NATIONAL HEALTH POLICY PROCESS FORMATION AND IMPLEMENTATION REGARDING ANTENATAL CARE HEALTH SERVICES DELIVERY AND UTILIZATION AT DISTRICT LEVEL IN BALUCHISTAN PROVINCE, PAKISTAN

Mr. Abdul Ghaffar

A Dissertation Submitted in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy Program in Public Health
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แนวทางในการจัดทำนโยบายสุขภาพแห่งชาติ และการนำสู่ปฏิบัติจริง ด้านให้และรับบริการของการดูแลครรภ์มารดาก่อนการคลอด ในระดับอำเภอ จังหวัดบาลูกิสสถาน ประเทศปากีสถาน

นายอับดุล การฟาร์

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรดุษฎีบัณฑิต
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อับดุล การฟาร์: แนวทางในการจัดทำนโยบายสุขภาพแห่งชาติ และการนำสู่ปฏิบัติจริงด้านให้และรับบริการของการดูแลครรภ์มารดาก่อนการคลอดในระดับอำเภอ จังหวัดบาลูกิสสถาน ประเทศปากีสถาน (NATIONAL HEALTH POLICY PROCESS FORMATION AND IMPLEMENTATION REGARDING ANTENATAL CARE HEALTH SERVICES DELIVERY AND UTILIZATION AT DISTRICT LEVEL IN BALUCHISTAN PROVINCE, PAKISTAN). อ.ที่ปรึกษา รศ.ดร.สถิรกร พงศ์พานิช, 207 หน้า

วัตถุประสงค์: 1) เพื่อประเมินการนำการให้บริการสุขภาพตามที่ระบุไว้ในนโยบายสุขภาพแห่งชาติ ปี 2001 ไปปฏิบัติ 2) เพื่อสำรวจปัจจัยท้องถิ่นที่มีผลต่อการนำนโยบายไปปฏิบัติ 3) เพื่อประเมินปัจจัยทางวัฒนธรรมที่มีผลต่อการนำนโยบายการให้บริการสุขภาพไปปฏิบัติ 4) เพื่อให้คำแนะนำเกี่ยวกับวิธีการและการดำเนินการเพื่อปรับปรุงการนำการให้บริการสุขภาพไปปฏิบัติในระดับเขต

วิธีการ: งานวิจัยเรื่องนี้ใช้รูปแบบการวิจัยเชิงสำรวจและการวิจัยเชิงพรรณนา โดยเก็บข้อมูลทั้งเชิงคุณภาพและเชิงปริมาณ วิธีการเก็บข้อมูลคือ การสนทนากลุ่ม การสังเกตการณ์ และการสัมภาษณ์เชิงลึกในระดับการบริหารจัดการสุขภาพในหลาย ๆ ระดับตั้งแต่ระดับรัฐบาลกลาง ระดับจังหวัด และระดับเขต และมีการสำรวจเชิงปริมาณกับสตรีตั้งครรภ์ในชุมชน การวิเคราะห์ข้อมูลเชิงคุณภาพกระทำโดยใช้การเปรียบเทียบข้อมูล ส่วนข้อมูลเชิงปริมาณผ่านการวิเคราะห์โดยใช้โปรแกรม SPSS version 16 ในรูปของสถิติเชิงพรรณนา ไคสแควร์และ การวิเคราะห์ถดถอย

ผลวิจัย: ข้อมูลเชิงคุณภาพแสดงให้เห็นว่าการสร้างนโยบายเป็นความรับผิดชอบของรัฐบาลกลาง การกำหนดประเด็น การกำหนดนโยบาย และการให้บริการสุขภาพแก่มารดา ตามนโยบายสุขภาพแห่งชาติ ปี 2001 อยู่ภายใต้การดำเนินการของรัฐบาลกลางเกือบทั้งหมด โดยดำเนินการผ่านการบริหารจัดการสุขภาพในระดับเขต บทบาทของจังหวัดถูกจำกัดอยู่แค่กระบวนการนโยบายในบริบทของจังหวัดบาลูกิสสถาน เท่านั้น ผู้เข้าร่วมวิจัยมีความเห็นว่านโยบายสุขภาพเป็นส่วนหนึ่งของโปรแกรมกำจัดความยากจนของรัฐบาล และยังมีความเห็นด้วยว่านโยบายถูกกำหนดมาจากรูปแบบชีวเวชของระบบสุขภาพ การนำไปปฏิบัติงานจริงยังไม่อยู่ในเกณฑ์ดี ในความเป็นจริงยังไม่มีการนำนโยบายไปใช้งานจริงในจังหวัดบาลูกิสสถาน ข้อมูลเชิงปริมาณที่เก็บจากชุมชนแสดงให้เห็นว่าประชาชนในชุมชนไม่ได้ใช้สวัสดิการต่าง ๆ มีสตรีมีครรภ์เพียงแค่ 14% ที่ได้ใช้ประโยชน์จากการฝากครรภ์และ 60% ประสบปัญหาต่าง ๆ จากการใช้บริการนี้ อุปสรรคสำคัญในการใช้บริการ คือระยะทาง การศึกษา รายได้ และปัจจัยทางวัฒนธรรม สตรีมีครรภ์มีความรู้ในระดับต่ำ สวัสดิการด้านสุขภาพที่มีอยู่ขาดความเหมาะสมและประชาชนมีเจตคติในทางลบต่อการใช้บริการสุขภาพของรัฐบาล นอกจากนี้สตรีมีครรภ์ขาดความตระหนักและสามีไม่ให้ความใส่ใจเกี่ยวกับสุขภาพของภรรยา ผลวิจัยยังแสดงให้เห็นว่าการสนับสนุนทางสังคมจากมารดาของสามี สามี และเพื่อนมีความสัมพันธ์กับการฝากครรภ์อย่างมีนัยยะสำคัญ

สรุปและข้อแนะนำ: งานวิจัยเรื่องนี้แสดงให้เห็นว่ามีช่องว่างระหว่างการให้บริการฝากครรภ์ และการใช้ประโยชน์จากบริการดังกล่าวในชุมชน นับเป็นโอกาสสำหรับการบริหารในระดับจังหวัดที่จะทำความเข้าใจกับวัฒนธรรมท้องถิ่น และสภาพสังคมเพื่อกำหนดนโยบายที่ครอบคลุมโดยตั้งอยู่บนพื้นฐานของหลักฐานที่เหมาะสม

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต .....

ปีการศึกษา 2554 ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์หลัก .....

##5379218353: Major Public Health Program
Keywords: Health Policy / policy process / implementation / antenatal care / utilization / service delivery / rural area / Baluchistan.

Abdul Ghaffar: NATIONAL HEALTH POLICY PROCESS FORMATION AND IMPLEMENTATION REGARDING ANTENATAL CARE HEALTH SERVICES DELIVERY AND UTILIZATION AT DISTRICT LEVEL IN BALUCHISTAN PROVINCE, PAKISTAN. Advisor: Assoc. Prof. Sathirakorn Pongpanich, Ph.D., 207 pp.

Objectives: To assess the current implementation of health services delivery mentioned in the national health policy 2001. 2) To explore the local factors effecting the policy implementation. 3) To assess the cultural factors effecting the policy implementation for health services delivery. 4) To recommend approaches and interventions to improve policy implementation of health services delivery at district level

METHODS: The study had an exploratory and descriptive design with both qualitative and quantitative methods. Focus group discussions, observations and in-depth interviews were conducted at different levels of health administration including federal, provincial, district and community, and a quantitative survey was also conducted in community among pregnant mothers. Qualitative data was analyzed through grounded theory and thematic approach, quantitative data was analyzed in SPSS version 16, using descriptive, Chi Square and regression analysis.

RESULTS: Qualitative data revealed that agenda setting, policy formulation and implementation of maternal health services according to NHP 2001 was almost done by federal government. Services are delivered through district health management. Provinces role was limited in policy process in context of Baluchistan province. The respondents were also on view that the health policy was a part of poverty alleviation program of the government. The respondents also expressed that policy was built on biomedical model of health system. The implementation was also poor. In real the policy was not implemented properly in the Baluchistan. The Quantitative study in the community revealed that people in the community were not using the facilities. ANC utilization was 14% among pregnant ladies and 60% complained perceived problems. The barriers proved to be significant were distance, education, income, and cultural factors and autonomy of the women. The knowledge of the pregnant ladies was low. The availability of health facilities was not proper and people developed negative attitude toward government health services. The pregnant ladies don't have proper awareness and males were not concerned about their health. Social support from the mother in law, husband and friends was significantly associated with ANC.

CONCLUSION: Study revealed that there were gaps between ANC services delivered and utilization by the community. It is an opportunity for the provincial government to understand the local culture and social setting and generate a broad policy based on proper evidence.

Field of Study: Public Health Student's Signature .....

Academic Year: 2011 Advisor's Signature .....

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For any errors or inadequacies that may remain in this work, of course, the responsibility is entirely my own.

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
BHU	Basic Health Unit
CD	Civil Dispensary
CMW	Community Midwives Workers
DHQ	District Head Quarter Hospital
ECC	Economic Coordination committee
ECNEC	Executive Committee of the National Economic Council
EDOH	Executive District Officer Health
FLCF	First level care facilities
GNI	Gross National Income
HFA	Health for All
LHV	Lady Health visitor
LHW	Lady Health Worker
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal and Neonatal Child Health
NEC	National Economic Council
NHP	National Health Policy
P&D	Planning and Development
PDWP	Provincial Developing Working Party
PHDS	Pakistan Demographic Health Survey
PHC	Primary Health care
RHC	Rural Health Center
SBA	Skilled Birth Attendant
SMI	Safe Motherhood initiative

TBA	Traditional Birth Attendant
WHO	World Health Organization
UC	Union Council
UN	United Nations

CHAPTER
INTRODUCTION

At the beginning of 21st century in September 2000 at the united nation headquarters in New York city 189 countries gathered in a summit and endorsed a declaration that was translated into eight Millennium Development Goals (MDGs) to be achieved by 2015 to enter the new millennium (Ronsmans & Graham, 2006) (Ronsmans & Graham, 2006). MDG 5 focuses on improving maternal health; while currently every day 1500 women are dying from pregnancy or childbirth-related complications (WHO, 2010a).

1.1 Introduction

1.1.1 Global Burden of the problem

According to the WHO estimates for 2008 there were 358,000 maternal deaths in the world or a maternal mortality ratio (MMR) of 260 maternal deaths per 100 000 live births. Of the estimated total of 358,000 maternal deaths worldwide, developing countries accounted for 99% (355,000) and a woman's lifetime risk of maternal death is 1 in 7300 in developed countries versus 1 in 75 in developing countries. Nearly three fifths of the maternal deaths (204,000) occurred in the sub- Saharan Africa region alone, followed by South Asia (109,000). Thus, sub-Saharan Africa and South Asia accounted for 87% (313, 000) of global maternal deaths (WHO, 2010a).

1.1.2 Circumstances in Pakistan

Pakistan is among first 11 countries of the world including Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Nigeria, Sudan, and the United Republic of Tanzania, which comprised 65% of all maternal deaths in 2008 (WHO, 2010a). Pakistan, India, Bangladesh, all these South Asian developing countries has a major share in maternal deaths worldwide. These countries account for about 28% of total births and 46% of maternal deaths in the world (Mussart, 2005).

Though in Pakistan MMR has declined with a change of 48% from 1990 to 2008 and is making progress but current MMR is about 260 maternal deaths per 100, 000 births

but still lagging behind from other south Asian countries (Midhet & Becker, 2010; WHO, 2010a).

The MMR is significantly higher in the rural areas and in the less developed province of Balochistan (Midhet & Becker, 2010).The situation in the Balochistan Province is even more worse as compare to other provinces where the Maternal Mortality Rate stands at 785 maternal deaths per 100, 000 live births (MICS, 2004; WPF, 2010; Yasir, 2009).

During pregnancy most of the Women die from a wide range of complications in pregnancy, childbirth or the postpartum period. Most of these complications develop because of their pregnant status and some because pregnancy aggravated an existing disease. The four major killers are: severe bleeding (mostly bleeding postpartum), infections (also mostly soon after delivery), hypertensive disorders in pregnancy (eclampsia) and obstructed labor. Complications after unsafe abortion cause 13% of maternal deaths. Globally, about 80% of maternal deaths are due to these causes (WHO, 2005). All of these causes are mostly preventable through proper understanding, diagnosis and management of labor complications. To reduce complications during pregnancy and labor it is essential to strengthen primary health care infrastructure and their utilization (Bhat, 1989) and antenatal care is the 'first contact' element, emphasizing the gate keeping function of safe motherhood/PHC in relation to other, more expensive health care services (Pedersen & Wilkin, 1998).

1.1.3 Pakistan Health Delivery system

Pakistan health system comprises the national public health program and three tiers of services delivery. National health program is set of disease specific federally led public health programs. The physical infrastructure of Primary Health Care (PHC) comprises many categories of services delivery outlets or First Level Care Facilities (FLCFs). In addition 1,138 Maternal and Child Health (MCH) Centers are providing services. Basic Health Units (BHUs) are also meant to deliver outreach services and serve as the implementation arm of national public health programs. Secondary care includes Tehsil Headquarters and District Headquarters Hospitals. Whereas tertiary

care comprises teaching hospitals with in country in all there 965 public hospitals, 1, 701 patients per bed and 1, 222 doctors per patient in Pakistan (MOH, 2010).

Private sector with 96,430 private health establishments, (including hospitals, dispensaries, hakims, homeopaths and others providing health services) is serving nearly 70% of the population and is primarily a fee-for-service system (EMRO, 2007).

Regarding human resources there are about 139, 555 doctors and specialist doctors are about 19,623. Dental services are provided through 9822 dentists. Presently there are 73, 244 nurses. The number of Midwives, Lady Health Visitors (LHV) and Lady Health works is 3000, 4000 and 95,000 respectively. Three thousand four hundred Lady Health Supervisors are providing health interventions as skilled persons (MOH, 2010).

1.1.4 Antenatal Care Services Utilization

According to Pakistan Demographic and Health Survey 2006-07, approximately 64% of women who gave at least one live birth received ANC, 61% from a skilled provider and 39% of births were assisted by skilled birth attendant (SBA). While 68% of births were reported to occur in the rural areas, women residing in rural areas had lower access to skilled care at delivery by 31 percentage point than their urban counterparts (NIPS, 2008).

By province, the survey reported that the utilization of SBA varied from 44% in Sindh to a low of 23% in Balochistan and 34% of births took place in health facility, highlighting that majority of births took place at home (NIPS, 2008).

In Balochistan province only 26% of women consulted a skilled health worker (Private or Government Hospital/ Clinic, Lady Health Visitor) for antenatal care. This ranged from 53% in urban to 21% in rural areas. This was highest in Quetta district (75%) and other districts like Jhal Magsi, Musa Khel, Ziarat, Awaran, Dera Bugti, Barkhan and Kohlu had less than 10% of pregnant women attending any skilled health worker. In Musa Khel, Kohlu, Ziarat and Jhal Magsi Districts none of the women had more than one visit for ante-natal care (MICS, 2004).

Studies have proved that improving the status of women, providing family planning programs, provision of safe abortion services, strengthening antenatal care, improving emergency obstetric services, training traditional birth attends (TBA) and community mobilization have provided optimistic and pessimistic views of the potential of antenatal care to reduce MMR (Carroli et al., 2001; Pandit, 1992).

1.1.5 Policy

Generally the policy can be defined as *a relatively stable, purposive course of action followed by an actor or set of actors in dealing with the problem or a matter of concern*. This definition focuses on what is actually done instead of what is proposed or intended; differentiates a policy from a decision, which is essentially a specific choice among alternatives; and views policy as something that unfolds over time (Anderson, 2003).

A government or society, which has formulated a health policy and defined its goals as well as its activities to combat health problems and improve life conditions, has to plan actions, allocate resources and build awareness. This so-called health policy process consists of different phases or stages such as agenda building and policymaking, planning, implementation, monitoring and evaluation (Falcone, 1980; Walt, 1994).

