise was conducted to collect information on currently provided MNCH services in the study districts. A day long training was organised for the Provincial coordinators and District supervisors on information collection. Following the training, a detailed implementation plan was developed for rolling out the mapping exercise.

The Provincial coordinators together with District supervisors held meetings with the District Officers of various social sectors to collect information about MNH services and initiatives in the respective private sector of the sample districts and FATA agencies. Thus, the information collected was verified by visit to each organisation, NGO and Community Based Organisation (CBO) and a list of MNH services and responsible organisation was prepared.

Selection of Target Districts

The study segregated districts falling in the conflict areas in the provinces of Balochistan, KP and in FATA agencies. 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 (Bajaur, North Waziristan, and Khyber agencies) having highest security risks. The criteria for the selection of conflict districts/agencies, including those with chronic conflict, were as follows:

- Internal displacement of population in last five years as a consequence of conflict.
- Damage to local health and education facilities, and water supply and sanitation system as a consequence of conflict.
- Districts/agencies where military operations were undertaken to deal with militants.
- Districts/agencies where communication system was damaged.

Selection of Study Subjects

The study subjects include those involved in the (i) supply side of the MNH services and (ii) demand side.

Supply Side Sample: The study first captured the perceptions, views, problems and suggestions of MNH service providers and managers at provincial and district levels, both from public and private sectors, using the IDI technique. These interviews were critical as they were the key informants who had first-hand knowledge of the impact of conflict on maternal and neonatal health. The information on supply side sample below the district level was mainly captured at PHC level from lady health visitors (LHVs), lady health workers (LHWs) and traditional birth attendants (TBAs) using FGDs.

Demand Side Sample: The study covered potential users of services, their immediate family members who matter in family level decision making and local influencers who have a sway in the community. FGDs served as a main research tool to understand their problems, beliefs, attitudes, value system, and needs/demands for the MNH services. Six FGDs were undertaken in each target district, one with each group as shown in the text Table 1 below. The location of each FGD was different to capture inputs from a wider group of audience. Besides FGDs, IDIs were also conducted with mothers to capture their views/perceptions and the challenges they faced in accessing the MNH services, outside the group dynamics.

Table 1: Number of FGDs and IDIs at Provincial and District Levels					
Type of Respondents	No. at Province Level			No. at District Level	Total
	KP	BIn	FATA		
FGDs with LHW, LHV/Midwife and TBA i.e. 3 per district 3 x 12	-	-	-	36	36
FGDs with Pregnant Women, Women having Child < 1 year, Husbands, Mothers/Mothers-in-law, Fathers/Fathers-in-law (each one per district) i.e. 5 x 12				60	60
FGDs with Local Influencers 1 per district i.e. 1 x 12				12	12
<b>Total No. of FGDs with Users' and Providers'</b>				<b>108</b>	<b>108</b>
IDIs with LHVs/Midwife 1 per district i.e. 1 x 12				12	12
IDIs with Private Sector Providers	4	4	0	36	44
IDIs with Provincial Managers	5	5	5		15
IDIs with District Managers 5 per district i.e. 5 x 12				60	60
IDIs with Mothers at 3 per district i.e. 3 x 12				36	36
<b>Total No. of IDIs</b>	<b>9</b>	<b>9</b>	<b>5</b>	<b>144</b>	<b>167</b>

Development of Research Tools

The review of national and international literature helped in identifying the following five key themes that lead to the development of research tools / guidelines:

- Existing MNH services;
- Reach and access to available MNH services keeping in view the security situation;
- Users' views on referral linkages to higher level health facilities;
- Perception and expectations of users to their MNH needs;
- How can communities participate in the delivery of services;

The formats for IDIs, FGDs and discussion guides were developed by the Anthropologist on the basis of key questions as explained above under the 'research questions section' for providers' and users' of services. The research tools/guidelines were translated to Urdu language and then translated back to English. The objective of re-translation was to ensure that all questions matched the original version. Any ambiguous words or phrases were discussed and corrections were made to Urdu translation. In total, 13 categories of research tools corresponding with various types of respondents for IDIs and FGDs were drafted reviewed and finalised (see Annex 2). These tools were supplemented with discussion guides/manuals for guidance and training of field researchers and included: (i) manual for conducting qualitative research, (ii) manual for conducting IDIs and (iii) manual for conducting FGDs.

Field Testing of Research Tools/Guidelines

The translated tools were pre-tested in the non-sample areas on respondents similar to those to be interviewed in the study area. The pre-testing helped in identifying problematic areas, misinterpretations or cultural objections to the questions and estimated time required to complete an IDI and FGD. The members of core team, who participated in the development of research tools, supervised the field testing. The results of the pre-test were incorporated into the final tools and discussion guides.

3 <sup>2</sup> Conflict areas in the perspective of this study are those afflicted by terrorism, insurgency, tribal fight over assets or power and religious ethnicity. By chronic conflict we mean the confrontation is going for generations, e.g. in Dera Bugti and Kurram agency.



## Selection of Field Researchers

Field staff comprised of two Provincial Coordinators, six District Supervisors, and six Field Teams each with a Social Mobilisers, Moderator and Note Taker. They were selected from the study areas because of their familiarity with the local language/dialect, local culture and routes for finding the study areas.

The Team Leader, Anthropologist and Programme Manager selected the two Provincial Coordinators from among professionals who had past experience of undertaking operations research at field level. The Provincial Coordinators then drew up a list of potential candidates for the position of District Supervisors, Social Mobilisers, Moderators and Note Takers from the respective areas in line with agreed qualification, experience and job description. The Anthropologist and Programme Manager then interviewed the candidates and made a final selection of the best qualified individuals.

## Training of the Field Researchers

Two training workshops were conducted in Islamabad, first training on IDIs for a period of 4-days and second on FGDs for a period of 5 days. The trainees included Provincial and District Supervisors, Social Mobilisers, Moderators and Note Takers. In both workshops, trainees were given a session on goals and objectives of the study followed by sessions on logic of doing qualitative research and made to practice using mock interview and 'role play' techniques. 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. This exercise enabled the field researchers to practice skills they had learnt during workshops.

## Supervision of Fieldwork

In addition to dispatching transcripts to SoSec office in Islamabad, the provincial and district level supervisors regularly monitored the fieldwork to ensure data quality and to resolve any problems encountered. 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.

## Strategy for Data Collection

The IDIs were conducted at provincial level by the Provincial Coordinators and at district level by District Supervisors. The FGDs were conducted after completion of IDIs to ensure full-time and effective supervision of FGDs. Salient strategic points for data collection comprised the following:

- Field staff contacted target respondents beforehand to secure definite appointment before the actual interview or group discussion explained to them the purpose of the meeting.
- The IDIs and FGDs were organised at a neutral place, generally away from their workplace, starting with less sensitive topics and then moving on to specific issues.
- Field teams carried identification cards and a letter of introduction, interview guides, pen/pencil, notebook, tape recorder and cassettes.
- Participants for the FGDs were selected on the basis of the following criteria: married persons; of different ages within the specified range; not related to each other; not close neighbours; and from different sects and tribes in the target area.
- Complete field notes were prepared soon after the IDI/FGD so as to reduce the time needed to refer to the recording and also to improve the accuracy of the information.
- Transfer of written notes early on to the Data Analysts for initiating data analysis.

## Ethical Considerations

The research tools/guidelines upon finalization were submitted to and approved by the RAF management. The following ethical guidelines were observed during data collection:

- Cultural, religious and social values were respected during the interviews by using appropriate language and behaviour and building rapport prior to actual interview.
- All the respondents for IDI were interviewed separately.
- Consent was obtained, on an informal basis, from all the participants after explaining them the objectives of the study and building their confidence that confidentiality of information obtained would be respected and maintained.

## Selection and Orientation of Data Analysts

Four senior researchers were selected as Data Analysts; one holds a Ph.D. degree in Anthropology, the second is a candidate for Ph.D. in Anthropology and the others are M.Sc. in Anthropology and Social Sciences.

The Data Analysis team was given detailed briefing on the study, its objectives and research questions. The team was apprised of the workload and other details of the data analysis and compiling of individual draft reports based on the insights arrived at analysis of the field data supported by quotes as an illustration of findings/insights. 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.

## Challenges in Implementing the Study

Some problems were encountered during the fieldwork and at the stage of organising and analysing the field data. Following is a brief mention of these challenges:

- The sample was quite large to manage within the approved study time and budget.
- Fieldwork got delayed due to various reasons such as the non-availability of some of the selected respondents on the mutually agreed upon time, difficulties in traversing the mountainous areas to reach and conduct FGDs and transport challenges due to destroyed roads or absence of roads.
- Re-doing of faulty/weak IDIs.
- Translation of Urdu transcriptions into English and then to feed the data in the computer was a very time consuming exercise for the Data Analysis team.

## Layout of Research Report

This report has been divided into seven chapters. The first introductory chapter covers the background, rationale, the design and methodology used to implement the qualitative study. The next five chapters (chapters 2 to 6) describe the perspectives of the service providers' and the users' of services, covering one theme in each chapter: existing MNH Services; reach and access to available MNH services keeping in view security situation; users' views on referral linkages to higher level health facilities; perception and expectations of users' to their MNH needs; and how can communities participate in the delivery of services. The seventh chapter is devoted to discussion and way forward that can help improving MNH services in the conflict areas.

Introduction

Every district in the country, with some variations from province to province and district to district, has standardised public sector physical infrastructure for providing health services to the citizens. At community level, a LHW, beside other outreach workers, is deployed to provide some components of preventive MNH services to around 150-200 households. At static level, one BHU is established in each Union Council (UC) for a population of around 15,000-35,000 persons and one RHC for a group of 2-3 UCs. At the level of district town, a DHQ hospital is established with 50-300 beds. Every BHU has a sanctioned post of SBAs called LHV to provide basic MNH services, and at RHC a SBA and a Woman Medical Officer (WMO) for basic MNH services and routine Emergency Obstetric and Neonatal Care (EmONC) services. A DHQ hospital ideally should have an Obstetrics and Gynaecology (Ob/Gyn) specialist, indoor beds and one or more delivery suits to manage emergency EmONC cases besides providing basic MNH services. However, a large number of sanctioned positions of female health staff remain vacant at all levels. This phenomenon is more prevalent in rural and security compromised areas, e.g. only one sanctioned post of LHV was filled in Dera Bugti district in 2012.

Budget allocation and sanctioned health workforce by the public sector in the study districts of Balochistan province as compared to other districts of the province, as an example, is presented below:

- Qilla Abdullah and Pishin (the study districts) were among the five districts of the province that were allocated minimal current budget in 2010/11, based on the ratio between the budget and the district population.
- Dera Bugti and Qilla Abdullah were among the five districts in the province having lowest number of paramedics, based on the ratio between the sanctioned posts and the district population.
- Qilla Abdullah was amongst five districts having lowest number of SBAs, based on the ratio between the sanctioned posts and the district population.
- Qilla Abdullah and Pishin were amongst five districts of the province classified as health poverty hit districts based on the above criteria.

The table 2 describes the main input indicators of study districts from Balochistan province with respect to human resource and budget allocation for the fiscal year 2010-11.

Table 2: Salient Input Indicators of Four Districts Included in the Study: Balochistan Province<sup>1</sup>

S. No	District	Bed per 10,000 Pop.	BHU/RHC per Union Council	One Doctor per Pop.	One SBA per Child Bearing Women	Allocation per Person in 2010/11 Current Budget (Rs)
1.	Qilla Abdullah	1.34	1.12	1:17,363	1:8,088	272
2.	Pishin	1.91	1.05	1: 8,740	12,733	282
3.	Dera Bugti	1.65	2.17	1:12,798	1:2,192	400
4.	Quetta	18.4	0.4	1:1,057	1:3,722	1,363

Another key provider of MNH services is unregulated and unregistered private health sector. The status of private sector development varies across provinces. In Balochistan, except Quetta, it is poorly developed in the sample study districts, while in KP all study districts have a relatively better developed private sector, especially Swat district. In FATA agencies, the private sector is least developed, with TBAs being the most common MNH service provider in rural areas. These assertions are based on anecdotal evidence, as perceived by health managers.

Khyber Pakhtunkhwa Province

Like rest of the country, KP has a three-tiered public health delivery system, i.e. at community, primary healthcare facilities and referral hospitals. Unregulated private for-profit health system is also providing MNH services across all study districts. The other major providers in conflict-affected districts are international NGOs such as Save the Children Federation, Medecine Du Monde.

Providers Perspective

At community level, LHWs provide MNH services and their responsibilities include: awareness and counselling for MNH services including family planning. LHWs keep record of all pregnant women in their area and submit periodic reports to the LHS. "LHWs also receive delivery kits twice a year for distribution to the expectant mothers", reports a public health manager. CMWs are providing basic EmONC services in some areas of Swat, where people have no access to BHUs.

All LHWs are local residents and belong to the same area, thus having easy access and direct interaction with the community. Being local, they also have access to marginalised women, including those who are either very poor or due to social barriers unable to visit health facilities.

The community level services are supervised by the Lady Health Supervisor (LHS). In certain areas like Buner and Swat districts, LHW, CMW and LHS work as a well-organised and coordinated team ensuring timely assistance to mothers. Health committee is constituted within the allocated area of each LHW. Presence of effectively functioning health committees at village level in some districts, like Buner and Swat, ensures regular supply of delivery kits, training of TBAs and participation of community elders in decision making, thus highlighting good coordination between providers and community

***In district Buner, there is a triangular system consisting of LHS, LHV and midwife, who work with mutual cooperation and coordination.***  
***District Coordinator National Programme, Buner: IDI***

***The TBAs are members of the health committee..... Every LHW village has such a committee with community elders also included as members .....delivery kits are distributed to the pregnant women by the community elders.***

***LHS, Swat: IDI***

***In the past only TBA used to deliver newborns. Since they were untrained, therefore the death rate was high. Introduction of MNCH services and CMWs has reduced the death rate.***

***EDO Health, Buner: IDI***

Although, the above mentioned teamwork was reported in some areas, but in most other places, LHW alone was responsible for provision of MNH services at community level. In

***To tell you the truth, maximum BHUs do not have any service whatsoever. In RHC, there is just one doctor who is responsible to do all sorts of jobs.***  
***National Programme, Master Trainer, Lower Dir: IDI***

Lower Dir, the appointment of LHW was seen by the community as a significant step towards improvement of services.

<sup>1</sup> The feminization of poverty means that women are, more often than not, the most disadvantaged segment of the society lacking the needed financial resources to access even the basic social services.

The MNH service package provided at BHUs and RHCs in all the districts of KP is facing similar problems and comprise: staff shortage in general and shortage of female staff in particular, staff absenteeism, and insufficient supply of equipment and medicines. Poorly constructed or maintained infrastructure is also a hindrance to the delivery of services, while in some cases no infrastructure was identified as the basic problem. These issues were highlighted in a number of IDIs and FGDs with the providers.

LHVs posted at PHC facilities were found running private clinics. They justified this action by giving two reasons: the utilisation of acquired skills to rightfully earn a living and to fill in the gaps in provision of MNH services. Their claim of being called doctors in many situations was unethical and concerned individual's behaviour, while in some cases users called them doctor either because of ignorance or as a sign of respect. The title was found to be a non-issue for the population who were more concerned about getting MNH services.

Services in the secondary hospitals were found to be satisfactory across all the study districts. The services available at this level were perceived to be much better and comprehensive than those offered at the RHCs and BHUs. The secondary hospitals provided comprehensive EmONC services including blood transfusion, surgical facility, and anaesthesia and Operation Theatre (OT) facilities for caesarean section and child care in addition to routine MNH services.

Some DHQ hospitals were found better equipped than others in terms of availability of facilities, services, equipment, medicines and specialists. In such instances people from other districts also visited such hospitals in search of improved services, e.g. Central Hospital Saidu Sharif, Swat.

DHQ hospitals in all study districts, however, were frequently reported as being over-crowded and not having enough space to accommodate the patients. Patients who came to the DHQ hospitals could be divided into three categories, given the purpose of their visit; those who were referred from BHUs and RHCs; those who come of their own choice, given the perception that services and facilities are better; and those who lived near the DHQ hospital.

**Health services at Secondary level are good.**

*LHS, Lower Dir: IDI*

**At Secondary level government has provided standard MNH services. There the staff and all other requirements are fully provided.**

*MNCH Coordinator, Lower Dir: IDI*

**Patients for MNH services who come to Central Hospital Saidu Sharif are not only from Swat, but patients from district Shangla and DHQ Bat Khaila are also referred here.**

*District Gynaecologist, Swat: IDI*

**This is a fact that the required strength of the staff cannot ensure a high standard of MNH services. Our Hospitals are short of staff and government needs to provide more staff at all levels. The shortage of staff is more pronounced and acute at BHUs and RHCs as compared to hospitals.**

*MNCH Coordinator, Lower Dir: IDI*

Some providers criticised the present lack of interaction and assistance between the public and private sector resulting in duplication and wastage of resources. While, ideally they should cooperate with each other, but in reality they work 'against' each other. There was a general consensus that if private and public sector work in collaboration, a significant improvement can be brought about in the awareness and provision of MNH services.

**Duplication can be classified into different types: one type is duplication of service and another is the duplication of service providers. For instance, there sits in the same RHC one lady doctor from Merlin International and other from Department of Health. They sit in different rooms performing the same task without any cooperation amongst them.**

*MNCH Coordinator, Peshawar: IDI*

It is believed that private hospitals are mostly well equipped compared to those in the public sector. The quality of care and behaviour of staff with patients too is often better. However, they charge heavy fees as compared to public hospitals, which provide services either free or at very nominal fee. Due to heavy treatment cost in private hospitals, poor and marginalised are often completely deprived of the services. The study data, on the other hand, does not cite any incidence wherein a private hospital refused admission to a seriously ill patient.

**Private clinics are better in terms of MNCH services compared to the government ones. This also includes the better behaviour of the doctors working in private hospital. Therefore, those who can afford prefer private hospitals.**

*LHS, Swat: IDI*

Although, public health providers' are aware of factors responsible for inefficiency of the health services, they appear either helpless or indifferent to the malpractices going on right under their noses. A provider from Swat gave an account of the situation, which was both serious and disturbing, and informed that the government had failed to supply the required stock of medicines and the necessary supplies for MNH services. The resulting situation has financial impact on the poor, who are unable to buy the supplies and medicines.

**At government health centres MNH related medicines are always in short supply. Mostly government does not provide medicines in enough quantity. Those medicines, which are supplied to the hospitals, disappear from there. This happens because there is no accountability and check and balance system.**

Staff working at public sector health facilities was found to be generally dissatisfied with the salary package and termed it as insufficient to meet even their basic needs and was nowhere near the salary being offered in the private sector. The low wages, especially of the basic cadres including LHW, CMWs, LHV and midwives put them on the lower social ladder within the society and hence they did not receive the respect they deserved.

**Salary of a midwife is Rs. 2,000 per month, which is nothing. There should be a raise in the salary so that status of midwives is enhanced in the society. People will respect them and take their advice seriously if they get good salaries.**

*District Coordinator National Programme, Buner: IDI*

**What is happening with us is that our salaries are small and even that is not paid on time. Just think that with such low salary in times of high inflation, how anybody would be motivated to work.**

*LHS, Lower Dir: IDI*



Users Perspective

Most respondents during FGDs reported their preference for private providers due to polite behaviour and better healthcare facilities. Many reported that though private providers charge high but they also provide quality treatment in return.

The poor people, on the other hand, preferred to visit public health centres if free medicine was available. While in case of emergency, they tried to avail health services both in public and private sector in the nearby cities depending on the funds available. In such instances they even took loans and sometimes sold jewellery or livestock to meet the expenses.

Another important issue highlighted was unsuitable location of public sector PHC facilities which was either far away from the village or difficult to access. This made it impossible especially for females to access the facility without a male family member even during day time. This phenomenon was both due to security factors and local norms that prevented women from travelling alone.

The research findings further showed that provision of MNH services is not limited to public health sector alone, private sector is also playing an active role and contributing in various capacities i.e. NGOs, medical centres, private hospitals, maternity homes, evening clinics and individual doctors are working to raise awareness about MNCH issues and provide services. The NGOs also cooperate with and fund the public sector health centres

***We prefer to go to private hospital because they have properly functioning labour room, facility of lab tests and ultrasound. They maintain the temperature inside the building. After the delivery we receive baby and mother in good condition, whereas in government hospitals we find both of them dead.***  
***Woman with <1 yr child, Buner: FGD***

***In private hospital, they behave politely, while in the public hospitals, the staff beat the patients at delivery time.***  
***Pregnant Woman, Swat: FGD***

Government centres regarding health are proving to be very helpful for people.  
Mother, DI Khan: IDI  
While on the other hand, a few respondents from IDIs appeared satisfied with the government hospitals and health centres to some extent. A mother from DI Khan said that health centre of their area provides good and free check-ups, vaccinations and medicines to the patients.

***Government centres regarding health are proving to be very helpful for people.***  
***Mother, DI Khan:***

Federally Administered Tribal Areas

The health system in FATA is also three tiered i.e. community outreach, primary health care and secondary care for specialised treatment including MNH services. Of all the conflict affected areas of Pakistan, the condition of health system is the worst in FATA. The infrastructure is old. The situation of supplies including medicines leaves much to be desired. Shortage of staff, not just in one specific cadre but in all cadres, at various levels in different agencies was highlighted by the providers. The decade old militancy has further undermined the system due to destruction of the facilities and threats to female providers by the Taliban.

Providers Perspective

At community level people have limited choices, as compared to the urban areas where there are many options for services ranging from private clinics, maternity homes and government hospitals. The availability of services at community level in Bajaur and Khyber agencies were stated unsatisfactory. In Khyber agency, there were many areas where even a midwife or LHV was not available and patients had to travel on foot to reach the health centre in the nearby town or travel to the main Agency hospital.

Low salaries, lack of transport facilities, non-availability of residential quarters, non-availability of necessary infrastructure and equipment/medicines, cultural taboos and many other factors including life threats by Taliban all contributed to the lack of motivation and frequent absenteeism among the staff. Staff absenteeism was most visible in far-flung and mountainous areas.

***The lack of proper infrastructure such as water, electricity and gas at the health centre, has become the main reason for the absence of the staff, especially the LHVs.***  
***TBA, Bajaur Agency: FGD***

***Staff of BHUs located in remote areas often remains absent from duty. Reason for their absence is mostly due to the absence of facilities at the BHUs.***  
***Assistant Director, National Programme, FATA: IDI***

***The absenteeism is an old practice here, but now it has increased on the pretext of security situation.***  
***LHW Coordinator, Khyber Agency: IDI***

***Medicines are available but deserving people do not get them. People with connection get the medicine and poor people suffer which is absolutely unfair.***  
***In-charge BHU, NWA: IDI***

A respondent from Bajaur agency commenting on the existing situation of secondary level services about need for female staff in particular and lack of equipment said:

***Specialists are available but less in number. Government needs to increase the number of female staff and provide necessary items required for MNH services.***  
***Agency Surgeon, Bajaur: IDI***

The most common complaint was the lack of female staff. In the absence of female staff, people in FATA do not like check-up of their women being conducted by male doctors.

***In the absence of female staff, men of this area do not allow examination of their women by male doctor, even if a woman is at the verge of death.***  
***Gynaecologist, NWA: IDI***

In general, the providers' attitude and lack of supervision and surveillance were common reasons for staff absenteeism and low performance, as action on monitoring reports get compromised in many situations through political interference. On the other hand, most providers were in favour of an accountability mechanism for ensuring check and balance. In their view, the implementation of accountability system is the only way to overcome the severe shortcomings that ail the system and hinder in the improved provision and utilisation of the health services.



Another strong and negatively affecting factor was widely prevalent practice of nepotism and political interference in the recruitment of staff and securing posting at preferred stations or deliberate inattention to staff, who attend duty irregularly.

Users Perspective

By and large, MNH services were available at community level in majority of the agencies except North Waziristan and Bajaur agencies. During IDIs and FGDs with mothers, a number of public and private health facilities available in the community were listed out. Among public sector facilities, the presence of LHWs at community level in majority of agencies whereas the availability of BHUs in only some of the communities was reported. However, during FGDs respondents identified the problem of non-functionality of LHWs in their area because of security reasons.

Since, the respondents (both in IDIs and FGDs) belonged primarily to rural communities, therefore they reported only about public health facilities available in their communities. On the other hand, a range of private health facilities were also available in the urban areas like clinics of doctors and LHVs, and services rendered by traditional Dais. In the communities where public or private facilities are not available, women mostly relied on local Dais. In addition, during IDIs with mothers, the role of dispensers (paramedics to dispense prescribed medicines and assist in minor procedures at PHC facilities) as providers of services for child health services was also pointed out in Bajaur agency. They run their private clinics and are considered as doctors at local level. Local people consult them because of low charges and non-availability of other options.

