



Research & Advocacy Fund

Priorities and Opportunities for Maternal and Newborn Health Programme Research and Advocacy  
**Provincial & Regional Stakeholders Consultation Meetings Report**

**Khyber Pakhtunkhwa & FATA**

**DISCLAIMER**

*This report is based on the views of the participants in the provincial and regional consultation meetings and do not necessarily reflect the views of the Maternal and Newborn Health Programme Research and Advocacy Fund (RAF).*

*This report has been developed to reflect the discussion points and significant findings from the provincial and regional consultation meetings and should be used as a reference material. Please note that this report is not meant to be a comprehensive or scientific account of the various themes that were identified, factors that influence or contribute to maternal and newborn health in Pakistan.*

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## LIST OF ABBREVIATIONS

<b>AusAID</b>	Australian Agency For International Development
<b>CMR</b>	Child Mortality Rate
<b>CMW</b>	Community Midwives
<b>DFID</b>	Department For International Development
<b>FATA</b>	Federally Administered Tribal Areas
<b>FP</b>	Family Planning
<b>GoP</b>	Government Of Pakistan
<b>HSRU</b>	Health Sector Reform Unit
<b>IMR</b>	Infant Mortality Rate
<b>MDG</b>	Millennium Development Goals
<b>MMR</b>	Maternal Mortality Rate
<b>MNH</b>	Maternal and Newborn Health
<b>NGO</b>	Non Government Organization
<b>NMR</b>	Neonatal Mortality Rate
<b>RAF</b>	Research And Advocacy Fund
<b>SOP</b>	Standard Operating Procedures

## 1. Introduction and Background

Pakistan's maternal and child mortality rates are the sixth highest in the world. Despite the Government of Pakistan (GoP) targeting improvements in maternal and child health over the last 15 years, maternal and neonatal mortality and morbidity remain significant challenges. An estimated 30,000 women die each year because of complications during pregnancy and delivery – the equivalent of one woman dying every 20 minutes<sup>1</sup>.

Nearly all maternal deaths worldwide are preventable. The Maternal and Newborn Health Programme Research and Advocacy Fund (RAF) recognises that policies implemented through interventions that aim to improve health outcomes for the poor and marginalized, women and children can reduce the premature death of women in pregnancy and childbirth and increase their chances of survival. And when they survive, their families, communities and countries thrive.

### 1.1 RAF's role in MNH

The Maternal and Newborn Health Programme Research and Advocacy Fund (RAF) is a five year national programme funded by DFID and AusAID - which aims to support research and advocacy initiatives to influence pro-poor policy and practice reform related to maternal and newborn health (MNH) in Pakistan.

The purpose of RAF is to improve MNH practices and supporting policies related to Millennium Development Goals (MDGs) 4 and 5. To do this, RAF supports quality non-clinical research and effective advocacy. In order to fund a portfolio of strategic projects, RAF offers three different models of funding that include open calls; restricted calls; and commissioned work. The three models enable RAF to fund strategic projects based on current gaps in MNH and the needs and realities of poor and marginalised women and their communities. To date RAF has undertaken four rounds of open calls for proposals. RAF is currently funding 16 projects covering 56 districts all over Pakistan and all 10 districts in Azad Kashmir. RAF funded research projects are generating evidence for; better functioning, acceptability management and scale up of CMW services, public private partnership model for family planning services, knowledge, perceptions and key family practices on MNH, improving birth preparedness for poor women provision and quality of antenatal services in first level care facilities, advocacy projects on post abortion care and MNH needs in crisis and post crisis situations are also being implemented.

The devolution of the Ministry of Health and vertical programmes to the provinces has huge implications for Maternal and Newborn Health in Pakistan. RAF recognises the need to support grantee work at provincial and regional levels and to fund work in provinces/region where it has not previously worked, particularly hard to reach areas and therefore held a series of consultations throughout Pakistan.