In Pakistan primarily the federal government is responsible for formulating national health policies, while the responsibility for implementation rests largely with the provincial and district governments. For providing health services Pakistan has developed three national health polices in 1990, 1997 and 2001, before these policy documents, health planning was carried out through the medical reform commissions, health study groups and Peoples Health Schemes 1972.

1.1.6 Policy Implementation

The policy making doesn’t end with the passage of a law or signing by the policy circles. The next important stage is implementation that is vital component of the policy process. Policy implementation, which is the process of putting policy into effect by public and private individuals, is a key element in development strategy.

During 1960s and 1970s a series of studies and reports stressed that policy designs should pay attention to the capacity to implement (Sapru, 2004).

Health systems are subject of competing and conflicting goals and information asymmetry between different actors, resulting in resistance to systems change (Biscoe, 2001). Policy formulation and implementation are processes that take place in a context. These processes and contexts can change the substantive policy content. The same is true of policy implementation(Gill, 1994).

Implementation is often perceived as a managerial or administrative affair that leads the effect of policy to the gross root level. In Pakistan the policies are implemented through provincial governments. The provincial department of health has several function and manifold responsibilities to improve the health standard, throughout the provinces. Functions of health department include delivery of health care services, health planning, management and development, development of human resource and regulatory functions.

1.2 Rationale and problem

Pakistan has four provinces including, Baluchistan, Khyber Pakhtoonkhoa, Punjab and Sindh. Baluchistan, the largest of the four provinces of Pakistan, spreads over an area of 347,190 Sq, Km forming 43.6 per cent of the total area of Pakistan. It has scattered population and is smallest in proportion as compared to that of other provinces. Its population, according to 1998 census, is 8 million and about 4% of the total population of Pakistan and having a low density per square kilometer (GoB, 2010).

Health services are provided through Provincial health department. Provincial Health Department was established in 1971 when Baluchistan was declared as province after end of one unit system. Prior to this Baluchistan comprised of 3 regions (Quetta, Kalat & Sibi).

Department of Health works under the Government of Baluchistan. Minister Health is In-charge. Secretary Health is Head of the Department while Director General Health Services (DGHS) is the Head of attached department. The Health Secretariat is the

apex management unit for the entire health department Executive District Officer Health (EDOH) is the district manager health. At present 29 functioning districts are established in the province (GoB, 2010).

1.2.1 MCH program

Maternity and child welfare are provided throughout primary secondary and tertiary levels same as other parts of country. Maternal health services through the organization of Maternal and Child Health (MCH) components of which include as under,

- Antenatal/natal/ postnatal care
- Family Planning & child spacing
- Nutrition & growth monitoring
- Health Education & Social Mobilization
- Immunization
- Curative Treatment for Minor Ailments
- Referral

Objectives of the program are

- To reduce Infant and MMR
- Increase the number and availability of Female Paramedical staff.
- Improve Quality and access of MCH and Family Services at the level of primary health care facilities.
- Improve the linkage with community through LHWs, TBAs and outreach workers and with the nearest referral services.
- Sensitization of community to reduce the gap between Service providers and community.
- Enhancing the quality of supervision.

The program is equipped with the following resources

- Staff at Provincial Directorate Provincial Coordinator
- Inspectors / Assist Inspectors Health
- MCH Centers
- Basic Health Units (BHUs)

Baluchistan province is lagging behind from other provinces of Pakistan in getting good indicators for maternal health. According to the MICS survey conducted in 2004 the maternal mortality ratio was 785/100,000 live births (NIPS, 2008) as compared to the national figure 279,

Regarding utilization of antenatal care services during pregnancy, only 26% of pregnant women consulted a skilled health worker (Private or Government Hospital/ Clinic, Lady Health Visitor) for antenatal care. This ranged from 53% in urban to 21% in rural areas. For all women, the most often consulted was a Local Dai (23%), followed by a Private Hospital/Clinic (12%) and Government Hospital/Clinic (8%). Other groups included trained TBA or Dai (3%), Lady Health Visitor (2%), Lady Health Worker (1%) and Family Welfare/Reproductive Health Center (1%). This was highest in Quetta district (75%) and Jhal Magsi, Musa Khel, Ziarat, Awaran, Dera Bugti, Barkhan and Kohlu districts had less than 10% of pregnant women attending any skilled health worker (MICS, 2004).

In urban areas, private hospitals/clinics are the preferred source for antenatal care (23%), followed by Government Hospital/Clinic (17%) and local/traditional Dai (17%). In rural areas, the preferred source for antenatal care is the local/traditional Dai (24%), whereas hardly any women attend the Family Welfare/Reproductive Health Centers.

For those attending antenatal care, 70% had 1-3 visits during the last pregnancy, 25% had 4-6 visits and 5% over 6 visits, the minimum recommended. At least 6 visits were more common in urban (10%) as compared with rural areas (4%), but the results for each are still far below recommended (MICS, 2004).

Regarding the place for the giving birth of the baby, Deliveries are mainly with a local/traditional Dai (66%) at homes, at a Private Hospital/Clinic (12%) followed by a Government Hospital/Clinic (7%), trained TBA (4%) and Lady Health Visitor or Lady Health Worker (3%) (MICS, 2004) were used.

It has been argued that lack of involvement of communities in safe motherhood programs is an important reason for persistently high MMR in developing countries

(Midhet & Becker, 2010). Antenatal care is generally aimed at producing a healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well being and that of their infants. The antenatal care period also provides a forum to supply information that may positively influence maternal and child health outcome (Osungbade et al., 2008). A study conducted in 2006 reveled that in Pakistan only 16% of the pregnant ladies had four or more antenatal visits during their pregnancy, 20 % had skilled attended at delivery (McClure et al., 2007).

1.2.2 Pakistan's commitment to the millennium development goals

Pakistan has made concrete commitments to the Millennium Development Goals 5 (MDGs). Through its major health intervention programs, the Ministry of Health has pursued practical strategies aimed at

5a Reducing:

The maternal mortality ratio from an estimated 530 in 1990 to a target of 140 by 2015 (WHO, 2010a)

5b Increasing:

Antenatal care coverage – Percentage of women aged 15–49 attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives) and the percentage attended by any provider at least four times. Proportion of births attended by skilled health personnel estimated 20% in 1990 to a target of > 90% by 2015.

The 2008 report of the MDG Gap Taskforce revealed that while there has been much progress during the last decade, the delivery on commitments particularly in MDG 5 has lagged behind schedule. Pakistan has (UN, 2008):

- Significantly reduced the maternal mortality ratio to 280; and
- Doubled the proportion of births attended by skilled health personnel to 40%

Pakistan national health policy 2001 provides an overall national vision for the health sector based on "Health for All" approach. The key to the success of the new Health Policy lies in its implementation. The new Health Policy has outlined implementation modalities and has set targets and a time frame for each of the key areas identified that would be implemented over a 10-year period. These have to be implemented in partnership between the federal Ministry of Health and the provincial Departments of Health, and in close collaboration with the district health set-up under the Local

Government structure. The private health sector would also be taken on board while implementing the key policy initiatives.

The NHP 2001 had ten key futures for the health reforms

- Reducing widespread prevalence of communicable diseases;
- Addressing inadequacies in primary/secondary health care services;
- Removing professional/managerial deficiencies in the District Health System;
- Promoting greater gender equity;
- Bridging basic nutrition gaps in the target- population;
- Correcting urban bias in health sector;
- Introducing required regulation in private medical sector;
- Creating Mass Awareness in Public Health matters;
- Effecting Improvements in the Drug Sector;
- Capacity-building for Health Policy Monitoring

Almost all national polices emphasized on improvement of maternal health specially making trained personal for attending births (LHVs, public health nurses, LHW TBAs) and expansion of MCH program to provide better antenatal care services at gross root level.

The question is that why so little has changed in maternal health indicators and utilization of services for antenatal care after providing such vast polices in Pakistan.

Baluchistan, the situation is worse where majority of the women live in the strict tribal system and don't have independent access to education, transportation, and maternal health services. Maternal mortality ratio is almost three times of the total and only 34% of births took place in health facility, highlighting that majority of births took place at home and in the district Jhal Magsi only 10% of the pregnant ladies utilized antenatal care services.

Furthermore the in the national health policy, implementation and service delivery were the core of policy, while it is argued that in developing the factors behind the under-utilization of services have often been neglected in the design and implementation of the interventions.

1.2.3 The 18TH Constitutional Amendment

Till 2011 maternal and neonatal health and broader health policy had largely been within the purview of the national government. However, in April 2010, Parliament approved the 18th Amendment to the Constitution but the devolution of the Ministry of Health, which was delayed until May 2011 that aims to substantially increase provincial autonomy, and devolve powers and responsibilities for micro-level social sector policies and service delivery to the provincial level.

Now provincial Governments are accountable for making the policies, targets, and budgets for health for the maternal health services. Vertical Programs will now be accommodated in the Health Departments and will be answerable to the Provincial Governments. Provincial parliament will assume the role of overseeing these programs, while district health department will be responsible for implementation, monitoring, and evaluation.

To acquire a realistic policy to provide efficient, effective, acceptable, cost-effective, affordable and accessible services, it is essential to understand the drivers of health-seeking behavior of the population in a complex health care system of Pakistan.

Considering the above facts that there is need of policy process evaluation and implementation to find out the gaps between health provider and community (consumers) to generate a new policy for ANC services and implement the policies more precisely and achieve the set goals and improve maternal health in the province of Baluchistan.

1.3 Research questions

Specific Questions

- Evaluate policy process, planning and implementation of NHP 2001 and health services delivery for antenatal care in Baluchistan Province?
- What approaches were taken to implement the policy for ANC services?
- Identify what hindered implementation of the policy within the health services delivery for antenatal care services?
- Does local and cultural factors were considered during policy formulation?

- Which approaches and interventions can be recommended to improve policy implementation for better provision of maternal health services delivery at district level?

1.4 General objectives

- To analyze policy formation and implementation of antenatal care health services delivery over the last decade, identify strengths and weaknesses, factors underlying these and make recommendations at district level in province of Baluchistan, Pakistan

Specific Objectives

- To assess the policy process and current implementation of health services delivery for ANC according to national health policy 2001.
- To explore the local factors effecting the policy implementation for ANC services.
- To assess the utilization of ANC in public health services and factors effecting the utilization for health services delivery.
- To recommend approaches and interventions to improve policy implementation of health services delivery for maternal health at district level.

1.5 Conceptual framework

The conceptual framework is based on finding the gaps between the availability of services and utilization for the antenatal care in the context of policy.

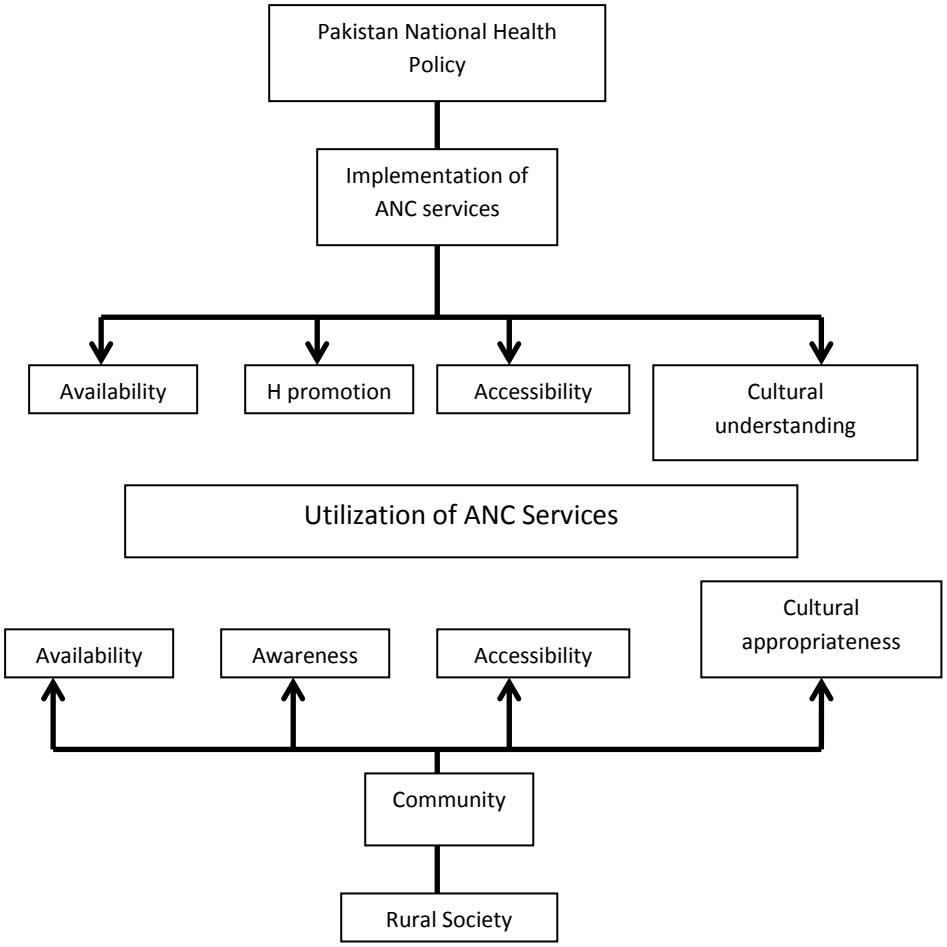

Figure 1: Conceptual framework of the study

1.6 Operational definitions

- *Antenatal care* refers to care provided by ant skilled health personal to pregnant mothers.
- *Maternal health* refers to the health of women during pregnancy, childbirth and the postpartum period.
- *Implementation* refers to the planning and provision of policy objectives to get expected outcomes related to community.
- *An Antenatal Care service refers* to the services provided for obstetrics related problem before partum.
- *Maternal Mortality* refers to the death of a woman related to obstetric problems.

- *Health services delivery* refers to the provision of health services at district level.
- *Service utilization* refers to use of ANC services by the pregnant mothers in the community.
- *Availability of services* refers to the physical presence of the ANC facilities.
- *Information and communication* means information gathered by the health department and translated in the policy and implantation.
- *Sociopolitical environment* refers to the support of political environment and community for the implementation of the policy.
- *Awareness of the community* refers to knowledge of the community regarding government health services.
- *Human resources* refer to the provision of staff according to international standards.
- *Organizational arrangements* refer to the infrastructure of the health department at district level to implement the policy.
- *Maternal and child and health center* refers to the health center which is providing health services
- *Stakeholder* refers one who will be affected, may be affected, or has an interest in an issue, or may have the ability to affect a decision or outcome. A stakeholder may be an individual, an organization or a group
- *Public participation* refers Processes in which individuals, groups, and organizations have the opportunity to participate in making decisions that affect them, or in which they have an interest
- *Policy analysis* refers the process of assessing situations, defining problems, clarifying values and goals, developing and recommending options, and implementing and/or evaluating outcomes
- *Community* refers to state of being shared or held in common; organized political, municipal or social body; body of people living in the same locality
- *Raising awareness* refers to the health promotion programs which increase the knowledge of the programs and health related prevention programs

1.7 Expected benefits

A health policy is a plan that steers the direction of investment and action designed to alleviate suffering, improve health care or prevent illness. Health policy makers are tasked with navigating a path between competing interests and demands to develop a pragmatic response to one or more health problems. There has been increasing interest in evidence-based policy making, which strives to use the best available evidence to inform policy.