**These are not doctors rather shopkeepers who are actually working as dispensers or persons who issue slips to patients. These people have opened their clinics in this area and local people take them as doctors.**  
**Mother, Bajaur Agency: IDI**

In NWA, there are fewer nearby functioning PHC facilities. The Agency Headquarters (AHQ) hospital and private hospitals and clinics are located in Miran Shah City – the agency town. It takes several hours to reach these facilities. Further, ongoing military actions and violence makes it difficult for the women to access the services in case of emergency. Because of militancy and violence, a number of posts of female providers are also lying vacant.

Balochistan Province

The poor MNH outcomes in the province are indicative of the health status of the population [4]. The research shows that the situation of MNH services is much worse in Baluchistan, than in KP. In Balochistan, TBAs mainly provide MNH services at the community level in contrast to LHWs and TBAs in KP.

Providers Perspective

At the community level, the MNH services are to be provided by the local LHWs. However, in the conflict districts, due to security risks and lack of medicines and supplies provision, the LHWs are unable to perform their duties. The coverage of services by the LHWs is poor in the province while the situation in the study districts is much worse.

The other key service providers at the community level are TBAs, who provide basic MNH services, such as random check-up of pregnant women, advice to the mothers how to keep proper diet, what precautionary methods should be used to prevent diseases, advice on family planning methods (in case of FGD at Quetta), and how and what to feed infants. However, in case of any complication, the patient is referred.

**Our work is to take care of the pregnant women during pregnancy, and carry out the delivery smoothly and without any problem for women and to deliver normal and healthy children.**  
**TBA, Pishin: FGD**

**We also look after the patients and suggest different suitable treatments, give them medicines if available. For the medicines we have to ask the LHV. She gives us the medicines if available.**  
**TBA, Qilla Abdullah: FGD**

Under the government initiative, training was imparted to TBAs to address the shortage of female staff, thus make them part of health system at the community level. Most TBAs who were trained in the delivery of basic MNH services were satisfied with the newly acquired knowledge and were presumably applying it to serve women in the community. The training and linking them with BHUs had reportedly enhanced their status in the communities. The current position conveyed importance of TBAs among the residents, and TBAs took pride in being trained as MNH service provider. However, evidence of supervision of TBAs by the female health staff was found lacking in the study districts; hence the proof of TBAs using new knowledge could not be validated.

Another significant change which has taken place is that many TBAs had a small private clinic where women come to seek services instead of TBAs going to the individual's homes to serve them. The situation has made an important impact on the community as whole.

**At BHU level only LHV is available which is not enough.**  
**Gynaecologist, Qilla Abdullah: IDI**

**LHVs are treating people at their private clinics. They claim to be the doctors.**  
**MNCH Coordinator, Chaman: IDI**

**At some places there are no BHUs while in other villages there are BHUs but no staff. This situation has weakened the standard of health services and created many problems for the local community.**  
**LHW Coordinator, Pishin: IDI**

Most of the LHVs employed at PHC facilities were not local residents of the areas they serve. Furthermore, majority of them do not reside within the premises of PHC facilities due to poor and dilapidated condition of residential quarters, besides security concerns and threats to their honour. Moreover, because of rundown buildings of BHUs and RHCs, inadequate medicines and supplies availability and absence of proper infrastructure, many LHVs are running private clinics and undertaking procedures for which they are not qualified. According to anecdotal evidence and not through our qualitative research, LHVs do undertake abortions. All these factors have adversely affected the provision of MNH services from the public sector PHC facilities.

It has been reported that LHVs are irregular and frequently remain absent from their duty. A TBA from district Pishin reported that most of the time the LHV does not perform her duties and remains absent or comes to the BHU for a short time. Some other respondents viewed it differently and said that though the LHV does not attend her office regularly but when she does come, she attends the patients properly.

In all the health facilities across different levels and districts, the public sector service providers complained about the short supply of medicines and stationary and poor state of equipment. The medicines supplied were either insufficient or not needed at the facility. The expenditure on medicines at the PHC facilities is low (7.5 percent of the total expenditure in 2011/12) [8], thereby transferring considerable prescription costs to patients'

pocket. In such situations, the service providers can only offer counselling to the patients, which according to them is not appreciated by the users/patients. Most of those who come to the public health facilities belonged to lower economic stratum and the absence of medicines discouraged the users to seek MNH services as counselling was perceived less rewarding by the users.

**General pattern here is that if the doctor does not give medicine, patients will not come for check-up.**  
*DHO, Qilla Abdullah: IDI*

**If one does not give medicine to patients, they will never visit the facility again. They say it is useless to go to the doctor if medicines are not given.**  
*LHW Coordinator, Qilla Abdullah: IDI*

**Medicines also play some role in weakening the health. At primary level, first there are no medicines available or if there are some available then they are not good. The situation is like this. “At some places instead of supplying the required/requested medicine, some other sorts which were not asked for are supplied. Most often these are expired ones”.**  
*LHW Coordinator, Pishin: IDI*

The secondary care hospitals were better equipped compared to the primary healthcare facilities for the provision of MNH services. The infrastructure, staffing and supplies situation is somewhat better as well. The people who are aware prefer to go to the district level facilities since there is availability of female doctors and in case of emergency all necessary facilities are also present. However, this meant more workload for the providers at the secondary hospitals.

**Big hospitals offer better services as compared to other facilities and people go to these hospitals.**  
*DHO, Pishin: IDI*

**At the secondary level, public sector has established hospitals and appointed good doctors and full staff.**  
*Coordinator MNCH, Qilla Abdullah: IDI*

IDIs and FGDs respondents from Dera Bugti district also mentioned absence of any functional government hospital in their district. In case of emergency, they had no other choice but to go to PPL hospital at Sui or to other districts. Carrying emergency to other far off hospitals is extremely difficult for families because of the time and finances involved. The situation is further aggravated by social traditions which restrict female mobility.

The health sector is plagued with chronic staff shortages. The number of LHWs, LHVs, nurses, female doctors and gynaecologist working in PHC sub-subsector and referral hospitals, except in Quetta district of the province, are inadequate in number. The situation in the study districts was found to be much worse than in rest of the province/Agency. The shortage of female staff highly undermines the provision of and access to MNH services in these districts. Being a conservative society, women are highly unlikely to see a male provider even in case of emergency. As a result, population is left with no other option but to seek traditional providers, e.g. local Dai, or travel to the secondary care hospital or a private provider.

There are 28 BHUs, 25 CDs, and 2 MCH centres in the district. There is no laboratory, no doctor and just one Dispenser and LHV. What would they do? In MCH centres, where even the dispenser cannot stay, how can a female provider stay there.

District Coordinator National Program, Dera Bugti: IDI

A public sector provider from Dera Bugti gave an account of the availability of staff and services and the type of PHC facilities in the district.

**There are 28 BHUs, 25 CDs, and 2 MCH centres in the district. There is no laboratory, no doctor and just one Dispenser and LHV. What would they do? In MCH centres, where even the dispenser cannot stay, how can a female provider stay there.**  
*District Coordinator National Program, Dera Bugti: IDI*

According to a provider from Quetta there are significant delays in salary payment. It affects their domestic life and mars their motivation to work. The health staff was also concerned about the low wage rate and said that paying them at par with those working in safe and secure districts is unfair. It is not only the lower cadre staff who receives low salaries; doctors also feel the pinch of low salaries. Doctors in Quetta compared their salaries unfavourably with those of their counterparts working in the province of Punjab. They also demanded that an extra allowance be given, as an acknowledgement and appreciation of their serving in areas facing security risks.

As such the salary is so low and on top of that it is paid after three months. It creates difficulties for the family.

LHS Centre, Quetta: IDI

Salaries of all the doctors are so low that I can say, they are working without pay.

DHO, Qilla Abdullah: IDI

If we compare our salaries with the salaries of doctors in Punjab, theirs' are many times more than ours.

LHW Coordinator, Qilla Abdullah: IDI

Quite a number of public sector staff was found engaged in part-time jobs in the evening on the pretext of low salaries and they considered monthly salary as a mere stipend. The moonlighting negatively affects their efficiency and attendance at the regular government job as income from the private sector demands more time, efficiency and attention.

**As such the salary is so low and on top of that it is paid after three months. It creates difficulties for the family.**  
*LHS Centre, Quetta: IDI*

**Salaries of all the doctors are so low that I can say, they are working without pay.**  
*DHO, Qilla Abdullah: IDI*

**If we compare our salaries with the salaries of doctors in Punjab, theirs' are many times more than ours.**  
*LHW Coordinator, Qilla Abdullah: IDI*

Private sector is another important provider of services in the study districts that includes both for-profit and not-for-profit. However, since no mechanism is in place for the regulation of private sector, the quality of services varies across providers. Moreover, those working in the rural areas are not always qualified to deliver MNH services. Due to non-registration and lack of regulation, some of these private clinics are run by less qualified persons (quacks). In addition, the services in the private hospital are expensive and out of reach for poor and marginalised.

**The private hospitals are very expensive and out of reach of the poor.**  
*Coordinator MNCH, Qilla Abdullah: IDI*

**The private clinics here are playing with the lives of the people. Only a few registered practitioners are actually doctors, while the rest are fake. Dispensers, unskilled staff and teachers disguisedly work as doctors in their medical stores. They are giving injections to children. Government and administration need to take immediate notice.**  
*District Coordinator National Programme, Dera Bugti: IDI*



Users Perspective

The Balochistan community in general did not have much demand for MNH services as they lacked awareness about the importance of maternal and neonatal health. This situation was further precipitated by low status accorded to women's health in the local culture. Further, the community also complained about non-availability of medicines and supplies at public sector health facilities. Lack of medicines reduces the credibility of health facilities in the eyes of local population and de-motivates them from accessing services. Mothers, thus turn towards traditional birth attendants for seeking MNH care. Women relied more on traditional providers, such as consultation with TBAs, who both examined women and performed deliveries. LHV's were mostly not present on duty or easily accessible to the mothers at the PHC facility. People having resources, like money and transport, and who were aware of the importance of MNH services did visit LHV's and even tried to reach lady doctors in nearby towns or city. Participants from Dera Bugti reported that wealthy and resourceful people would go for better health facilities as far as Rahim Yar Khan and DG Khan in the province of Punjab. Poor and marginalised, in case of emergencies, visit LHV or nearby public sector secondary hospital.

**Eighty percent of the poor people consult TBAs who are working for hundreds of years, i.e. generation after generation. Doctors are out of their reach.**

**Community Influencer, Dera Bugti: FGD**

**Our Balochi medicines are very effective. Our customs do not allow women to go out of their home. Please do help us; we are leading our lives in very miserable conditions.**

**Mother, Dera Bugti: IDI**

The respondents from areas with no health services said that they relied on various home remedies and local herbs to treat minor and maternal health problems. At times they also consult Hakims (practitioners of traditional medicine) and Moulvi (religious leader) for Taveez (amulet) and Damm (spiritual healing) as a recipe for pregnancy complications. The non-availability of health services and restrictions on female mobility leaves women no other option but to get treatment from informal providers and use traditional remedies.

**Since we cannot go to well established doctors for minor ailments that is why we take help from Hakim and Moulvi.**

**Mother, Pishin: IDI**

**Most of the population here is poor; so they prefer to go to the government health centre or civil hospital. I also choose MNH services from civil hospital because of expenses. My husband is the only earning member of the family and is responsible for his mother, brothers and me. I try to get cheaper treatment.**

**Mother, Quetta: IDI**

Women from the poorer households lack access to proper health facilities at the community level and only go to the facilities in the nearby districts in case of serious complications or emergency situation, without mentioning the seriousness and type of complication. There are private providers, but it requires financial resources to seek care from them, which they do not have. Therefore, they use local remedies and consult the TBA. Even if the poor understand the importance of antenatal care, delivery from SBA and other needed services to manage maternal complications, poverty remains a major barrier in accessing the available MNH services. The male members of the households or local communities also do not facilitate their women for availing MNH services.

Summary of findings and Conclusions

The public health sector has a three-tiered health delivery system: LHWs at community level and community midwives (CMWs) in some area, LHV's and doctors at 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 due to higher security threats and limited provision of supplies. TBAs are also important service providers. KP and Balochistan provinces have trained some TBAs in the recent past.

MNH services at PHC facilities are facing a series of problems such as 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). However, these facilities are 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 the 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 lesser than 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 LHV's.

Lack of awareness 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.

The main findings are summarised in the template given below.

Issues: Existing services	Major Challenges		
	Khyber Pakhtunkhwa	FATA Agencies	Balochistan
Community awareness	Relatively better	Poor	Generally Poor
Community outreach services	LHWs, CMWs & TBAs provide services in most areas	TBAs provide services, LHWs generally non-functional	LHWs mostly not available, services provided by TBAs
Services at PHC facilities	Provided by LHV's and sometimes doctors	LHV's provide services at some facilities	LHV's provide services at some facilities
Secondary Level Care (EmONC)	Better equipped and staffed	Agency hospitals manage most cases while some in KP	Generally for minor complications except Dera Bugti; others sent to Quetta
Female Staff	Mostly available and working	Acute shortage at PHC and community level	Acute shortage at all levels except Quetta
Infrastructure	Poorly maintained and inadequate	Poorly maintained and inadequate	Poorly maintained and inadequate
Supplies and Equipment	Not supplied according to needs	Highly inadequate	Inadequate
Access and utilization	Reasonable	Poor	Inadequate
Private sector	Better developed, mostly urban based	Very basic, mostly urban based	Well established in Quetta, evolving in urban locations

Introduction

Militancy and insurgency in KP province and FATA has claimed lives of thousands of innocent citizens and cause mass destruction of physical infrastructure especially schools and some health facilities. It has also caused displacement of population from the affected districts and FATA agencies [9] and nearly a complete cessation of social services because of fear of killing and kidnapping for ransom by the militants. Some of the districts and agencies are areas of chronic conflict e.g. North Waziristan, while in others such occurrences are of more recent origin.

Up to 2009, approximately 3.6 million people and 0.531 million households were displaced in KP and FATA [10], of which up to July 2013 still more than 1.2 million people and 0.172 million households remained displaced [11]. The crisis affected not only the IDPs but also those who stayed behind, some of whom being just as poor and vulnerable as the IDPs. It is generally believed that the delivery of health services, including the MNH services, has deteriorated in conflict areas with consequent worsening of the MNH indicators.

The impact of disasters, compounded by socio-political and economic instability, resulted in increased marginalisation of women and children, especially the access to social services. Against this backdrop and the existing patriarchal structure of the society, women's education and health continue to remain neglected with gender disparity clearly visible across most of the MDG indicators [12].

Militancy and armed conflict has not only caused destruction and damage to some of the health facilities but has also led to displacement of trained health staff. However, following the military action of 2009, peace has been restored in many parts of FATA and districts of KP province. However, health facilities and quality of healthcare services, especially the MNH services, in most conflict districts and FATA agencies are highly inadequate.

The security landscape of Balochistan is punctuated by a combination of insurgency, militancy, Taliban presence in the northern part of the province, politically motivated targeting and attacks on North Atlantic Treaty Organisation (NATO) supplies. At this level of human security, acute deprivation, under development, abject poverty, illiteracy, chronic unemployment and continuous deterioration in the law and order situation the local population has been forced to migrate to the relatively safer localities. Ironically, the settlers (those who migrated from other provinces) who have lived in Quetta for generations feel unsafe to leave. Similarly, arbitrary arrests, enforced disappearances, extrajudicial killings, use of excessive force by state agencies against political rallies, illegal detentions, torture of political activists during interrogation, and uncalled for house raids and searches have sowed the seeds of deep insecurity among the masses [13].

Although there has been minimal damage to the health infrastructure from the ongoing conflict in Balochistan, the dearth of essential medicines and qualified health professionals, especially the female health staff, is a serious concern. There has also been sporadic events of killing and kidnapping of doctors and NGO workers [14].

Khyber Pakhtunkhwa Province and Federally Administered Tribal Areas

Perspective of Users and Providers

Peace has been restored in most areas of KP, but fear of Taliban still continues amongst the people. People are still afraid to travel, especially during night time. Many health providers highlighted the threats they faced from militants and the resulting fear that they experienced in delivering health services in general and MNH in particular.

The destruction and occupation of the health facilities has deprived citizens of needed health services in their areas. Further, poor law and order situation has caused closure of many health facilities. Other challenges

*The army is not doing operations in the area any more, but there are military check posts everywhere for the checking of vehicles, and etc. The military forces do not let us go out even if there is patient needing emergency treatment.*

*Father/Father-in-law, Lower Dir: FGD*

include dearth of trained health staff and supplies. At the same time, due time, due to ever-worsening law and order situation in

*Security is a big issue. People feel fear and have difficulties to come BHU even in daytime.*

*Doctor In-charge BHU, NWA*

FATA agencies, people are suffering economically owing to loss of jobs and business. In this scenario, poor

population seem to have no other choice except to go back to their traditional methods of MNH treatment recipes and/or suffer from serious complications due to lack of access to quality services.

The majority of health workers have either been kidnapped, killed, remain absent from duty or have gotten themselves transferred to safer places. The providers face fear of being kidnapped. The fear as well as frequent curfews imposed, especially during night, has also forced the providers to stay indoors and not perform their duties, especially in terms of dealing with cases of delivery or pregnancy related complications.

The female health workers like LHWs and LHVs and their family members are threatened with dire consequences when seen performing their duties. The serious patients and their families who take risk of reaching the health facilities away from their local area have either to walk through difficult/hard terrain or transport patients on the dilapidated roads to reach hospital. In both situations they face a potential threat from Taliban.

Respondents from district D.I. Khan also highlighted target killing as a critical barrier. Males cannot go outside their houses to arrange for transport and hence women cannot access MNH services in a timely manner. The transporters are mostly not willing to transfer emergencies to the hospital and if they agree, only at double the charges.

The episodes of conflict have seriously damaged and undermined the MNH services in affected districts and agencies. The interviewees stated that during the conflict period life, honour and assets of both MNH service providers' and care seekers were at high risk. A LHS from Swat district who had been working in the district for last seven years informed that during period when Taliban had taken control of this place, LHWs were particularly harassed and threatened.

*Due to the security issues LHW and NID Programmes have been badly affected. LHWs were particularly threatened and warned to stay at homes. Having official identity plates outside their houses Taliban could easily identify LHWs, which increased their vulnerability.*

*LHW Coordinator, Swat: IDI*

Law and order conditions are very bad. People were kidnapped. Many health workers were also kidnapped and assassinated.

LHW Coordinator North Waziristan: IDI

Security is a big problem. Due to terrorist activities of Talban, the law and order situation is worst. People are in fear. Curfew is imposed regularly.

Gynaecologist Agency Hospital, NWA: IDI

Due to the security issues LHW and NID Programmes have been badly affected. LHWs were particularly threatened and warned to stay at homes. Having official identity plates outside their houses Taliban could easily identify LHWs, which increased their vulnerability.

LHW Coordinator, Swat: IDI The worst affected areas are the FATA agencies. The findings show that Taliban



target rich, educated and skilled health professionals intentionally because they are the strength of any civil society. Attacks on them demoralise the rest of the population especially the weak, poor and marginalised who, therefore seek refuge in joining the Taliban - the main power currently prevailing in the area. It facilitates in the spread of Talibanisation and seems a viable solution for the survival of their captives.

**Law and order conditions are very bad. People were kidnapped. Many health workers were also kidnapped and assassinated.**  
**LHW Coordinator North Waziristan: IDI**

Kidnapping for ransom is a most frequently reported threat in remote areas of FATA agencies. Travelling in such areas is risky, especially at night. Some of the healthcare providers have left due to security reasons. Intertribal conflicts are not new in some parts of FATA. When fights are ongoing, people do not dare to leave their homes. Patients urgently needing health services are the ones most seriously affected. Responses show that conflicts have resulted in irreparable losses, extreme damage to the infrastructure and demography of the area.

In areas where peace has been restored to a certain extent, for example districts of Lower and Upper Dir and Swat, military check posts are still operating and regarded as a source of delay in timely accessing the needed MNH services.

Besides militancy, army operations, curfew and check posts are the other major factors which have interrupted the MNH programme in NWA and Bajaur Agency. When curfew is imposed people cannot come out of their homes. Curfews can last for hours and days. If a family member has to travel in emergency, one has to go through physical checking on the check posts. There are long queues of people waiting for clearance. Those who have had experience found it to be very frustrating and humiliating. Patients with complications travelling to the referral hospital had to go through these additional miseries and these delays resulted in fatalities in many instances.

Mothers from Buner district reported that women of their area do not seek services even in case of emergency because of security risks. An event was reported in which a woman was shot on her way to the hospital which demoralised the whole community. In many places because of army check posts or curfew, travelling becomes a big challenge for the women as they are not allowed by the men in their family to deliver at the health facility due to security problems.

**We were travelling as I needed to seek health service. On the way Army men did not allow us to go as they suspected us to be militants as well. At that time the situation was worse due to extreme militancy**  
**Mother, North Waziristan: IDI**  
**It has been the fear of terrorism and curfew conditions that pregnant women died on their way to hospital.**  
**Mother, Lower Dir: IDI**

Respondents from NWA, Khyber agency and Swat district reported that the major factor hindering the provision of MNH services is the unstable security conditions. LHVs and LHWs cannot move in the community due to the fear of Taliban. Both providers and the users face difficulties during curfew enforcement particularly in NWA and extensive checking at the Frontier Constabulary (FC) check posts and search operations in Swat. Travelling to the health facilities in emergency is not less than a nightmare. In such conditions, transport disappears and the patients cannot reach the hospitals for timely seeking the treatment, and consequently many patients have died.

**The military operations have been taking place for the last seven years in Khyber Agency. The imposition of curfew has made a world record as it is being imposed for the five years and is still going on. The markets are closed. The rich and poor both have been destroyed financially. All of them come to queue up at the Jalozai Camp for their monthly ration worth Rs. 2,500. Those who could afford have migrated to other areas. People living here do not have money to buy medicines after for check-ups. The people are desperate to get bread twice a day.**  
**Husband, Khyber Agency: FGD**

**In North Waziristan the frequency of curfew is a constant source of tension for the population whereas in Bajaur the mobility is restricted only in certain areas.**  
**Mothers/Mother-in-law, Bajaur Agency: FGD**

Of all the conflict affected agencies in FATA, situation of law and order is most acute in NWA and Khyber agency. Most of the respondents from the tribal areas are of the view that clashes/ conflicts between the insurgents and the security forces, and long imposed curfew have devastating effects on both health providers and users of MNH services. Due to security threats and curfew, the staff is unable to reach their place of duty. The problems faced by users are also similar as of the providers.

**Once the curfew was imposed in the area, a woman of our relative had to go to health centre. She was very poor and had no money for transport. Money and a vehicle were arranged and they set out for the city. On their way they were stopped at the check post due to curfew. After a lot of request they were allowed to go forward. When they reached the hospital, doctor told them that the delivery will be with operation. During operation the women lost her life while her baby survived. The doctor commented that her delayed arrival at the facility has caused death.**  
**Pregnant Women, Khyber Agency: FGD**  
**Curfew and military operations are taking place in the area where the government hospital is located, which is not all the time accessible. If Allah is willing, the state of affairs will improve in the area soon and people will be able to move freely.**  
**Mother/Mother-in-Law, Khyber Agency: FGD**

Non-Government Organisations (NGOs) providing health services too are facing severe threats from Taliban in the tribal areas of NWA and Bajaur Agency. They have suspended / stopped their activities in these areas. Both public and private health providers are rarely seen present and providing services in the conflict areas.

The security concerns and military operations are the major barriers in accessing MNH services. They have affected all, the providers, the users and the stakeholders' in the worst possible ways. Security issues are responsible for rendering health centres dysfunctional, insufficiency of staff and perpetual fear of travelling by the residents. For instance, in Samar Bagh UC of Lower Dir district, the hospital was rendered dysfunctional due to security concerns. The army has taken over the building and is staying there.

**Since Taliban have come to our area, we have not slept peacefully. Everyday somebody is kidnapped, accused of being an American spy, slaughtered and the body is thrown on roadside. I would say that here the only issue is of security.**  
**Agency Surgeon, North Waziristan: IDI**  
**I am local and fearful to go out of my home. Taliban have ruined our peace of life. They have kidnapped our doctors, took huge amounts of ransom money from them. Our educated people are frightened.**  
**In-charge BHU, North Waziristan: IDI**

According to the FGDs respondents, the tribal conflicts are common in both FATA agencies and KP, however, the frequency of occurrence and intensity is much higher in FATA agencies. In North Waziristan and Khyber agencies, the tribes involved in disputes start firing bullets even on minor issues, resulting in worsening of law and order situation in the area. Under such circumstances people usually prefer to stay indoors and do not dare to go out of their homes. The women are the worst affected under such conditions, as it further restricts their mobility even to visit the health facilities. One respondent from Bajaur agency told that intertribal fights are started on issues like land, woman, or as result of an insult to honour. These fights get converted to long term enmities lasting over decades or in some cases over generations.