## 2. Khyber Pakhtunkhwa and FATA -MNH Status

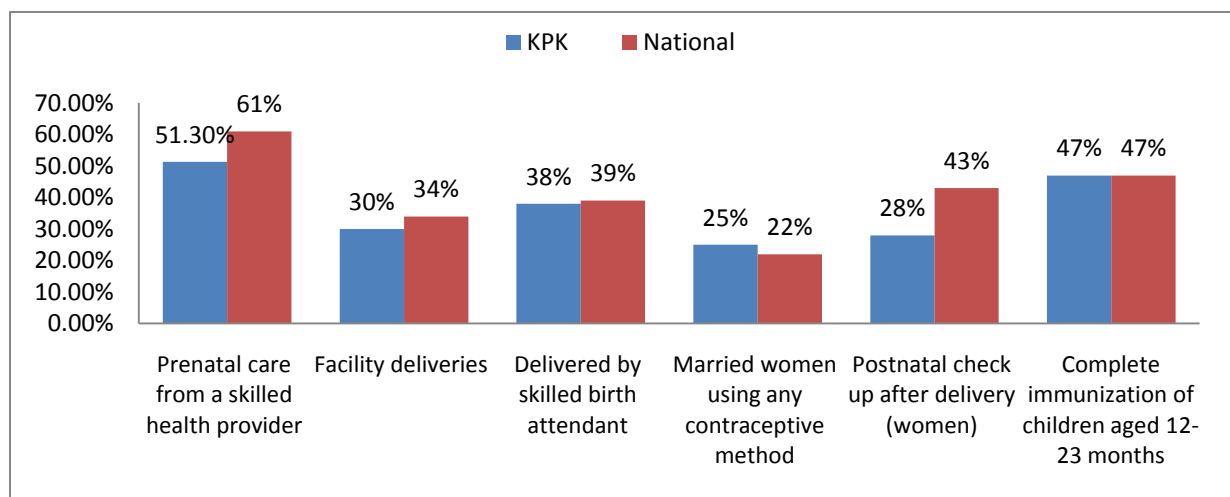
The comparison of socio-economic and health indicators of Khyber Pakhtunkhwa and national indicators are as follows:

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<sup>1</sup> A community-based nested case-control study of maternal mortality F.F. Fikree, R.H. Gray, H.W. Berendes, M.S. Karim International Journal of Gynecology & Obstetrics Volume 47, Issue 3, December 1994, Pages 247-255.

**Table 1. Health Indicators of Khyber Pakhtunkhwa**

Characteristic	KPK	National
<b>Maternal Mortality Rate</b>	275/100000 live births	272/100000 live births
<b>Neonatal Mortality rate</b>	41/1000 live births	54/1000 live births
<b>Child Mortality rate</b>	101/1000 live births	94/1000 live births
<b>Total Fertility Rate</b>	4.3 children per woman	4.1 children per woman

**Figure 1. Maternal Health status in Khyber Pakhtunkhwa compared with National figures**


Source: PDHS 2006-07

### 3. Aim and Objectives

RAF's main aim is to improve MNH practices and supporting policies related to MDG 4&5. The overall objective of the provincial and regional stakeholders' consultations is to identify the province specific opportunities for RAF to fund through restricted calls or direct commissioning. The specific objectives are to:

1. Increase provincial and regional ownership in the post 18th amendment situation
2. Identify provincial and regional MNH priorities, research gaps and needs for evidence and/or advocacy opportunities
3. Prioritize 3-5 potential opportunities for RAF funding in each province/region

### 4. Methodology

Consultative meeting was held with the representatives from the departments of MNCH, HSRU, NGO's working on Mother and Neonatal Health from Khyber Pakhtunkhwa. The agenda of the meeting can be viewed at *Annexure I* with the complete list of participants at *Annexure II*.

Participatory approach was followed during the consultative meeting by first sharing the current MNH status in the province and citing some examples which may be considered in context of post devolution scenario. The main steps for prioritizing new opportunities are described as follows

### 1. Step One: Identifying priority issues/challenges influencing MNH

Participants were asked to identify the issues and challenges which influence the MNH status in their province by using 'zop' cards. These were then further re-grouped under various thematic areas after further discussion and reaching a consensus. These prioritized issues and challenges identified were further translated into the problem statements

### 2. Step Two: Determining research gaps and advocacy opportunities

Each problem statement (under the various thematic areas) were further discussed so as to determine whether there is some existing evidence for the causes of that particular problem; alternatively what research may be needed so that this identified problem can be properly addressed for improving MNH care. Similarly a separate discussion was also held to identify the "advocacy" opportunities.