Generally, national health policies in developing countries suffer from various weaknesses and do not offer appropriate solutions to many health problems in accordance with the comprehensive principles of modern health paradigms. Although evidence from research is not the only factor influencing policy making, it has considerable potential to contribute to effective health policy. Evidence from this health policy analysis can potentially increase policy impact and provide information that may assist with the allocation of scarce resources, to understand past policy failures and successes and will hopefully assist policy makers to improve the chances of successful implementation of future policy. In the developing countries like Pakistan there is little coherent theory for explaining how government could intervene in the most efficient and effective manner. This analysis will help in understanding how policy makers should set objectives, make decisions on health priorities and take actions for most rural areas and including local socio-cultural norms, as in many developing countries various international health programs including Health for All (HFA) and Primary Health Care (PHC) did not achieve their targets during the last three decades.

The study hopefully will also answer the question that why so little has changed in maternal health regarding antenatal care in Pakistan especially in Balochistan, as well as in other rural areas of the country. The analysis will also help to elaborate the views of different stakeholders at different levels of policy making, its implementation and utilization of services delivered through national health Policy 2001 recommendations.

1.8 Summary of the Chapter

The MMR is significantly higher in the rural areas and in the less developed province of Baluchistan (Midhet & Becker, 2010).The situation in the Baluchistan Province is even more worse as compare to other provinces where the Maternal Mortality Rate stands at 785 maternal deaths per 100, 000 live births (MICS, 2004; WPF, 2010; Yasir, 2009).

The MDG 5 focuses on improving maternal health; while currently every day 1500 women are dying from pregnancy or childbirth-related complications. Antenatal care is generally aimed at producing a healthy mother and baby at the end of any pregnancy. It presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well being and that of their infants. The antenatal care period also provides a forum to supply information that may positively influence maternal and child health outcome.

In Pakistan primarily the federal government was responsible for provision of national health policies, while the responsibility for implementation rested largely with the provincial and district governments. For providing health services Pakistan has developed three national health policies in 1990, 1997 and 2001.

Pakistan health system comprises the national public health program and three tiers of services delivery. National health program is set of disease specific federally led public health programs. The physical infrastructure of Primary Health Care (PHC) comprises many categories of services delivery outlets or First Level Care Facilities (FLCFs).

According to Pakistan Demographic and Health Survey 2006-07, approximately 64% of women who gave at least one live birth received ANC, 61% from a skilled provider, and 39% of births were assisted by skilled birth attendant (SBA). While 68% of births were reported to occur in the rural areas, women residing in rural areas had lower access to skilled care at delivery by 31% than their urban counterparts.

Baluchistan province is lagging behind from other provinces of Pakistan in getting good indicators for maternal health. According to PDHS the maternal mortality ratio was 785/100,000 live births as compared to other national (NIPS, 2008) figure 279.

Regarding utilization of antenatal care services during pregnancy, only 26% of pregnant women consulted a skilled health worker (Private or Government Hospital/ Clinic, Lady Health Visitor) for antenatal care. This ranged from 53% in urban to 21% in rural areas.

After the 18th Amendment to the Constitution in 2011 provincial Governments are accountable for making the policies, targets, and budgets for health for the maternal health services. Vertical Programs will now be accommodated in the Health Departments and will be answerable to the Provincial Governments.

The study hopefully will also answer the question that why so little has changed in maternal health regarding antenatal care in Pakistan especially in Baluchistan, as well as in other rural areas of the country. The analysis will also help to elaborate the views of different stakeholders at different levels of policy making, its implementation and utilization of services delivered through national health Policy 2001 recommendations.

CHAPTER II
LITERATURE REVIEW

This chapter is based on the related literature review regarding policy process and policy implementation national and international studies along with a brief history of policies in Pakistan and a framework for analysis of the policy and implantation regarding antenatal care in Pakistan.

2.1 What is Policy?

In general, the term policy designates the behaviors of some actors or a set of actors, such as an official, a governmental agency, or a legislature, in an area of activity such as public health or consumer protection. Public policy may also be viewed as whatever governments choose to do or not to do (Thomas, 1972).

Brooks and Stephen defined Public policy as *the broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem* (Brooks, 1989).

According to Daneke and friends policy can also be defined as *a broad guide to present and future decisions, selected in light of given conditions from a number of alternatives; the actual decision or set of decisions designed to carry out the chosen course of actions; a projected program consisting of desired objectives (goals) and the means of achieving them* (Daneke et al., 1978).

More precisely a policy can be defined as *a relatively stable, purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern* (Anderson, 2003).

There are various types and forms of policy. Among these are: broad policy that expresses government-wide direction; more specific policy, which may be developed for a particular sector (Health) or an issue-area (maternal health); operational policy that may guide decisions on programs, and project selection. With respect to the forms that government policy can take, it is reflected most typically in legislation, regulations, and programs. These are often referred to as policy instruments (Anderson, 2003; Gill, 1994).

According to political scientist David Easton public policies are those produced by government officials and agencies “authorities” in a political system namely “elders, paramount chiefs, executives, legislators, judges, administrators, councilors, monarchs and the like” and these are the persons who are recognized by the system as having responsibility for the daily life matters and take actions that are accepted as binding most of the time by most of the members so long they act within the limits of their roles (Easton, 1965).

There are several ways to implicate this concept of public policy as relatively stable, purposive course of action followed by government in dealing with some problem or matter of concern.

Firstly the definition by Anderson stated earlier, links policy to purposive or goal-oriented action rather than to random behavior or chance occurrence. They are instead designed to accomplish specified goals or produce definite results, although these are not always achieved. Proposed polices may be usefully thought of as hypothesis suggesting that specific actions be taken to achieve particular goals. Thus to improve health the federal government must concentrate on every aspect of the related policies. The goals of the policy may be somewhat loosely stated and cloudy in content, thus providing general direction rather than precise targets for its implementation.

Second, policies consist of courses or patterns of action taken over time by governmental officials rather than their separate, discrete decisions.

Third, policies emerge in response to policy demands, or those claims for action or inaction on some public issues made by other actors-private citizens, group representatives, or legislators and other public officials-upon government officials and agencies. In response to policy demands, public officials make decisions that give content and direction to public policy.

Fourth, policy involves what governments actually do, not just they intended to do or what officials say they are going to do. Relevant here is the concept of policy output, or the action actually taken in pursuance of policy decisions and statements. This

concept focuses our attention on such matters as number of hospitals built, number of teaching institutes built for skilled personals and foreign-aid projects undertaken. Finally, public policies are laws and authoritative and members of society usually accept them as legitimate.

2.2 Origins of public policy

Policy issues can be divided into two categories: those already on the public policy agenda, and those that are not. If an issue is already on the public-policy agenda, it has a sufficiently high profile, and a formal process is likely to be in place. If an issue is not on the public-policy agenda, the job of the stakeholders/community is to provide information and education, and to take other steps to raise awareness and get it on the agenda (Brewer & DeLeon, 1983; Buse, Mays, & Walt, 2005).

Insofar as they arise from conscious reflection and deliberation, policies may reflect a variety of intentions and ideas: some vague, some specific, some conflicting and some unarticulated (Gill, 1994).

(Gerston, 1997) Suggests that an issue will appear and remain on the public policy agenda when it meets one or more of three criteria. It must have sufficient *scope* (a significant number of people or communities are affected), *intensity* (the magnitude of the impact is high) *and/or time* (it has been an issue over a long period).

Policy development is reactive when it responds to issues and factors that emerge, sometimes with little warning, from the internal or external environments by (Bourgon, 1996):

- Resolving problems and issues
- Meeting stakeholder/public concerns
- Reacting to decisions by other governments, other levels of government, or other departments with intersecting or interrelated mandates
- Allocating fiscal resources, natural resources, etc.
- Reacting to media attention (generally adverse)
- Reacting to crises or emergencies

Policy development is pre-active when it responds to triggers that are recognized because we are scanning the operating environment, identifying potential issues and factors that could affect us, and predicting and preparing for mitigation and/or contingency through:

- Planning
- Strategic choice
- Risk management
- Criteria determination
- Priority setting
- Establishing partnerships

It is very rare that formal policy development is genuinely proactive. The complexity of the horizontal issues and challenges associated with developing integrated policy requires a big picture as entire system perspective that can identify and address root causes as well as symptoms. This may offer the best opportunity for proactive policy development, which can move organizations, governments and society in a truly new direction. At this point, however, truly proactive policy seems more vision than reality (Anderson, 2003). Political leaders, health departments, inter-sectorial bureaucratic committees, and a very powerful stakeholder such as an industrial lobby group related to health, or by the community can drive public health Policies.

In conclusion demands for policy actions stem from problems and conflicts in the environment and are transmitted to the political system by groups, officials, and others. The environment, broadly viewed, includes geographic characteristics such as climate, natural resources, and topography; demographic variables such as population size, age distribution, racial composition and spatial location; political culture; social culture or the class system; and the economic system.

2.3 Framework for Policy Analysis

There are a number of widely used frameworks and theories of the public policy process. Framework for this study is based on the concepts of the stages heuristic by Brewer and Deleon, it divides the public policy in to four stages (Brewer & DeLeon, 1983; Gill Walt et al., 2008)

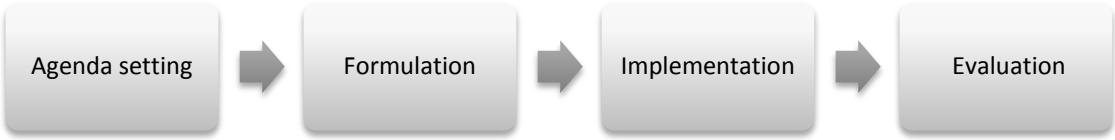

Figure 2: Framework Analyses

2.3.1 The Policy Process

While attempting to understand policy making in any country, it is essential to ask certain basic questions. At the top of political system, individuals, groups, and institutions play a crucial role in decision-making process and what are their respective roles and relationship in this process? Where from their information and organization stem? At operational level, what mechanism exists to coordinate the major institutions involved in the conduct of health policy? How influential are experts and specialists, and through what channels their opinion is expressed. Above all, it is imperative to understand how decisions are made and for whose interest? (M. M. Khan & Van den Heuvel, 2007; Steel, List, Lach, & Shindler, 2004; Taeihagh, Bañares-Alcántara, & Wang, 2009). James Anderson defines policy process as "policy formation denotes the total process of creating, adopting and implementing a policy" (Anderson, 2003)

Public policies may be developed *horizontally*, with several agencies coordinating efforts at the national, provincial and local level. Policy may also be developed *vertically*; in this approach, the decision at one level – commonly the national – are carried out on behalf of all parties or perhaps assigned to another level – often the other states – for execution (Gerston, 1997). The process of policy is series of intellectual activities that are carried out with in a process comprised of activities that are essentially political. These political activities can be described usefully as the policy making process and visualized as series of interdependent phases arrayed through time (Dunn, 1994; Hoogerwerf, 1990).

2.3.2 Policy Problems

Policy problem can be defined as a condition or situation that produces needs or dissatisfaction among peoples and for which relief or redress by governmental action is sought (Anderson, 2003). It is important to know both, why some problems are

acted and others are neglected and why a problem is defined in one-way rather than other. In order to understand and explain public policy, different stakeholders' perceptions of the policy problem need to be scrutinized (Hanberger, 2001).

Older studies of policy formation devoted little attention to the nature and definition of the problems and problems were taken as "givens" and analysis moved on from there. However it is now conventional wisdom that if the policy study does not consider the characteristics and dimensions of the problems that stimulate government action, it is less than complete (Anderson, 2003; Gerston, 1997). In other words policy design involves understanding the causation, instrumentation and evaluation (Linder & Peters, 1984).

Public problems are those affecting a substantial number of people and having broad effects, including consequences for persons not directly involved and they are impossible to be resolved by individuals (Anderson, 2003). Conditions can be defined as problems, and redress for them can be sought by other than those are directly affected (Smith, 1964).

Professor Aaron Wildavsky contends that officials are unlikely to deal with a problem unless coupled with solution. As he states, "A problem is a problem only if something can be done about it" (Aaron Wildavsky, 1978).

Some public problems may be diffuse or invisible, their nature and scope may be difficult to specify. Because measurement may be quite imprecise, policy makers may be uncertain about the magnitude of the problem and in turn about effective solutions, or even whether there is a need for governmental action (Gill, 1994).

According to the Gerston policy problems can be divided in to two broad categories (Gerston, 1997):

Substantive; issues are those areas of controversy that have a major impact on society like regulation of the economy, welfare reform, civil rights legislation and environmental protection. These issues are usually quite difficult to resolve because of their comprehensive effect, and may remain on the public agenda for long time.

While *symbolic* issues center on irritating public problems and need quick action to fix them off public agenda. Responses to these issue area tend to be provide more psychological relief than actual change in the political system. Outcomes are generally uncontroversial because the policy commitment does not threaten major shifts of social, economic or political capital. For example vertical programs regarding public health issues needed to be responded quickly to reduce the burden of disease and have impact as psychological relief.

2.3.3 Agenda setting

Agenda setting is the first phase, the issue sorting stage, during which some concerns rise to the attention of policymakers while others receive minimal attention or are neglected completely. The importance of this phase lies in the fact that there are thousands of issues that might occupy the attention of policymakers, but in practice only a minority actually do gain their consideration (Brewer & DeLeon, 1983).

Kingdon defines policy agenda as "the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time"(Kingdon, 1984).Within the general domain of the, for example, the minster of the health will be considering, at any one time, many problems and issues like insufficient hospital services, insufficient trained staff, the rise in the number of people smoking, the distribution of pharmaceutical products, how to regulate a fast growing health sector (G Walt, 1994). Out of the all set of conceivable issues or problems, some get attended to seriously in preference to others. The agenda setting process narrows down the set of possible subjects to those that actually become the focus of attention (Anderson, 2003).

To achieve agenda status, problem must be converted into an issue, or a matter requiring governmental attention (Anderson, 2003), or in other words an issue arises when a public with a problem seeks or demands governmental action, and there is public disagreement over the best solution to the problem (Eyestone, 1978).

Types of Agenda

Professor Roger W. Cobb and Charles D. Elder classify agenda in two basic types: the systematic agenda and the institutional, or governmental agenda (R. W. Cobb & Elder, 1983).

Systemic Agenda

They defined systemic agenda as it "consist of all issues that are commonly perceived by numbers of political community as meriting public attention and as involving matters with in the legitimate jurisdiction of existing governmental authority". Thus a systemic agenda will exist for every national, state and local political system. The systemic agenda is essentially a discussion agenda. Most of the items on it will be general or abstract rather than specific or detailed (Anderson, 2003)

Institutional or Governmental Agenda

Is consists of problems to which legislators or public officials feel obliged to give serious and active attention. Only few of the issues that concern legislative or administrative policy-makers are likely to be widely discussed by the public. An institutional agenda is basically an action agenda and thus will be more specific and concrete in content than a systemic agenda (R. W. Cobb & Elder, 1983).

Why Do Issues get on the policy agenda?

It is important to understand why issues get on the policy agenda and this question always had been plaguing the policy analysts and why do policy makers take action when they do? Clearly they sometime react to crisis but much policy making is politics-as-usual changes, routine day to day problems that need solutions (M S Grindle & Thomas, 1991). But when the does the pulse arise for change and reform before crises, several scholars have tried to provide models that explain how, and why, some issues are taken seriously by government officials when there is no apparent crisis. Many scholars who have studied the political dynamics of policymaking believe that the rationality model does not capture how agendas are formed in practice, questioning the presumption that actors deliberate in a logical, linear fashion. Among the points they raise are that actors have limited information, are not able to imagine all the alternatives, even if cognizant of multiple alternatives

are not likely to consider each systematically, hold ambiguous goals, and change these goals as they act. An alternative understanding of the agenda setting process, termed incrementalism, emerged that takes into account a number of these critiques (J. W. Kingdon, 1984). Drawing in part from research on public budgetary processes, scholars have postulated that policymakers are inclined to take the status quo as given and carry out only small changes at a time, making the policymaking process less complex, more manageable and more politically feasible than a comprehensive rational deliberative process would entail (Lindblom, 1959; A Wildavsky, 1979). Applying this idea to health, we can observe that one of the most reliable predictors of the size of a national health budget, as well its subcomponents such as hospital construction and maternal and child health, is the previous year's budget, evidence that policymakers alter their priorities slowly.