In addition, imposition of curfew due to poor law and order situation is also a major barrier in accessing the MNH services. In case of an emergency, people have to make special efforts to get to health centres. As highlighted during FGDs, the frequency of imposition of curfew is high in FATA agencies and some part of KP. After every attack on army or security forces, curfew is imposed in the area, thus making it impossible for people to come out of their homes. Many cases were mentioned during the discussion regarding delivery on way to the health facility, thus resulting into either complications or death of women or the newborn.

Taliban have given serious threats to the NGOs and also to the private sector health workers who were collaborating with them. Consequently, the NGOs had to pull out and some of the private health facilities run by their support also faced sustainability problems.

It is also believed that not everyone is threatened in the same way; in terms of organisations it is the NGOs, while with reference to gender it is women who are more vulnerable. Due to security concerns the providers and care seekers both fear travelling. Thus, users' delay bringing the patients to the MNH centres and the providers refuse travelling to distant places in particular. This situation ultimately affects the health of mother and child. However, such problems are not reported in the city towns of districts.

Another change in the traditional practice related to endurance of labour pains has been generated by the compromised security situation, which under the given circumstances works as a survival strategy. During the fieldwork a new phenomenon was reported about preferred time for the child delivery during daytime. In the past traditional practice, the delivery was preferred at night-time, but now babies are preferably delivered during the day, when the security risks are less in accessing the health facilities or the provider's movement is possible. However, field researchers did not explore the means and methods used by the local communities to trigger daytime delivery.

***It has been the tradition of Khyber Agency that when a pregnant woman feels labour pains in the daytime, she would continue to bear the pains and try to delay the child delivery till night time, a time period culturally prescribed for child birth. Now due to the security situation daytime is preferred.***  
***MNCH Agency Coordinator, Khyber Agency: IDI***

**Balochistan Province**

In Balochistan security concerns are of different nature compared to those in KP province. Inter-tribal conflicts, target killing, vehicle snatching and kidnapping for ransom including those of health workers are the main threats rendering travelling risky and unsafe, more so in study districts. The travel, on the other hand, is generally tough in Balochistan due to poor road conditions, difficult terrain and long distances between the population clusters. Travel at night time in particular means risking one's life. Due to increasing militancy and tribal conflicts, travelling to seek healthcare at odd hours is very difficult and risky especially in the study districts. The situation holds true for both providers of services as well the users.

***The situation of law and order is a big problem because it's difficult to travel at night due to the fear of getting robbed or kidnapped for ransom. So people can't access the facilities for MNH services.***  
***District Support Manager, Pishin: IDI***

***Law and order conditions are bad. People have fear to travel. Sudden bomb blasts are happening even at the health facilities killing many providers.***  
***LHS, Dera Bugti***

As highlighted by the respondents of the IDIs, the law and order situation is the key problem affecting everyday activities of people and in particular in accessing healthcare including MNH services. For example, in the city of Quetta, with worsening security situation, common problems facing both providers and consumers of health services include unavailability of transport, road blocks, kidnapping, bomb blasts and target killing. As a result of such events, health providers are unable to get to the place of work and the patients remain confined to their homes.

Males are more vulnerable to kidnapping and killing. As a result, most of the health staff is afraid to travel long distances to either provide or monitor the health services. During discussions held with the midwives, they highlighted that it is not safe for both men and women to travel between and within the districts because of militancy and inter-tribal conflicts. This problem is especially acute for the communities who suffer the most because of non-availability of health staff.

A situation specific to Balochistan is increasing sectarian violence. In the recent past, the situation in Quetta city is tense most of the times. Consequently, health workers avoid attending the health facilities because of the fear of being killed or injured. Such a situation further adds to the problems of the citizens, who are unable to get services, especially during the delivery due to the lack of availability of healthcare providers.

***Security conditions in Quetta city are worst in Hazara Town, Saryab Road, Baroori and Wahdat colony. Healthcare staffs, especially the females, are afraid to perform duties. Absenteeism is reported high.***  
***Principal Midwifery School, Quetta***  
***Roads to Quetta are very bad. Patients face difficulty in reaching Quetta. On their way they may face robbery, target killing, kidnapping, vehicle snatching and crossfire in tribal fights. Many people got robbed on these dangerous routes.***  
***Midwife, Qilla Abdullah: IDI***

During data collection, the respondents from Quetta, Qilla Abdullah, Pishin and Dera Bugti reported that major factors hindering the provision of MNH services are the unstable security conditions. The providers mentioned that poor security and the tribal conflicts in Dera Bugti make it either difficult or impossible for the LHWs to perform their duties. In such circumstances, providing MNH services to the needy patients means risking one's life.



*Security issues are also very serious here; we cannot go for the visits in such conditions. “Major problem of our area is security due to which I have to take two family members, one male and a female, with me during my visits in community. This challenge weakened the health programme and no one can work freely”.*

**LHW, Quetta: FGD**

*We are faced with security issues. Doctors are vulnerable in particular. Since the past few years kidnapping for ransom has emerged as a serious problem due to lack of security. The standards of MNH services cannot be improved unless the security issues are resolved in the area.*

**PHM, LHW Coordinator, Pishin: IDI**

*We have security issues here. Until and unless the government ensures safety and security, it would not be possible to deliver quality MNH services. Dacoits/Banditry and theft is common here. It is very difficult for the female staff to live on her own here.*

**PHM, LHW Coordinator, Qilla Abdullah: IDI**

*There are many problems in providing MNH services because of security related issues. Among them issues like tribal enmity, theft and robbery top the list. Inadequate staff is also because of the insecure environment here. Since most of the staff is Punjabi settlers, they fear travelling and avoid moving about freely. It is extremely dangerous to travel during the night in persisting problems of insecurity. Many unfortunate incidents have taken place \*People have been deprived of their cars and valuables.*

**PHM, MNCH Coordinator, Qilla Abdullah: IDI**

The information was further endorsed by the LHW participants in FGD conducted in Qilla Abdullah, Pishin, Quetta and Dera Bugti, wherein they confirmed the poor situation of MNH services in the conflict affected areas. The most difficult challenge cited in delivery of services was travelling to the place of work, wherein movement of females is already restricted in conservative society. Many of the LHWs showed their inability to travel alone as a reason for absence from duty during the times of violence, curfew or when there were security threats in the Quetta city even during the day time. Kidnapping for ransom is a most frequently reported threat in the remote areas of Balochistan (likewise in FATA agencies). Travelling to or crossing through certain areas, especially at night, means risking one's life. Some of the health service providers have left due to security reasons. Inter-tribal conflicts are not new in some parts of Balochistan, but when fights are on then people do not dare to get out of their homes. Patients needing health services are the ones most affected. From Dera Bugti and Pishin a number of such incidents were shared.

Balochistan health sector is already plagued with scarcity of trained staff, especially the females. Deteriorating law and order and increasing kidnapping and incidents of violence have further precipitated the situation. A large number of healthcare providers, mostly the settlers, are either migrating to other provinces or avoid travelling to their place of duty. This scenario has further undermined the provision of MNH services, more so in the rural areas. The situation of staff absenteeism is worst in the conflict affected districts, in particular the female staff. The local residents are also afraid of travelling to health facilities and therefore depend on the local untrained dais (TBAs) to conduct deliveries.

*People are afraid of travelling long distance due to security issues. To avoid travelling, they prefer to conduct deliveries by untrained Dais. That often leads to maternal and neonatal mortality. Therefore, women of this area are generally poor in health.*

**LHV, Dera Bugti: IDI**

Inter-tribal conflicts were mentioned frequently by the users from Qilla Abdullah, Dera Bugti and Pishin districts. They went on to say that these conflicts, many a times, became so massive that in many instances they resemble a war. Such incidents were cited as frequent happenings. These conflicts have affected the MNH services as women in need of services can neither go to the health centres nor can the health staff. The public transport also disappears during such times, further precipitating the plight of both the providers and the consumers.

*There are conflicts in our area and there is no peace. Security is the biggest problem. Most of the people have migrated to other places. If security issues are there, then every person is worried about safety and property. We are unable to get out of our homes even for food what to say of health for myself and my children.*

**Mother, Dera Bugti: IDI**

*If sick, because of conflict even if we wanted, we cannot travel to the health facilities to seek services for ourselves or the children.*

**Mother, Pishin: IDI**

The acts of terrorism and militancy have adversely affected the MNH services. They have disrupted normal activities of life. The roads get blocked, public transport disappears and both the health services staff and patients find it impossible to reach the health centres. In case of emergency, women are mostly referred to the district hospital for management, but many a times either the staff is not available at the facility or there is lack of transport. In such instances, many a times the result is death of the mother or the baby or both.

*Now a day's Taliban are in great number here. When their meeting is arranged then reaching hospital becomes impossible because every way is closed and Taliban fear is too much that no one allows their family member to go outside. \*We cannot reach hospital in such situations because transport is also not available”.*

**Mother, Pishin: IDI**

In Balochistan, there are not many private providers and NGOs working in the conflict affected districts. In some districts like Quetta where they were providing services, many have left due to kidnapping, killing of their workers and security concerns, leaving the users to the mercy of the traditional health providers.

### Summary of findings and Conclusions

Dera Bugti district in Balochistan 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 socio-economic 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 jobs 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 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.

REFERRAL LINKAGES TO  
HIGHER LEVEL HEALTH FACILITIES

The main findings are summarised below.

Security Issues	Major Challenges		
	Khyber Pakhtunkhwa	FATA Agencies	Balochistan
Kidnapping for ransom	Not many incidents reported	Many incidents of health providers	Many incidents of health providers
Intertribal Conflicts	Not an issue	Common, resulting in poor law and order	Common occurrence and can escalate to major fighting
Military check posts	Create hurdles for both providers & users	Major hindrance for both providers & users	Major hindrance for both providers and users
Curfews	Not a problem after army operation	A major challenge and very common	In Quetta but not frequently
Insurgency	Minimal after military operation	Ongoing, even during military operation	Ongoing
Sectarian violence	Isolated incidents; no major impact on provision of MNH services	Not reported in the study areas	Major issue for both providers and users in Quetta
Availability of health providers	A Minimal issue	Serious issue in rural areas	Serious issue in rural areas & Dera Bugti as a whole
Transport to reach health facility	Not an issue during day time	A acute problem	Shortage of transport, charges very high at night

Introduction

Referral is a process by which a health worker or a health facility transfers the responsibility of care to another worker or a facility. It is a two-way care system to ensure continuum of care. In this qualitative research study covering security compromised areas, the referral system has been assessed from the perspective of both the providers and users of MNH services. The study underlines how the responsibility of care is passed on from the community health worker to the PHC facility to the referral hospital. The study also captures the mode of travel and availability and access to transport, being an integral component of continuum of care.

Pregnancy and childbirth also brings potential for ill-health and suffering for both the mother and the newborn, particularly if the referral system is poorly functioning and decisions are not made in time. The potential for first delay is the time taken by the family to avail and locate referral services at the time of identification of a complication; the second delay occurs in search of transport to reach the referral facility; and the third delay happens at the referral facility in managing the referred patient timely[15].

The impact of first two delays is more pronounced in conflict areas under study, as decision to avail referral services get compromised because of a variety of reasons, such as difficulty in getting transport to reach the referral hospital, security risks during travel, temporary restrictions imposed by the law enforcement agencies en route, curfews, fear for safety while on the road, absence of essential staff at the referral place, and others.

The social implications of ill-health and limited access to referral services in security compromised areas have received little attention in the past. The research on this dimension, with a focus on experience in obtaining EmONC services in security risk areas, will go a long way in helping social institutions understand the challenges from the users' and providers' view point, and to think 'out-of-the-box', to effectively provide a continuum of care.

Khyber Pakhtunkhwa Province

The referral structure for the MNH services in the province is pyramidal with largest number of community level providers comprising LHWs and TBAs, and small number of PHC facilities (BHUs) at the base. The number of health facilities decreases gradually in ascending order for referral support. The referral facilities are generally better equipped and staffed to deal with simple and complicated cases referred from the community and BHUs. The referral facilities in ascending order comprise RHCs, Tehsil hospitals, District Headquarters (DHQ) hospitals and tertiary care/teaching hospitals. The DHQ and teaching hospitals (e.g. in Swat and Peshawar) have the skills and resources to deal with maternal and newborn complications during pregnancy, delivery and the post partum periods.

Providers Perspective

The referral procedure, as mentioned earlier, is a chain system wherein patients are referred from the lower level to the higher level health facilities. Ideally, it should work in an organised way but in practice it is either non-functional or poorly functioning e.g. absence of or non-functional: referral form, transport system either by the public sector or by the community, reporting desk at the referral facility to guide the patient's attendant and feedback to the referring facility. Bureaucratic procedures also make the referral system complicated for e.g. a long process to get permission for using the hospital ambulance service and lengthy admission procedure for emergencies.

Most frequent problems in the referral chain mentioned by the providers comprise non-availability of ambulance, lack of funds for fuel and absence of driver, improper transportation of emergencies (e.g. transportation in vehicles used for commuting passengers), high cost of transportation, delayed referrals and dishonouring the referrals at higher level facilities in terms of disregarding the referral slip or non-availability of skilled person. Most of the DHQ and specialised hospitals are not equipped with needed protocols and facilities that meet the needs of referrals from primary healthcare level. Unfortunately, no significant action is being taken by the department of



health to improve the referral system. In most cases, the patient's family has to arrange the transport on their own.

***To use the ambulance of a government hospital, one has to go through a lengthy process of getting the permission. After the permission, one finds that the ambulance is out of fuel or the driver is not available.***

***LHV, Upper Dir: IDI***

***Those who can afford to reach the public sector referral hospital, they do so at their own and the one who cannot afford take the patient back home.***

***LHV, D.I. Khan: IDI***

***In my opinion, our referral system is extremely faulty because of the bureaucratic formalities. If referred, the patient must take permission from the M.S to use the ambulance which takes at least an hour or more. And if the permission is granted hospital charges double the fare compared to private transport. This needs to be strictly monitored.***

***In-charge Gynae unit, Lower Dir: IDI***

Quality of referral system has been questioned by a number of providers in DHQ hospital Buner. LHVs appeared unhappy with non-cooperative behaviour of the hospital staff. According to them, the staff does not give proper attention and treatment to the patients. Sometimes they even throw the referral slip in the dustbin. The common reasons cited were overcrowding in the hospital and a tactic used by the specialist to attract the patients to their private clinic.

***Patients are not well received at DHQ hospital because of overcrowding.***

***LHV, Buner: FGD***

***Patients don't come here because of fear of staff behaviour. Behaviour of staff at DHQ hospital is bad because of overcrowding.***

***LHV, Buner: FGD***

***There is only one OBGYN specialist in the district. Specialist insists patients to visit her private clinic.***

***LHV, Buner: FGD***

Another major hindrance to the timely management of EmONC cases at the referral hospitals is the shortage of female staff and necessary supplies and equipment. Many secondary level hospitals lack capacity to deal with complication of pregnancy and that of neonates. Many providers also reported incidents of bad staff behaviour as well as mismanagement of referred patients.

***There is shortage of equipment for providing MNH services at the DHQ hospital.***

***EDO Health, Buner, IDI***

***There is no gynaecologist at Tehsil hospital.***

***EDO Health, Swat: IDI***

***59 posts of nurses are vacant.***

***EDO Health, Upper Dir: IDI***

Private health facilities are reluctant to refer their patients unless it becomes inevitable and the condition of the patient becomes serious. In case of delayed referrals, the medical history of patient is usually not given to protect the person referring the case.

***When private facilities refer a case, they do not give their prescription and detail of treatment given to the patient out of the fear that they will be held responsible in case of death of the patient.***

***LHV, Upper Dir: IDI***

The department of health has provided ambulances at the referral hospitals. However, a number of providers reported that the ambulances are much less in number compared to the patients load. As most patients belong to the lower socio-economic stratum, arranging money and transport tends to take a considerable amount of time, putting the life of the mother and the baby at risk. A number of private transport facilities are also available near the hospitals, as reported by a number of providers. These are owned either by a private company or philanthropic organizations e.g. Al-Khidmat or Edhi Foundations under philanthropy. They lamented high fares charged by the private transporters but appreciated the role played by the foundations.

***Al-Khidmat Foundation offers ambulance service at DHQ level.***

***District Coordinator LHW Programme, Buner: IDI***

***It is only Al-Khidmat Foundation which provides free transportation but only at Taimar Garah.***

***LHW Programme Master Trainer, Lower Dir: IDI***

***Edhi and Al-Khidmat Foundations provide ambulance service but not in rural areas. They charge some fee.***

***Assistant Director LHW Programme, Swat: IDI***

***In DHQ Saidu Sharif, Al-Khidmat Foundation and Edhi provide ambulance service. But peripheral areas remain deprived of such services.***

***LHS, Swat: IDI***

Users Perspective

Those directly involved in the process of the referral include pregnant women and their families. They are the ones who go through physical and financial ordeal. The plight is more in the case of women belonging to rural far flung areas. These remote areas lack proper roads and local transport while the health facilities are plagued with dearth of female staff. All these problems are further precipitated due to ongoing conflict and security threats.

Another issue cited by the mothers during FGD was the non-availability of female doctors. The situation becomes very difficult in case of emergency, since women are not allowed to seek care from male providers because of the local traditions and norms. Hence, there is no option but to consult a private female doctor. However, many users are unable to afford private sector services.

In the conflict affected areas, ambulance from the department of health is not available and people have to rent a vehicle to take the patient to the hospital. In communities where private transportation services are available, people have the option of renting out a vehicle in case of emergency. In the absence of such services, a male member of the family or some other male kin has to go to a nearby place to rent a vehicle.

The respondents from Buner shared that security is still a major problem. Bomb blast, search operations, curfew and military check posts are some of the problems due to which no one can travel at night to reach the referral hospital. The broken roads and lack of transport further add to the problems.

***It is difficult to travel and avail referral care, as all the time the risk and fear of death hovers over us because of militancy.***  
***Mother, Buner: IDI***

A mother from Upper Dir complained that their area lacks proper roads to reach secondary level health facility. The BHU is located on a mountain and patients have to walk to get there. She narrated her personal experience that in an emergency, she was taken to the health facility by tying her on a cot in order to secure her from falling down because it was an uphill walk. She delivered the child on the middle of the way to the health facility.

***Our homes are situated on high mountains and the roads are far below that level. When a woman with complications needs to be taken to the health facility, she is carried on shoulders and brought to the road side. It is a very difficult situation for both the person carrying as well as the patient. Once we reach hospital after going through hardships and difficulties, we fail to get attention from the hospital staff.***  
***Woman with <1yr Child, Upper Dir: FGD***

A number of mothers appeared to be satisfied with the role of PHC facilities in the referral of emergencies. However, users mostly preferred to get referral treatment from the private health sector due to good quality of services. The elements of good quality care were described as facility for undertaking all tests, availability of staff and specialists, passionate behaviour and less wait time.

***I and my family members prefer to go to private hospital. The doctors are always available there. Though money is spent in private hospital but all facilities related to mother and child health are provided. While, at the government hospitals doctors are often not available and even when present they do not give much attention. At these hospitals one always face problems in the availability of bed and medicines.***  
***Mother, D. I. Khan: IDI***

Some respondents also appeared satisfied with the behaviour of the staff and case management at the public sector hospitals. However, many respondents from D.I. Khan complained about lack of medicines and other services needed for the management of emergencies at public sector hospitals. Inappropriate behaviour of staff was also reported by some respondents from Swat and Buner e.g. lack of privacy during consultation or even during delivery, scolding like mother-in-law, informal payments.

***The government hospitals staff works only for people who bribe them. With rest of the patients, staff behaves in rude manner. Because of their behaviour, some people prefer going to the private hospital.***  
***Mother, Swat: IDI***

**Federally Administered Tribal Areas**

The status of referral MNH services is much worse in FATA agencies compared to other conflict affected areas of KP. This state of affairs is because of limited opportunities for accessing appropriate transport, damaged roads, army actions and curfew, shortage of female health staff, and shortage of supplies and equipment for handling the emergencies. In addition, the local cultural norms restrict female mobility, further restricting the access of women to referral facilities during pregnancy, delivery and post-delivery complications.

**Providers Perspective**

The findings from FGDs with LHWs revealed that in delivery cases, they refer pregnant women to the relevant BHUs/RHCs of the area they serve. However, they seemed unsatisfied with the behaviour of the facility staff in managing the referred women. Further, explaining the situation, they said that when they refer a patient to BHU, the staff and the doctor at the BHU neither pays attention nor properly manages the referral that damages the trust and relationship between the community and the LHW.

LHWs from Khyber Agency were of the opinion that the BHU staff make experiments on the referred patients and do not skilfully handle the cases. After a successful delivery the staff demands a reward from family of the patient. This unbecoming behaviour of the staff at BHU puts off most people who then prefer to go to a private facility for delivery.

The IDIs with higher level staff paints a mixed picture of the capacity of the Agency hospitals for managing the referred patients and those MNH complications. Agency hospital, North Waziristan is stated to be well equipped to deal with referrals. The capacity of the Agency Hospital at Bajaur is stated to have some deficiencies. Khyber Agency hospital manages around 400 deliveries every month, meaning thereby a reasonable potential to cope with MNH emergencies.

***There is lack of some necessary facilities at the Agency hospital, e.g. laboratory services.***  
***Gynaecologist, Bajaur Agency: IDI***  
***Facilities are available to some extent at secondary level.***  
***MNCH Coordinator, Bajaur Agency: IDI***  
***Agency hospital is well equipped to deal with referrals.***  
***Agency Surgeon and Gynaecologist, NWA: IDI***  
***About 400 deliveries are conducted every month.***  
***Gynaecologist, Khyber Agency: IDI***

There are cases where ambulances are parked at the hospital but cannot be made available to the patients due to lack of resources for fuel and maintenance, as reported by LHWs and LHV's during FGD from Khyber and Bajaur agencies. If patients want to use the ambulance, they have to pay higher charges. Other times the ambulance drivers are not willing to take the patients to the hospital.

***Suzuki pickups and 5 ambulances are standing in the hospital but they are not functional. When somebody requests the relevant staff to allow using the ambulance, the request is turned down on the pretext that the fuel cannot be arranged.***  
***LHW, Khyber Agency: FGD***

A major challenge in the rural communities and remote mountainous areas is the lack of transport/ambulance. There are not many private transporters in the area. Those who have private vehicles, agree to transport the patients at a high cost. However, this offer is available only during the day time. At night, they refuse to transport patients for any amount of money due to fear of the Taliban. The gravity of the problem increases when a vehicle is not available, and the family has to make an extra effort to arrange some kind of transport for taking the mother to the referral facility. Therefore, it becomes difficult for the users to access and avail the referral services for the management of pregnancy related complications

***Drivers are not willing to provide transport service to the patients due to the fear of Taliban. Taliban would snatch the vehicle from the driver and if face resistance they kill the driver and take away the vehicle. The drivers only provide this service when patients are referred to Bannu or Peshawar.***  
***LHW, North Waziristan***

Owing to more than a decade of militancy and insurgency, NGOs or not-for-profit organizations are not working in FATA. The participants during the discussion were of the view that the government should make special efforts to contact NGOs and provide them necessary facilitation in running the ambulance service to strengthen referral for the MNH services, especially in the remote areas.

**Welfare organizations, like Fatmid and Khalq Foundation, should also work in agencies and provide ambulance services. Government should improve existing transport system in the hospital and also provide new ambulances, besides expenses for fuel and driver's salaries.**  
**LHW, Jamrud, Khyber Agency: FGD**

In most of the FATA agencies, self-referral is used both for the complicated as well as the normal deliveries. In majority of the areas, this practice is adopted because of the non-availability of services like skilled female staff, lack of medicines and infrastructure at the BHUs. According to the LHV's there is an acute shortage of female staff all over FATA agencies with consequent impact in dealing with MNH complications. LHV's suggest that if BHUs are strengthened to cater for basic MNH services, it will not only save the family from experiencing a delay in getting proper care, but would also prevent unnecessary maternal and newborn deaths.

Users Perspective

The communities in FATA are very conservative. Observance of purdah is widely imposed and women are not allowed to travel without a male escort. The terrain is also hilly and the roads are either non-existent or are unpaved and not transport friendly. Mothers from Khyber agency reported that in view of purdah, it is necessary to arrange a special vehicle to take female patient to the hospital.

**Our husbands, as a special consideration for Purdah, rent private vehicles to reach the facility.**  
**Mother, Khyber Agency: IDI**

Some mothers complained about transporters' monopoly and the unaffordable fares that are charged by them. This problem is exacerbated by the fact that it becomes extremely difficult to arrange the cost of travel in case of emergency.