### 3. Step Three: Setting priority for research and advocacy opportunities

This step constituted of identification of the most pertinent MNH research areas and advocacy opportunities in reference to the problem statements. The identified areas were later given a scores of 1 - 4 (where 1 was lowest and 4 was highest) based on their

- a. Potential for impact;
- b. Addressing equity Issues;
- c. Scalability and ;
- d. Policy practice implications.

In the end the cumulative scores of each of the prioritised areas were compared for final selection of top scoring research topics and/or advocacy opportunities. The complete details of the methodology followed during the sessions and their expected output is given in the *Annexure III*.

## 5. Key Findings

### 5.1 Identifying priority issues/challenges influencing MNH

The stakeholders brought forward the following specific issues and challenges for the improvement of the MNH in the context of the status after 18<sup>th</sup> amendment in Khyber Pakhtunkhwa and FATA.

- a. There was consensus on the fact that there are **barriers to accessing** MNH services in Khyber Pakhtunkhwa and FATA, due to issues on both demand and supply side. The public facilities are underutilized due to the reservations of the females to be specifically seen by female healthcare provider, low perceived quality of the public facilities and the issues of communication between the providers and the clients: these issues and specific health seeking behaviours needs to be further explored through research.
- b. It was debated that the quality of care at the MNH service delivery point is not up to the standard. The discussion highlighted the need for research and evidence on the influence of monitoring and task shifting on improved quality of care.

- c. The other most debated theme which was considered to be the root cause of many of the problems is **inadequate capacity for the management**, faulty management design along with inadequate planning and coordination which results in unnecessary delays in the execution of projects. There was consensus on the need for research on responsiveness and reflective processes in managing projects/programs. The different management approaches and practices also needs to be looked both at public and private institutions to provide evidence for better management.
- d. All the participants proposed a dire need for research on mapping of MNH as rights based approach at the community level; and the need for improvement in **Governance/accountability** was considered to be extremely important in the post devolution scenario. Assessment of the scalability of the successful MNH projects is declared to be another less focused area for research. These research areas will help in proposing a legislative framework and ultimately contribute to improving governance.
- e. The **Human Resource for Health** is the basic pillar in provision of services at the health facilities; the dearth of female healthcare providers needs to be explored in depth for overcoming this problem in the long run; this issue is of high importance for improving MNH in Khyber Pakhtunkhwa especially in the conflict hit zones of FATA. The special MNH requirements of these areas needs to be focused through research for better understanding of the impact of the changing law and order situation on the overall physical and mental health of the women and children. The other issues like deployment, training and marketing of newly introduced cadre in health; community midwives CMW is also pointed out by the participants, which needs further research.
- f. In the context of **nutritional status** of women and children, the need for advocacy and implementation of interventions based on the available information/data is highlighted by the stakeholders.
- g. The participants of the meeting also identified the need on institutionalising MNH in community investment funds and for exploring alternate means for **Healthcare Financing** through research.

The list of research gaps/needs and the identified issues and challenges are summarized in the *Annexure IV*.

## 5.2 Determining research gaps and advocacy opportunities

In line with the above discussion, the issues and challenges were translated into the following problem statements;

1. There are barriers to accessing MNH services in KPK and FATA (demand side and supply side).
2. There is poor quality of care by providers/service delivery points for MNH services.
3. The capacity for management is inadequate.
4. The Human Resource for Health is not adequate.
5. The overall Governance/accountability needs improvement.
6. The nutritional status of the women and children is under focused.
7. There is lack of institutionalised MNH Healthcare Financing.

## 5.3 Setting priority for research and advocacy opportunities

The above mentioned thematic statements were discussed further for the research and advocacy opportunities under these broader themes and the following opportunities were identified.

The main priorities for research are as follows:

1. How to Institutionalize MNH care in community investment funds?

2. How to do mapping of rights based approach for MNH at community level?
3. Assessment of scalability of 'successful' projects
4. What are Issues/challenges for working as a team amongst LHWs, CMWs, and LHVs?
5. What are the issues of availability of female HCPs?
6. What are responsive and reflective processes in managing projects/programs;
  - How to monitor and evaluate Learning?
  - Top down vs. bottom-up
  - Public and Private management approach
7. What is the Impact of conflict on MNH (psychological, access, nutrition, pregnancy outcome)?
8. What is the Satisfaction level of services of HCPs?
9. How monitoring influences Quality of Care.
10. What is the health seeking behaviour of the community?
11. What are the financial sustainability options for CMWs
12. How modelling of nutrition interventions will improve MNH status (based upon Lancet series)?
13. Can task shifting improve Quality of Care?