2.3.4 Agenda setting Models

2.3.4.1 The Hall Model: legitimacy, feasibility and support

Hall and colleagues (Hall, Land, Parker, & Webb, 1975) produced one of the earliest works that considers the role of power in public policy agenda setting. They argue that an issue is more likely to reach the policy agenda if it is strong on three dimensions: legitimacy, feasibility and support.

1. Legitimacy refers to the extent to which the issue is perceived to justify government action. For instance, the control of tobacco use in the United States formerly had little legitimacy, defined in these terms, but this situation has changed.
2. Feasibility refers to the ease with which the problem can be addressed, and is shaped by factors such as the availability of a technical solution and the strength of the health system that must carry out the policy. For instance, the development of a vaccine for polio made control of this disease much more feasible.
3. Support refers to the degree to which interest groups embrace the issue and the public backs the government that is to address it. Healthcare reform in the United States failed under the Clinton administration in part because organized medical interests mobilized to oppose its enactment.

2.3.4.2 Kingdon Model: Agenda setting through three streams

Kingdon (J. Kingdon, 1984) argues that polices are only taken seriously by government when a major 'window of opportunity' opens up in each of three streams, including the problem stream, the politics stream, and the polices stream, at the same time.

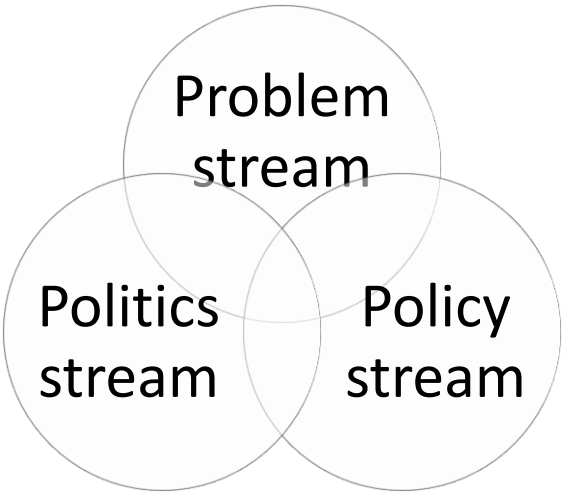

Figure 3: Kingdon three Stream Policy Model

He argues that agenda setting has a arbitrary character in which problems, policies and politics flow along in independent streams.

The problems stream is the flow of broad conditions facing societies, some of which become identified as issues that require public attention. Government officials learn about conditions, through indicators, focusing events or feedbacks. Indicators may include routine information on health statistics, for example increase in maternal mortality and decrease in utilization of government health facilities. Feedback comes from programs already in place.

The policy stream refers to the set of alternatives that researchers and others propose to address national problems. This stream contains ideas and technical proposals on how problems may be solved.

Finally, there is a politics stream. Political transitions, global political events, national mood and social pressure are among the constituent elements of the politics stream.

At particular junctures in history the streams couple, and in their confluence windows of opportunity emerge and governments decide to act. The opening of these windows usually cannot be anticipated. Prior to the coupling there may be considerable activity in any given stream, but it is not until all three streams flow together that an issue emerges on the policy agenda.

2.3.4.3 Reich Model

Based on the basic ideas of the Kingdon model, Reich (Reich, 1995) explains how particular health issues emerge on policy agendas by using five streams. He argues that five political streams – organizational, symbolic, economic, and scientific and politician politics – all favored child over adult health through the 1990s, explaining the higher position of the former on the international health agenda.

By organizational politics he means efforts by organizations such as the WHO and World Bank to use their resources to enhance their authority.

Symbolic politics concerns how actors use descriptions to advance their positions – for instance UNICEF's effective use of the tragedy of child ill health to mobilize social institutions and raise funds.

Economic politics concerns the ability of for profit organizations to advance their interests, such as the power of the private health industry has wielded to block efforts to control private industry.

Scientific politics concerns the influence of financial support and other political factors on public health research agendas.

Those four streams described above shape the cost benefit calculations of national politicians – the politicians' stream – concerning which problems to place on national policy agendas.

2.3.5 Policy change under crisis

Crises denote periods of disorder in the seemingly normal development of human affairs, along with widespread questioning or discrediting of established policies, practices, and institutions (Nohrstedt, 2009). Consequently, crises are frequently cited

as essential causal drivers for major or non-incremental policy change. Some research attributes the explanation for major policy change to the magnitude of the crisis, building on the maxim that 'the bigger the cause, the bigger the impacts (Cortell & Peterson, 1999; Keeler & John, 1993).

A crisis exists when the important policy makers that one excites, that is a real threatening crisis, and that failure to act could lead to even more disastrous consequences (Walt, 1994), and situations that don't have all the characteristics described by Walt are likely to be tolerated until the worst has blown over.

A question that frequently arises in the wake of major emergencies is how to prevent them from happening in the future, and/or how to respond more effectively if they do occur again. The very occurrence of crisis may call attention to the need for change in the existing arrangements, as might an ineffective emergency response. Crises can thus generate strong symbolic and political pressure to make a clear break with past governance practices if those practices are discredited. Crises can also infuse a sense of urgency into ongoing and often stagnant policy struggles or discussions over institutional arrangements in a policy sector. This raises the possibility that crises act as 'reform triggers', 'change agents' or 'learning opportunities' (Boin & Hart, 2003; Keeler & John, 1993).

2.3.6 Policy formulation

Until now, most research into policy-making has concentrated in the scientific literature, which reflects the last steps of the policy cycle, namely, policy implementation and evaluation. However, this has led to a gap in information about other crucial areas, such as how a health problem is constructed by society or how institutions react to the perceived problems by formulating policies (Peiró et al., 2002).

Policy formulation is one of the gears of pre-decision segment of the policy process, and is the development of policy substitutes for dealing with problems on the public agenda (Dye, 2002). Government bureaucracies, interest group offices, legislative committee rooms, meetings of special commissions and policy planning organizations are the platforms of the policy formulation.

Written policies and laws go through many drafts before they are final. Wording that is not acceptable to policymakers key to passing laws or policies is revised. Policy formulation also includes setting goals and outcomes of the policy or policies. The goals and objectives may be general or narrow but should articulate the relevant activities and indicators by which they will be achieved and measured (Hardee et al., 2004). The goals of a policy could include, for example, improved health status, or increased access to reproductive health services.

James Anderson (Anderson, 2003) suggests several factors for formulators to keep in mind to enhance their chances of success, include following,

- *Is the proposal technically sound? Is it directed at the problem's causes? To what extent will it resolve or lesson the problem?*
- *Are its budgetary costs reasonable or acceptable?*
- *Is the proposal politically acceptable? Can it win the needed support of legislators or the public health officials?*
- *If the proposal becomes law, will it be agreeable to the public?*

2.3.7 Policy implementation

Converting policy commitments in to Practice

Study of policy implementation is concerned with the agencies and offices involved, the procedure they follow, the techniques they employ, and the political support and opposition they encounter. In so doing, it focuses attention on day to day operation of government (Ripley, 1986).

Anderson defines policy implementation as "what happens after a bill becomes a law, it encompasses whatever is done to carry a law into effect, to apply it to the target population and to achieve the goals" (Anderson, 2003).

Political scientist Gerston defines implementation as "the implementation represents the conscious conversion plans in to reality" and is the "follow – through" component of the public policy making process (Gerston, 1997).

Therefore to say simply public policies are commitments to something and even though implementation is toward the back side of the decision making process, policy

execution inevitably depends upon the components of the public policy that precede it.

Furthermore Gerston reveals the importance of the implementation as mirror of strengths and weaknesses for the decision making and implementation relies on connections for its purpose and direction (Gerston, 1997).

Exploring the policy implementation further, political scientists divulge as, the Policy is commonly used as a label for a field of activity (for example, foreign policy), or as an expression of general purpose or a desired state of affairs - or it can be a specific proposal or decision of government, including programs and legislation (Barrett & Fudge, 1981; Hogwood & Gunn, 1984a).

A social policy expresses "ongoing strategies for structuring relationships and coordinating behavior to achieve collective purposes, ways of exerting power, of getting people to do things that they might otherwise not do" and the implementation of a policy requires that resources come from wherever necessary to enact the relevant program(s) and "that the economic structure, social institutions, and political processes will be shaped to protect and maintain that commitment" (Watt et al., 2005).

According to Adamolekun (Adamolekun, 1983), policy implementation refers to the activities that are carried out in the light of established policies. It refers to the process of converting financial, material, technical and human inputs into outputs – goods and services (Egonmwan, 1984). Edwards (Edwards & George, 1980) defines policy implementation as a stage of policy making between the establishment of a policy (such as the passage of a legislative act, the issuing of an executive order, or the promulgation of a regulatory rule) and the consequences of the policy for the people whom it affects. It also involves a wide variety of actions such as issuing and enforcing directives, disbursing funds, making loans, assigning and hiring personnel, etc.

Service delivery is also linked to policy and policy implementation. The question is how one enhances policy implementation strategies to ensure successful service

delivery. Policy development, implementation and service delivery therefore need to be consolidated so that a more coherent policy and strategy system with ongoing review and performance management mechanisms are developed.

Federal legislation and other organizations may provide goals, policy, technical assistance, financial aid the like, but much of the day to day administrative action needed to apply policies to the target populations must come from the provinces.

It has been observed that policy implementation is one of the major problems confronting in developing nations. Thus, for national polices to be successfully implemented, one of the requisites may be the coordination and cooperation among a web of federal, provinces and local government and agencies. Policy implementation in any health care system relies upon provider commitment. Policies that do not address the organizational, professional and social contexts are unlikely to achieve successful implementation (Watt, et al., 2005). To achieve this, national polices may have to be tempered to better accord with national and local interests and perspectives.

As Gerston (1997) argues "while some disagreement over the elements that compose the implementation, certain assumption seems to have widespread acceptance, for implementation to occur" that include:

- There must be an entity with sufficient resources assigned to carry out the implementation task.
- The implementing agency must be able to translate goals in to an operational framework.
- The entity assigned the implementing task must deliver on its assignment and be accountable for its decision.

2.3.8 Policy Implementation models

Reviewing the literature reveals many different approaches for the implementation of the adopted policies; Gill Walt divides the implementation in two broad categories as Theoretical models and Implementation in Practice, as policies are influenced by many external forces (G Walt, 1994).

2.3.8.1 Theoretical Models

Top-down approaches

In a top-down model, it is assumed that policy formulation occurs within national government, or at international level, between donors and national policy makers. Once devised it is a largely technical process to be implemented by administrative agencies at the national or sub-national levels (Gill, 1994; Sabatier, 1986)

Hogwood and Gunn drew up ten preconditions which would have to be achieved if polices ere to be implemented as to achieve their objectives (Hogwood & Gunn, 1984b).

The model is useful as a checklist against which to score the likely hood of any policy being successfully executed, although the chances of attaining of all ten preconditions are negligible.

A perfected implementation model suggests that:

1. *The circumstances external to the agency do not impose crippling constraints*
2. *Adequate time and sufficient resources are available*
3. *The required combination of resources is available*
4. *Policy is based on valid theory of cause and effect*
5. *The relationship between cause and effect is direct*
6. *Dependency relationships are minimal*
7. *There is an understanding of, and agreement on, objectives*
8. *Tasks are fully specified in correct sequences*
9. *Communication and coordination must be perfect*
10. *Those in authority can demand and obtain perfect compliance*

Bottom-up approaches

In this approach the implementers often play an important role in policy implementation, not only as managers of policy dripped downwards, but as active participants in an extremely complex process that informs policy upwards too (Sabatier, 1986). Thus implementers may change the way a policy is implemented or even refine the objectives of the policy because they are closer to the problem and the local situation (G Walt, 1994). Walt further argues that rather than seeing

implementation as stage in the sequential transmission of policy from formulation to implementation, it should be seen as a much more interactive process, and just as policy formulation may be characterized by bargaining, so may implementation be characterized by negotiation and conflict.

Therefore, staff at the periphery level may distort or interpret differently the initial intention of the policy makers. The introduction of the concept of street-level bureaucrats proposed by Lipsky highlights the importance of these actors at the periphery level. As cited by Lipsky "the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out" (M, 1980).

2.3.9 Implementation in Practice

International influence

There has been a recent, rapid proliferation of Global Health Partnerships (GHPs), with establishment of new partnerships peaking around 2001. In developing countries a variety of stakeholders are involved in policy implementation that can influence significantly and must be taken into account. Health systems in low-income countries depend among others on support from donors, adhesion from the population and commitment of the health workers.

Global organizations affianced in policy dialogue with national policy makers often seem to assume a disconnection between policy formulation and implementation. It seems that donors often underemphasize the practical consequences of adopting particular polices, where as this is in particular what preoccupies national policy makers (Walt, 1994). Further the validity of conditions demanded as part of aid is some time questioned on the basis that foreign negotiators are insufficiently informed by local understanding and knowledge (Ozvaris et al., 2004; Walt, 1994).

Literature review also reveals that donors are less concerned with implementation than they should be their decision about aid affect policy execution in a number of ways. For example, polices may be decided by one ministry on behalf of another (implementing) ministry. There are many countries where government has accepted

aid to build a new central hospital, against the ministry of health objections to the long term recurrent expenditure implications (Walt, 1994).

Some studies on policies also concluded that donors complicate decision making, and that power is asymmetric, this depends on the level of aid. A study suggested that countries who were heavily dependent on external resources, negotiations were often dominant by recipient submissiveness and donor assertiveness, and in those courtiers where aid was a small part of Gross notational product (GNP) national negotiators were often and uncompromising (Elgstrom, 1992; Gill, 1994).

Central-local relations

All most all governments move authority or diffuse some power in public planning, management and decision making from national to sub-national levels, or from higher to lower levels of government (Mills, 1994). While at the other end lower level authorities may have substantial prudence in the interpretation of central policy. Implementation of policy is clearly affected by the prevailing system (Elgstrom, 1992; Gill, 1994; Mills, 1994).

Implementation is clearly affected by where the funds come from to carryout policy, and who control them. The ability of the center to pay for a particular part of public expenditure is a powerful inducement for lower level authorities to follow central policy proposals (Atkinson, 2002). Thus in a federal system the national government may exercise some control over even relatively autonomous states, by providing financial support for particular programs. Indeed, attempt to reclassify funding from federal to state levels are likely to be met with considerable protest (Brown, 2009).

Lack of resources also makes local level authorities vulnerable to policies which may not be cost effective, but which bring other rewards (Atkinson, 2002; Bossert & Mitchell, 2011; Brown, 2009; Enikolopov & Zhuravskaya, 2007). Therefore implementation of policy is heavily dependent on the extent to which the center can expect lower level authorities to follow its guidelines and in many countries this control is safeguard by the center through financing mechanism (Gill, 1994).

2.3.10 Who Implements Policy

In the modern political system, the implementation is a process of complex array of administrative agencies, also known as bureaucracies, a term that carries both descriptive and negative connotations (Goodsell, 2004).

In case of the health polices decisions by politicians and bureaucrats within the ministry of health are communicated to planners in the health planning unit (they may be or not be involved in the policy formulation), who operationalize policies by designing appropriate programs, with guidelines, rules, and monitoring systems. These are then transferred to local health authorities at the provincial or district levels or to health care institutions to put in to practice (Gill, 1994).

Administrative agencies perform most of the day to day work of Government like collecting taxes, regulate banks, utility companies and agricultural production, provide medical benefits and services and perform many other tasks of modern government, hence their action affects citizens more regularly and directly than those of other governmental bodies (Anderson, 2003). In other words policy success depends on how bureaucratic structures implement government policies (Gerston, 1997).

After reviewing the public administration we can conclude that politics and administration are separate and different spheres of the activity. Politics, dealt with formulating the will of the state, with making value judgments, and with determining what governments should or should not do, in short with policy making. Administration on the other hand, is concerned with the implementing of the will of the state, with carrying into effect the decisions of the political branch (Goodnow, 1990).