Normal deliveries are conducted at homes and if any complication occurs then TBAs advise the families to take the pregnant women to the hospital. In such situations, delay in arranging money and transport and sometimes security issues act as barriers and unfortunate consequences have to be faced. It was also reported that many mothers lost their infants on the way or after reaching the hospital, because TBAs notified them of critical conditions at the eleventh hour. A mother from North Waziristan narrated her personal experiences during emergency.

**My condition was very critical. Dai advised my family to take me to the hospital as my condition was deteriorating. On her advice my family took me to Miran Shah Hospital in a pickup, but I lost my child because of delay.**  
**Mother, North Waziristan: IDI**

One of the pregnant mothers from Khyber Agency shared her own experience of her last pregnancy during a focus group discussion.

**During the sixth month of pregnancy, suddenly bleeding started and I fainted. Delay in arranging private vehicle caused more complications. Though I reached the hospital but due to delay my baby expired. I often think that my baby might have survived if I could have reached the health facility in time without any delay.**  
**Pregnant Woman, Khyber Agency: FGD**

The situation of mothers from Bajaur Agency was not found to be very different from that prevailing in other agencies. For a patient to reach a hospital in case of emergency has become almost impossible. Due to a poor law and order situation, and the ensuing security concerns, the arrangement for transport is not less than an ordeal. All these factors make travel impossible, especially late in the evening and at night.

**Now the situation is so bad that stepping out of one's home is like pushing oneself into a well. So going to hospital has become a dream for us now.**  
**Mother, Bajaur Agency: IDI**

In North Waziristan, the Agency hospital as well as private hospitals and clinics are located in Miran Shah City – the agency town. It takes several hours to reach these facilities. Further, ongoing military actions and violence makes it difficult for the women to access the services in case of emergency.

However, a mother from North Waziristan is satisfied and thankful to the staff of government hospital. She was provided with timely referral and good treatment and care during delivery.

**The staff of the government hospital rescued me from going into the jaws of death.**  
**Mother, North Waziristan: IDI**

Balochistan Province

Balochistan is the largest province by area and is the home of only around 5 percent of the population of Pakistan. In addition, the terrain is difficult, distances are large between the villages and local transport system is under developed. The health systems across all districts are weak and the quality of MNH services leaves much to be desired. The health department is faced with many challenges, most important being the acute shortage of trained female staff and specialists with most being concentrated in the urban areas, especially in Quetta. The PHC facilities are neither fully manned nor equipped to deal with deliveries and referrals received from TBAs and LHWs. The referral system is rudimentary and in most places ineffective.

Providers Perspective

Most providers consider the referral system as poorly developed and even non-functional. The providers in the tertiary hospitals receiving advanced complicated cases from many districts considered it a challenge for an already overloaded hospital. The department of health has not made any effort to improve and strengthen the referral system. The facilities being referred-to lack trained staff, necessary supplies and equipment to deal with the emergencies. Strong criticism was also made on LHV's and TBAs serving in the periphery regarding delays in referrals. Cases with advanced complications cannot be handled at the district hospitals as they lack both staff and supplies, and are thus referred to the tertiary hospitals in Quetta or similar facilities in the nearby provinces.

During IDIs and FGDs discussion, it emerged that coordination among the initiating and receiving referral facilities is generally weak. They do not tend to keep any record for follow-up on either side. They usually do not ask for any previous prescriptions and may only enquire from the family member accompanying the patient about earlier treatment given. In case of poor and marginalised people who are usually illiterate and unaware about the details of treatment given earlier, the receiving facility staff can be even more indifferent.



**The referral system is poor. The patients are referred to the tertiary hospital quite late. It puts a lot of stress on the staff of the hospital. The LHV or TBA keep the patients with them too long and use the medicines unnecessarily. Consequently, the patients are referred to the tertiary hospital when they are at the terminal stage like ruptured uterus, etc. At this stage arrangement of transport becomes another issue. The delay is prolonged and the patient's condition deteriorates. At times the patients are referred to Karachi.**

**Gynaecologist, Quetta: IDI**

**From BHUs patients are initially referred to PPL hospital in Sui - a big hospital or to a nearby surgeon. In case of serious emergency and if the services required are found unavailable, the patient is referred to DHQ in Rahimyar Khan in Punjab. From the peripheral areas patients are referred to DHQ hospitals at Loralai, DG Khan or a nearby city in Punjab.**

**District Coordinator, LHW Programme, Dera Bugti: IDI**

**Due to untrained staff at the peripheral level, it becomes difficult to decide about the complicated pregnancy cases where the patient should be referred.**

**Principal Public Health School, Quetta: IDI**

**Previously, the LHVs used to take the pregnant women for check up to the doctors themselves. Now we do not have any contact with the MNCH services. The MNCH Programme is working independently and there is a lack of coordination.**

**District Coordinator, LHW Programme, Quetta: IDI**

In the absence of a fully functional PHC system, MNH services in rural areas are mostly provided by the TBAs. Some cases are referred by the community level providers to the nearby MCH centre/BHU/RHC or a private clinic.

The other key provider of MNH services is the private sector, where the referral situation is even worse. The public sector secondary hospitals in the study districts, other than Quetta, are not trusted by the private providers. During discussions, it was observed that private sector avoids referring women with complications for the fear of losing money. If they do refer as a safeguard against death, they refer either to other private sector colleagues or to public sector hospitals at Sadiqabad or Rahim Yar Khan in the province of Punjab which are better equipped and staffed.

**In private sector there is no referral system. They don't refer patients for the sake of money. However, if the condition is complicated and life of mother and child is in danger only then they refer to main hospitals. The referrals are usually made to Sadiqabad and Rahim Yar Khan.**

**Senior Nurse NGO, private hospital, Dera Bugti: IDI**

**The private and NGO facilities avoid using referral system as their main focus is on collecting the fee; so they try to treat patient in their own facility. They don't have transport of their own. Patients when referred use private conveyance to reach the main hospitals.**

**President, PMA, Pishin: IDI**

**In private health facilities, we do not have a referral system. In case of emergency, we refer the patient to a friend doctor. This is how private facilities coordinate with each other.**

**Private Clinic Gynaecologist, Quetta: IDI**

The issue of transport for referral of patients, whether to the public or a private facility, needs to be understood in the backdrop of prevailing situation of law and order and security risks in the province, as already explained in chapter 2 of the study.

In the public sector, few RHCs and secondary hospitals have ambulance facility. Where an ambulance is available, its accessibility is limited to the patients for a number of reasons including the lack of funds for fuel, non-availability of driver or need for the ambulance for other purposes. The key sufferers in such situations are, therefore, the poor and marginalised.

Secondary hospitals that have functional ambulance charge money. In such instances, the cost is higher than what is charged by the private sector, leaving people with no option but to use the private transport. The private transporters too charge high fares and in case the patient is to be transported at night time, the charges are further increased.

**The transport system is non-existent. There is only one ambulance in the whole district and that too in the DHQ hospital. Broken/dilapidated roads also lead to delays in treatment.**

**LHW Coordinator, Pishin: IDI**

**We have an ambulance at district hospital, but due to lack of funds the patient has to bear the fuel charges. In case of emergency, everybody is cooperative. Families sometime arrange a private transport. However, poor usually face problems.**

**District Coordinator LHW Programme, Dera Bugti: IDI**

**There are 4 ambulances but without funds for fuel. The patients must pay for it. The charge is Rs. 5000 for an ambulance travelling from Chaman to Quetta, which is higher than what private transport charges. Poor families fail to afford fuel charges. People usually arrange private transport themselves. However, poor patients cannot even afford private transport.**

**Gynaecologist, Qilla Abdulla: IDI**

Other than the high transport costs, convincing a driver is also a problem because travel in security compromised areas implies putting one's life at risk. Travelling at night is more life threatening. The situation is much worse in areas where there is no private transport. In such situations, the families have no option but to keep the woman at home, use local methods of treatment and pray for her recovery.

Given the non-affordability by the poor, Edhi Foundation is providing ambulance facility to the poor in Quetta. In absence of functioning public sector ambulance system, another system was tried to facilitate the transportation of poor referred patients. One such example was quoted from Dera Bugti, wherein 'zakat' funds were mentioned as a source of funding for ambulance charges, but did not last long. Sustainability of such welfare activities usually becomes a problem, as it is easy to start but sustaining it becomes a challenge.

**Previously zakat funds were used to provide free transport to the poor patients. But now neither the government nor the affluent people provide any financial assistance. There is no NGO here which would work for such issues faced by the people.**

**District Coordinator, LHW Programme, Dera Bugti: IDI**

## Users Perspective

Pregnancy and delivery related services are generally provided by the TBAs, especially in the rural areas. According to the users, TBAs either advise the family or accompany the mother to visit the nearby MCH centre/BHU/RHC or a private clinic in case of complication.

A mother from Dera Bugti complained the lack of proper referral services for the rural areas. She went on to say that women are dependent on the TBAs, who many a times are unable to handle the case thus endangering the lives of women and babies during delivery. She lamented that, 'because we are poor that is why the Balochistan government does not take notice of our sufferings.'

**Government should take notice of the non-availability of health services here. We people also deserve to be provided with required health facilities.**

**Mother, Dera Bugti: IDI**

Majority of the participants complained about the lack of staff, equipment and medicines in the referral facilities especially those of public sector and Dera Bugti district in particular. They also complained about the bad behaviour of the staff. A respondent from Dera Bugti said: 'May Allah improve the situation of our area; in that case all problems would be fixed and our children would be able to get education.' (Mother, Dera Bugti: IDI)

**Mothers from Dera Bugti express their dissatisfaction with irregular and insufficient medical supplies and absence of the female doctor. The only health staff at the facility is LHV. She alone cannot treat the patients especially when the patient needs to be operated. In this situation the patients are referred to the main hospital for operation.**

**Mother, Dera Bugti: FGD**

**One of my friends got complication during delivery. TBA suggested that she should be taken to the hospital because normal delivery was not possible. The family of my friend is very poor. After great difficulty they arranged for a Rickshaw and took her to the hospital. At that time no staff was available in the hospital. Someone advised them to take her to Quetta. Ambulance was also not provided to them at that time. Then they arranged transport and took her to Bolan Medical hospital. But it was too late and her child had died before delivery. The hospital staff could only save her life.**

**Mother, Pishin: IDI**

Not all women during the discussions appeared dissatisfied with the MNH services provided at the public sector facilities. Mothers from Pishin and Qilla Abdullah mentioned that they are satisfied with the referral services provided by the staff of government hospitals. They appreciated the good work being done by health providers. The women in two separate incidents appreciated their work in resource constrained settings.

**Good people are present even in this era. Thank God that service providers were available at the critical time of delivery of my daughter.**

**Mother, Pishin: IDI**

**Delivery of my daughter got complicated and we took her to the referral hospital. In my view, at that time the staff of the facility handled the situation very well.**

**Mother, Qilla Abdullah: IDI**

Some families face difficulties to get to the hospital due to security issues and tribal conflicts. In districts like Dera Bugti and Pishin, females face security threats to get to the referral hospital. Users also face difficulties to arrange transport not only because of purdah and cultural practices but also due to rough roads, security issues and financial problems. Many a times, if more than one woman of the same community needs to travel to the same health facility during day time, then they arrange and travel together in one vehicle in order to economise the travel. In such situation male chaperon is also not required.

**If there is more than one woman who at the same time needed to travel to the health centre, they hire one vehicle and divide the fare equally among themselves.**

**Mother, Dera Bugti: IDI**

Mothers from Qilla Abdullah highlighted the role of family elders including mother-in-laws in seeking permission to avail MNH services at the referral facilities. They explained that a lot of opposition is faced from the family heads, who insist on continuing the old practice of delivering a baby at home by a TBA. A respondent narrated an event of a female relative who needed emergency care for delivering her baby, but her father-in-law opposed and refused to take her to the hospital. In districts like Dera Bugti and Pishin, females also have to face family restrictions besides security threats to get to the referral facilities.

**"Her father-in-law said that all of our children were delivered at home. What is the need to take her to the hospital? She should deliver her child at home as well."**

**Mother, Qilla Abdullah: FGD**

### Summary of findings and conclusions

Considerable delays have been observed in making decision to avail the referral services and in search of a suitable transport to carry the mother to the referral facility, especially in the rural, far flung and mountainous areas. The quality of services at the referral hospitals is compromised because of the absence of referral procedures or protocols, shortage of female staff and specialists, and shortage of supplies and medicines at the secondary hospitals, more so in FATA agencies and Balochistan (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. Furthermore, permission of elders is also required for seeking care at secondary hospitals, especially in FATA and rural areas of KP and Balochistan.

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



## PERCEPTIONS AND EXPECTATIONS OF USERS AND PROVIDERS TO THEIR MATERNAL AND NEWBORN HEALTH (MNH) NEEDS

### Introduction

Users and providers perspective means capturing the experience of accessing MNH services by the childbearing women and their families as well as providers experience in meeting the needs of users. Individual users are 'the experts' to best articulate their needs for MNH services. Such a perspective is a lived experience and will describe the events of receiving, or being unable to receive the essential MNH services when needed for the health and survival of a mother and her future baby. The 'lived experience' is often under-recognised and even undermined by the social institutions that govern contemporary social life. Therefore, looking at the delivery of MNH services from the point of view of users and providers is necessary to explore, especially as women get marginalised and discriminated in the conflict ridden areas.

In summary, users and providers perspective will help the social institutions to find out: how users and providers rate the available MNH services in terms of quality, access and timing; whether the services meet the MNH needs of those living in the conflict affected areas; and how to better serve the users.

### Khyber Pakhtunkhwa Province

### Providers Perspective

There are several deficiencies affecting the quality of MNH services. First, there are infrastructure deficiencies affecting the quality. A gynaecologist from DHQ hospital, Buner, explained the situation as follows:

***Electricity load sheeding is a major challenge. Many a times electricity goes off during the operation .....Merlin International has supplied the generators but can not be put to use due to non-availability of funds for fuel ..... water shortage is also a problem.***

***District Gynaecologist, Buner: IDI***

Infrastructure is relatively better off in the health facilities located in the cities and at the district and tehsil level hospitals as compared to BHUs and RHCs located in the far flung areas, except those which got support from international NGOs in Swat and Buner. Building of the PHC facilities, as reported by the LHV, are either very old or in need of renovation. The other shortcomings comprise repair and replacement of furniture, shortage of electricity, gas and water.

***When we are dealing with a delivery case and electricity goes off, you cannot imagine the problems which we have to go through.***

***LHV, Lower Dir: FGD***

Secondly, the required equipment either has never been supplied or is not in working condition due to the non-availability of funds for repair. A provider from Swat states that the government has failed to provide the required demand of medicines.

Required staff strength cannot ensure better standards of MNH services. Government needs to provide more staff at all levels. Our Hospitals are short of staff. But the shortage is more pronounced and acute at BHUs and RHCs as compared to hospitals.

MNCH Coordinator, Lower Dir: IDI Thirdly, staff shortage in general and female staff in particular is negatively impacting the availability and quality of MNH services, more so at the PHC facilities. Shortage of few cadres has been distinctly mentioned by the health providers. Buner has a very low number of lady doctors and LHWs. In Lower Dir, there is shortage of lady doctors, especially at RHCs. In Swat, again it is the LHW whose number is reported significantly low.

Components of referral system	Major Challenges		
	Khyber Pakhtunkhwa	FATA Agencies	Balochistan
<b>Standard procedures and protocols</b>	Not established, system poorly functioning	Not established, system poorly functioning	Not established, system poorly functioning
<b>Capacity of facilities to referrals</b>	BEmONC poorly functioning, CEmONC reasonably functioning	BEmONC & CEmONC poorly functioning; acute shortage of female staff and supplies	BEmONC & CEmONC poorly functioning; acute shortage of female staff and supplies except in Quetta
<b>Public sector Ambulance service</b>	Limited access to users	Extremely limited access to users	Extremely limited access to users
<b>Availability of private transport for referral</b>	Not a major issue. Ambulances also operated by some NGOs in urban areas	Major challenge, especially in rural & remote mountainous areas	Major issue, high chares. An NGO ambulance service functioning in Quetta city
<b>Family decision to avail referral</b>	Considerable delays at decision level & in search of transport	Major delays at decision level & in search of transport	Major delays at decision level & in search of transport
<b>Security situation &amp; referral</b>	Much improved, not a major issue	Major concern, militants threat to providers & users, especially at night	Challenge in some areas especially in Dera Bugti and Quetta and at night
<b>Road infrastructure</b>	Relatively better developed	Mostly in rural areas	Distances are large, terrain difficult & roads in poor state
<b>Local customs and tradition</b>	Not all women observe purdah. Women can access healthcare without male escort in urban areas	Purdah observance universal, restriction on women mobility, not allowed without male escort	Purdah not a big issue for Baloch population, a must for rural Pashtun females, some restriction on mobility of women



**Required staff strength cannot ensure better standards of MNH services. Government needs to provide more staff at all levels. Our Hospitals are short of staff. But the shortage is more pronounced and acute at BHUs and RHCs as compared to hospitals.**

**MNCH Coordinator, Lower Dir: IDI**

In addition to staff shortages, especially in the peripheral facilities, the recruitment of appropriately qualified staff is a major hindrance in the provision of quality MNH services. It was reported that in recent times, especially since deterioration of law and order situation, there has been a lot of political interference in the recruitment of technical staff. This situation not only undermines the selection on merit but also adversely affects the quality of care. The staff selected on the basis of nepotism is found more involved in corrupt practices including absenteeism.

**Nepotism and political interference in the recruitment of staff directly affects the efficiency and the standard of MNH services.**

**District Manager, Buner: IDI**

**If political interference, nepotism and corruption is not eradicated and staff performance is not monitored, then the quality of MNH services will continue to decline.**

**LHW Programme, Master Trainer, Lower Dir: IDI**

**The recruiting authorities make erroneous appointments. With these poor appointments one cannot expect quality services. The appointments once done cannot be terminated. If we take an action against a person who is not performing the duty properly, we are politically influenced so that we do not pursue it.**

**MNCH Coordinator, Peshawar: IDI**

Where PHC facilities are either inadequate or non functional due to shortage of staff or supplies, the major burden for the provision of MNH services falls on the secondary hospitals. If a DHQ hospital of one district is better equipped in terms of availability of facilities, services, equipment, medicines and specialists, then patients from other districts also visit the better equipped hospital. This situation is observed in Central Hospital Saidu Sharif Swat.

**Patients who come to the gynae ward of Central Hospital Saidu sharif are not only from Swat, Patients from district Shangla and Butt Khaila are also referred here.**

**Gynaecologist, Swat: IDI**

In summary, public sector health providers are well aware of the factors weakening the health services and making them inefficient. However, most of them appeared to be either indifferent or helpless to improve the conditions prevailing around them. The important shortcomings comprise the lack of renovation of buildings, shortage of funds for utilities like fuel for generators, lack of repair of worn out furniture or its replacement, shortage of funds for medicines and repair of equipment, staff shortages especially in the rural areas and staff recruitment on political connections.

Public sector staff was found to be generally dissatisfied with the low salary package. They deemed the package as being insufficient to meet the basic needs and also not compatible with those offered by the private sector. The low wages especially of basic cadres like LHW, CMWs, LHV and midwives led to low job satisfaction and affected their performance. Another commonly reported problem shared by LHS was that the salaries were not paid even on time.

**Salary of a midwife is Rs.2,000 per month, which is nothing. There should be a raise in the salary so that the status of midwife is enhanced in the society. People will respect her and take their advice seriously if they get good salaries.**

**District Coordinator LHW Programme, Buner: IDI**

**Our salaries are small and even not paid on time. Just think that with this salary, in such inflation, how anybody would be motivated to work.**

**LHS, Lower Dir: IDI)**

Private sector also plays an active role and contributes in the provision of MNH services, as stated by the providers. NGOs, medical centres, private hospitals, maternity homes, and evening clinics provide services including health education on MNCH. It is generally believed that private hospitals are better equipped compared to those in the public sector. The quality of care and behaviour of staff with the patient too is comparatively better. However, the charges are heavy compared to public hospitals, which provide services either free or charge nominal fee. The poor and the marginalised are unable to seek treatment in a private hospital.

**Private clinics are better in terms of MNCH services and staff behaviour compared to the government one. Those who can afford prefer private hospitals.**

**LHS, Swat: IDI**

**Private hospitals charge heavy fee.**

**Master Trainer, LHW Programme, Lower Dir: IDI**

NGOs are also facilitating public sector MNCH providers in conflict districts and initiated MNH programmes in these areas only after the militant activities. They provided material aid ranging from delivery kits, to medicines and furniture to meet the needs of the BHUs.

However, the most notable work has been done by Merlin International, which not only played a major role in facilitating existing MNCH services at DHQ level but also in creating awareness among the population about MNH services. A similar pattern of public private partnership was reported by a provider from Swat where public sector has been financially and materially facilitated by the international organisations, after the peace returned, these developmental projects have been discontinued.

**Merlin International started MNCH service soon after the devastating effects in the conflict ridden Buner district. Patients were given medicines, blankets and baby kits. MNCH services were improved including public awareness campaign. Further, many NGOs have provided various items like delivery kits, medicines and furniture, and etc at BHUs.**

**LHS, Buner: IDI**

**After the devastation in Swat, different NGOs like Merlin, Malteser International constructed three rooms in each unit in various BHUs and RCHs, provided training to LHWs and conducted programmes on Nutrition. These interventions improved not only MNCH programme but also created awareness among users of services.**

**Assistant Director LHW Programme, Swat: IDI**

There are lessons to be learned from the performance of NGOs in the conflicts affected areas of swat and Buner. As explained in detail in Chapter 7 under “discussion and way forward”, if public sector makes adequate investments in timely repair and maintenance of infrastructure and equipment, provision of needed medicines and supplies, filling of vacant posts with qualified staff and inputs on continuing education along with supportive monitoring and supervision, major improvements can be made in the quality of services. But the challenge is would public sector be able to finance all the needed inputs, and if not should users participate and how?

Users Perspective

Treatment is provided up to ones' satisfaction level at private facilities. Though money is spent but one gets satisfied.

Mother, D.I. Khan: IDI  
Satisfaction level with private sector. Most users preferred treatment at private hospitals and clinics. The private sector in general is reported providing all the required services like antenatal care, delivery, postnatal and neonatal care, laboratory tests, ultrasound, medicines, and etc. Most users reported polite behaviour of the staff and better health services. According to them, though private providers charge high fees but provide quality treatment in return.

*Treatment is provided up to ones' satisfaction level at private facilities. Though money is spent but one gets satisfied.*

*Mother, D.I. Khan: IDI*

*I go to private clinic because in government hospitals they scold us like our mothers-in-law. Mother with child <1year, Lower Dir: FGD*

*We prefer to go to private hospital because they have properly functioning labour room, facility of lab tests and ultrasound. They maintain the temperature of inside the building. After the delivery we receive baby and mother in good condition whereas in the government hospitals we find both of them dead.*

*Mother with child <1 year, Buner: FGD*

Satisfaction level with public sector. Overall, respondents from both IDIs and FGDs were not satisfied with the services provided by government health facilities. Users cited rude behaviour of public sector service providers as one of the reasons for dissatisfaction. The other reasons included non-availability of lady doctor and trained staff, and shortage of equipment and medicines.

Few IDI respondents, however, seemed satisfied with government hospitals and health centres. One of the respondents from DI Khan said that health centre of their area provides good and free check-ups, vaccinations and medicines to the patients. They went on to say that the staff of government hospital do their duties well and take good care of mother and child.

Many families make choices for getting MNH services not on preference but more often on the basis of affordability. For instance, some users said that they preferred deliveries at home by TBAs, as private hospitals were expensive and beyond their reach. Further, public sector PHC facilities lack trained staff and necessary supplies.

*We get the normal delivery cases handled at home. The private hospitals charge a lot of money and the public/government hospitals of our area don't have the required staff.*

*Father/father-in-law, Lower Dir: FGD*

In summary, the users and their families appeared to be dissatisfied with the MNH services provided by the public sector, e.g. untrained staff, bad behaviour, improper location of PHC health facilities, non-supply of medicines and other equipment, and poor road conditions in rural areas limiting access. They also complained about the non-availability of transport at the public sector for patients' referral. On the other hand, users appreciated the quality of services provided by the private sector, but termed it unaffordable.

PHC facilities location. Ill planed location of PHC facilities, built on donated land, has created many problems to access MNH services. A mother from Upper Dir stated that BHU in our area is located on the top of the mountain. We tie the patient on a cot and travel upwards on foot to get to the facility. Another mother, also from upper Dir, shared her experience that she delivered on way to the BHU located on the top of the mountain.