The main advocacy opportunities identified are as follows

1. Policy changes with the changing environmental situation especially in IDPs context/terrain/geography
2. There is a need for advocacy to integrate programs post-devolution.
3. MNH as Rights-based Approach for legislation (post 18th Amendment).
4. Advocacy by Social Mobilizers
5. Role of media in improving access to MNH services
6. Proper deployment according to the skill mix and needs.

## 6. Prioritized Research and Advocacy Opportunities

The participatory discussion exercise was concluded by scoring of the prioritized MNH opportunities (the details of the scoring criteria are given in the methodology section) identified by stakeholders and finalization of the potential advocacy opportunities that can be funded by RAF in Khyber Pakhtunkhwa and FATA followed by summarizing the whole consultative process. Complete list of the scores achieved against the individual research and advocacy opportunities is given in the *Annexure IV*. The most important and high ranking research and advocacy opportunities as perceived by stakeholders are given in the table below. Same scoring priorities have been grouped together.

**Table 2. Top scoring research gaps and advocacy opportunities**

Research Gaps And Need For Evidence	Score	Advocacy Opportunities	Score
Institutionalising MNH care in community investment funds.	192	Policy changes with the changing environmental situation especially in IDPs context/terrain/geography.	108
Mapping of rights based approach for MNH at community level.	128	There is a need for advocacy to integrate programs post-devolution.	108
Assessment of scalability of 'successful' projects.	108	MNH as Rights-based Approach for legislation (post 18th Amendment).	96
Issues/challenges for working as a team amongst LHWs, CMWs, LHV		Advocacy by Social Mobilizers.	36
The availability of female HCPs.	Role of media in improving access to MNH services		
Responsiveness and reflective processes in managing projects/programs <ul style="list-style-type: none"> <li>▪ Monitoring Evaluation Learning.</li> <li>▪ Top down vs. bottom-up.</li> <li>▪ Public and Private.</li> </ul>	Proper deployment according to the skill mix and needs		
Impact of conflict on MNH (psychological, access, nutrition, pregnancy outcome).	96		
Satisfaction level of services of HCPs.			
Monitoring influencing Quality of Care.			
	72		

## 7. Conclusion

The consultative exercise brought forward access and coverage issues related to MNH as a main source of debate along with a need for advocacy of MNH as a rights based approach for legislation especially in context of post devolution scenario. Media and social mobilizers are thought to be able to play a vital role for advocacy.

Management related issues like monitoring and evaluation, deployment according to skills, reflective processes in managing programmes, and public private partnerships are key areas highlighted for research. Mass migration in context of IDPs also needs to be catered with relevance to policy change. All these issues need to be focused for their influence in context of quality of care.

Health care financing is also a much debated issue in the consultation especially along the lines of institutionalizing MNH care in community investment funds.

It needs to be pointed out that although a separate workshop was not held for FATA, The stakeholders from FATA were present in the Khyber Pakhtunkhwa consultative meeting and pointed out similar research and advocacy opportunities as that of Khyber Pakhtunkhwa. However the stakeholders from FATA emphasized that the changing security situation in their province and its psychosocial impact on maternal and newborn health should be considered by the policy makers for future plans.

# Annexure

## Annexure I. Agenda of the meeting

Provincial & Regional Consultation on Priorities and Opportunities for Maternal and Newborn Health Research and Advocacy in Khyber Pakhtunkhwa & FATA: Date: 14 September 2011 Venue: Pearl Continental Hotel , Islamabad	
<b>Session I: Introduction &amp; Background</b>	
<b>11:00 – 11:45</b>	Welcome Remarks
	Introductions
	RAF – Introduction and Overview
	RAF Priority Themes
	Purpose and layout of the workshop
<b>Session II: Plenary discussion and Priority setting</b>	
<b>11:45 –12:05</b>	Participatory exercise (identifying the MNH needs and gaps)
<b>12:05-12:20</b>	<b>Tea Break</b>
<b>12:20 - 13:50</b>	Ranking and prioritizing
	Agreeing on research gaps and/or needs for evidence and advocacy opportunities
<b>Session III: Concluding remarks and way forward</b>	
<b>13:50- 14:30</b>	Summarising the consultative process and sharing prioritized opportunities
	Next steps
	Vote of Thanks and Wrap-up
<b>14:30</b>	<b>Lunch</b>