Furthermore administration dealt with questions of fact, with what is rather than what it should be, and consequently could focus on identifying the most efficient means (or "one best way") of implementing policy.

As institutions and their responsibilities have become more complex, bureaucracies have been established to carry out government directed objectives and when state

faces acute crises chronic problems or even apathy, the positive government responds; and the response usually includes a bureaucracy (Gerston, 1997).

Vertical versus Horizontal Implementation: *Adventures in Federalism*

Some time implementation efforts may move between levels of government and/or with in levels of government. Indeed, the requirements of federalism, the multifaceted web of intergovernmental relations, make it likely that most public polices will be implemented by a series of institutions or levels of government (Nice, 1987). At the same time, the implementation process will be encouraged or discouraged, in part by the route of policy application (Crosby, 1996). On the other hand, when one or more segments of the national Government must interact with institutions at other levels on the federal ladder, the implementation challenges increase (Gerston, 1997).

As public policy increases in complexity and in layer of interaction, its implementation activities may transcend both the vertical and the horizontal dimensions of bureaucracy and the political process. With each new dimension of government involvement, the policy faces a new power base, a different set of interpretations, and the potential of resource scarcity. Because of hazards associated with implementation of overlapping institutions and levels of government, the coordination issue can become as compelling the policy itself.

2.3.11 Conditions that Promote Implementation

The implementation of a policy requires that resources come from wherever necessary to enact the relevant program(s) and "that the economic structure, social institutions, and political processes will be shaped to protect and maintain that commitment" (Watt, et al., 2005).

As different political actors and institutions are connected with each policy, the implement framework varies with each public policy enactment that awaits execution. Moreover the opportunities both structural and political to halt, delay, or modify policy commitments are numerous. Some of these inducements include adequate funding, boilerplate provisions, limitations of the number of on the number of agencies involved, and political controls on the bureaucracy.

Funding

Financial resources are one of the vital components that are necessary for policy implementation. The content and effectiveness of public policies often depend substantially upon the amount of the funds provided for their enforcement or implementation.

Adequate financial resources allow for making long term plans, making staff arrangements, making policies operational, and completing policy objectives. Most of all funding is the hall mark of commitment (Gerston, 1997). At the extreme polices without funding become nullities.

The budget conveys a good overview of the government's total set of policies for the fiscal year it covers. In the budget one can find or extract answers such as policy issues as the balance between private and governmental spending, whether medical spending will be accelerated or slowed (Anderson, 2003).

Boilerplate Provisions

Public policies sometime are written in such a manner that their implementation is contingent upon the agreement of state and local government agencies or recipients in the private sector to a series of previously established conditions. Known as boilerplate provisions, these conditions represent commitments to general social goals created through programs adopted at earlier points in time (Gerston, 1997; 2004). The implementation of one policy may, the, may be dependent on continuous enforcement of other law or regulation.

Their importance lies not only with specific legislation to which they are connected, but also with general commitments made at previous points in the public policy-making process.

Boilerplate provisions are particularly vital to those governments that rely upon federal financial assistance for support of their own programs (Crosby, 1996).

Limited Number of Agencies

While considering the challenges for the implementation of the public policies Robert Lineberry observed that the larger the number of actors and agencies involved, the

lower the probability of successful implementation(Lineberry, 1977). At the national level executive, legislative, judicial, regulatory and (to some extent) bureaucratic both compete and share authority. Similar divisions of authority not only occur at the state and local levels, but also must interact with the power that follows from the national sector.

Political Controls on the Bureaucracy

As discussed earlier bureaucracies are important parts of policy implementers and the political process because they translate orders, laws, and decisions in to concrete application.

Charles Jones notes, "The policy process relies heavily on the communication of words and their meaning. Interpretation – what did they mean by that? Is crucial to understanding what goes on at every stage of decision making" (Gerston, 2004; Jones, 1984).

Marc Landy and his colleagues observed during examination of Environmental protection agency that "without political controls on the bureaucracy, implementation of the intended policy may drift away from policy objectives" (Landy, 1994).

But control on the bureaucracy need not only occur from within the internal bureaucratic apparatus. If policy makers accept accurate implementation of their goals, their participation in the policy making process must continue beyond the point at which decisions are made. Robert lineberry cites several strategies that policy makers may use to assure that their commitments are carried out as intended. These include:

1. Change the law to tighten loopholes that bureaucracies use for the discretionary authority.
2. Overrule the bureaucracy through the powers that exist in the presidency or cabinet level officials.
3. Transfer responsibility for administration elsewhere so that new bureaucrats will be more respectful of actual policy commitments.
4. Replace a recalcitrant agency head when the current official in charge repeatedly thwarts clear legislative, executive, or judicial intent.

5. Make the legislation more detailed to force the bureaucracy into conformity with specific instructions and narrow laws.

Concluding the political control Gerston recommends that "Member of the executive branch can supervise implementation through tight controls of cabinet agencies and occasional executive orders where appropriate: legislators can oversee implementation through watchdog committees and the power of the purse; even judges can affect implementation by issuing new court orders" (Larry, 2004).

Nevertheless, political control of the bureaucracy remains the most effective means by which to guarantee precise implementation.

2.3.12 Conditions that Obstruct Implementation

Clear, specific and well directed policy decisions are essential prerequisites for implementation (van den Bergh & Gatherer, 2010). Full implementation of policies requires implementation at multiple levels—national, state, district, and municipal. However, national policies are often broad framework documents that are not always accompanied by guidelines or plans that specify implementation mechanisms and the roles and responsibilities of specific agencies. Some of the most critical obstacles include bargaining; Lack of funds, changing of priorities, multiple goals and poor oversight.

Bargaining

During the decision making process, which includes compromise, bargaining is a commonly accepted ingredient of politics and during implementation phase time to discuss the merits of various policy proposals theoretically is over (Larry, 2004). As small portion of the many political actors who make the policy are also involved, further debate would could the original issue and obstruct completion of the original public policy objective. Bargaining has a different character in public policy implementation than it has during the period of policy creation (Grol & Grimshaw, 2003).

Once a public policy decision has made, the need for exact application in vital if it is to reflect realistically upon the policy and policy makers alike. Nevertheless,

bureaucrats are often allowed to bargain or to negotiate, as a means of smoothing out any unforeseen problems connected with implementation. The more implementing agency is allowed to bargain, the more likely it is that the policy in question may be administrated in an arbitrary way. While bargaining may make life easier for the bureaucracy, it decreases the value of policy and law (Edwards & George, 1980; Sword et al, 2004).

Depending upon the policy area and the affected parties, bargaining can be a major roadblock to the implementation of a policy per its intentions or design (Watt, et al., 2005).

Lack of Funding

As discussed earlier funding is a critical ingredient in the implementation of public policy commitments. It may seem conflicting for a decision making authority to decide upon a commitment without subtle resource for implementation (Watt, et al., 2005).

But in some instances, policymaking agents intend to fund their programs but fail because of political breakdown or because of a fierce struggle over resource after the program's passage. Some time a policy may fail to garner funds because of conflict between the actors in two or more institutions which share responsibility for creation of a public policy (Cohen, 1994; Watt, et al., 2005).

Simply stated, inadequate funding is virtual guarantee of programmatic disaster at the point of implementation. If a program lacks necessary resource, or if competing arenas of power disagree on the necessary commitment, substantial amount of policy making energy may be wasted (Larry, 2004).

Changes in Priorities

It is useful to consider health policy development as involving three complementary tasks: first, identifying the major disease problems, assessing their social and economic consequences, and evaluating the costs and effectiveness of alternative intervention strategies; second, designing health care delivery systems including establishing the human and physical infrastructures, providing for drugs and logistical support, and developing managerial capacities and funding mechanisms; and third,

defining and choosing what governments can do through the full range of policy instruments that are at their disposal in the areas of persuasion, taxation, regulation and the provision of services (Jamison & Mosley, 1991).

Abrupt policy changes are common in developing countries politics. Unstable political situation, ill-defined relationships among policy makers, bureaucrats and powerful interest groups generally work in favor of rapid change in the policy arena (Dye, 2002; Larry, 2004). Tendency towards incrementalism, or slow change, dramatic new demands or events occasionally lead policy makers to respond with new commitments. At these points in the decision making process, one long standing public policy nay be replaced by another, or an existing may be dropped without replacement (Dye, 2002). New directions in public values can, in fact, bring implementation of existing programs to an abrupt halt.

Multiple Goals

Health policies in developing countries are often pieced together as coalition products, the result of intense negotiating and compromise among several actors (Gill, 1994). As policies are subject to many pressures, they may appear to be hybrid compilations born out of the conflict. Because of the complex negotiations along the path to adoption, a new policy, therefore may stress several goals at the same time as the price for keeping ad hoc coalition intact (Larry, 2004).

During adoption of multiple goals, which may be political necessity in order to assure a policy passage, incomplete coordination of competing objectives into compatible goals can bring on implementation failure (Barrett & Fudge, 1981; Daneke, et al., 1978). In some cases, the objective of national policy makers and local recipient agencies may be so divergent that policy implementation falls short of either groups goals (Daneke, et al., 1978; Larry, 2004).

Constraints to implementation

Gadomski and friends used a five component model to explore some of the difficulties in implementation and suggested that implementation may face problems on the following five stages (Gadomski, Black, & Mosley, 1990).

1. Inputs

The interface of technology with field conditions can precipitate problems and are only as effective as those who deliver them mistakes, inaccuracies, or wrong timing can all lead to poor execution.

2. Process

The implementation process involves the interaction between the community and health services as well as between provider and recipient.

3. Outputs

Rather than counting the direct outputs, outputs that count the effective use by the recipient are better test of usefulness.

4. Out come

Effective coverage means reaching the most in need of the intervention or those at high risk.

5. Impact

At the end of line of the implementation, there remain many constraints including biological constraints, that attenuate the impact interventions can have reducing mortality.

Implementation may also be refused or to be accepted at the organizational level depending on the basis of the thrust for change or reform. Martin suggests a frame work of four dimensions that describe the process of implementing change within organizations (Martin, 1994).

- Rationale-empirical dimension (problem solving approach)
- Social system approach (human interrelationships and interpersonal aspect of change)
- Power politics
- Values-vision (new perspective of purpose and commitment)

In conclusion to implement polices two main issues are clear, first implementation cannot be seen as a part of a linear or sequential policy process, in which political dialogue takes place at the policy formulation stage, and implementation is undertaken by administrators or managers. It is a complex interactive process, in which implementers' them-selves my affects the way policy is executed and is active

in formulating change and innovation. Second to avoid the gap between formulation of policy and implementation, all policy makers should be engaged in policy analysis that includes a strategy for implementation, taking into account anticipated objections from the public and the government bureaucracy, as well as the financial, and management and technical aspects of the policy.

2.4 Origin of health policies in Pakistan

A brief history

The government of Pakistan is responsible for providing free national health care services to all citizens, including hospital care free of charge, and such services exist in almost all cities and towns (Pakistan, 2004). A major difficulty in determining the size of public and private health expenditures is how to determine the boundaries of health care and which expenditures to include (Pakistan, 1994). Human health resources include physicians, nurses, pharmacists, dentists, environmentalists, social scientists, public health professionals, and other persons promoting health.

In October 1943, the then British Government of India appointed a "Health Survey and Development Committee" (the Bhore Committee) (Verma, 1991). The committee published its report on March 1, 1946, with its contents markedly resembling the 1942 Beveridge Report in the UK that led to the creation of the National Health Service and other institutions of the British welfare state(Duggal, 1991; M. M. Khan & Van den Heuvel, 2007). The main principles underlying the Bhore Committee proposals for future health services development included the idea that no individual should lack adequate medical care because of an inability to pay. Health consultants were to be provided with the laboratory and institutional facilities necessary for proper diagnosis and treatment of all sick people. The Bhore Committee also placed a strong emphasis upon prevention. It recommended that medical and preventive health care services be provided as close as possible to the people. After independence, the fledging Government of Pakistan adopted most of the proposals of the Bhore Committee, including provision of free medical treatment to all sick people and an emphasis upon disease prevention.

In the following years, a series of commissions and expert panels examined the health sector development process in Pakistan. A Medical Reforms Commission, appointed on November 24, 1959, issued several reports from January to April of 1960 (Duggal, 1991; M. Khan, M. Van, D, H, 2007; Pakistan, 1994). These reports recommended the take-over of municipal hospitals and envisaged the district as the apex of a pyramid of health services radiating down through sub-districts to dispensaries.

The Rural Health Centers (RHC) scheme was announced in 1961 in order to provide essential health facilities and is a categorized system of medical care across rural Pakistan. Sometimes later, in 1969, a new Health Study Group was appointed, which issued its report in March 1970 (Ronis & Nishtar, 2007). This report recommended the development of autonomous hospital authorities, a stronger emphasis upon preventive care, the reorganization of paramedical services, and the integration of several vertical programs into health care.

In 1972, the government announced the “People’s Health Scheme” with an importance on prevention and development of facilities in rural areas. The Planning Commission framed a set of national guidelines to mirror the main concern of this scheme in 1973. The government and the World Health Organization further swayed these strategies in order to streamline health planning. Finally, in 1978, Pakistan formally adopted the strategy of the World Health Organization’s" Health For All (HFA) by the Year 2000" (Ali, 2000; Pakistan, 1997).

First National Health policy

One of the five principles to emerge from Alma-Ata focuses on disease prevention, health promotion, and curative and rehabilitative services. Policies to address this principle in Pakistan did not appear until 1990 when the Pakistan Government announced its first plan for a national health policy in 1990 (Pakistan, 1990). The 1990 National Health Policy (NHP) stated that Pakistani people pay a heavy toll of life from diseases, many of which are easily preventable, and that improvements were needed in the area of clean water, sanitation and housing as well as birth control (Malik, 2009; Pakistan, 1990). The NHP 1990 intended to give a higher priority to the neglected health sector and upgrade the medical education and health care system. It

stated that government would devote more attention to environmental protection, sanitation, clean water supplies and housing in order to prevent disease. The NHP 1990 intended to provide universal health coverage in accordance with the strategy HFA 2000. In line with the HFA initiative, the NHP policy document identified the following main objectives (Pakistan, 1990):

- Health services should be effective, efficient, affordable and acceptable.
- Efforts to deal with health should include disease prevention, health promotion and curative services.
- There should be universal coverage for health services. Individuals and communities should participate in health activities that promote self- reliance and reduce dependence.
- Health activities should be integral to community and national development.

To attain its objective, particularly of making Primary Health Care (PHC) available to all, the NHP policy program aimed to control child and maternal mortality by increasing the coverage for immunization against major childhood diseases (measles, tetanus, whooping cough, diphtheria, and tuberculosis) through establishing public health services. It also aimed to combat anemia among women of childbearing age, provide adequate antenatal care and better maternity practices, and to ensure an adequate level of nutrition for children and women of child- bearing age. Furthermore, health care professionals would be trained in the area of pregnancy, childbearing, and childcare. Drug packages for treatment of common diseases would also be provided in the rural areas (Pakistan, 1990). Outlays for health in the national budget would be increased, and additional sources of revenues would be identified to finance this policy.

On an organizational level, the NHP 1990 planned to decentralize the health system and to provide Primary Health Care (PHC) services via basic health units (BHUs) and rural health centers (RHCs) in rural areas. In urban areas, PHC services would be improved by training more physicians and other PHC professionals (Pakistan, 1990). To reduce infant/child mortality and child diseases such as congenital infection, tetanus, measles, whooping cough, diphtheria and diarrhea, services would have to be improved in the areas of nutrition, immunization against childhood diseases, and

maternal and child health care. In addition, public education and awareness programs would be launched in the area of maternal and child health and family planning. Family planning services would be provided through health outlets, and health programs would be integrated with family planning programs (Pakistan, 1990).