PHC services. In users view, better MNH services are provided at the urban hospitals than at PHC level. According to them, services provided at community and PHC level are few and poor. TBAs were particularly mentioned, who have no skills to manage any complication other than assisting the normal delivery. Majority of users also criticised TBAs, though many were trained in the study districts, for their lack of concern for cleanliness and poor hygiene practices. The limited skills of TBAs lead to a higher risk to the life of mother with complications. Users also reiterated the higher vulnerability of pregnant women and newborns in rural areas. Though not explored in the study population, traditionally, pregnant women from rural areas generally do not stay with their relatives close to the good secondary hospital before the start of labour.

*What to do if there isn't even a TBA available at the village level? Whenever you go to the big hospitals of other cities, the doctors are available round the clock, beside all other facilities. But this is not the case in our D.I. Khan.*

*Father/father-in-law, D. I. Khan: FGD*

*The quality of healthcare services at the community level is zero regarding pregnancy, childbirth and the new-born baby's healthcare, because there is no LHV, medicines and equipment. The LHVs who are available can only advise our women. They can't do anything else. The TBA can only assist in a normal delivery. The mother and baby's life is at risk if there is an abnormal delivery. The TBA doesn't even take care of the hygiene and sanitation.*

*Father/father-in-law, Lower Dir: FGD*

Behaviour change communication. Following military action and floods, the interventions by government and NGOs have contributed a lot in raising awareness among the communities on MNH issues including antenatal care and delivery by SBA. Most of the respondents mentioned that now they are more aware of the benefits of MNH services to reduce maternal related health risks and enhance health conditions of mothers and newborn. Most stakeholders stated that they were also in favour of routine check-up during pregnancy and after childbirth. Thus, recent behaviour change communication had positive impact on the uptake of MNH services.

Local culture and traditions. Families prefer delivery by TBAs because of 'purdah' and privacy concerns. Purdah requirements confine women to the privacy of home. Cultural values prohibit public exposure of pregnant women. For this reason the deliveries should be done at home with the help of TBAs, as explained by a mother-in-law from Lower Dir.

*The normal delivery takes place at home because for a pregnant woman it doesn't look nice to go out of the house.*

*Mother/mother-in-law, Lower Dir: FGD*

Elderly stakeholders including mother, mother-in-law, father and father-in-law, revealed that there is a generation gap with reference to perception about MNH services. While all younger stakeholders favoured seeking formal MNH services, the elders believed that they should be availed only when traditional ways of handling pregnancies fail. Also various complications in pregnancy were perceived as problems that have emerged only in recent times. These were non-existent in the past when the women were well-looked after using home/herbal remedies and given traditional care during both pregnancy and delivery.

Federally Administered Tribal Areas

Providers Perspective

Research presents a rather dismal picture of the provision of MNH services at various levels in conflict affected FATA agencies. Other than TBAs, public sector is the only provider of MNH services, while deficiencies render the system inefficient. The problems like lack of transport facility, non-availability of residential quarters, life threats from Taliban especially to the female staff, non-availability of equipment and medicines, low salaries and cultural taboos all contribute to the lack of motivation of staff with consequent absenteeism. Staff absenteeism is most visible in the far flung and mountainous areas.

**Staff in the BHUs located in remote areas often remains absent from duty. Reason for their absence is mostly due to the absence of facilities at the BHUs.**  
*Assistant Director, LHW Programme, FATA: IDI*

**The absenteeism is an old practice here, but now it has increased on the pretext of security situation.**  
*LHW Coordinator, Khyber Agency: IDI*

Staff shortages were reported by the providers not just in one specific cadre but in all cadres and at various levels, especially the female staff. In the absence of female staff, families are reluctant to get their women checked by a male doctor.

**In the absence of female staff, men of this area do not allow examination of their women by male doctor even if a woman is at the verge of death.**  
*Gynaecologist, NWA: IDI*

Providers also attributed lack of supervision as another reason for staff absenteeism. Political interference in the recruitment of untrained and unskilled staff is also widely prevalent malpractice.

Poor infrastructure, including shortage of medicines and equipment, was stated by the providers as one of the reasons for inefficient functioning of peripheral health facilities and consequently the low quality of MNH services. The other issue included the lack of electricity creating problem for the service providers in the delivery of services except Bajaur agency, where problem had been overcome to a significant extent by the installation of solar panels.

**After its' construction the BHU building was never renovated. Now whenever it rains, the water comes in the rooms and makes it impossible to even sit there. We cannot deliver services under these circumstances.**  
*In-charge BHU, NWA: IDI*

Users Perspective

**Here the buildings are in a better condition but the problem of electricity and water shortage persists. Electricity issue, however, has been resolved to a considerable extent by the use of solar system. Eight (8) hospitals are benefitting from this system. If government will not pay due attention to infrastructure insufficiencies then MNH services will be negatively affected.**  
*Agency Surgeon, Bajaur: IDI*

In the absence of functional public health facilities, the MNH needs of the women are generally met by the TBAs in most communities. Though they do not have any formal training but are trusted by the community elders, since they are part of the same set up. They are frequently approached for childbirth and other pregnancy related problems, mostly owing to financial constraints as most people are poor. However, many women narrated incidents where the advice by the TBA threatened their lives. Only in some villages where BHUs have been set up and functional, are the sources of MNH services.

**TBAs have been handling most of the deliveries in NWA for a long time. They are neither trained nor do have any certificate. TBAs are famous in the village for being experts in handling the deliveries. Therefore, people call them whenever there is a delivery case. Many women in the village have lost their lives because of these (so called) “experienced” TBAs. It is a good thing that now the BHUs have been set up in some villages where the midwives and LHWs have been appointed and some people get delivery cases handled by them.**  
*Husband, NWA: FGD*

**TBA is an untrained provider. If any child has cord infection, she advises to paste horse dung on it for cure.**  
*(WC, North Waziristan: FGD)*

A mother-in-law from Bajaur agency was in favour of using local recipes for problems related pregnancy and childbirth; she narrated her past experience in a positive way. Users from NWA reported that they have no local tradition and culture for antenatal check-ups.

**I am also in favour of the routine check-up but there is no need to take the pregnant woman to the doctor if she can feel better by using home remedies. If there is some problem during childbirth/labour, then we mix “Ajwain” (a herb) in tea, boil it thoroughly and make the pregnant woman to drink it. We also massage her during pregnancy. We never had any operation for childbirth.**  
*Mother/mother-in-law, Bajaur Agency: FGD*

Another major obstacle is absence of a reliable system of transport to avail emergency services at the hospital, located in the main city. The situation became a threat if the travel is at the night owing to the fear of Taliban.

At face of dearth of health facilities especially in the remote rural areas, many a times people have to take their patient to the Agency hospital which is far away and the transport cost is usually high. Financial constraints become a major deterrent for many people to seek MNH care. The decision of taking women to the larger hospital is usually done out of compulsion rather than by preference. Agency hospitals are preferred simply because of the availability and accessibility of all kinds of services, which are lacking in the peripheral facilities.



**We take our patients to the expert gynaecologist in Miran Shah because there is no BHU, RHC or Civil Dispensary nearby. We have to go to the main hospital due to compulsion and it costs us a lot of money for which we even take loans to meet the expenses.**

**Husbands, NWA: FGD**

**We go to Agency Hospital Khar for services related to childbirth/delivery. All facilities are available in the hospital. One can buy medicines from the nearby stores. The most important thing is that it is not expensive hospital. An LHV is available all the time.**

**Mother/mother-in-law, Bajaur Agency: FGD**

Mothers also complained about the female staff in the government facilities regarding their attendance; they usually come late and then force the patients to visit them at their private clinics. The travel time to the city takes considerable time and by the time patient reaches, the staff has either left or ready to go. Corrupt practices of service providers were also expressed who have made arrangements with medical stores, laboratories and radiologists. For their commission, they force the patients to visit specific supplier.

**When we go to Miran Shah, we reach there around 1:00 o'clock which is the scheduled time of one of the two available vehicles. By that time the staff has left and we have to stay night at Miran Shah for check up the next morning. The journey is also very dangerous because at times Taliban suddenly come on the road, assassinate people and disappear.**

**Women with <1 year child, NWA: FGD**

A mother from Bajaur Agency also specifically points out that women cannot make decision to go to the health facility as it will create problem for their men because of threat from Taliban, who have banned the movement of women without escorts. Another reason cited was the lack of proper roads as a barrier for accessing MNH services. In case of mountainous terrain, women have to travel a lot and sometime even deliver on way to the health facility as shared by a woman from Bajaur Agency.

**Taking this mountainous route to get to the facility during pregnancy is not free of risk. There are more chances of pregnancies resulting in miscarriages due to jerks on uneven way.**

**Mother, Bajaur Agency: IDI**

Most of the participating mothers disclosed that decision making power to avail MNH services lies with elders, e.g. husbands, mothers-in-law and/or fathers-in-law. Mothers-in-law usually make all the decisions regarding the use of MNH services.

**Men have the power to decide while woman is a child producing machine. She is there only to do work.**

**Women with <1 year child, NWA: FGD**

**My mother-in-law has imposed restrictions on my going out of house. If I need any consultation during pregnancy, my mother-in-law calls our local Dia for consultation. If there is a complication, only then she allows me to go to a health facility but she never approves for check-up from there.**

**Pregnant Woman, NWA: FGD**

For normal pregnancy, visiting health facility or a doctor is an issue of 'honour' for men in general and husbands in particular. In very conservative societies, honour is considered to be a major issue especially in the context of females. Therefore, visit to those facilities is only acceptable to men in many situations where privacy is observed. According to women privacy is observed more at the lower level health facilities than in the hospitals like at Khyber Agency. Hence, these facilities are preferred despite the fact they lack other services that are available in the bigger hospitals. Private hospitals are appreciated for their efforts to maintain privacy than the government hospitals.

**We have many problems related to honour. Sometime men (husbands) say that you do not tell anybody about your pregnancy, it is our honour. Do not tell about your delivery to anybody, it is our honour.**

**Women with <1 year child, NWA: FGD**

With improving awareness about importance of MNH services and their role in saving lives of mothers and newborns, the husbands of younger generation prefer seeking antenatal, natal and post natal services from the formal health sector. However, mothers/mothers-in-law have always come up against the use of these services for their daughters and daughter in laws. The older women tend to downplay the need for accessing formal care on number of pretexts, without having a reasonable justification. According to them comparing old practices of their times with the modern medical facilities of present time is called as generation gap, highlighting jealousy and tension among women of different generations exerting individual control and authority.

### Balochistan Province

#### Providers Perspective

The number of BHUs and civil dispensaries (CDs) in all the study areas has been reported as disproportionate to the population. The number of facilities is insufficient given their large catchment area. It has also been stated that the DHQ hospitals are better structured and equipped compared to other health units, particularly those situated in the rural areas.

**CDs are insufficient in number and lack facilities. In the city the situation is better whereas in the rural areas there is considerable lack of infrastructure and equipment.**

**DHO, Quetta: IDI**

The female doctors, gynaecologist, nurses, LHVs and LHWs working in various districts are inadequate in number. TBAs, mostly untrained, are the main service providers especially in the rural areas. The gravity of the situation can be assessed from the responses given below.

**In our District Hospital there is only one lady doctor, one nurse and three dais. There is acute shortage of female staff.**

**DHO, Pishin: IDI**

**There is not a single lady doctor and a gynaecologist in the district**

**District Coordinator, LHW Programme, Dera Bugti: IDI**

Health facilities generally face infrastructure deficiencies across the study area and vary from being highly deficient to minimally lacking. Lack of residential quarters for the service providers is also seen as a hurdle. Those that are available are in bad condition. For example, quarters for LHVs in Qilla Abdullah have been reported in unliveable condition. In Baluchistan, since most LHVs are nonlocal, come from other areas, and therefore need a secure accommodation.

***Dera Bugti covers a vast area of 10,160 square kilometres. It is primarily a rural district and quite a difficult terrain. Buildings were constructed in General Ayub's era and nearly 45 years old and on the verge of collapsing. No renovation or up gradation has ever been done except if a 'wadaira' (local landlord) has been generous enough to renovate a part.***  
***District Coordinator LHW Programme, Dera Bugti: IDI***

***We do not have proper accommodation for the LHV's. The quarters are in dilapidated condition, the roofs are leaking in rainy days and there is no heating arrangement during winter.***  
***LHW Coordinator, Qilla Abdullah: IDI***

Public sector providers complained about the short supply of medicines at all levels and fuel for ambulances. Most of the patients who come to the public sector facilities belong to lower economic stratum and absence of medicines discourage them from accessing MNH services. Providers from Qilla Abdullah and Pishin districts showed their concern on the short supply of medicines.

***At primary level medicines are not available; if some are available then they are no good. The situation is like this: "At some places instead of supplying the required/requested medicines, some other medicines which were not asked for are supplied. Most often these medicines are expired".***  
***LHW Coordinator, Pishin: IDI***

***General pattern here is that if the doctor does not give medicine, patients will not come for check-up.***  
***DHO, Qila Abdullah: IDI***

***If one does not give medicines to the patients they will never visit the facility again. They say it is useless to go to the doctor if medicines are not given.***  
***LHW Coordinator, Qilla Abdullah: IDI***

Political interference and nepotism is frequently cited as basic reason for the recruitment of inappropriate staff, staff absenteeism, transfer of staff to other areas, and the construction of health units at places not suitable for the purpose.

A provider from Quetta criticised the low pay package, being a major concern of the health providers. It affects their domestic life and motivation to work. Province of Punjab was cited as a comparator for doctors' salary. Salary is so low and on top of that it is paid after three months. It creates difficulties for the family.  
LHS, Quetta: IDI

Feeling of indifference by the government towards the health staff working in the conflict-ridden areas was reported by the staff in Dera Bugti. It is believed that conflict- ridden areas pose a number of difficulties for the service providers. They considered their salaries as inadequate being equivalent to that given to staff working in safe and secure districts is unfair.

***Salary is so low and on top of that it is paid after three months. It creates difficulties for the family.***  
***LHS, Quetta: IDI***  
***If we compare our salaries with the salaries of doctors in Punjab, theirs' is many times more than ours.***  
***DHO and LHW Coordinator, Qilla Abdullah: IDI***

Interventions by the NGOs and voluntary work in MNCH area was found significantly missing in the province. Only Medecins Sans Frontieres (MSF) and Mercy Crops have been engaged in the delivery of MNH services in the security compromised areas. However,

***Presently political interference and nepotism are our biggest weaknesses.***  
***DHO, Qilla Abdullah: IDI***

***BHUs have been constructed under political influences and for political reasons.***  
***LHW Coordinator, Qilla Abdulla IDI***

***There are habitual absentees who have political backing and receive salaries at their home without performing duties.***  
***Public Health Manager, Dera Bugti: IDI***

Mercy Crops has closed its offices in Balochistan province since mid-June 2010 due to security risk; four staff members were kidnapped in 2010 from Qilla Abdullah. Christian Mission Hospital, Quetta provides MNH services to the poor as part of philanthropy.

Private health sector is least developed in Balochistan. For-profit facilities are restricted to the capital city and to some extent to the district towns, while hospitals are mostly concentrated in Quetta city. The less qualified practitioners' fill-in the gaps, as mentioned by a provider from Dera Bugti.

Moonlighting is quite pervasive. Quite a number of public sector staff was found engaged in the evening practice on the pretext of low salaries. This negatively affects the efficiency at their regular government job as income from the private sector demands efficiency and more attention.

**Users Perspective**

Majority of the population is dependent on the TBAs, owing to the lack of nearby or non-functional health facilities. Only in case of emergency and complications of delivery, we go to the public or private facilities in the main cities. This is the situation of last resort, since most of the population is poor and lack the required financial resources.

***I try to get treatment from local Dais which cost much less. Most of the population here is poor, so they prefer to go to government health centre or civil hospital.***  
***Mother, Quetta: IDI***

Most respondents from severely compromised security districts criticised the government facilities for lack of trained staff especially the female. Even where available, they either come late or remain absent from duty. The staff attitude is generally discourteous with the patients. Many also work elsewhere and only get their pay from the place of posting.

***In government hospitals doctors and staff is not available. What is the advantage of such hospitals?***  
***Mother, Dera Bugti: IDI***

Mothers from Dera Bugti reported that factors hindering access to MNH services is owing to the cultural milieu and absence of female staff like lady doctors, LHVs and LHWs. It was also stated that infrastructure of hospital is in bad shape. Hospital lacks doors, fans, electricity, medicines, ambulance and equipment for operations.

**Poor and marginalised people rely only on Dais (TBAs). If the patient survives, it is her luck. However, few people can afford to travel long distances to reach the health centres.**  
**Community Influential, Dera Bugti: FGD**

Though the quality of services varies from area to area but one common issue is the absence of LHV and non-availability of female doctors. Local Dais are the only service providers available in almost all areas.

Another factor limiting access to MNH services was short working hours of health facilities. Most of the centres are closed by 12 00 hours and if any patient comes later, then she has to go back without check-up. The official closing time of health centres is 14 00 hours. Because of difficult terrain and long distance to the facility, it becomes barely possible to reach the facility during the restricted working hours.

**The staff and LHV in the centre work till 12:00 o'clock. If we need her services after 12pm, we have to implore her.**  
**Mother with <1yer child, Pishin: FGD**

Lack of proper transport is one of the major problems in accessing health services at the time of emergency. Users from all the districts faced many difficulties in arranging transport because of rough roads, security issues and financial problems. Most of the peripheral health facilities lack ambulance service; where available in the hospitals, these are not functioning for lack of funds for fuel or driver.

Traditionally, there is dominance and control of mother-in-law or a male in the family in all the health related matters, specifically for access to and utilisation of MNH Services. This applies not only for going to a facility but also about the TBA coming to the house with necessary permission.

The mothers from Dera Bugti, on the other hand, revealed that females, even elderly women or mothers-in-law do not have any right to make or participate in the decision making process. It is only the prerogative of male to decide and female has to submit. It is for males who decide whom to consult for seeking care. They seldom take opinion of their wives in this regard.

**Even Dai cannot come to our house if my mother-in-law does not permit.**  
**Mother, Pishin: IDI**

**My father-in-law makes all decisions of our family affairs, regarding marriages, treatment and all other family related matters. He controls the finances of the family. All of his sons have to handover their earnings to him. We have to seek his permission to visit our own parental home. In his absence, my elder brother-in-law takes decision only in case of emergency.**  
**Mother, Dera Bugti: IDI**

Going to the health facility, hospital or doctor at her own is something unthinkable for a woman. The account presents a suffocating scenario of a mother from Dera Bugti district.

**Pregnant women should not travel in the vehicle as it is against our traditions. These days because of security check-up one has to stand and wait at various check posts.**  
**Mother, Dera Bugti: IDI**

On the contrary, mothers reported that there are also a number of families where husbands and mothers-in-law decide after discussion and consent of wives/daughters-in-laws, whether to use MNH services from a health facility or to deliver at home with services from a TBA.

Besides the notion of male honour there are many other socio-cultural practices to maintain male authority over females and younger males. All such prescriptions adversely affect women's access to MNH Services. For example, preference is given to the use of home remedies or spiritual healing over medical care, restricting women within the boundaries of home and banning their travel. Women stated practicing these modes of treatment mostly under duress and against their choice. Many a times the men either attribute these restrictions to security concerns or traditional customs. In summary, women are generally accorded low status in the society, therefore, their opinions or choices about MNH care do not matter.

Summary of findings and conclusions

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, 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 utilization of services due to short supply of medicines, lack of or worn out equipment, staff absenteeism, 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 restrict 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. The template below describes area wise variations.



### Introduction

The improvements in health outcomes are not only the responsibility of health sector, but needs a strong cooperation between providers, users and communities. In a well-functioning governance system, citizens who use the services are neither beneficiaries nor consumers but in fact the “shapers and makers” of services [16]. One facet of governance system is how government and its social organizations interact with citizens and how decisions are made. Based on this concept, users of MNCH services and their families in security compromised areas were invited to share their views how communities can engage and participate in the delivery of MNH services.

To explore this thematic area, users were invited to provide their inputs in following areas:

- Viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in their area.
- Workable options to organise local transport for transportation of emergencies to the nearest referral health facility.
- How to go about organising village level MNH committee which would take a lead role in areas like: sorting out local level challenges, creating a culture of some savings to finance expenses of MNH services, awareness creation for adopting healthy MNH practices at household level, and signs of complication and emergency.

The service providers were also invited to suggest measures for improving MNH services. The main questions comprised: suggestions for improvements in the current package of MNH services at various levels with inputs to make these improvements doable; role of community in filling the gaps; suggestions for minimising various barriers to access; priorities to meet human resource needs; implications for improving services; and the role that private sector and associations can play.

In-depth Interviews (IDIs) and Focus Group Discussions (FGDs) with various categories of providers and users identified a number of areas wherein working together could bring about improvements in the delivery of MNH services.

### Khyber Pakhtunkhwa Province

### Providers Perspective

Inadequate behaviour change communication has been identified as one of the key reasons for low utilisation of MNH services. Public sector managers identified lack of awareness about MNH issues as one of the key reasons for low utilisation of services. As suggested by district manager from Buner district, the community's health seeking behaviour needs to be changed through social mobilisation and health promotion, especially in the rural areas.

***In rural areas social mobilisers and health promoters should be appointed to create awareness among the people about MNCH services which is lacking due to low literacy rate and absence of media.***  
***District Manager, Buner: IDI***

To counter the security risks, local communities can play a vital role in ensuring the safety of the healthcare providers through involvement of tribal elders and notables. In many parts of KP (and FATA in particular) local elders and Jirgahs (assembly or council of elders) form an informal system of governance, particularly as a medium of conflict resolution. The local elders can negotiate with representatives of militant groups operating in the areas to spare and let the health workers provide services to the poor local communities. Security support by local communities can help boost provider's morale and motivate them to perform their duty and serve the users in a timely manner.

***Local community should provide security to the staff.***  
***Provincial Manager, LHW Programme: IDI***

Components of Perceptions and Expectation	Major Challenges		
	Khyber Pakhtunkhwa	FATA Agencies	Balochistan
Human resource in public sector facilities	Political interference, shortage of staff especially female, staff absenteeism	Political interference, Severe shortage of staff especially female, staff absenteeism	Political interference, severe shortage of female staff, short working hours & absenteeism
Health facility infrastructure	Generally shortages	Poor, especially of PHC facilities	Poor & inadequate infrastructure
Equipment and medicines	Short supply or non-functional equipment	Shortages	Severe shortage
Transport for referral	Access to hospital ambulance service limited	Absence of reliable transport system, both at public and private sector	Major challenge; access to hospital ambulance & private transport limited
Utilities	Shortage of electricity, gas and water	Electricity and water supply shortage	Funds shortage for ambulance functioning
Location and distribution of PHC facilities	Improper location at many place	Shortage of PHC facilities & improper location at many places	Insufficient in number given the long distances
Skills of TBAs	Generally untrained	Mostly untrained	Mostly untrained
Private sector services	Private hospitals better equipped	Restricted to towns, privacy well observed than In public sector	
Local cultures and traditions	Less favourable	Family elders decide on the use of services	Invariably males decide on the use of services
Staff behaviour	Indifferent by public sector staff, passionate by private providers	Indifferent by public sector staff	Indifferent by public sector staff
Staff salaries to work in security risk areas	Demand for salary increase & supported by users	Not presented as an issue	Salary increase demanded by providers

**The local community should cooperate with the staff and make sure that the staff remains safe and protected while coming to duty and going back to their home.**

**Gynaecologist, private sector, Buner: IDI**

Poor road conditions in rural areas and unsuitable location of some health facilities have been cited by the providers from Upper and Lower Dir as one of the key impediments in accessing the MNH services. The local health committees should, therefore, be constituted to advocate to local elders and politicians for seeking improvements in road infrastructure and construction of more suitably located new health facilities.

The providers stressed the Department of Health to squarely address the human resource (HR) and related issues in the security compromised areas. Filling of vacant positions is one of the key areas that need to be addressed, backed by reinforced monitoring system to ensure staff availability, and institutionalising continuing medical education (CME) to fill-in the missing skills.

**Shortage of staff i.e. LHV, midwife and other female staff, should be overcome. Staff should be made duty bound, vacant positions should be filled. Technical training to staff should be provided.**

**LHV, D.I Khan: FGD**

On the subject of supportive supervision, providers did not discuss much on topics like: (i) who should be the supervisors, (ii) how frequently the supervisory visits should take place and (iii) what criteria should be used to undertake the supervision. Only health managers from district Upper Dir suggested the constitution of monitoring teams for the supervision of MNH services.

**A supervision team should be constituted for supervision of all staff without political interference.**

**EDO Health, Upper Dir: IDI**

**A monitoring team should be constituted for supervision of MNH services at PHC level**

**MNCH Coordinator, Upper Dir: IDI**

The government should provide financial incentive to the staff working in the security compromised areas, provided they remain on duty. Staff working at public sector health facilities was found to be generally dissatisfied with the salary package. They cited the package as insufficient to meet the basic needs. The low wages, especially of the basic cadres including LHW, CMWs, LHV and midwives, put them on the lower rung of socio-economic ladder.