## Annexure II. List of Participants

S.NO	NAME	DESIGNATION	DEPARTMENT
1	Mr. Masood ul Mulk	Chief Executive Officer	SRSP
2	Dr. Faisal Siraj		Association for Community Development
3	Dr. Nazish	Consultant	HDP Swabi
4	Dr. Shahida Sultan	Education Advisor for NIDA Pakistan	National Integrated Development Association
5	Dr. Begum jan	Chairperson	Tribal Women Welfare Association
6	Dr. Maryam Bibi	CEO	Khwendo Kor
7	Ms. Shazia Noreen	Manager Education	Sungi Development Foundation
8	Dr. Irshad Danish	Manager	SPARC
9	Dr. Zohaib Khan	Assistant Director R&D, KMU	Khyber Medical University
10	Dr. Rashid Ahmed	Additional Secretary Population Welfare	Department of Population Welfare
11	Dr. Abdul Rashid Khattak	Director	Provincial Health Services Academy
12	Dr. M. Riaz	Coordinator	Health Sector Reforms Unit
13	Dr. Pervaiz Kamal	MNCH Provincial Coordinator, FATA	Provincial MNCH Program
14	Dr. Emel Khan	Director	FPHC Mardan
15	Dr. Rehman Khattak	Provincial Coordinator	TRF
16	Ms. Seema	Social Dev. Direct	Consultant
17	Dr. Haroon Rasheed Afridi	MNCH officer	WHO
18	Dr. Zalmey Shahy	Consultant	TWWA

## Annexure III. Methodology

The methodology adapted for the consultative meetings is discussed below. The discussion points were generated through a participatory exercise.

### Session I: Introduction & Background

This session included:

- Welcome note by the facilitator/RAF Representative
- Introduction of the participants
- RAF – Introduction and update of research and advocacy activities initiated by RAF
- Current MNH status of the Province
- Success stories on key areas in that province and/or elsewhere
- Post devolution opportunities

#### Expected Output of Session I

The participants will be able to appreciate the role played by RAF in supporting research and advocacy initiatives to influence policy and practice reforms related to MNH in Pakistan, especially in post devolution scenario.

### Session II: Plenary discussion and Priority setting

This session included:

- Participatory exercise

For determining the MNH priorities in their respective provinces, participants were requested to use a card (colloquially called “zop” card) one MNH priority per card, using at least 3-5 cards. These were pasted on the wall and then grouped to come up with thematic areas. It was envisaged that there will be 5-8 maximum of thematic areas. The thematic areas were then listed on a flip chart and scored 1-4 in pre-defined categories such as research gap, opportunity for advocacy, potential for scalability, potential for impact, policy/practice implications etc. Once scored the scores were collated to come up with a provincial/regional MNH priorities agreed by all the participants.

This followed by picking the top most MNH priority and generating a discussion to identify research gaps and/or needs for evidence and later on recognise advocacy to improve MNH status in the province/region.

This is illustrated in the following matrix:

MNH PRIORITIES	RESEARCH GAPS AND NEED FOR EVIDENCE	ADVOCACY OPPORTUNITIES

Depending on the interest of participants and discussion generated, there will be further discussion to reach consensus on 3-5 potential specific opportunities on either research gaps and/or advocacy needs.

#### Expected Output of Session II

The participants will identify MNH priorities for conducting research and advocacy.

### **Session III: Concluding remarks and way forward**

This session concluded the event by summarising the consultative process and sharing of the prioritised opportunities to be funded by RAF in that particular province/region as identified by stakeholders.

The RAF representatives would then thank the participants, share concluding remarks and give an outline of the way forward.

#### **Expected Output of Session III**

The Participants will have developed a sense of ownership for identifying the research and advocacy needs to improve MNH in their province and helping to develop the prioritised opportunities to be funded by RAF.

