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SUMMARY REPORT

Literature Review (including Systematic Review) of Published and Unpublished Literature on The Impact of Platforms of Service Provision in Conflict Areas on Maternal and Newborn Health and Their Applicability in Pakistan

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Introduction

Pakistan's health indicators for women and children are among the worst in the world. An estimated 276 Pakistani women die for every 100,000 live births. Approximately 65% of women in Pakistan deliver their babies at home; only 34% deliver in a facility. The infant mortality rate is 59 per 1,000 live births and under-five mortality rate is 72 deaths per 1,000 live births (UNICEF). The indicators in Khyber Pakhtunkhwa (KP), Federally Administered Tribal Areas (FATA) and Balochistan are among the poorest in all provinces; these are also the areas most affected by conflict and displacement of populations.

According to a WHO report, armed conflicts can result in a number of adverse health effects. The conditions in conflict areas are ideal for disease and trauma to proliferate and in such scenarios, women and children are at high risk. Moreover, it is difficult to deliver effective health services as organisations, institutions, and resources are adversely affected by conflict and political instability. The unavailability of healthcare providers (especially female), unavailability of drugs and resources, and disease outbreaks have a high impact on maternal and newborn health (MNH) outcomes.

In Pakistan, a large number of people have been displaced by conflicts. The number of internally displaced persons (IDPs) was a staggering three million in 2009, mostly due to the violent conflict in KP and FATA.

Various models and strategies have been implemented over the years in different parts of the world to improve MNH in conflict affected areas." By evaluating these strategies and healthcare delivery systems, we can identify issues that may have caused hurdles in planning and implementation. We can also identify solutions to these problems and come up with guidelines that can be utilised in the future.

Objectives and Methodology

Phase 1, of the study was aimed at conducting a literature review to collate and synthesise global and local (Pakistan) information from conflict areas on MNH health service provision at community and/or facility level to improve MNH, within the last ten years.

In phase 2, consultative meetings were held with key stakeholders at provincial and district levels to discuss the findings of the literature review and to gather key information on acceptability/adoptability of various models in conflict areas and the future policy implications in Pakistan.

In phase 3, based on the results from phases 1 and 2, an analytical summary of current evidence was developed and specific recommendations for improving MNH service delivery in conflict areas in Pakistan.

Results

Our literature search revealed very few published and unpublished studies that evaluated the impact of strategies for MNH service delivery in conflict areas. We have included 11 studies that describe such MNH service delivery platforms. These studies are from Afghanistan, Pakistan, Myanmar (Burma), Sudan, Tanzania, Liberia, Guatemala, and the Democratic Republic of Congo. We did not come across any randomised control trials or studies comparing intervention with a control arm. A few of the included studies are narratives with no quantitative data, but are included to highlight different models of healthcare used in effort to uplift MNH. Most of the studies and reports were found in grey literature. Some of the included studies were presented in the Reproductive Health Response in Conflict (RHRC) conference proceeding in 2003 (Belgium). Only abstracts are available for these studies and details of the methodology and results are not clear.

Our search shows that with utilisation of community services, the greatest impacts were observed in skilled birth

attendance and antenatal consultation rates. Results from different studies evaluating such programmes in eastern Burma and Afghanistan show that skilled birth attendance increased between 12% to 42%, while antenatal consultation rates increased by approximately 33%. Outreach services increased antenatal consultation rate from 55% to 88%. It also increased prenatal and childbirth care by midwives from 71% to 89%. Facility level services show that with labour room services provided for an IDP camp in Balochistan, Pakistan, showed a decrease in unregistered deliveries from 17% to 8%, increased antenatal care coverage from 55% to 78%, increased contraceptive prevalence rate from 1.4% to 3.5%, and decreased maternal mortality ratio from over 350 to 197 per 100,000 live births.

Consultative meetings and discussions in both Quetta and Peshawar revealed that no systematic models of MNH service delivery especially tailored for conflict areas are available. During conflict, even previously available services and infrastructure suffer due to various barriers specific to times of conflict and unrest. Security risk, lack of skilled staff, lack of resources, and lack of political will were considered significant barriers to MNH service provision in conflict areas. Suggestions for improving MNH services in conflict areas were also given. Improved policy focus, increase in available skilled staff, financial support, and strong administration and monitoring were considered to be critical to successfully coping with MNH health needs in conflict areas.