National Health Policy 1997

In 1997, the second National Health Policy (Pakistan, 1997) was launched and health promotion and health education received a prominent place under priority health programs and non-communicable diseases for prevention and control measures.

The policy also stressed on renewing and upgrading health policy in accordance with modern health paradigms was one of its basic objectives and that the previous health policy had not adequately covered all areas of PHC and the Health For All (HFA) strategy. It also aimed to make health service more responsive to current health needs in accordance with HFA. It identified many emerging health problems, including HIV/AIDS, cancer, diabetes, (road traffic) accidents, violence and crime, mental health and tuberculosis. To combat these health problems, a greater focus would be needed on the prevention of disease and promotion of health in accordance with modern health paradigms (Pakistan, 1997).

Policymakers made it clear that the government was committed to achieving the goal of health for all through better governance. Good governance was to be the cornerstone of health development. Human resource development needed to be rationalized, the private sector given greater responsibility, and local communities empowered (Pakistan, 1997).

The ultimate aim of the new health policy was to improve the level of health across the entire population by providing universal health care coverage through an integrated PHC approach (Pakistan, 1997).

It intended to launch mass media awareness campaigns focusing on a healthy lifestyle in order to control and prevent cardiovascular diseases, blindness, diabetes, cancer, burns, injuries, and drug abuse. It also called for providing special training to health professionals in the area of public health and health promotion. In the area of

disease control and prevention, the 1997 policy document specified several priority health programs, including an expanded program of immunization (EPI), a family planning program, a maternal and child health program (MCH), a program for reproductive health, a malaria control program, a tuberculosis (TB) control program, a national AIDS control program, and a cancer control program (Pakistan, 1997).

National Health Policy 2001: *The Way Forward*

The government of Pakistan launched its third (current) National Health Policy in 2001 by acknowledging the need for a comprehensive health policy to address health problems and improve life conditions (Pakistan, 2001a). The 2001 NHP is the current health policy document for Pakistan. It aims to reform the health sector in order to prevent disease, promote health, and improve the overall health status of the population in line with the principles of HFA (Pakistan, 2001a).

The key to the success of the new NHP 2001 lied in its implementation modalities. The NHP 2001 has outlined implementation modalities and has set targets and a time frame for each of the key areas identified that would be implemented over a period of 10 year. These were to be implemented in partnership between the federal Ministry of Health and the provincial Departments of Health, and in close collaboration with the district health set-up under the Local Government structure. The private health sector would also be taken on board while implementing the key policy initiatives (Pakistan, 2001a).

2.5 Antenatal Care

The Safe Motherhood Initiative (SMI) of 1987 led to a new drive of research that defined the policy and strategies needed to combat continuing high levels of maternal deaths. The greatest focus has been placed on increasing access to skilled birth attendants and obstetric emergency care (De Brouwere, Tonglet, & Van Lerberghe, 1998; Gerein, Mayhew, & Lubben, 2003) and One of the most widely used strategies to improve maternal health was, and still is, antenatal care (Gerein et al., 2003).

Antenatal care is designed for the early detection of deviations from normal pregnancy, and the early treatment of medical conditions that can have an unfavorable effect on the mother and/or the infant (Wedin, Molin, & Crang Svalenius, 2010) and

as an important part of preventive care, its purpose being to maintain the mother in health of body and mind, to anticipate difficulty and complications of labor, ensure the birth of a healthy infant and help the mother care the child (Acharya, 1995; Blondel, Dutilh, Delour, & Uzan, 1993). Antenatal care services indirectly save the lives of mothers and babies by promoting and establishing good health before childbirth and the early post-natal period. It often presents the first contact opportunities for a pregnant woman to connect with health services, thus offering an entry point for integrated care, promoting healthy home practices, influencing care-seeking behaviors and linking women with pregnancy complications to a referral system; thus impacting positively on maternal and neonatal outcomes (Bulatao & Ross, 2000; WHO/UNICEF, 2003).

The very low maternal/infant morbidity and mortality rates reported for developed countries compared with the extremely high figures in developing countries have been attributed to the higher utilization of modern obstetric services by the former (Cook & Dickens, 2001).

Studies in developing countries have shown that the use of health-care services is related to the availability, quality and cost of services, as well as to the social structure, health beliefs and personal characteristics of the users (Chakraborty et al., 2002; Kulmala et al., 2000).

In 2002 WHO introduced a manual for antenatal care, which is one of the components of global WHO efforts to improve maternal health, describes the basic components of new WHO antenatal care model. The new model provides detailed instructions on how to conduct the four-visit schedule of the basic component of the new WHO antenatal model. The new WHO model of antenatal care separates pregnant women into two groups: those likely to need only routine antenatal care (some 75% of the total population of pregnant women), and those with specific health conditions or risk factors that necessitate special care (25% of pregnant women). Some of the components may be undertaken by formally trained midwives, nurses, and medical assistants, other elements require the skills of a qualified physician for execution and interpretation (WHO, 2002).

The WHO antenatal care model divides pregnant women in two categories, those eligible to receive routine antenatal care (basic antenatal components) and those who need special care.

Basic Components of ANC

The activities included in the basic component fall within three general areas:

- Screening for health and socio-economic conditions likely to increase the possibility of specific adverse out comes.
- Providing therapeutic interventions known to be beneficial.
- Educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them.

Basic components can be executed by formally trained midwives, nurses and medical assistants and trained TBA (WHO, 2002).

2.5.1 Focused Antenatal Care

Focused antenatal is essential link in the household-to-hospital care continuum. It is an intervention that can be provided at both household and peripheral facility levels (GraftJohnson et al., 2005). In this model the community is mobilized as a vital link between families and the care they need through community health workers (CHW) and skilled attendants (GraftJohnson et al., 2005).

The provision of High-quality, basic antenatal care with safe, simple, and cost-effective interventions that all women should receive- helps maintain normal pregnancies, prevent complications and facilitate early detection and treatment of complications. The major goal of focused antenatal care is to help women maintain normal pregnancies through (USAID, 2007):

- Targeted assessment based on the woman’s individual situation to ensure normal progress of the pregnancy and postpartum/newborn period, and to facilitate the early detection of, and special care for complications, chronic conditions and other potential problems that can affect the mother and newborn.

- Individualized care to help maintain normal progress, including preventive measures, supportive care, health messages and counseling (including empowering women and families for appropriate and effective self care), and birth preparedness and complication readiness planning.

In Europe routine antenatal care has been considered a self-evident part of health services for a long time. But many aspects of care have been addressed in order to provide appropriate care for high- and low-risk mothers and to reduce the cost of health services. In most countries the main care provider was an obstetrician/gynecologist, but two countries relied on midwives (includes public health nurses in Finland). Furthermore, in Denmark midwives in the shared care system had an important role (Hemminki & Blondel, 2001).

2.5.2 Antenatal Care in Developing Countries

Healthcare priorities differ between developing and developed countries. Yet in many developing countries the allocation of resources for healthcare, as well as healthcare practices, remains modeled on those of developed countries. A more effective resource allocation, complemented by efforts to implement only those practices that is effective, is a priority if reproductive health services in developing countries are to improve (J. H. Rizvi & Zuberi, 2006).

The situation in low income countries seems to be worse, as a substantial number of ladies don’t get antenatal care throughout their pregnancy (Zanconato, Msolomba, Guarenti, & Franchi, 2006). A WHO compilation on maternity care showed that in most countries in south Asia, less than 55% of the pregnant women get proper care throughout pregnancy. Many of those who attend antenatal clinics come only once or twice and sometimes late in pregnancy; when this happens, the quality of the care provided is inevitably poor (WHO/UNICEF, 2003) figure 4.

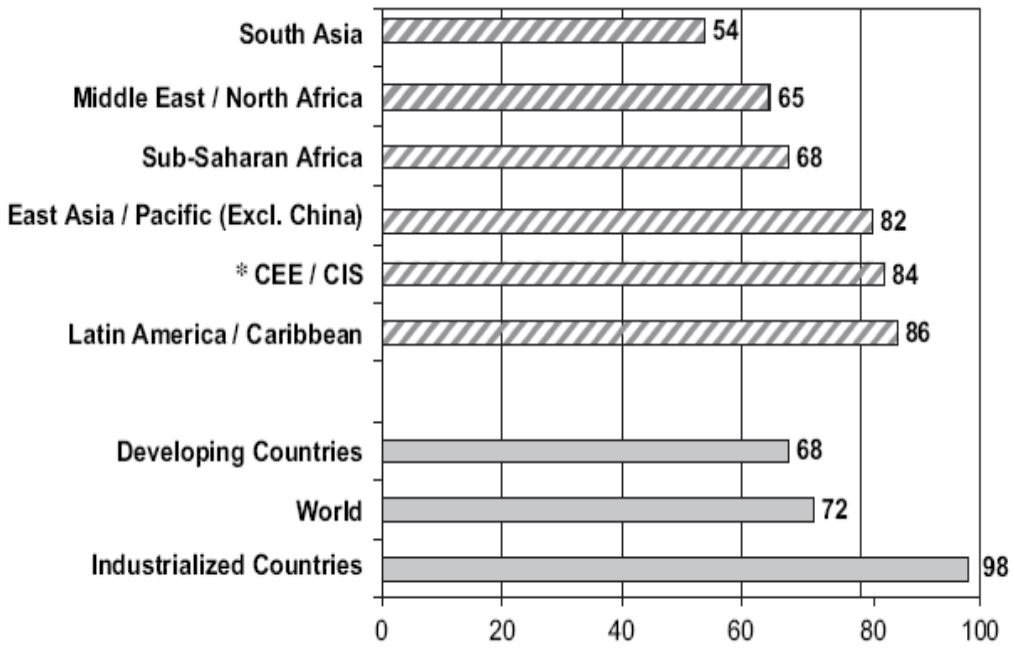

Figure 4: ANC coverage region based

*Central and Eastern Europe/Commonwealth of Independent States and Baltic States. Source: UNICEF/WHO 2002, Data from Pakistan demographic and health surveys (PDHS).

2.6 Barriers to use of antenatal care services utilization

In different studies from developing world major barriers identified were economic, Physical barriers, Psychological and socio-cultural and those related to the women's and family perception including Beliefs about the quality of health services, their condition, Limited knowledge or misinformation about health professionals and services Organizational barriers (Adamu & Salihu, 2002; Matsuoka et al., 2010).

In particular, the utilization of delivery services can be influenced by the number of children in the family and distance to health facility (Mwaniki, 2002), as well as the quality of service (Afsana & Rashid, 2001; Sauerborn, 2001). Negative perceptions and dissatisfaction with service quality also affect health seeking behaviors and the utilization of services (Dunfield, 1996; Duong et al., 2004; Foster et al., 2010; Truant & Bottorff, 1999). Meanwhile, high costs, together with the widespread practice of ‘informal’ or so-called ‘under the table payment’ and other indirect costs, contribute

to the under-utilization of public services (Jahn, 2002; Margaret et al., 2001; Nahar & Costello, 1998). In addition to these factors, family income and ability to mobilize resources are strongly associated with the health service utilization patterns of the communities (Haddad et al., 1998). Moreover, decision on the utilization of delivery services can be affected by the low socio-economic status of women in certain countries. Some women are denied access to necessary care, either because of the cultural practice of seclusion, or because decision-making is the responsibility of other members of the family, such as husbands or parents-in-law (WHO, 1999).

2.7 Summary of the chapter

This chapter presented detailed descriptions of different parts of policy and framework for policy analysis and its implementation. The chapter also provides details about history of policies in Pakistan. The last part of the chapter contains details about ANC services and its importance.

Brooks and Stephen defined Public policy as *the "broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem"*

In general, the term policy designates the behaviors of some actors or a set of actors, such as an official, a governmental agency, or a legislature, in an area of activity such as public health or consumer protection. Public policy may also be viewed as whatever governments choose to do or not to do.

Policies are analyzed through different methods by different researchers. Framework for this study is based on the concepts of the heuristic stages produced by Brewer and Deleon, it divides the public policy in to four stages, including Agenda setting, formulation, implementation and evaluation.

Agenda can be divided in two basic types: the systematic agenda and the institutional, or governmental agenda. There are many famous models for agenda setting. The Hall model is based on feasible, support and legitimacy. The Kingdon model is based on three streams and when they meet window of opportunity appear for agenda.

Policy formulation is one of the gears of pre-decision segment of the policy process, and is the development of policy substitutes for dealing with problems on the public agenda. Government bureaucracies, interest group offices, legislative committee rooms, meetings of special commissions and policy planning organizations are the platforms of the policy formulation.

Political scientist Gerston defines implementation as “the implementation represents the conscious conversion plans in to reality” and is the “follow – through” component of the public policy making process. Service delivery is also linked to policy and policy implementation. The question is how one enhances policy implementation strategies to ensure successful service delivery. Policy development, implementation and service delivery therefore need to be consolidated so that a more coherent policy and strategy system with ongoing review and performance management mechanisms are developed.

National polices to be successfully implemented; one of the requisites may be the coordination and cooperation among a web of federal, provinces and local government and agencies. Policy implementation in any health care system relies upon provider commitment. Policies that do not address the organizational, professional and social contexts are unlikely to achieve successful implementation.

Focused antenatal is essential link in the household-to-hospital care continuum. It is an intervention that can be provided at both household and peripheral facility levels (GraftJohnson et al., 2005). In this model the community is mobilized as a vital link between families and the care they need through community health workers (CHW) and skilled attendants (GraftJohnson et al., 2005).

CHAPTER III
RESEARCH METHODOLOGY

Analysis of health policy formation and its implementation is multi-disciplinary approach that aims to explain the interaction between institutions, interests and ideas in the policy process and its implementation.

This study analyzes antenatal care related components of the Pakistan national health policy 2001; it's planning at provincial level with implementation and provision of services at district level in the province of Baluchistan.

This chapter presents the methodology of the study, includes study sites, research deign, methods and procedures for data sampling, variables and their measurement, and procedures for data collection, and procedure for data analysis. Similarly, trustworthiness, credibility and transferability issues in qualitative studies are also dealt with in this chapter.

3.1 Scope of the study

The study was conducted in Pakistan. As per constitution of Pakistan before, 18th amendment 2011, policy was the responsibility of the federal government and implementation was the responsibility of provincial government and district authorities. Both federal and provincial governments provided maternal health services in primary, secondary and tertiary care level. Antenatal care is a part of maternal health. The study focused the policy process, implementation, ANC services delivery and utilization for antenatal care after the NHP2001. After ten years policy 2001 only 15% of pregnant women were registered by the health facilities for ANC in Baluchistan province (DHIS, 2010). In Gandawa town and union council Pattri both health services and behaviors of the pregnant ladies towards ANC were focus of the study. The study also focused male concerns on ANC in the community.

3.2 Study Design

The study had mixed design including both Qualitative and Quantitative research with an analytical framework approach.

It’s the potency of the mixed study designs that expanded the use of qualitative research in health services investigations, mixed methods or multi-method research holds potential for rigorous, methodologically sound studies in primary care (Creswell et al., 2004). Mixed method investigations involve integrating quantitative and qualitative data collection and analysis in a single study or a program of inquiry (Creswell et al., 2003). Qualitative designs emphasis on the qualities of entities and on processes and meanings that cannot be experimentally examined and stress the socially contracted nature of reality and answer questions that stress how social experience is created and given a meaning (Norman K Denzin, 2003).

Qualitative techniques have a wide range of applications in health care research and have been commonly used in research documenting the experiences of chronic illnesses and in the functioning of organizations (Bowling, 2009; Patton, 2002). The method enables a various range of evidence types to be synthesized in order to examine potential relationships between a public health environment and outcomes (Baxter et al., 2010).

Qualitative methods are first and leading research methods. There are ways of finding what people do, know, think, and feel by observing, interviewing, analyzing documents (Patton, 2002).