**Salary of a midwife is Rs 2,000 per month, which is nothing. There should be a raise in the salary**

.....

**District Coordinator, LHW Programme, Buner: IDI**

**Our salaries are small and even that is not paid on time.**

**LHS, Lower Dir: IDI**

A number of providers stressed the role of Health Committees in improving the delivery of MNH services. An active and functional health committee could help resolve a number of issues at PHC level such as oversight of staff presence, staff safety, repair and maintenance of building, regular supply of medicines and equipment and building users' trust on MNH services. Further, health committees should be entrusted with the institutionalisation of local transport system and assist the poor and the marginalised in availing MNH services.

Effective functioning of health committees at village level, supply of delivery kits, training of TBAs and participation of community elders are the key elements of good coordination and timely assistance as reported from districts of Swat and Buner.

**Every LHW village has a health committee with community elders also included as members .....delivery kits are distributed to the pregnant women by the community elders.**

**LHS, Swat: IDI**

**Local communities can act in three different ways: (i) cooperate with the MNH service providers; (ii) act as a vigilance group to report any misconduct by health staff, and (iii) advocate with the government the need for required staff, equipment and supplies**

**Health Manager, Upper Dir: IDI**

Referral of patients to secondary hospitals is a big challenge. The health committee can help solve this issue by coordinating with private transporters or community members owning vehicles.

**Health Committees should be formed to facilitate the access of women to MNH services and arrange for ambulance service. In some areas people live below the poverty line and cannot afford MNH services; these committees can help provide them with financial assistance.**

**District Manager, Buner: IDI**

Public sector providers stressed the need for the regulation of private health sector. In addition to the public sector, private sector is also a major player in delivering the MNH services in the conflict districts. The public sector providers complained about untrained practitioners and high fees charged by them. They suggested that the government should properly regulate the private sector and urged the community to inform the Department of Health about the unqualified providers.

Private sector is an important player in the delivery of MNH services, especially in the urban areas of KP province. Private sector providers made important suggestions to enhance the quality and improve the utilisation of MNH services, mentioned the need for establishing a system to supervise the services and for monitoring the over prescribing of surgical procedures.

**Government should monitor the private sector; eliminate non qualified and untrained staff while qualified and trained staff should be registered.**

**LHV, Lower Dir: FGD**

**Role of private clinics, hospitals, and maternity homes is very significant. However, these must be regularly visited by a supervisory body.**

**Principal Midwifery Association Upper Dir: IDI**

**NGOs are performing well. They should coordinate with government and private health centre so that operations can be performed on need basis.**

**PMA representative, Upper Dir**

### Users Perspective

The users identified the lack of information on MNH and the associated services available as a key reason for poor utilisation of services. Users highlighted the need for increased awareness among the population. They further stressed that there is need for all stakeholders in the community to coordinate and collaborate with each other and demand better MNH services.



**People should be made aware about MNH services and cooperate with the health staff. The influential persons should help in sensitising the people and create awareness about cooperation with the health staff.**

**Woman with child, Lower Dir: FGD**

In general most participating users were of the opinion that community awareness is an important intervention for improving the utilisation of MNH services. This role can be effectively played by the community notables and elders, who could convince the families to seek MNH care from trained health providers.

Pregnant women from Upper Dir said that community elders can raise their voices and liaise with government to resolve local level problems. Some of these problems include the appointment of female staff at the health facilities, ensuring supply of medicines, improving governance and preventing staff absenteeism.

Users and community influencers stressed the need for village level MNH committees. The committee should comprise of village notables, both male and female. These committees can play many important functions e.g. monitoring of staff presence, arranging transport for referrals, coordination between the community and health providers, and raise awareness on MNH. The committee will also peruse the Department of Health for filling of vacant positions and maintenance of adequate supply of medicines. The committee can also play an important role in persuading the families to save so that they may be able to shoulder the financial expenditure associated with availing MNH services.

**MNH committees at local level should create awareness in the community so that people cooperate with health staff to solve the MNH problems. If any staff is found not working then action should be taken against him/her. Through these committees we can also create awareness about the problems of our area and means to solve these problems.**

**Pregnant Women, Swat: FGD**

**It will be better if these committees create awareness to have savings for MNH services.**

**Pregnant women, Upper Dir: FGD**

**People should arrange money before delivery.**

**Mother, Swat: IDI**

financial expenditure associated with availing MNH services.

Most families from this region are poor and lack resources. Furthermore, arranging transport for referrals takes considerable time, thus increasing the risk to the mother and the baby. Users suggested setting up a 'revolving fund' under the MNH committee for arranging transport through collection of funds from the households. A number of private vehicles are usually available with the community members and the committee could hire the available vehicle for timely referral.

**In case of emergency, our community is unable to arrange for transport to reach nearby health centre because people are very poor and the transportation charges are very high. It is only possible if government also cooperate with the community.**

**Pregnant Women, Upper Dir: FGD**

**It is not possible that people of our area can arrange transport because they are very poor. The notables, teachers, religious people and influential of the area can play an important role in money collection and set up a fund to arrange transport.**

**Women with child, D. I. Khan: FGD**

## Federally Administered Tribal Areas

### Providers Perspective

Providers identified community involvement and participation as a key intervention to improve access to and utilisation of MNH services. According to the providers, local communities lack information and understanding of MNH issues and the benefits of services from the skilled staff. The providers suggested bringing communities on-board by sensitising them on MNH related issues and how to manage them.

Providers also suggested the involvement of communities in the oversight of health facilities to ensure staff security, staff availability and performance, and building their morale for better services. A female provider was of the view that until and unless communities have a direct role in the management of health facilities, MNH services cannot be improved.

**To address the weaknesses of MNH services, community can play an important role. Community should know about the MNH services. Community should provide security to the staff of BHUs, RHCs and CDs. If staff is not performing their duties, they should file complaint against them to the higher authority. Community should take interest and resultantly the conditions can improve.**

**Gynaecologist, NWA: IDI**

Service providers stressed the need for promotion of BCC campaign among male members of the community for creating awareness about MNH issues and service needs. FATA is a patriarchal society where women have no say in the choice of a service provider or the facility for MNH services. In such circumstances, it is important to undertake BCC interventions among the male members of the community for their full involvement in improving the MNH services.

**Non acceptance and mistrust on seeking medical assistance can be minimized with the help of community. Educated and influential people of the community can play vital role. They can motivate the families and pregnant women to come for routine check-up so that complications can be timely identified.**

**LHV, Landi Kotal: IDI**

Another respondent from the private sector suggested that MNH services can be improved by ensuring staff availability. He added that communities can ensure staff security either by assigning a security guard from among local men or through involvement of tribal/religious leaders and local politicians, who can ensure safer environment for the health providers. Once the staff is available at the facilities, people will start utilising the services

**The community can provide security to the staff so that they can regularly fulfil their duties. For staff protection community can provide a security guard. For the requirement of female staff and new medical equipment, community should give application to the government and cooperate with the private organizations.**

**President PMA, NWA: IDI**

Providers also suggested that community elders should advocate with health authorities for the construction of more PHC facilities at accessible locations



Providers stressed the need for filling the vacant posts on priority basis, especially the ones for female staff. The militancy has changed the human resource scenario in FATA agencies by forcing the migration of health staff to safer places, thus further increasing the vacant posts at PHC facilities. Providers advocated that the Department of Health should take necessary steps to fill-in the existing posts as far possible. In the meantime, steps should be taken to train local TBAs to improve their knowledge and skills.

**Female staffs are not regular in their duties due to security reasons. The other reason for less number of female staff is that posts are vacant for a long time. Vacant positions should be filled.**  
**LHV, Bajaur Agency: IDI**

**Community should cooperate with doctors, provide accommodation facility to the staff, adequate security ----. Government should also strive to train dais. These steps can remove many weaknesses.**  
**Gynaecologist, Bajaur Agency: IDI**

In view of poorly organised ambulance system at the hospitals, providers advocated motivating communities to develop a village level transport system, especially to meet the needs of the poor and the marginalised. The providers were of the view that the tribal elders and Jirga can play a positive role.

**Local community should play role in settling transportation issues. There should be a permanent vehicle in the village to carry patients to the hospital. Jirgas should be held at village level to raise awareness among people on MNH issues and for managing the vehicle.**  
**LHV, NWA: FGD**

Service providers from the private health sector also made some suggestions that were within purview to take an action. The two important areas comprised improving the knowledge of private health providers by organising monthly workshops and then educating their clients at the clinic on the benefit of MNH services, both for the mother and the newborn.

**PMA should arrange workshop once in a month on MNH for private service providers.**  
**President PMA, NWA: IDI**

**Private providers should educate users on MNH services to increase awareness.**  
**In-charge doctor, private hospital, NWA: IDI**

**Private clinics should start counselling of patients on MNH services.**  
**Chairman PMA, Khyber Agency: IDI**

Users Perspective

Lack of awareness was mentioned as key reason for low utilisation of MNH services. When asked about their preference for seeking information, many women wanted to learn from educated women, while others preferred to learn from the mosque and local elders.

Most women stressed the need for increasing awareness about MNH issues. They suggest that tribal elders or local Maliks of the community should organise awareness raising sessions with the community on MNH issues and services.

**There should be awareness raising sessions about the MNH issues to the people by gathering them in the mosques and "Hujras".**  
**Women with child<1yr, Khyber Agency: FGD**

**Counselling programme should be introduced for mother-in-laws on the importance of medical check-up during pregnancy.**  
**Pregnant women, Bajaur: FGD**

An influential member of the community suggested that a group of notable people from the community should be formed for the sole purpose of raising awareness among the community on MNH issues and to improve the utilisation of MNH services. This will help motivate the men to take their women to health facilities for MNH care. In addition, the community influential can advocate with the government for providing necessary supplies and services needed for MNH care.

The community group should also be given other tasks for improving MNH services such as arranging for transport, ensuring staff presence at the health facilities, pursue families to save for financing MNH service.

A group of women during FGD proposed that Government should provide ambulance service at different locations and an honest person should be assigned the duty to manage the ambulance service. Another suggestion was to negotiate with vehicles owners at the village and convince them to charge only fuel cost from the poor while transporting emergencies to the nearest hospital. Though not suggested by the women, payment for food and some honorarium to the driver might work as a good incentive for such an intervention.

**In every area, government should provide one ambulance and an honest person from the community should be the manager. Vehicle owners from the community should only charge fuel cost from the patients in case of emergency.**  
**Pregnant women, Khyber Agency: FGD**

**Maliks (local landlords) can arrange vehicle in a better way. If taxies are introduced in our area, then we can also get taxi in emergency. But our most people are poor and cannot afford the rent of taxies.**  
**Women <1yr child, FATA: FGD**

**These community groups can be effective in saving trends.**  
**Pregnant mother, Bajaur: FGD**

Another feedback on how to organise the referral of MNH emergencies was to use the institution of mosque for mobilising community resources including fundraising.

**At community level people should help each other, shift women in emergency to the hospital and also help them with money by raising funds in the mosques for needy people.**  
**Woman with<1year child, Khyber Agency**

Women demanded the availability of skilled staff at community level (SBA) to meet their routine needs at the doorstep, keeping in view the local customs, poor communication systems and security concerns. Three different categories of staff were proposed by the pregnant women from three agencies: LHW, community midwife or trained TBA.

- 1. There should a lady health worker in every village who guide the clients.*
- 2. Trained Dai or midwife should be provided.*
- 3. Midwife will be a blessing and she will help in resolving the issues of pregnant women and provide needed information.*
- 4. A skilled birth attended should be appointed at village level for home visits. It will help those women who are not able to go to the hospital during pregnancy.*

**Pregnant women NWA: FGD**

***A skilled birth attended should be appointed at village level for home visits. It will help those women who are not able to go to the hospital during pregnancy.***

**Pregnant women, Bjaour: FGD**

**Midwife or trained TBA should be appointed at village level.**

### ***Pregnant women, Khyber Agency: FGD***

## Balochistan province

## Providers Perspective

According to the grass root health workers, mobilisation and coordination with community can play a vital role in expanding the MNCH services. Communities should be motivated to organise themselves into Health Committees and take on the role of oversight and monitoring, health workers security and transport arrangement for MNH emergencies including for poor as they are unable to afford a private vehicle. Health Committee should

***The most vital role is of the community. Communities' cooperation will result in better access to MNH services.***

**LHW Coordinator, Pishin: IDI**

also advocate with Department of Health to undertake renovation and repair of health facilities infrastructure. Health committees under the LHW Programme may be revived and given the task of facilitating the users and the providers.

There is also a need to educate communities for effective utilisation of available MNH services. Such an intervention can help bring a change in the people's behaviour towards health in general and MNH services in particular. The communities can be mobilised by arranging periodic health education sessions on various MNH issues and timely use of available services.

**Health session should be organized to mobilize community.**

### LHV, Pishin: IDI

**Community can play its role by raising awareness among people convincing them to use existing health services provided by the Government.**

### ***LHV, Qilla Abdullah: FGD***

**Seminars should be organized at community level and people should be given awareness regarding health and MNH issues.**

### ***LHV, Dera Bugti: FGD***

Staff, especially the female, should be provided necessary amenities at the place of posting including residence and facilities for their children's education, to ensure their availability for service provision. The availability of these essential facilities, as part of health infrastructure, becomes more meaningful in far flung rural areas of Balochistan where rental services are less likely to work. Female health workers from different districts shared their concerns, as mentioned below.

***Staff from outstation is scared to perform duties due to security issues. To avoid travel, staff should be provided residence and basic facilities within the health facility. While posting, due consideration should be given for education of children.***

**LHV, Pishin: FGD**

**Immediate measures should be taken at BHU and tehsil levels. Presence of staff should be ensured. Staff should be facilitated with residential quarters, gas, electricity and education for their children so that they can easily live over there and serve with more dedication.**

**LHV. Qilla Abdullah: IDI**

Health staff made a demand for an extra allowance as an acknowledgement and appreciation of their services being rendered in the security risk areas. The health staff working in conflict ridden districts considered their salaries inadequate. Doctors also feel the pinch of low salaries compared to their counterparts working in the province of Punjab. Paying them at par with those working in safe and secure districts is unfair.

***The salary is low and on top of that it is paid after three months. It creates difficulties for the family.***

**LHS Centre, Quetta: IDI**

***If we compare our salaries with the salaries of doctors in Punjab, theirs' are many times more than ours.***

**LHW Coordinator, Qilla Abdullah: IDI**

On the role of private health sector, providers made a number of suggestions to expand access and improve the quality of MHH services. The suggestions are mainly focused on continuing medical education of private sector staff through monthly meetings under the Umbrella of Pakistan medical association (PMA) and counselling of patients by the providers.

***Awareness raising sessions should be organised jointly by the public and private sectors.***

**District support manager, PPHI, Pishin: IDI**

**Private sector should organise CME sessions to train their staff.**

**PMA Secretary, Qilla Abdullah: IDI**

***Private providers should start counselling the patients on MNH needs.***

**Gynaecologist, Private sector, Pishin: IDI**



Users Perspective

In the absence of fully functional MNH services at the primary level, pregnancy related issues are mostly the domain of LHVs and TBAs, and for complications the nearby secondary hospitals or hospitals at the provincial capital. The users, on the other hand, are illiterate women who have limited exposure outside their community, low level of awareness of MNH issues and trivial comprehension of likely options to improve the services. This situation prevails not only in Balochistan but also in other study districts. The contribution of users is, therefore, found limited in terms of their participation in the services.

There was a general understanding among the users that the Department of Health should make efforts to educate communities about the MNH issues, the likely complications that can happen and the benefits of availing the services. Furthermore, the communities should facilitate in the awareness raising campaign.

The community should provide oversight by establishing Health Committees and or Women Groups, to make the people aware of their MNH needs, mobilise communities to utilise the services and motivate them to save in order to meet MNH needs. These committees can also play a supervisory role in ensuring quality of services at the PHC level.

**Health Committees should organise regular seminars to educate people and help to understand the importance of MNH so that more people are able to use the services from the health facilities.**  
*Mother, Dera Bugti: IDI*

**Health committees can persuade people to save money so that saving could be utilised at time of need.**  
*Pregnant mother, Quetta: FGD*

Mothers from Pishin district also highlighted the need for the establishment of a Committee at Union Council level comprising village elders and Imams of masjid for creating awareness on MNH issues and motivating families to use the services, since they are respected in the community and people listen to their advice.

**Committees of community elders and Imam masjid should be established at Union Council level. Committees should create awareness and ensure easy access to MNCH service.**  
*Mother, Pishin: FGD*

Furthermore, Health Committees should liaise with the Department of Health at district level to advocate for recruitment against the vacant positions of LHV and gynaecologists, ensure regular supply of medicines and equipment and the presence of staff at the duty station. These steps will improve the cooperation and coordination between the providers and users of MNH services and all players will be able to perform their respective role.

Another area needing community support is the transport arrangement for transferring the emergencies to the higher level health facilities. Like in provinces and agencies, ambulance service at secondary hospitals is generally not accessible to the patients. Security issues and financial constraints, on the other hand, are some of the common challenges faced by the people, especially those who travel at night. The community can help resolve some of these issues by making private transport available, especially for those who are poor and marginalised.

Summary of findings and conclusions

Service 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 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 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. User from FATA also stressed the need to provide CMWs, both to expand the services as well as to meet local customs restricting 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.

Areas Identified for Improvements	Major Challenges		
	Khyber Pakhtunkhwa	FATA Agencies	Balochistan province
Facility level MNH/ health committees/ users groups	Establishing local health committees	Constitute groups of community elders	Establish health committees and women groups
Transport for referrals	Health committee to coordinate with private sector & households having vehicles; set revolving fund	Tribal elders to organise local transport system; Government to provide ambulance at selected locations	Health committee to organise transport system especially to assist poor and marginalised
Human resource	Government to fill vacant posts , increase staff pay, care from SBA, introduce CME,	Filling of vacancies especially of female, post SBA at village level, train TBAs	Filling of vacant posts of female, enhance pay package, provide residence to LHVs
Awareness of users on MNH services and issues	Inputs for BCC, educate on savings for MNH services	Inputs for BCC with focus on men, savings for MNH services	Support for BCC, savings for MNH services
Monitoring and supervision	Monitor staff presence by health committee	Monitor facility staff presence	Facility oversight by health committee
Security of public sector staff	Elders to ensure safety of providers	Tribal Jirgas to ensure safety of providers	Local Sardars can negotiate with militants
Infrastructure and supplies at public sector facilities	Make up infrastructure deficiencies, increase medicines supply	Increase necessary supplies	Make up infrastructure deficiencies
Private sector	NGOs to organise ambulance service; supervision of private health facilities by a body	Counselling of patients by private providers, monthly sessions of private providers on MNH	Counselling of patients, start CME of private providers



All emergencies whether acute or chronic situations of conflict, war or civil disturbance, natural disasters or other crises that affect large civilian populations, often result in significant increase in morbidity and mortality [17]. The conflict crises are often characterised by collapse of basic health services, damage to local infrastructure, deterioration of law and order and resultant security concerns calls for specific interventions to address the plight of the most vulnerable segments of the population especially women and children. Conflict, whether acute or chronic increases plight of women and children. In addition to high fatality rates due to direct impacts of the conflict often leads to indirect and prolonged effects on maternal and neonatal health that result in increased mortality and poor health outcomes.

Mothers and children are disproportionately affected and under-five mortality rates can be several-fold higher during crises [18]. In particular, newborns younger than 28 days old have the highest risk of mortality [19]. Of the ten countries with the highest maternal and neonatal mortality rates, six – Afghanistan, Central African Republic, Democratic Republic of the Congo, Pakistan, Sierra Leone and Somalia – are currently or recently affected by conflict and other humanitarian emergencies.

Pakistan in recent years is facing ongoing conflict and insurgency in the provinces of Khyber Pakhtunkhwa (KP), Balochistan, and Federally Administered Tribal Areas (FATA). All social services have been adversely affected by ongoing conflict however, health, education and communications has been the worst affected. In areas already marked by under development, low literacy levels and poor health indicators, the conflict situation has further led to deterioration of maternal and newborn Health (MNH) services. The ongoing military action and insurgency has made study districts highly security compromised, thus making it difficult for the women to seek care. This situation has been further compounded by massive floods of 2010 and 2011.

There is a need to develop, further understanding of how best to address MNH needs in Pakistan's conflict areas, with sustained and result based interventions. It is well understood that several issues e.g. lack of government capacity, lack of political will or the breakdown of social fabric in the conflict areas can impair and complicate service delivery. Usually in such circumstances, capacity development is often replaced by more urgent needs and staff is also either demoralised due to insecure and poor working conditions or they are actively targeted by the oppressive elements.

Improving access to maternal and neonatal health services are a major challenge in many of the conflict stricken districts. In order to improve these services it was important to understand the underlying dynamics of low performance and utilization of MNH services. Therefore this qualitative research study scrutinised MNH services on both the demand and supply sides of governance equation. The specific objectives of the study were to: (i) Assess MNH situation in the conflict areas of Pakistan; and (ii) Identify factors that are detrimental for access to and utilisation of MNH services, especially for the most marginalised belonging to the poorest quintile, socially excluded and displaced populations and vulnerable groups in the conflict areas.

The qualitative research study explored the following five key thematic areas in nine districts and three FATA agencies: (i) existing MNH Services; (ii) reach and access to the available MNH services keeping in view security situation; (iii) users' views on referral linkages to higher level health facilities; (iv) perception and expectations of users' to their MNH needs; and (v) how can communities participate in the delivery of services.

### Existing Maternal and Newborn Health (MNH) services

The public health sector has a three-tiered health delivery system: LHWs at community level and community midwife (CMW), LHVs and doctors at PHC facilities, and specialists at hospitals. Private sector also provides MNH services, especially in the urban areas. LHWs play a significant role in the delivery of community level MNH services but are less active in FATA and Balochistan due to higher degree of security threats, curfews and limited provision of supplies. TBAs are also important service providers. KP and Balochistan have trained TBAs in the recent past.

MNH services at PHC facilities are facing a series of problems, like: shortage of female staff, absenteeism, insufficient equipment and medicines, poorly maintained infrastructure and inappropriate location of some facilities. 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 appeared 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 passionate. 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 wages 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 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.

### Access to available MNH services keeping in view security situation

Dera Bugti and North Waziristan agency (NWA) 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 socio-economic 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 acts of terrorism and militancy have adversely affected the MNH services. During the attacks, the roads get blocked, public transport disappears and both the health providers and patients find it impossible to reach the health facilities. In such situations, many a times the result is the death of the mother or the baby or both.

### 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 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 (except Quetta). In some situations, the emergencies have to be carried to tertiary hospitals that are distantly located far away.

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 Pakhtun communities residing in KP and Balochistan provinces. Further, permission of elders is also required for seeking care at referral hospitals, especially in FATA, and rural areas of KP and Balochistan.

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

**Perceptions and expectations of users and providers to their MNH needs**

The quality, access and utilization 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, absenteeism and political interference in staff recruitment and posting. The other challenge is the deficiencies in health infrastructure like the lack of repair and maintenance of buildings, and absence of or unliveable state of the residential quarters which affect 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 terms of access to and utilization of services due to short supply of medicines, lack of or worn out equipment, staff absenteeism, indifferent staff behaviour, short working hours of health facilities, insufficient 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 hinder the mothers from seeking timely 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.

**How Communities and providers can participate in service delivery**

Services providers and users suggested a number of interventions for increasing access to and utilisation 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 local transport system for referral, facility oversight, monitoring staff presence, pursuing 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 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.

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

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, counselling of patients and monthly CME sessions of private providers on MNH.

**Discussion**

The major obstacles to seeking care are, especially the MNH services, in the security compromised areas can be classified under the following categories:

- Security challenges
- Health human resource issues and quality of care
- Health Committees
- Stock outs of medicines and supplies
- Local culture and traditions
- Lack of awareness about MNH issues and services
- Distance to health facility

- Cost of treatment
- Plight of internally displaced persons (IDP)

Security challenges. The study areas under discussion are in the grip of an ongoing militancy since the last 10 years. The militants have destroyed female educational institutions and health centres, further reducing the number of already limited facilities. This situation reflects the attitude of insurgents against female empowerment, since education is an instrument for the development of mankind and health system for taking care of the health of the people.

Militants deliberately target well-off, educated and skilled health professionals because they are the strength of the civil society for further increasing the quality of life. Restricting females to participate in the delivery of social services in collaboration with males and without purdah, including health services is also on the agenda of militants as part of their self-styled belief. Attacks on them demoralise the rest of the population especially the weak, poor and marginalised who therefore seek refuge in joining the Taliban - the main power currently prevailing in the area. It facilitates in the spread of Talibanisation and seems a viable solution for the survival of their captives.