## Annexure IV. Participatory Exercise

Step 1: Identified Thematic areas	
THEMATIC AREAS	SPECIFIC ISSUES/CHALLENGES
Access/ Coverage	There are barriers to accessing MNH services in KPK and FATA (demand side and supply side)  Demand: Health seeking behavior, acceptability, perceived quality of public services, Supply: Female HCPs, communication issues,
Quality Of Care	Poor quality of care by providers/service delivery points for MNH services
Management	The inadequate/improper style or capacity for management  Linkages/Integration. Management Capacity. Support System for Management. Planning and Coordination.
Governance/ Accountability	Rights-based Approach Scalability Accountability Political Will Legislative Framework Corruption
Human Resource For Health	Deployment Training Marketing
Nutrition	Maternal Nutrition Anemia in mothers Psychosocial effects Impact of conflict
Healthcare Financing	Transportation Microfinancing

Step 2: Research gaps and advocacy opportunities		
SPECIFIC MNH PRIORITIES	RESEARCH GAPS AND NEED FOR EVIDENCE	ADVOCACY OPPORTUNITIES
<b>Access/Coverage</b>		
There are barriers to accessing MNH services in KPK and FATA <ul style="list-style-type: none"> <li>• Demand: Health seeking behaviour, acceptability, perceived quality of public services.</li> <li>• Supply: Female HCPs, communication issues.</li> </ul>	The availability of female HCPs.	Advocacy by Social Mobilizers.
	Health seeking behaviour.	Policy changes with the changing environmental situation especially in IDPs context/terrain/geography.  Role of media in improving access to MNH services.
<b>Quality of Care</b>		
Poor quality of care by providers/service delivery points for MNH services.	Satisfaction level of services of HCPs.	
	Monitoring influencing Quality of Care.	
	Can task shifting improve Quality of Care?	
<b>Management</b>		
The inadequate/improper style or capacity for management <ul style="list-style-type: none"> <li>• Linkages/Integration.</li> <li>• Management Capacity.</li> <li>• Support System for Management.</li> <li>• Planning and Coordination.</li> </ul>	Responsiveness and reflective processes in managing projects/programs <ul style="list-style-type: none"> <li>• Monitoring Evaluation Learning.</li> <li>• Top down vs. bottom-up.</li> <li>• Public and Private.</li> </ul>	There is a need for advocacy to integrate programs post-devolution.
<b>Governance/Accountability</b>		
<ul style="list-style-type: none"> <li>• Rights-based Approach.</li> <li>• Scalability.</li> <li>• Accountability.</li> <li>• Political Will.</li> <li>• Legislative Framework.</li> <li>• Corruption.</li> </ul>	Assessment of scalability of 'successful' projects.	MNH as Rights-based Approach for legislation (post 18 <sup>th</sup> Amendment).
	Mapping of rights based approach for MNH at community level.	
<b>Human Resources for Health (HRH)</b>		
<ul style="list-style-type: none"> <li>• Deployment.</li> <li>• Training.</li> <li>• Marketing.</li> </ul>	Issues/challenges for working as a team amongst LHWs, CMWs, LHV's.	Proper deployment according to the skill mix and needs.
<b>Health Financing</b>		
	Institutionalizing MNH case in community investment funds	
	What are the financial sustainability options for CMWs	

STEP 3 : SUMMARY OF THE SCORES ACHIEVED	
RESEARCH GAPS AND NEED FOR EVIDENCE	SCORE ACHIEVED
Institutionalizing MNH care in community investment funds	192
Mapping of rights based approach for MNH at community level.	128
Assessment of scalability of 'successful' projects.	108
Issues/challenges for working as a team amongst LHWs, CMWs, LHV's.	108
The availability of female HCPs.	96
Responsiveness and reflective processes in managing projects/programs Monitoring Evaluation Learning. Top down vs. bottom-up. Public and Private.	96
Impact of conflict on MNH (psychological, access, nutrition, pregnancy outcome).	96
Satisfaction level of services of HCPs.	72
Monitoring influencing Quality of Care.	72
Health seeking behaviour.	54
What are the financial sustainability options for CMWs	54
Modelling of nutrition interventions for improving MNH (based upon Lancet series). <ul style="list-style-type: none"> <li>▪ Social</li> <li>▪ Cultural</li> <li>▪ Gender</li> </ul>	48
Can task shifting improve Quality of Care	16
ADVOCACY OPPORTUNITIES	SCORE ACHIEVED
Policy changes with the changing environmental situation especially in IDPs context/terrain/geography.	108
There is a need for advocacy to integrate programs post-devolution.	108
MNH as Rights-based Approach for legislation (post 18th Amendment).	96
Advocacy by Social Mobilizers.	36
Role of media in improving access to MNH services.	36
Proper deployment according to the skill mix and needs.	36