The focus group method of interviewing has become popular as a fairly inexpensive but effective way to get the reactions of a small group of people to a focused issue and FGDS will help to draw background information about on this sensitive issue (Baker, 1999). Focus groups provided general impressions, the interests of the local people about the services provided by the government for antenatal care and these lead to the innovative ideas. The FDGS also provided the negative and positive aspects of the services and their utilization (Stewart & Shamdasani, 1990). The focus group is a collectivistic rather than an individualistic research method that focused on the multivocality of participant’s attitudes, experiences and beliefs (Bowling, 2009).

Qualitative research aims to study people in their natural social settings and to collect naturally occurring data and to understand the individuals view without any value judgments during the data collection (Bowling, 2009; Walt et al., 2008). Qualitative

study methodology provides tools for researchers to study complex phenomena within their contexts. When the approach is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs, and develop interventions (Bowling, 2009).

In conclusion qualitative research is a type of scientific research and consists of an investigation that:

- Seeks answers to a question
- Systematically uses a predefined set of procedures to answer the question
- Collects evidence.
- Produces findings that were not determined in advance
- Produces findings that are applicable beyond the immediate boundaries of the study.
- Especially effective in obtaining culturally specific information about the values, opinions, behaviors, and social contexts of particular populations (Leys, 2003)

The province of Baluchistan which is the most backward and underdeveloped province and information is not completely available regarding the behaviors and utilization of the Government services and complex socio-cultural settings and implementation of the polices in the periphery districts, the qualitative investigation will provide an opportunity to get close to the research material, and can obtain a great deal of in depth information that can be tested in subsequent quantitative studies if necessary and appropriate.

At district level both Qualitative and quantitative study designs were applied to analyze the policy implementation, services utilization and barriers to utilization. In the quantitative study a household survey was conducted in union council Pattri district Jhal Magsi among pregnant women aged 18 to 40 years.

3.3 Study Sites

The study was conducted at three levels including national, provincial and district level including federal capital Islamabad, provincial capital Quetta and tehsil Gandawa district head quarter, district Jhal Magsi.

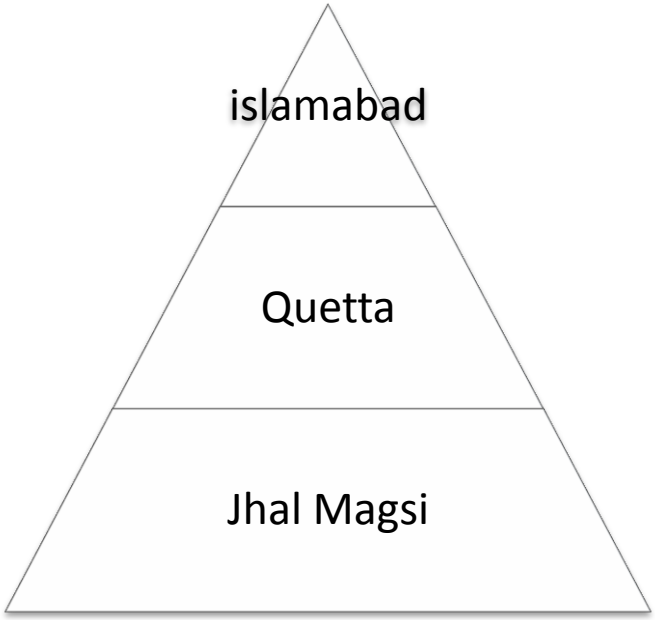

Figure 5: Study Sites

Federal capital Islamabad

Before 18th Amendment the health policy generation was the responsibility of the federal ministry of health. In-depth interviews and policy related documents analysis was carried out in Islamabad.

Provincial capital Quetta

Quetta district is the capital city of Baluchistan province. Provincial ministry of health is the chief organization, which has the responsibility of planning and implementation. Provincial health setup is consisting of office of the minster of health, health department civil secretariat and office of the director general of health services.

District Jhal Magsi

District Jhal Magsi is one of the districts that was separated from the District Kachhi in 2001 and is composed of two tehsils Gandawa and Jhal Magsi. Gandawa is also the District headquarter with a population of 20000. All the administrative offices, major health facilities and major economic centers are in the town of Gandawa. District Jhal Magsi is chosen for operational /implementation at the gross route level for the services delivery and utilization of health services provided by government and impact of the policies. In the town both Government and private health facilities are available. Before the creations of district Jhal Magsi the town of Gandawa had a

Rural Health Center (RHC) and after getting the district headquarters status the RHC was upgraded to the District Headquarter Hospital (DHQ) in the same building.

Figure 6: Map of Pakistan showing study sites

3.3.1 Rationale of selecting District Jhal Magsi

District Jhal Magsi is located in the Naseerabad Division of Balochistan province. It is bordered by district Kachhi, district Jaffarabad, district Naseerabad, district Khuzdar and district Shadadkot (Sindh province). The district is divided into two sub-divisions: Gandawa and Jhal Magsi. The district is subdivided administratively in to two tehsils Jhal Magsi and Gandawa, which contain a total of nine Union Councils. The population of Jhal Magsi District was estimated to be 158219 in 2011. Majority of the population is Baloch tribe including Lashari and Magsi are the main clans. Over 97% of the people of the area are Muslims (GoB, 2010). Jhal Magsi district is on the districts with low literacy rate in Balochistan province with 17% of population educated.

Many parts of the district are still without basic infrastructure such as electricity, road connection, and public health services facilities. Agriculture and animal husbandry are the main occupation in the hills and medium to large-scale business in the towns. In the primitive tribal society, a vast majority of women are uneducated and their mobility is limited.

According to DHIS only 15% of the pregnant women were registered for antenatal care in 2010 (DHIS, 2010) and only 2% of the pregnant ladies visited skilled health personal for antenatal care, and about 5% had birth care from skilled health worker. Overall Jhal Magsi is one of the districts among others like Musa Khel, Ziarat, Awaran, Dera Bugti, Barkhan and Kohlu had less than 10% of pregnant women attending any skilled health worker, denying almost all of crucial preparation for their newborn (MICS, 2004).

3.3.2 Data Collection Sites

The data was collected from following five sites:

1. Federal level (in-depth interviews)
    - Representatives of MOH and department of health services
    - Representatives of national planning commission
    - Representatives of Donor community
    - Representatives of NGO's involved in policy making
2. Provincial level (in-depth interviews)
    - Representative of political wing of MOH
    - Representative of bureaucrats including planning cell and administrative sections
3. District level (in-depth interviews and FGDS separately with males and females)
    - Executive District officer Health
    - Political representative of the district
    - Individuals in the community

    3.1 Facility level
        - In-charges of health facility including, BHU's and MCH,

3.2 Community level

- Pregnant ladies
- Married males

3.4 Research Measurements tools

3.4.1 Observations

Observation is a method that includes methodically picking, viewing, and recording behavior and characteristics of living beings, objects, or phenomena. The study used field note instrument for the health seeking behavior of pregnant women, health services provision and male perception for antenatal care.

Field notes have been recognized instrument for the out put of observational data. Field notes provide the most important reason if you don't record what happens you might as well not be in the setting (Patton, 2002; Pranee, 1999). No common recommendations around the procedure of and measures on behalf of taking field notes are achievable because different setting provides themselves to different ways of proceeding (Patton, 2002). The focus of the observation was behaviors of the health providers and the behaviors of the families and community for providing ANC to the pregnant ladies.

Cross validation and triangulation was obtained through multiple and mixed methods gathering different kinds of data including observations, interviews, and documents.

3.4.2 Focus Group discussions

Quality of FGDS depends greatly on questions asked (Pranee, 1999). For focus group discussions pretested guidelines were used. In this study a set of five questions regarding antenatal care, assessing knowledge and attitude, health problems, socio-cultural support, and barriers to ANC utilization guided the group discussions. The guidelines were generated with the help of Chulalongkorn university professors, senior health consultants in the Baluchistan province and observations. Participant and non-participant observations results also provided support for the guideline generation.

Table 1: Focus Group Guidelines

Focus Group	Measures
Married Male	• Health concern of pregnant ladies • Concerns about hospital services • Change during Last ten years • Utilization • Barriers
Pregnant Female	• Importance and need of ANC • Where to go for ANC • Problems during pregnancy • Social and cultural support • Barriers for Utilization

3.4.3 In-depth interviews

Collecting qualitative data through open-ended interviews can be carried out through three approaches including formal conversation interview, general interview guide and standardized open-ended interview, with different types of preparation, conceptualization and instrumentation (Patton, 2002).

a. Informal conversational interview

Informal interviews were conducted during participated observation and relied on spontaneous generation of question related to ANC utilization; policy formation, policy implementation, health services provision, perceptions of community and services providers both at provincial level and in the study population in the provincial capital Quetta and district Jhal Magsi.

b. General interview guide approach

This approach was used for the managers in the provincial level. The issues were set before interview with respondents, which were based on the policy process formation (provincial role) planning, policy implementation (strength and impediments), and future recommendations.

c. Standardized open ended interviews

Standardized interviews were carried out among in federal, provincial and district level. The KI were policy makers and implementers and stakeholders. The instruments were generated from the past national and international studies (Collins,

2005; Gill, 1994; Lashari, 2004; Peiro et al., 2002; Ramji, 2009; Siddiqi, 2004; Gill Walt, et al., 2008), through the guidelines of the respected teachers in Chulalongkorn University. Informal conversational interviews and general interview guide approach also guided to assess the local situation and produce a more standardized guidelines. Different tools were used for provincial and federal level key informants. The instrument included questions about policy process, planning and implementation. Codes and probes were allotted to the questionnaires.

3.5 Methods of data collection

The data was collected through observations, in-depth interviews, and document analysis, focus group discussions with stakeholders, institutions, health facilities and community. The key informants involved in the health policy process were identified by document analysis and from the key informants. The document analysis was based upon policy documents, official reports of health ministries, health related departments and international agencies.

3.5.1 Observations

The permission was granted by the District health Officer to conduct the research. The observations were based on a period of 3 months.

Many visits were made to the government & private health facilities, in villages of union council Pattri. The actors observed were both health service providers (doctors, nurses, pharmacist, community health workers, technicians, paramedics, private non registered health practitioners) and people visiting these health facilities. The Activities observed in the community and health facilities include need of ANC services, behaviors of the pregnant ladies visiting health services and the health service provider's behaviors of the people.

I started participant observation in different villages of union council Pattri and health facilities Gandawa town. I maintained an interest in the villagers use of health care resources as part of my participant observation activities, as doctor I offered my services for general health services along with local health practitioners, I provided them my vehicle to refer the pregnant ladies during emergencies to Gandawa town or referral hospitals anywhere when they needed in the community.

The aim was to investigate the maternal health services provided by the government in context of national health policy 2001 at district level. To investigate the aim study relied on participant observation, non-participant observation and informal interviews at district level.

To familiarize myself with maternal health services and government efforts to provide services I conducted informal conversational interviews with senior health management team and visited district health office frequently and office of the people's primary healthcare initiative (PPHI), and attended their community health sessions for strengthen community empowerment and sessions with doctors as well.

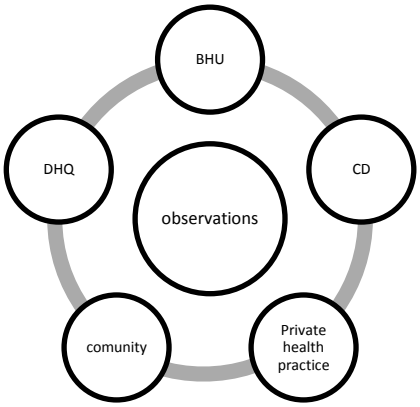

Figure 7: Observation Cycle

3.5.2 In-depth interviews

Key informants (KI's) were selected on the bases of their theoretical relevance and concerned involvement with topic of study (Kavle, 1996). The key informants who were involved in NHP 2001 or at least have been working in the policy related institutions at least for five years at district, provincial and Federal level.

Key informants were approached at different levels in their working places for the interviews, the policy maker key informants were approached in federal capital Islamabad, the key informants in the provincial level approached at their work place at Quetta in their related offices. At district level the key informants were interviewed in District Jhal Magsi in the office of District health officer Gandawa and District head Quarter hospital Gandawa.

Face-to-Face in-depth interviews were conducted at all three levels of the study i.e. at federal level, provincial level and district level. The format of the interviews was open-ended, with all three basic approaches (Patton, 2002) including the informal conversational interview (Fontana & Frey, 2000), the general interview guide approach and the standardized open-ended interviews with maximum flexibility to pursue information. At some level open-ended questionnaire using some basic lines of inquiry were pursued with each KI interviewed. Different sets of guidelines were used for policy makers; health services providers and among individuals in the community Table 2.

Table 2: In-depth interview details

Interview	Site	Key Informants	Interview Aspects
Informal conversational interview & General interview guide approach	Islamabad	Planning Commission of Pakistan DG health services Finance division	Policy process Planning Implementation
	Quetta	Civil Secretariat • Health department • P&D • Finance • Planning cell Office of DG heath services Balochistan • DG Health • PD MNCH • PD MCH • PD Finance • PD Logistics • PD DHIS/HIMS • PD Population and Welfare • IPH Provincial WHO office UNICEF	Policy process Planning Implementation Service delivery Feedback Utilization Support
	Jhal Magsi	Office of EDOH Assistant EDOH Medical officers Health service providers (Private, government, unregistered, religious healer, TBA) UC Pattri TBA Health service Provider Married Men Village heads	Health seeking behavior Services provision Availability Accessibility Utilization Barriers
Standardized open ended In-depth interviews	Islamabad	HSA NGO's Planning commission of Pakistan	Policy process Planning Implementation
	Quetta	DG Health Office Civil secretariat IPH	Policy process Planning Implementation
	Jhal Magsi	EDOH Medical Officers	Policy process Planning Implementation

3.5.3 Focus group discussions

A total of 8 focus group discussions were carried out in the 8 villages, four of the 8 were with pregnant women and remaining four FDGS were conducted among married males. Three female trained research assistants facilitated the female FGDS. The

researcher with the help of two research assistants moderated the male focus group discussions.

The discussions were recorded and notes were also made for the analysis of the data. Sampling for the group discussion was purposive and only pregnant ladies were invited for the group discussions. Men who were married and at least had one child were invited for the study.

Union council is consisting of villages and each village contains wards, number of ward varies among villages. Each village has 5 to 10 wards. One member was invited from each ward to participate in study in every village figure 8.

Due to cultural values researcher himself couldn't facilitate group discussions. For focus group discussions with pregnant ladies a team of female was trained to facilitate the focus group discussions and take notes. The FGDS were lasted for 60-90 minutes with the members ranging from 5 to 7 in each group. FDGS with males were carried out with help of two male research assistants; each focus group lasted for 60-90 minutes along with 6-9 members male focus group discussions were recorded and notes were also taken.

Focus groups were carried out in local language, but were written in Urdu language as research assistants could read or write Urdu language. All the data that was collected in Urdu language and was also analyzed till last in the Urdu and final results were translated to English.

At the end of the each interview and focus group discussion, notes were compared with research assistants to fill the missing points and I write up the interviews at home at the end of the day.