So far there has been minimal progress in conflict resolution at the political level. In many areas in KP province and FATA agencies Military check posts have been established since 5-6 years to maintain peace. Resolution of conflict falls under the ambit of political government and the Army; the Departments of Health have little role in supporting peace talks but their problems multiply enormously in maintaining the continuity of health services in terms of staff availability, maintaining supply chain of medicines and utilities to the health facilities and keeping the health facilities open for services. The Departments of Health in conflict affected areas can best take appropriate steps specific to the given situation so that the provision of health services, and in this case the MNH services, are less disrupted. In most cases, provincial Departments of Health will have to think out-of-the-box, to maintain the provision of medical services such as higher pay package, posting staff in their domicile districts, adequate supply of essential medicines and supplies, proper upkeep of physical infrastructure of health facilities.

Health human resource and quality of care. Among various health problems in the security compromised areas, the shortage of health human resource (HHR) is the most important and urgent issue. Research in other countries shows a correlation between quality of care, health outcomes and the availability of HHR [20], and this is particularly relevant to re-establishing the health services in conflict affected areas [21].

There is common complaint that health facilities, especially in rural and far-flung areas, are not operating according to the needs of the users in the security compromised areas. Neither the users trust in terms of staff presence, drugs supply and opening hours, nor do health facilities provide a full range of services. However, special measures need to be taken that lifeline services, like MNH services, must be operative to offer both routine and EmONC services as the time between life and death becomes telescoped in maternal and neonatal emergencies.

Failure to tackle the local situation based remedial measures in maintaining the service delivery has devastating effects on the health and survival of mothers and infants. The inaction on the part of Departments of health of FATA agencies and KP province can be seen from the following statistics [22]:

- 180 out of 274 health outlets have been closed in North Waziristan Agency, a hub of militants activities
- The number of female patients at FATA health facilities has decreased since 2005; the number dropped from 70,000 in 2006 to 9,234 in 2010 up to September. The number of women having surgery fell from 3,467 in 2008 to 445 in 2010.
- On paper 72 specialists, 495 medical officers, 62 female doctors and 209 nurses are on the payroll in FATA agencies, but it is hard to find many.
- In KP province 5,639 female doctors and 5,435 nurses are on their payroll, but only 5 percent are posted in the security compromised areas.



Political stability is crucial to meet HRH shortages in the conflict affected areas, but is beyond the direct control of health intervention strategies. However, remedial measures at the level of the Departments of Health to keep running the lifeline services could take many shapes like: local community elders, Jirgahs and Sardars negotiating with the militants to exempt health staff from kidnapping/killing; posting skilled 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, development or expansion of a cadre of community level MNH services providers, paying more for work in the security compromised areas and others.

Standard Operating Procedures (SOPs) for the referrals of patients between the facility referring the patient and the facility receiving the patient do not exist. However, the problem is not specific to the health services in the security compromised areas but an overall absence of institutionalised referral system all over the country. The deficiency in the system, however, becomes more visible in the conflict affected areas when referred patients from the lower health facilities are not properly honoured at the secondary hospitals. The system of continuing medical education (CME) also does not exist.

Health committees. Although Health Committees have been established around each LHW catchment area, but these committees have generally been functioning sub-optimally. However, in Swat district many of the Health Committees have become well-functioning with two way linkages between the users and the providers. Two inputs acted as a catalyst to make the committees well-functioning: (i) a trio formed between the supervisor (LHS) and the service providers (LHV, LHW and TBA) to timely provide MNH services to the users; and (ii) activation of already established LHW level sub-optimal functioning Health Committees by the LHS to expand MNH services, including empowering committee members to distribute the delivery kits to the pregnant mothers. Buner district is also functioning on a similar pattern. Taking a lead from this intervention in Swat and Buner, the district level health managers and supervisors can expand the concept of Health Committees at each health facility.

The Jirgah is a type of community level administrative setup to resolve local level disputes and issues based on local customs and traditions. In FATA and some parts of KP and Balochistan, where appropriate, the local Jirgah could also take over the functions of a Health Committee.

Stock-outs of essential drugs and supplies is an acute problem at health facilities in general and is not peculiar to facilities operating in the security compromised areas. However, patients feel severe pinch of the shortage of needed medicines because of lack of adequate access to the market and enhanced poverty levels in the security risk areas. To deal with this challenge, the option for the Department of Health should be to review the drugs allocation quota accordingly.

Local customs and traditions restrict movement of females without Purdah and male escort, especially in FATA and rural Pashtun women in KP and Balochistan provinces. Further, permission of elders is also required in these areas for seeking MNH care at health facilities. Militants have also imposed restrictions on women to move out of home without a veil and male family member.

In general, low status is accorded to women's health in the local culture. The situation is further worsened by lack of awareness about the importance of MNH services leading to low utilisation of services. This situation is further precipitated by low status accorded to women's health in the local culture.

Behaviour change communication. This is a grey area as the Departments of Health have least focus all over the country, both in terms of deployment of 'health education specialists' as well as introducing continuing medical education on this topic to the health workforce. Logically its needs priority in the security compromised areas. The example of change in the pattern of delivering newborn during the night time has been adjusted by the local communities to day time in FATA agencies so as to minimise the risk of transporting risk pregnancies to the hospitals at night time.

Distance between the users of MNH services and health facilities is not a consequence of militancy but security threats becomes very acute because of long distance travel effort especially at night, damaged roads and lack of adequate access to local transport system. Again some local solutions need to be jointly tailored by the users and the Departments of Health, such as streamlining community level vehicles for transporting emergencies and developing and or expanding community level cadre of MNH workers (trained TBAs, CMWs).

The high cost for treatment comes in to play in security risk areas, particularly with respect to transport for managing emergencies, short supply of medicines at the public sector health facilities and the high cost of treatment at the private health facilities. The poor families at time might have to take loan or sell their assets. Further, there is lack of coordination between the public and private health sector for lack of regulatory framework for the private health sector. To offset some of implications of the high cost of treatment, communities should look for local solutions such as educating the families for savings to meet MNH costs.

IDPs. The protocols of this qualitative study do not cover assessing the needs for additional resources required for services to the IDPs. Further, the IDP camps are generally established in low risk areas outside conflict-ridden zones. Hence, it is out of the purview of this study to provide estimates of additional resource envelope needed for health services to the IDPs. Under the existing arrangements, Bureau for Democracy, Conflict, and Humanitarian Assistance (DCHA) and Office of U.S. Foreign Disaster Assistance (OFDA) in collaboration with Federal Disaster Management Authority (FDMA) of Pakistan and provincial governments work together to mitigate the impact of conflict on populations in Pakistan. The services comprise distribution of emergency relief supplies, provision of social services including health services and implementation of economic recovery activities for internally displaced persons (IDPs) and returning populations.

### Proposed way forward

Some of the short-term and medium term potentially viable options, proposed by providers and users, and sieved from literature review are discussed below. The proposed interventions need further analysis and unfolding to translate in to an actionable plan.

Shortage of human resource and low salaries: There is need to map out vacancies in the conflict affected districts. Based on the mapping, staff domiciled from those districts should be encouraged to move to their native districts. In parallel working should be done by the provincial Finance Departments to adequately enhance the salary package of technical staff for serving in the identified high-risk areas. The two pronged strategy should provide some relief in improving access to MNH services in many security compromised areas.

Expansion of community level MNH services: Provincial Departments of Health have already made a beginning in some areas of KP and Balochistan in terms of retaining TBAs, and training and deployment of CMWs on self-employment basis. The case management skills of these community level staff should be enhanced using MNH protocols [23]. Detailed planning needs to be undertaken by provincial departments of health for further expanding and improving the community level MNH services in the rural areas, starting from more acutely deprived conflict affected areas. This plan meets both the technical criteria as well as the socio-cultural restrictions imposed on women mobility. The strategy is not only least cost solution but will also generate local level self-employment opportunities.

The good experience of trio working in Swat district has been reported where working relations between TBAs, LHWs and CMWs have been strengthened at local level, and Lady Health Supervisor (LHS) is providing monitoring support with regular linkages with the nearest health facility. This model needs to be further studied and expanded wherever such human resource is in position. Where CMWs are not in place, the existing link between the TBAs and LHWs needs to be reinforced and monitored to alleviate the misery of rural mothers who have minimal options to go against local cultural norms. The TBAs training component needs to be dovetailed with this initiative to improve the quality of the routine MNH services.



Behaviour Change Communication (BCC): There is a need to establish efficient link between the users and providers of MNH services so as to apprise the users of the consequences of irrational practices, and then reinforce the messages by informing them about services the public health sector would offer under the proposed new arrangements. To implement this option, public sector needs to employ enough professionals and electronic and print media in educating the health providers, members of health committees and users for affecting behaviour change including ability to recognise danger signs, backed by adequate financing for skill development activities (especially the LHVs, CMWs, TBAs, LHSs and members of future health committees) and the supply of information brochures.

Under the prevailing pathetic situation, behaviour change communication especially focused on males, and creation of cadre of community level SBAs should be the least cost and most rewarding strategy to improve the health outcomes in the security compromised areas.

At the face of shortage health education officers at the district level, the introduction of BCC at the facility and health committee levels would fall under the medium term time frame. Involving local NGOs in BCC campaign might work in some areas.

Health committees and their role: The concept of local level management of health services is not a new idea; it has been applied in Makueni district of Kenya as early as 1999 [24]. For capitalising on this local level management system, certain countries like Zimbabwe has even developed “training manual” for establishing and making functional the health centre committees [25].

Establishing Health Committee at health facility level was a concept generally favoured by most of the stakeholders. Institutionalising such a local level management system was considered a mechanism of two way participation of both the users and the providers in improving the quality of and access to MNH services. The functioning Health Committees in LHWs catchment areas have already been reported in the conflict affected areas of Swat district. Where appropriate, the local Jirgah could also take over the functions of a Health Committee.

The stakeholders also expressed their views on the composition and roles and responsibilities of Health committee. With respect to composition, there was common understanding to include local elders and Pesh Imam of mosque, including women representation. Activating health committees around each LHW area was another option.

Stakeholders suggested five discrete functions for the health committee, which appear very logical in streamlining the MNH services, and comprise:

- Act as a vigilance group to monitor the presence of health staff and assist them in addressing service delivery challenges
- Minimise security concerns of health staff by negotiating with militants in their area
- Liaise with the Department of Health at district level to advocate for recruitment against vacant positions and the needs for required equipment and supplies
- Organise local transport system for timely transferring emergencies to the higher level health facilities
- Together with health staff, organise awareness raising sessions to help communities understand the importance of MNH service and create a culture of savings for unforeseen MNH needs

Minimising delay in availing the referral services: Stakeholders have opined that they need to work on this area by exploiting and streamlining the local level transport system through negotiations by the good offices of health committee. Therefore, the forerunner for organising the transport is to establish local level health committees.

Streamlining the local level transport system will have quite a few positive impacts, namely: (i) facilitate in minimising the second delay in accessing the referral facility, (ii) person operating at local level is more familiar with routes that are more safe or less risky; (iii) these vehicles can be registered with security checks posts for the

ease of priority clearance; and (iv) there could be options for even deferred payment by the users.

Referral procedures and protocols: It may be worthwhile to address this area as part of the package for improving MNH services in the security compromised areas. The tasks under this intervention could be divided in to two parts, namely development of referral procedures along with SOPs followed by staff training in the use of SOPs.

Infrastructure challenges: The provincial and district health departments should judiciously use annual development budgets with a priority for improving the existing infrastructure of health facilities, especially in rural and far flung areas, so that the staff feels comfort in staying and residing in the facilities. A detailed planning will have to be done to prioritise health facilities needing urgent inputs.

There are many health facilities which are located at places away from the communities and the users have problems in accessing those facilities, especially at the face of cultural limitations on the mobility of women and security risks. Consideration should be given to relocate those facilities within the community by renting out suitable houses with due modifications, wherever feasible. Relocation will create comfort for the users and persuade providers to stay at the work place.

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 gaps in various areas identified under the way forward, the feasibility 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/agency on the basis of area specific challenges and tailoring interventions that are situation specific. The task of developing district/agency 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/agency specific strategic plans along with commitment to finance key implementation areas, without directly involving itself in implementation.

ANNEXURE

ANNEX 1

ANNEX 2

PROJECT CORE TEAM

GUIDELINES FOR IN-DEPTH INTERVIEWS AND FOCUS GROUP DISCUSSIONS

ANNEX-I

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GUIDELINES FOR IN-DEPTH INTERVIEWS AND FOCUS GROUP DISCUSSIONS

The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

Guidelines for IDIs with Public Health Managers at District and Provincial level

Area 1: Existing MNH related services and practices

- What are your views about the current package of MNCH services provided at the public sector facilities at
  - Community level
  - PHC level
  - Secondary care level
- What proportion of women, in your views, have access to MNCH in conflict areas, at basic health units, rural health centres, tehsil hospital and district hospitals level especially those who are poor and marginalised?
- How would you describe the quality of MNCH services provided at various levels in the public sector in conflict area?
  - At Community level
  - At PHC level
  - At secondary level
- What common reasons in your views are contributing to low quality of MNCH services? We would like hear you with reference to these topics and in other areas in your view :
  - Human resource
  - Staff skills
  - Wage rates
  - Medicines and supplies
  - Equipment and supplies
  - Infrastructure
  - Security issues
- How effective private health sector (including maternity homes, clinics, hospitals etc.) is playing its role in the delivery of MNCH services in the conflict areas for poor and marginalised?
- Is there any partnership between public and private health facilities to provide MNH services: If yes, how successful is their coordination mechanism to avoid duplication of services?
- Which one of the available public health programs at district level are popular among the users and why?
- Is there any public health program which people never prefer to use?

Area 2: Reach and access to the available MNH services keeping in view the security situation:

- What are the common physical barriers in conflict areas, in your view, for poor access to MNCH services?
- Probes
  - Absence of service providers/ staff
  - BHU/RHC is far away;
  - Private sector health facilities are far away
  - Security issues
  - Fear of travel
- What are the common social barriers, in your view, compromising the access to MNCH services in your area?
- Probes



- o Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
- o Absence of female health staff
- o Short working hours at health facilities
- o Absence of staff from duty
- o Behaviour of the staff with clients

### Area 3: Referral linkages to higher level health facilities

- Would you describe the functionality or otherwise of existing referral system of public sector to receive and manage maternal and neonatal complications?
- What are the major challenges in your view in exiting referral system at face security risks?
- How good or bad is the existing transport system at public and private sectors to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in conflict areas at providers and consumers levels hinder the use of existing transport system?
- Is there any free transport system (like EDHI) which poor and marginalised people could use to reach to the referred hospital?
- Given the opportunity how would you like to reform the patients transport system in the conflict areas?
- What options do you suggest to improve the referral system?

### Area 4: Perceptions and expectations of service providers meeting users MNH needs

- How would you comment on the available human resources in the public and private sector to meet the MNCH needs of population in conflict areas?
- Which cadres are in short supply and why?
- Which type of cadre is in acute shortage, keeping in view the continuing security risks and why do you say so?

### Area 5: Improving delivery of MNH services:

- Would you like to suggest any improvements or additions in the current package of MNCH services at various levels and why so?
- Are these improvements doable and how?
- What role community can play in filling the gaps?
- What are your suggestions to various service providers to minimise various access barriers?
  - o Role of public health sector
  - o Role of private health sector
  - o Role of communities
- If you have decision making power, what would be your priorities and strategy to meet the human resource need?
- Do you have any other suggestion to improve the quality of and access to MNCH services in the conflict areas?

#### Implications for improving the services

- Would you like to summarise the implications for improving MNCH services
  - o At community level including community participation
  - o At primary healthcare level
  - o At secondary level

### Guidelines for IDIs with Private Health Managers

Pakistan Medical Association, Midwifery Association, NGOs and private hospitals/ maternity homes  
The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

### Area 1: Existing MNH related services and practices

- What are your views about the current package of MNCH services provided at the private and NGO sector facilities at
  - o Community level
  - o Outpatient clinic/ NGO clinic level
  - o Private hospitals/ maternity home level
- What proportion of women, in your view, has access to MNCH in conflict areas, at private and NGO level facilities especially those who are poor and marginalised?
- How would you describe the quality of MNCH services provided at various levels in the private/ NGO sector in conflict area?
  - o At Community level
  - o Private/ NGO clinic level
  - o Private hospitals/ maternity home level
- What common reasons in your views are contributing to low quality of MNCH services? We would like hear you with reference to these topics and in other areas in your view:
  - o Human resource
  - o Staff skills
  - o Wage rates
  - o User fees
  - o Medicines and supplies
  - o Equipment and supplies
  - o Infrastructure
  - o Security issues
- Is there any partnership between public and private/NGO health facilities to provide MNH services: If yes, how successful is their coordination mechanism to avoid duplication of services?

### Area 2: Reach and access to the available MNH services keeping in view the security situation:

- What are the common physical barriers in conflict areas, in your view, for poor access to MNCH services of private/NGO sector?
 

**Probes:**

  - o Absence of service providers/ staff
  - o Private sector health facilities are far away
  - o Security issues
  - o Private health facilities charges are very high
  - o Fear of travel
- What are the common social barriers, in your view, compromising the access to MNCH services of private /NGO sector?
 

**Probes**

  - o Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients

### Area 3: Referral linkages to higher level health facilities

- Would you describe the functionality or otherwise of existing referral system of private/NGO sector

- to receive and manage maternal and neonatal complications?
- What are the major challenges in your view in exiting referral system at face security risks?
- How good or bad is the existing transport system at private/ NGO sectors to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in conflict areas at providers and consumers levels hinder the use of existing private/ NGO sector transport system?
- Is there any free transport system (like EDHI) which poor and marginalised people could use to reach to the referred hospital?
- Given the opportunity how would you like to reform the private/ NGO sector transport system in the conflict areas?
- What options do you suggest to improve the referral system?

#### Area 4: Perceptions and expectations of service providers meeting users MNH needs

- How would you comment on the available human resources in the private/NGO sector to meet the MNCH needs of population in conflict areas?
- Which cadres are in short supply and why?
- Which type of cadre is in acute shortage, keeping in view the continuing security risks and why do you say so?

#### Area 5: Improving delivery of MNH services:

- Would you like to suggest any improvements or additions in the current package of MNCH services at various levels and why so?
- Are these improvements doable and how?
- What role community can play in filling the gaps?
- What role PMA should play in filling the gaps?
- What role private clinic/ private hospitals/ maternity homes should play in filling the gaps?
- What role health related NGOs should play in filling the gaps?
- What are your suggestions to various service providers to minimise various access barriers?
  - Role of pure private health sector
  - Role of NGO sector
  - Role of local communities
- What role PMA and its members/NGO like yours can play to minimise barriers for access to MNH services?
- What role PMA/ private sector/ NGO should play to meet the human resource need?
- Do you have any other suggestion for private/ NGO sector to improve the quality of and access to MNCH services in the conflict areas?

#### Implications for improving the services

- Would you like to summarise the implications for improving MNCH services
  - At community level including community participation
  - Private/ NGO clinic level
  - Private hospitals/ maternity home level

#### Guidelines for IDIs with Lady Health Visitors/ Midwives

The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

#### Area 1: Existing MNH related services and practices

- What are your views about the current package of MNCH services provided at:
  - Your health facility
  - Community level
  - District/ agency or Tehsil hospital in your area/ district
- How would you describe the quality of MNCH services provided at your health facility?
- What common reasons in your views are contributing to low quality of MNCH services at your health facility? We would like hear you with reference to these topics and in other areas in your view :
  - Human resource
  - Staff skills
  - Low Wage rates
  - Medicines and supplies
  - Equipment and supplies
  - Infrastructure
  - Security issues
- How effective private health sector (including maternity homes, clinics, hospitals, etc.) is playing its role in the delivery of MNCH services in the conflict areas for poor and marginalised?

#### Area 2: Reach and access to the available MNH services keeping in view the security situation:

- What proportion of women, in your view, has access to MNCH services in your area especially those who are poor and marginalised? Has the number of women seeking MNH services increased or decreased in last five years due to the conflicts? Probe for reasons.
- What are the common physical and financial barriers in your area, in your view, for poor access to MNCH services?
- Probes**
  - Absence of community midwife
  - BHU/RHC is far away;
  - Private sector health facilities are far away
  - Security issues
  - High informal fees at Govt. Health facilities
  - Private health facilities charges are very high
  - Fear of travel
- What are the common social barriers, in your view, compromising the access to MNCH services in your area?
- Probes**
  - Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - Absence of female health staff
  - Short working hours at health facilities
  - Absence of staff from duty
  - Behaviour of the staff with clients
- Which women are regular in seeking MNH service from your health facility?
  - Settlers
  - Locals (natives)
  - Displaced (Refugees)

#### Area 3: Referral linkages to higher level health facilities

- Would you describe the functionality or otherwise of existing referral system of public sector to

- receive and manage maternal and neonatal complications?
- What are the major challenges in your view in exiting referral system at face security risks?
- Does your facility provide any facilitation to the client to reach the referred hospital? If yes how?
- How good or bad is the existing transport system at public and private sectors to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in conflict areas at providers and consumers levels hinder the use of existing transport system?
- Is there any free transport system (like EDHI) which poor and marginalised people could use to reach to the referred hospital?
- What are your suggestions to improve the patients' transport system?
- What options do you suggest to improve the referral system to deal with maternal and neonatal complications occurring in your area?

#### **Area 4: Perceptions and expectations of service providers meeting users' MNH needs**

- How would you comment on the available female health staff in the public and private sector in your area to meet the MNCH needs?
- Which type of cadres are in short supply; LHV, Midwife, female doctor etc. and why?
- Which type of cadre is in acute shortage, keeping in view the continuing security risks and why do you say so?

#### **Area 5: Improving delivery of MNH services:**

- Would you like to suggest any improvements or additions in the current package of MNCH services at BHU/community level/ tehsil/ district/ agency hospital level?
- Are these improvements doable and how?
- What role community and families can play in filling the gaps?
- What are your suggestions to various service providers to minimise access barriers?
  - Role of public health sector
  - Role of private health sector
- What are your suggestions to meet the needs of the staff at BHU and community level?
- Do you have any other suggestion to improve the quality of and access to MNCH services in the conflict areas?
- What else private sector should do in your view to expand its role in your area?

#### *Implications for improving the services*

- Would you like to summarise the implications for improving MNCH services
  - At community level including community participation
  - At primary healthcare level (BHU, RHC, MCH centre)
  - At hospital level

### **Guidelines for IDIs with Mothers**

We will have discussion on mother and child health related practices. Please share your own experiences keeping in view your previous pregnancies.

#### **Area 1: Existing MNH related practices**

- Do/did you regularly seek health services during pregnancy, delivery or postpartum period? Details and reasons for seeking or not seeking such services?
- Where do/did you generally prefer to go for check-up during your pregnancies? Please explain in detail your preferences for our understanding. (Probe for preferences).
- Many types of birth attendants would be working in your area for assistance during delivery. How do you/your family choose a birth attendant? And who are the three types of birth attendant you/your family most commonly use their services? Why. Probe for reasons (avail/ afford/ prefer (exceptions)
- After the child delivery, what are the practices for postnatal care of mother and newborn in your family, whom does your family generally; choose for providing care and services? Probe specifically whether it is a traditional practice or modern service-elaborate).
- When a complication is noticed during pregnancy, delivery or after childbirth, which types of health facilities or service providers your family most commonly consult for treatment? Please share your personal experience.
- Can you tell me what kind of FP services is available in your area?
- Have you ever used any FP method:
  - If yes which methods and details of preference of using the methods
  - If no, why you have never used any method?
- If ever used, which type of health facilities or service providers do you generally consult for family planning services and reasons for such preferences?
- What type of health facilities or service providers for MNH services are available in your area?
- Why do you choose these services providers or health facilities for MNH services? Please explain in detail the reasons for such preferences.

#### **Area 2: What is the reach and access to the available MNH services keeping in view the security situation?**

- What are the local traditions or culture regarding whom to consult during pregnancy, delivery or after delivery (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?
- Who makes the decision at your family level to consult whom? Probe: can you make a decision at your own?
- Do you generally have the permission to go to nearest health facility at your own? Probes: Who generally accords you permission? Who generally accompanies you?
- What is the mode of travel to the local health facility and associated challenges, especially at the face of security issues? How much does it generally cost to reach the health facility?

#### **Area 3: Users' views on referral linkages to higher level health facilities** (If she has never experienced any emergency ask about experience of any other friend or relative)

- In case of emergency (i.e. if a complication occurs during delivery, birth or after birth), please explain how do/did you reach the hospital and what challenges you and your family has/had to face?
- In case of emergency do/did you decide on your own to reach the referred hospital, was that a public or private facility, how did you travel to the facility, who accompanied you to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) have ever provided you any support in referral of emergencies and if so what role did their staff play?
- Please share your own experience, both positive and negative, how well the emergency was managed at the referral hospital?