The available evidence and discussion with stakeholders showed that service delivery mechanisms being used in conflict affected areas are not much different from those in stable areas, with the exception of special setups in IDP camps. The critical point is to choose the best combination of mechanisms according to the conditions in a particular area of conflict, the condition of local health infrastructure, the terrain, and acceptability in the local population. The following recommendations emerge from the literature and consultations.

Conclusion

During conflicts and emergency situations, conflict affected populations often find themselves without food, shelter or healthcare, and are therefore susceptible to poor health and infectious disease outbreaks. Women and children are particularly vulnerable to these health effects. Different modalities are required to fulfil MNH healthcare needs of the population within conflict zones or for those who have been displaced due to conflict. In Pakistan's context, the government and other stakeholders need to synchronise their efforts to ensure provision of human resource (HR), funding, infrastructure, equipment and supplies for MNH services in these areas. Achieving that would help in limiting maternal and neonatal morbidity and mortality in the country's conflict affected areas.

Recommendations

1. Provincial strategies for provision of MNH services in conflict affected areas should be developed with the collaboration of involved actors. A lead role should be played by provincial health departments, MNCH (Maternal Neonatal and Child Health) programmes and provincial disaster management authorities. Active involvement and consultation with local and international NGOs working in the area, UN agencies and community representatives has to be ensured for consensual strategies ensuring smooth implementation.
2. The roles of various government agencies and their geographical areas of responsibility in times of conflict must be clearly delineated. This is especially important with regard to service provision to IDPs when they move from one province/territory to another such as when displaced people from FATA move to KP. In such situations, responsibilities of the relevant provincial governments and the federal government must be clearly defined and implemented to avoid loopholes in service delivery arising from ambiguity about the respective roles of various agencies.
3. Policies must be put in place to ensure that the provision of MNH services is isolated from the political dimensions of the conflict as much as possible, especially when the state is an active party in the conflict. This

could be ensured by making legal stipulations for imposing a health emergency in the area on humanitarian grounds, with the primary authority for declaring the emergency resting with the Health Department. This would allow international agencies such as UN agencies to rapidly deploy their resources minimising MNH morbidity and mortality.

4. Negotiations should be held with non-state actors in conflict zones to allow safe passage of health workers, women, children and relevant supplies on humanitarian grounds, for better maternal and neonatal outcomes. This is important in areas where the state is involved in the conflict and its access to some non-state actor strongholds is compromised.
5. In areas that are currently going through conflict, additional regular budgetary support must be available for fulfilling healthcare needs of population affected by conflict. For filling any budgetary gaps, monetary or in-kind support from non-governmental sources and philanthropic organisations could be sought.
6. While preparing packages of service delivery, both contextual analysis of the region and a mapping of current service realities are essential. The contextual analysis will aid in understanding the fragility of the current features and accordingly devising realistic indicators for both short and long term service delivery.
7. Where large numbers of healthcare providers are leaving because of the security situation, special incentive packages should be provided to retain skilled health workers in the area. Training and some level of task shifting to local community health workers could be used to cover the remaining gaps; the modalities of such task shifting should be defined beforehand so that they can be quickly activated. Collaboration with international organization working in conflict affected areas should be done to ensure the presence of their personnel where they are most needed.
8. Given that conflict reduces ability and willingness to travel, it may be possible to improve maternal health by strengthening local healthcare services. For example, training community health workers could improve Emergency Obstetrics and Newborn Care (EmONC) provision at home when other formal services are unavailable. Providing services closer to home through mobile health staff, in times of acute need, could also reduce the need to travel in inhospitable conditions.
9. Conflict affected areas require greater flexibility in the provision of antenatal care and other maternal health services. Temporarily decentralising health services, which allows institutions to tailor services to local conditions, such as empowering local health personnel with more authority for decision making, could achieve this flexibility.
10. Continuous monitoring of the state of services in conflict affected areas is needed through either third party or combined monitoring by government and other stakeholders, based on relevant District Health Information System indicators.
11. Rapid evaluation and reconstruction of health infrastructure must be done as the conflict ends, so that repatriation of IDPs can be facilitated without interruptions to their MNH care needs.

Thus properly designed and implemented policies, whether initiated by government agencies or NGOs, can mitigate the effect of violent conflict on maternal and neonatal health.