**Areas 4: What are the perceptions and expectations of users to meet their MNH needs?**

- Please share your satisfaction level with the existing MNH services provided by the government health facilities, private health facilities, private practitioners, local level TBAs, and LHWs
- What are your suggestions to improve the existing MNH services in line with your needs?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for MNH providing in a timely manner?

**Area 5: How communities can participate in the delivery of MNH services?**

- Please describe some viable options where households and community can contribute and participate in improving the MNH services in your area.
- Is it a workable option to organise local transport owned by the households for transportation of emergencies to the nearest health facilities? How could it be organised? Who are the main players to make it a functional arrangement?
- How about organizing village level MNH committee to take a lead role in areas like: sorting out local level challenges, creating a culture of some savings to finance expenses of MNH services, awareness creation for adopting health MNH practices at household level, and etc.

**Guidelines for FGDs with Lady Health Visitors/ Midwives**

The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

**Area 1: Existing MNH related services and practices**

- What are your views about the current package of MNH services provided at:
  - o Your health facility
  - o Community level
  - o District/ agency or Tehsil hospital in your area/ district
- How would you describe the quality of MNH services provided at your health facility?
- What common reasons in your views are contributing to low quality of MNH services at your health facility? We would like hear you with reference to these topics and in other areas in your view :
  - o Human resource (Non-availability of staff, absenteeism, lack of commitment)
  - o Staff skills and behaviour
  - o Low Wage rates
  - o Medicines and supplies
  - o Equipment and supplies
  - o Infrastructure
  - o Security issues

**Area 2: Reach and access to the available MNH services keeping in view the security situation:**

- In your view, what type of security issues are present in your community:
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Internal tribal conflicts
  - o Internal rivalries
  - o Any other
- In your view, what kind of people can be considered as poor and marginalised?
- Keeping in view the security situation, what proportion of women, has access to MNH services in your area especially those who are poor and marginalised?
- Has the number of women seeking MNH services increased or decreased in last five years due to the conflicts and security situation? Probe for reasons.

- In your view what are the common physical and financial barriers in your area, for poor access to MNH services?

**Probes**

- o Absence of community midwife
  - o BHU/RHC is far away;
  - o Private sector health facilities are far away
  - o Security issues
  - o High informal fees at Govt. Health facilities
  - o Private health facilities charges are very high
  - o Fear of travel
- What are the common social barriers compromising the access to MNH services in your area?
- **Probes**
    - o Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
    - o Absence of female health staff
    - o Short working hours at health facilities
    - o Absence of staff from duty
    - o Behaviour of the staff with clients
    - o Honour

**Area 3: Referral linkages to higher level health facilities**

- Would you describe the functioning of or otherwise of existing referral system of public sector to receive and manage maternal and neonatal complications?
- What are the major challenges in exiting referral system in the face of security risks?
- How good or bad is the existing transport system at public and private sectors to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in conflict areas hinder providers and consumers to use the existing transport system?
- What are your suggestions to improve the transport system for patients?
- What options do you suggest to improve the referral system to deal with maternal and neonatal complications occurring in your area?

**Area 4: Perceptions and expectations of service providers for meeting users' MNH needs**

- How would you comment on the available female health staff in the public and private sector in your area to meet the MNH needs?
- Which type of cadres are in short supply; LHV, Midwife, female doctor etc. and why?
- In the current and continuing security situation which type of cadre is in acute shortage? Why?

**Area 5: Improving delivery of MNH services:**

- In your views how can the following help in minimizing barriers for service providers?
  - o Role of public health sector
  - o Role of private health sector
  - o Role of local influential
  - o Role of community
- Do you have any suggestion to improve the quality of and access to MNH services in the conflict areas?

### Guidelines for FGDs with Lady Health Workers

The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

#### Area 1: Existing MNH including FP related services and practices

- What are your views about the current package of MNH services including FP services provided at:
  - o Your health facility
  - o Community level
- How would you describe the quality of MNCH services including FP services provided by the BHU with whom you are attached?
- What common reasons in your views are contributing to low quality of MNH services including FP services at your BHU with which you are attached? We would like to hear you with reference to these topics and in other areas in your view :
  - o Human resource (Non-availability of staff, absenteeism, lack of commitment)
  - o Staff skills and behaviour
  - o Low Wage rates/ payments not at time
  - o Medicines and supplies
  - o Equipment and supplies
  - o Infrastructure
  - o Security issues

#### Area 2: Reach and access to the available MNH services including FP services keeping in view the security situation:

- In your view, what type of security issues are present in your community:
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Internal tribal conflicts
  - o Internal rivalries
  - o any other
- In your view, what kind of people can be considered as poor and marginalised?
- Keeping in view the security situation, what proportion of women, has access to MNH services including FP services in your area especially those who are poor and marginalised?
- Has the number of women seeking MNH services including FP services increased or decreased in last five years due to the conflicts and security situation? Probe for reasons.
- What type of services you provide to women during pregnancy, delivery and after delivery and children in your catchment area?
- What additional services women demand from you?
- Have you ever experienced/ observed any security issue that hindered you/ other LHW in providing MNH services including FP services?
- Do you receive enough supplies and contraceptives to meet the needs of your clients? What items are generally in short supplies and why?
- What are the common physical and financial barriers in your area, for poor access to MNH services including FP services?
- **Probes**
  - o Absence of community midwife
  - o BHU/RHC is far away;
  - o Private sector health facilities are far away
  - o Security issues

- o High informal fees at Govt. Health facilities
- o Private health facilities charges are very high
- o Fear of travel
- In your view what are the common social barriers compromising the access to MNH services including FP services in your area?
- **Probes**
  - o Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour

#### Area 3: Referral linkages to higher level health facilities

- Would you describe the functioning of or otherwise of existing referral system of public sector to receive and manage maternal and neonatal complications?
- What are the major challenges in exiting referral system in the of face security risks?
- How good or bad is the existing transport system at your village to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in your area hinder the use of existing transport system?
- What are your suggestions to improve the transport system for patients?
- What options do you suggest to improve the referral system to deal with maternal and neonatal complications occurring in your area?

#### Area 4: Perceptions and expectations of service providers in meeting users' MNH needs

- How would you comment on the available female health staff in the public and private sector in your area to meet the MNH needs?
- Which type of cadres are in short supply; LHV, Midwife, female doctor etc. and why?
- In the current and existing security situation which type of cadre is in acute shortage? Why?

#### Area 5: Improving delivery of MNH services:

- In your view how can the following help in minimizing these barriers for service providers?
  - o Role of public health sector
  - o Role of private health sector
  - o Role of influential
  - o Role of community
- Do you have any suggestion to improve the quality of and access to MNH services including FP services in the conflict areas?

### Guidelines for FGDs with TBAs

The discussion will revolve around antenatal care, assistance during delivery, postnatal care, newborn care, referral for EmONC, immunization, health education and counselling, and family planning services with reference to poor and marginalised populations.

#### Area 1: Existing MNH related services and practices

- What are your views about the current package of MNH services provided by:
  - o Yourself as TBA
  - o your community level health facilities
- How many TBAs from your area have received Midwifery training organised by any public or private health program?
- Do these trainings have improved their knowledge and performance? How
- Why did you not attend any such training?
- How did you acquire this skill of becoming TBA? (learning from elders/ learning during assisting deliveries with others)
- Is there any LHW/s conducting deliveries in your area? If yes, have they attended any training other than LHW's training?
- How would you describe the quality of MNCH services provided by your community level health facilities?
- What common reasons in your views are contributing to low quality of MNH services at your community level health facilities? We would like to hear you with reference to these topics and in other areas in your view :
  - o Human resource (Non-availability of staff, absenteeism, lack of commitment)
  - o Staff skills/ behaviour
  - o Low Wage rates
  - o Medicines and supplies
  - o Equipment and supplies
  - o Infrastructure
  - o Conflict and security issues

#### Area 2: Reach and access to the available MNH services keeping in view the security situation:

- In your view, what type of security issues prevail in your community:
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Internal tribal conflicts
  - o Internal rivalries
  - o Any other
- In your view, what kind of people can be considered as poor and marginalised?
- Keeping in view the security situation, what proportion of women, has access to MNH services in your area especially those who are poor and marginalised?
- Has the number of women seeking MNH services increased or decreased in last five years due to the conflicts? Probe for reasons.
- What type of services you provide to women during pregnancy, delivery and after delivery and children in your catchment area?
- What additional services women demand from you?
- Have you ever experienced/ observed any security issue that hindered you/ other TBA in providing MNH services?
- What are the common physical and financial barriers in your area, in your view, for poor access to MNH services?

#### · Probes

- o Absence of community midwife
- o BHU/RHC is far away;
- o Private sector health facilities are far away
- o Security issues
- o High informal fees at Govt. Health facilities
- o Private health facilities charges are very high
- o Fear of travel
- What are the common social barriers, in your view, compromising the access to MNH services in your area?
- Probes
  - o Social restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour

#### Area 3: Referral linkages to higher level health facilities

- Would you describe the functioning or otherwise of existing referral system of public sector to receive and manage maternal and neonatal complications?
- What are the major challenges in your view in exiting referral system at face security risks?
- How good or bad is the existing transport system at your village to transfer maternal and neonatal emergencies to referral places?
- How do security concerns in your area hinder the use of existing transport system?
- What are your suggestions to improve the transport system for patients?
- What options do you suggest to improve the referral system to deal with maternal and neonatal complications occurring in your area?

#### Area 4: Perceptions and expectations of service providers in meeting users' MNH needs

- How would you comment on the available female health staff in the public and private sector in your area to meet the MNH needs?
- Which type of cadres are in short supply; LHV, Midwife, female doctor etc. and why?
- In the current and existing security situation which type of cadre is in acute shortage?

#### Area 5: Improving delivery of MNH services:

- In your view how can the following help in minimizing these barriers for service providers?
  - o Role of public health sector
  - o Role of private health sector
  - o Role of influential
  - o Role of community

Do you have any suggestion to improve the quality of and access to MNH services including FP services in the conflict areas?



### Guidelines for FGDs with Pregnant mothers

Now we shall discuss mother and child health related practices. Please share your own experiences keeping in view your current pregnancy.

#### Area 1: Existing MNH related practices

- Have you undergone routine check-up during this pregnancy and where?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
  - o Mother and child health centre
- In your view what are the common reasons contributing to low quality of pregnancy related services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

#### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
- Generally what type of people are considered as poor and marginalised?
- Do you face any problems to access routine check-up during pregnancy?
  - o at village level
  - o Basic Health Units, Rural Health Centres,
  - o Tehsil Hospital or District/Agency Hospitals level
- Are there any physical barriers hindering your access to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues
  - o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel
- Are there any social barriers hindering your access to pregnancy related check-up
  - o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty

- o Behaviour of the staff with clients
- o Honour related issues
- What are the local traditions and practices regarding whom to consult during pregnancy, (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?

#### Area 3: Users' views on Referral linkages to higher level health facilities (If women have never experienced any emergency ask about experience of any friends or relatives)

- In case of emergency (i.e. if a complication occurs during pregnancy), please explain how do you reach the hospital and what challenges you and your family has/had to face?
- In case of emergency during pregnancy did you decide on your own to reach the referred hospital, was that a public or private facility, how did you travel to the facility, who accompanied you to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) have ever provided or any support in referral of emergencies during this pregnancy and if so what role did their staff play?
- Please share your own experience, both positive and negative, how well the emergency was managed at the referral hospital?

#### Areas 4: What are the Perceptions and Expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your needs for pregnancy related services?
- What are your suggestions to improve the pregnancy related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

#### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy related services in your area.
- Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
- How about organizing village level MNH committees to take a lead role in areas like:
  - o sorting out local level challenges,
  - o creating a culture of some savings to finance expenses of MNH services,
  - o awareness creation for adopting health MNH practices at household level,
  - o Any other suggestion

### Guidelines for FGDs with Mothers having Child <1year

Now we shall discuss mother and child health related practices. Please share your own experiences keeping in view your last pregnancy.

#### Area 1: Existing MNH related practices

- Did you go for routine check-up during last pregnancy and where?
- Why did you choose that specific facility for the check-up?
- Which ones of you did not go for routine check-up during last pregnancy and why?
- Where each one of you delivered last time and why did you prefer that facility?
- How would you describe the quality of pregnancy, delivery and child health related services you received at various levels?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
  - o Mother and child health centre
- In your view what are the common reasons contributing to low quality of pregnancy, delivery and child health related services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

#### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
  - o Any other
- Generally what type of people are considered as poor and marginalised?
- What problem/s, if any, each group member faced in the past 5-years for access to services during pregnancy, delivery, after delivery and sickness of newborn at:
  - o Village level
  - o Basic health units, rural health centres
  - o Tehsil hospital or district/agency hospitals level
- Are there any physical barriers hindering your access to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues
  - o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel
- Are there any social barriers hindering your access to pregnancy related check-up

- o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
- o Absence of female health staff
- o Short working hours at health facilities
- o Absence of staff from duty
- o Behaviour of the staff with clients
- o Honour related issues
- What are the local traditions and practices regarding whom to consult during pregnancy, delivery and child health related issues (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?

#### Area 3: Users' views on Referral linkages to higher level health facilities (If women have never experienced any emergency ask about experience of any friends or relatives)

- In case of emergency (i.e. if a complication occurred during pregnancy, delivery and child health related issue), please explain how did you reach the hospital and what challenges you and your family had to face?
- In case of emergency during pregnancy, delivery and child health related issue did you decide on your own to reach the referred hospital, was that a public or private facility, how did you travel to the facility, who accompanied you to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) have ever provided you any support in referral of emergencies during last pregnancy, delivery and child health related issue and if so what role did their staff play?
- Please share your own experience, both positive and negative, how well the emergency was managed at the referral hospital?

#### Areas 4: What are the Perceptions and Expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy, normal and complicated delivery and child health related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your needs for pregnancy related services?
- What are your suggestions to improve the pregnancy, delivery and child health related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

#### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in your area.
- Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
- How about organizing village level MNH committees to take a lead role in areas like:
  - o Sorting out local level challenges,
  - o Creating a culture of some savings to finance expenses of MNH services,
  - o Awareness creation for adopting health MNH practices at household level
  - o Any other suggestion

### Guidelines for FGDs with Husbands

Now we shall discuss mother and child health related practices. Please share your own experiences/ observations in this regard.

#### Area 1: Existing MNH related practices

- Are you in favour of routine check-up during pregnancy and after delivery? If no why not?
- What type of health facility or service provider/s you generally prefer for check-up and why so?
- Where do you prefer for normal delivery to take place and what are the reasons for such preference, please explain?
- In case of any serious problem related to pregnancy, delivery and newborn sickness which place or health provider you generally select for seeking medical care? Why do you prefer such option/s?
- How would you describe the quality of pregnancy, delivery and child health related services at various levels?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
- In your view what are the common reasons contributing to low quality of pregnancy, delivery and child health related services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

#### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
  - o Any other
- Generally what type of people are considered as poor and marginalised?
- What problem/s, if any female from your family faced in the past 2-years for access to services during pregnancy, delivery, after delivery and sickness of newborn at:
  - o Village level
  - o Basic health units, rural health centres
  - o Tehsil hospital or district/agency hospitals level
- Are there any physical barriers hindering access to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues
  - o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel

- Are there any social barriers hindering access to pregnancy related check-up –
  - o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour related issues
- What are the local traditions and practices regarding whom to consult during pregnancy, delivery and child health related issues (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?

#### Area 3: Users' views on Referral linkages to higher level health facilities

- In case of emergency (i.e. if a complication occurs during pregnancy, delivery and child health related issue), please explain how one can reach the hospital and what challenges the family has to face?
- In case of emergency during pregnancy, delivery and child health related issue who generally decide to reach the referred hospital, how one can travel to the facility and who generally accompanies to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) provide any support in referral of emergencies during pregnancy, delivery and child health related issue and if so what role their staff plays?

#### Areas 4: What are the Perceptions and Expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy, normal and complicated delivery and child health related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your needs for pregnancy related services?
- What are your suggestions to improve the pregnancy, delivery and child health related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

#### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in your area.
- Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
- How about organizing village level MNH committees to take a lead role in areas like:
  - o Sorting out local level challenges,
  - o Creating a culture of some savings to finance expenses of MNH services,
  - o Awareness creation for adopting health MNH practices at household level
  - o Any other suggestion



### Guidelines for FGDs with Mothers/ Mothers-in-law

Now we shall discuss mother and child health related practices. Please share your observations keeping in view the experiences of your family in this regard.

#### Area 1: Existing MNH related practices

- Are you in favour of routine check-up during pregnancy and after delivery? If no why not?
- What type of health facility or service provider/s you generally prefer for check-up and why so?
- Where do you prefer for normal delivery to take place and what are the reasons for such preference, please explain?
- In case of any serious problem related to pregnancy, delivery and newborn sickness which place or health provider you generally select for seeking medical care? Why do you prefer such option/s?
- How would you describe the quality of pregnancy, delivery and child health related services at various levels?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
- In your view what are the common reasons contributing to low quality of pregnancy, delivery and child health related services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

#### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
  - o Any other
- Generally what type of people are considered as poor and marginalised?
- What problem/s, if any female from family faced in the past 2-years for access to services during pregnancy, delivery, after delivery and sickness of newborn at:
  - o Village level
  - o Basic health units, rural health centres
  - o Tehsil hospital or district/agency hospitals level
- Are there any physical barriers hindering access to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues
  - o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel

- Are there any social barriers hindering access to pregnancy related check-up –
  - o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour related issues
- What are the local traditions and practices regarding whom to consult during pregnancy, delivery and child health related issues (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?

#### Area 3: Users' views on Referral linkages to higher level health facilities

- In case of emergency (i.e. if a complication occurs during pregnancy, delivery and child health related issue), please explain how one can reach the hospital and what challenges the family has to face?
- In case of emergency during pregnancy, delivery and child health related issue who generally decide to reach the referred hospital, how one can travel to the facility and who generally accompanies to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) provide any support in referral of emergencies during pregnancy, delivery and child health related issue and if so what role their staff plays?

#### Areas 4: What are the Perceptions and Expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy, normal and complicated delivery and child health related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your needs for pregnancy related services?
- What are your suggestions to improve the pregnancy, delivery and child health related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

#### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in your area.
- Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
- How about organizing village level MNH committees to take a lead role in areas like:
  - o Sorting out local level challenges,
  - o Creating a culture of some savings to finance expenses of MNH services,
  - o Awareness creation for adopting health MNH practices at household level

### Guidelines for FGDs with Fathers/ Fathers-in-law

Now we shall discuss mother and child health related practices. Please share your observations and experiences of your family in this regard.

#### Area 1: Existing MNH related practices

- Are you in favour of routine check-up during pregnancy and after delivery? If no why not?
- What type of health facility or service provider/s you generally prefer for check-up and why so?
- Where do you prefer for normal delivery to take place and what are the reasons for such preference, please explain?
- In case of any serious problem related to pregnancy, delivery and newborn sickness which place or health provider you generally select for seeking medical care? Why do you prefer such option/s?
- How would you describe the quality of pregnancy, delivery and child health related services at various levels?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
- In your view what are the common reasons contributing to low quality of pregnancy, delivery and child health related services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

#### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
  - o Any other
- Generally what type of people are considered as poor and marginalised?
- What problem/s, if any female from family faced in the past 2-years for access to services during pregnancy, delivery, after delivery and sickness of newborn at:
  - o Village level
  - o Basic health units, rural health centres
  - o Tehsil hospital or district/agency hospitals level
- Are there any physical barriers hindering access to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues
  - o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel

- Are there any social barriers hindering access to pregnancy related check-up –
  - o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour related issues
- What are the local traditions and practices regarding whom to consult during pregnancy, delivery and child health related issues (probe questions: consultation with mother-in-law, local Dai/TABA, LHW, LHV at the health facility)?

#### Area 3: Users' views on Referral linkages to higher level health facilities

- In case of emergency (i.e. if a complication occurs during pregnancy, delivery and child health related issue), please explain how one can reach the hospital and what challenges the family has to face?
- In case of emergency during pregnancy, delivery and child health related issue who generally decide to reach the referred hospital, how one can travel to the facility and who generally accompanies to get to the facility?
- Whether local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) provide any support in referral of emergencies during pregnancy, delivery and child health related issue and if so what role their staff plays?

#### Areas 4: What are the Perceptions and Expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy, normal and complicated delivery and child health related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your needs for pregnancy related services?
- What are your suggestions to improve the pregnancy, delivery and child health related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

#### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in your area.
  - Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
  - How about organizing village level MNH committees to take a lead role in areas like:
    - o Sorting out local level challenges,
    - o Creating a culture of some savings to finance expenses of MNH services,
- Awareness creation for adopting health MNH practices at household level

## Guidelines for FGDs with Community Influential

Now we shall discuss mother and child health related practices prevailing in your community. Please share your observations keeping in view the experiences of your community.

### Area 1: Existing MNH related practices

- Are you in favour of routine check-up during pregnancy and after delivery? If not why?
- Is your community in favour of routine check-up during pregnancy and after delivery? If no, why not?
- What type of health facility or service provider/s your community generally prefer for check-up and why so?
- Where does your community prefer for normal delivery to take place and what are the reasons for such preference, please explain?
- In case of any serious problem related to pregnancy, delivery and newborn sickness which place or health provider your community generally selects for seeking medical care? Why
- How would you describe the quality of pregnancy, delivery and child health related services at various levels?
  - o At Community level by TBA or LHW or midwife
  - o At BHU or RHC level
  - o At public sector hospital level
  - o At private health facility
- In your view what are the common reasons contributing to low quality of pregnancy, delivery and child health services? Please give your views with reference to these topics:
  - o Non-availability of staff - LHV, midwife or female doctor
  - o Lack of privacy at examination
  - o Shortage of medicines and supplies
  - o Security issues
  - o Any other reason

### Area 2: Keeping in view the security situation, what is the Reach and Access to the available MNH services?

- What type of security issues prevail in your community?
  - o Military operation
  - o Curfew
  - o Drone attacks
  - o Militants' hold
  - o Intra tribal conflicts
  - o Internal rivalries
  - o Any other
- Generally what type of people are considered as poor and marginalised?
- What is your knowledge about the problem/s, if any female from your community faced in the past 2-years for access to services during pregnancy, delivery, after delivery and sickness of newborn at:
  - o Village level
  - o Basic health units, rural health centres
  - o Tehsil hospital or district/agency hospitals level
- Are there any physical barriers in your view, hindering access of your community to services at the above facilities
  - o Absence of Community midwife
  - o BHU/RHC is far away;
  - o Private Sector health facilities are far away
  - o Transport problems
  - o Travel cost
  - o Security issues

- o High informal expenses at Govt. Health facilities
  - o High charges at Private health facilities
  - o Fear of travel
- Are there any social barriers in your view, hindering access of your community to pregnancy related check-up –
  - o Restrictions from the family and society (*purdah*/ mobility/ deciding authority)
  - o Absence of female health staff
  - o Short working hours at health facilities
  - o Absence of staff from duty
  - o Behaviour of the staff with clients
  - o Honour related issues
- What are the local traditions and practices in your community regarding whom to consult during pregnancy, delivery and child health related issues (probe questions: consultation with mother-in-law, TABA, LHW, LHV at health facility)?

### Area 3: Users' views on Referral linkages to higher level health facilities

- In case of emergency (i.e. if a complication occurs during pregnancy, delivery and child health related issue), please explain how people of your community can reach the hospital and what challenges they have to face?
- In case of emergency during pregnancy, delivery and child health related issue who generally decides to reach the referred hospital, how one can travel to the facility and who generally accompanies to get to the facility?
- In your view, do local health facilities (dispensary, MCH centre, basic health unit, rural health centre or local practitioner) provide any support in referral of emergencies during pregnancy, delivery and child health related issue and if so what role their staff play?

### Areas 4: What are the perceptions & expectations of users to meet their MNH needs?

- Are you satisfied with the current package of services offered for pregnancy, normal and complicated delivery and child health related services at:
  - o Community level – LHW, TBA
  - o BHU/RHC level
  - o Tehsil/District/Agency hospital
- How would you comment on the available female health staff in the public and private sector to meet your community's needs for pregnancy related services?
- What are your suggestions to improve the pregnancy, delivery and child health related services?
- What are your views on posting a skilled birth attendant (like trained midwife) by the government at local level, who would be available for providing MNH services in a timely manner?

### Area 5: How can communities participate in the delivery of MNH services?

- Please describe some viable options where households and community can contribute and participate in improving the pregnancy, delivery and child health related services in your area.
- Is it a workable option to organise local transport owned by the community for transportation of emergencies to the nearest health facilities? How could it be organised? Who can be the main players to make it a functional arrangement?
- How about organizing village level MNH committees to take a lead role in areas like:
  - o Sorting out local level challenges,
  - o Creating a culture of some savings to finance expenses of MNH services,
  - o Awareness creation for adopting health MNH practices at household level



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