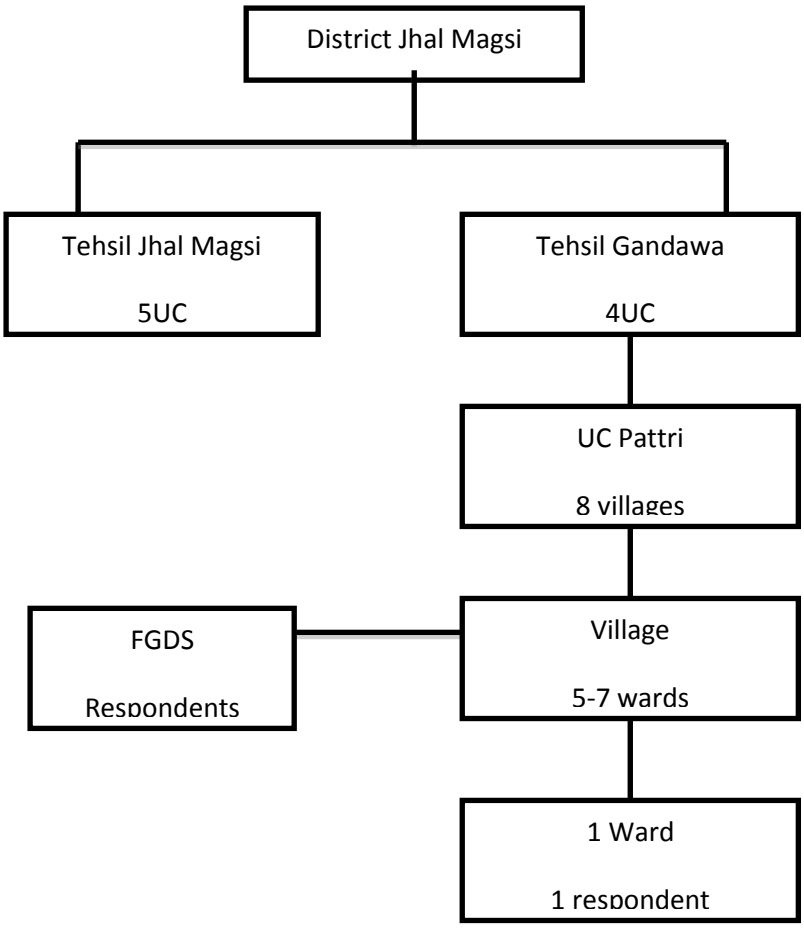

Figure 8: Focus group discussions

3.6 Data analysis

3.6.1 Observation and Focus group discussions

Qualitative research methodologies can generate rich information about health care including, but not limited to, patient preferences, medical decision making, culturally determined values and health beliefs, consumer satisfaction, health-seeking behaviors, and health disparities (Bradley et al., 2007).

Analyses and interpretation is the process of bringing order, structure and interpretation in to the mass of collected data from the field. The procedure will be collection of data, coding by theme or category, analyses and presentation.

The data collection and analysis went side-by-side in continues manner. Both deductive and inductive methods of coding were used (Bowling, 2009).

Initially the data was red for index and categories. All data relevant to each category was identified and examined using a process of constant comparison, in which each item was checked or compared with the rest of data to establish analytical categories (Karen et al., 2005). In the beginning, all data was manually coded under different themes generated from the research issues. Comparison was made for access and utilization of health services and participation of the local community in the health services management.

Leading practitioners of the qualitative methods in the conduct of social sciences research have been arguing that participant observation is the most comprehensive of all types of research strategies (Patton, 2002). The observations were carried out at different levels including document analysis in the Governmental institutions; health services deliveries and behaviors of the consumers.

For focus group discussions method of constant comparison with inductive themes were used. The strength of data analysis for observation was inductive design, rather than going with a predetermined hypothesis to test, the research depended on finding out new information in the community. The fundamental process that supported this inductive design involved participant observation and analyzing field notes daily.

3.6.2 In-depth interviews

Thematic approach along with deductive coding was used to analyze the data gathered from the in-depth interviews.

The steps were as follow

- At the end of the day after interview, the recorded interview was transformed on the laptop using MS word
- All the interviews were red many times for understanding the themes
- As the approach was deductive a framework of codes was developed for the different components of the policy
- And again the data was red line by line to review the data
- Coding was carried out to organize the data, uncovering and documenting additional links within and between concepts and experiences described in the data

- The coding process included development, finalization, and application of the code structure
- At the end of code finalization in the framework produced different themes and experiences

3.6.3 Document Analysis

The development of policy documents is one part of the policy process that enables goals, opportunities, obligations and resources to be recognized in a concrete form and, through careful analysis of the documents (policy document analysis), the extent to which a policy adheres to certain principles, such as stakeholder and legislative support and goal clarity, may be ascertained (Cheung et al., 2010; Rütten et al., 2003)

Different types of documents were searched for the study including, letters, memos, personal inquiry surveys, interviews, project evaluation reports, program evaluation reports and IEC materials.

Document analysis was carried out through a modified framework used by Rutten and Cheung (Cheung et al., 2010; Rütten et al., 2003) at different levels including

- Policy document analysis and its process making were analyzed from the documents related to policy making from the different offices including planning, finance division and DG office health Islamabad and Quetta.
- For planning, management and implementation the document analysis was carried out in the provincial office of ministry of health.
- The documents analysis was also carried out in the health facilities where antenatal care services were delivered.

3.7 Quantitative survey

The quantitative survey was carried out after the data collection of Qualitative study.

Study Design

The study was a cross sectional household survey among pregnant ladies on the health seeking behaviors, utilization and barriers towards Antenatal Care service at union council Pattri.

Study population

The study population was women who were pregnant aged 18-40 years.

Sample size estimation

The sample size was estimated using the following formula**:**

$$\mathbf{N = Z^2 \alpha/2p\ (1\text{-}p)/d^2}$$

N = estimated sample size

Z = Standard score, in this study is set at 95%confidence interval (z=1.96)

ρ = Utilization of ANC in Baluchistan according to PDHS 2006-07.

α = .05

d^2= Allowance of error (.08)

N = 350

However to increase the generalizability, the list of the pregnant ladies was obtained from EPI district office and entire union council was sampled. A total of 513 pregnant ladies were interviewed.

Data collection

The subjects were approach at their home, only one pregnant lady was considered at on household. In case of more than one pregnant lady simple random selection was used the select the respondent.

Inclusion Criteria:

- Women who were in age between 18-40 years
- Only pregnant ladies were included
- Pregnant ladies must have at least one live birth previously
- Pregnant women who were willing to participate and sign consent form

Exclusion Criteria:

- Women who will not voluntarily agree to participate in study.
- Women who are seriously ill or have mental problem will be excluded from the study

Sampling technique

Cluster sampling technique was applied to represent the entire district.

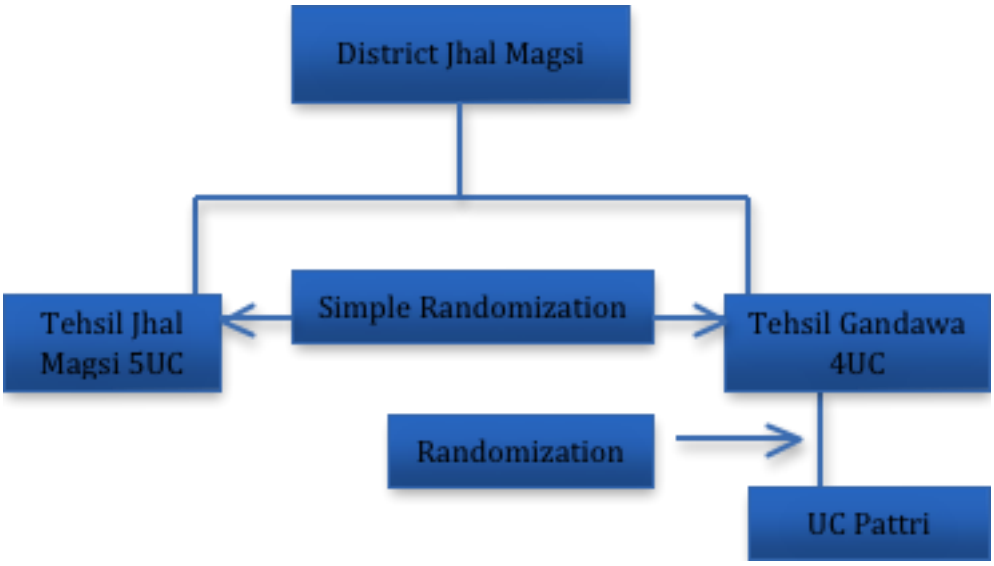

Figure 9: Sampling of the respondents for quantitative study

Research instruments:

A research assistant administered questionnaire that was pretested and revised after the qualitative phase of the study, health facility, individual perceptions and access to the services after elaborating local and cultural factors.

Structured Questions were the instruments in this part of the study. Most of the questions were close-ended questions, and a few were open-ended as well. Using a structured questionnaire translated in Urdu language and verbal translation to Balochi was used to interview the respondents with the help of research assistants. The objectives of research were clarified to the respondents and they were assured for maintaining privacy.

The questionnaire consisted of the following parts

Part 1 Socio-demographics

1. The questions about socio-demographics of respondents such as age, education, occupation, and family income.

2. Knowledge of women towards ANC service. This part included 14 questions with total score of 14. One score was given for correct answers and 0 score for incorrect answers, do not know or no response according to Benjamin Bloom Criteria.

3. Attitude of women towards ANC service. It was measured by asking mother 10 questions with a total score of 30. These sentences consist of 6 positive and 4 negative attitude questions sentences and with 3 possible responses (agree, undecided and disagree) to a statement. For positive question:

Agree = 3 points

Undecided = 2 points

Disagree = 1 point

For negative questions:

Disagree = 3 points

Undecided = 2 points

Agree = 1 point.

In descriptive analysis, attitude was divided into two levels, positive and negative attitudes. For positive attitude score ranges from 20-30 and 10-19 for negative attitude

Part 2. Enabling factors

This part includes the questions about accessibility to ANC service such as distance, travel cost, medical fee, and satisfaction on service including: waiting time, room environment, and skills of health personnel. This part consisted of 15 questions

Part 3. Reinforcing factors

This part included the questions asking about:

1. Source of information from health worker family members, friends, mass media. This section consisted of multiple answers.

2. Social Support: this part consisted of multiple answer questions about the support from husband, mother in law, neighbors, friends and community.

Part 4. ANC visit

This part includes the questions asking about regular practice on ANC service obtained by women during pregnancy that is complete utilization of ANC services, which means at least 4 times according to the WHO guidelines. The pregnant women

should visit ANC service for check up one time at 1st trimester, one time at 2nd trimester, two times at 3rd trimester during pregnancy.

Analysis of data:

The data was coded and analyzed by using SPSS software version 16. Descriptive statistics were used to find out the frequency, mean, median, percentage, range and standard deviation. Chi square test was used to find out the association between independent and dependent variables and the significant level of statistical test was set up at $\alpha = 0.05$. Binary logistic regression was also applied to Asses the correlation between independent and dependent variables.

3.8 Trustworthiness, Reliability and Transferability

Four Kinds of triangulation can contribute to the verification and validity of qualitative analysis (Patton, 2002)

Table 3: Trustworthiness & Reliability

Trustworthiness & Reliability	Measures
Method triangulation	• Observation • In-depth interview • FGDS • Quantitative survey
Triangulation of sources	• Policy makers • Planners • Implementers • Pregnant ladies • Community • Documents
Analyst triangulation	• Researcher himself • Thesis Advisor and college teachers
Theory/perspective triangulation	• The data was interpreted by many ways, • Qualitative data: content analysis (inductive), thematic deductive approach • Quantitative data: Quantitative analysis

As the study was conducted at three levels and two phases different methods were used to define the trustworthiness of the study. KIs at national level among policy makers will be interviewed who were involved in the making policy 2001 including

bureaucrats and political leaders and other organizations involved. At provincial level KI for the policy process and documents analysis relating to planning was enhance the credibility of the study. Transcripts and some of the analyzed results were sent back to some of the interview participants to reconfirm and ensure the completeness of the information gathered. At district level pretesting of the KIs interview and FGDS tools was carried out in a non-study district. After pretesting the tools were revised according to the need. After the completion of the phase one (qualitative study) in the district level and information gathered from KI, and document analyzes a quantitative study based on the result from the phase1 comparison increases the trustworthiness of the study.

Information on Key service indicators gathered through document analysis was useful to triangulate data with in-depth interviews. Data quality was assured through checking of representativeness, triangulating, checking the meaning of outlier's follow-up visits, and checking out opponent explanation.

As the implementation responsibilities lies on the shoulder of provincial governments the study was implemented at two levels in the Baluchistan province. The planning process for the implementation was analyzed at provincial office of the health department, and Implementation challenges and difficulties faced by the operational level were limited to one district. As per provincial experiences, its health facilities and administrative structure are similar to other districts of the province in terms of some characteristics, such as administrative set up down to the village level, organizational structure and staffing pattern per health facility. The district provided adequate information on the entire management cycle in great depth, and the challenges faced by this district are similar to other districts of Baluchistan province. Therefore, the explanation of the implementation process and outcomes are likely to be transferable to similar other settings of the province and to some extent to other underdeveloped districts of Pakistan.

The reliability of the study was enhanced by triangulation; the data was collected through different methods including Observation, FGDS, IDI and a household survey in the rural community.

Generalizability of the study was assured by the criteria given by Silverman (Silverman, 2002).

Table 4: Generalizability Measures

Generalizability measures
• Combined qualitative and quantitative study • Purposive sampling • Theoretical sampling

Thus, the results of this study are likely to be transferable to other similar settings at both national and international level where decision makers have to make decisions amongst competing claims under unstable political environment and constrained resources.

3.9 Ethical Issues

The study was conducted after the approval from Chulalongkorn university ethical committee. The following steps were taken to address the ethical issues in this study: i) Obtaining informed consent of the participants before the interview, ii) not exploring sensitive issues before a good relationship was established with the informants, and iii) ensuring the confidentiality of the data obtained iv) participant information sheets were distributed among the participants. The participants who could not read the documents were briefed in detail about the study before data collection. Approval for this study was granted by the MOHP and EDOH district Jhal Magsi.

3.10 Biases

Sampling Biases

The sampling biases were controlled through purposive and theoretical sampling. In the quantitative study multistage randomization was the strength of the reducing biases. The samples were selected randomly from the community in the households as well. Enough representation was given to different study groups of the respondents involved in policymaking, planning and implementation, and utilization of the ANC services.

Measurement Biases

Measurement biases were reduced by using instruments developed from extensive literature review, revising already used tools according to current study, and the pretest.

Interviewer Biases

Risk of note takers bias on information was reduced by detailed orientation on the questionnaires and importance of valid data collection. In this study research assistants were used to collect data in the quantitative survey and facilitate the focus group discussion this may lead to produce intentional biases. To control the biases the researchers were trained and exercises were conducted. The data was reviewed immediately after the collection.

Response Bias

The results of this study may have been influenced by recall bias. As the policy was introduced under the military regime and transformation of the democratic government took place in 2008, few KI generated a more negative influence on the KI in the way not to carry the responsibilities of the past government on their shoulder.

3.11 Limitations of the study

Methodological Limitations

At the community level in district Jhal Magsi the literacy rate was very low and respondents could not read or write any language. The Quantitative study instruments were translated to the national language Urdu and research assistants were trained to translate the questions verbally in Balochi Language and fill the Questionnaire in Urdu.

In the both community and provincial level in-depth interviews were conducted in Urdu and Balochi languages and later on they results were translated in the English, many round of translation seems one of the important limitations.

An important limitation in this study may be the characteristics of respondents; pregnant females eventually may feel uncomfortable position in expressing their opinions in front of the researchers.

Due to cultural values the researcher himself could not facilitate the FGDS and the team trained for the FGDS may have some effects on the data collection. The key informants, who declined to share experience in the study, might have added some significant information.

Resource Limitations

This is a self-financed study where the researcher did not have flexibility to investigate a larger sample and conduct a thorough study within a flexible time span in federal level. Therefore, lack of sufficient resources and time are some major constraints in this case. It would have been beneficial to involve politicians in the KI informant list; however, political situation, logistic and time constraints did not allow for this.

3.12 Summary of the Chapter

The study has mixed design including both Qualitative and Quantitative research with Analytical Framework approach. The study was conducted in Pakistan from April 2011 to December 2011. Data was collected from three sites including Islamabad, Quetta and Jhal Magsi. In Qualitative part Participant and non-participant observation, In-depth interviews, FGDS and document analysis were conducted. A cross sectional survey was conducted in quantitative part.

The purpose of the observation was to know the behavior of the community seeking health for ANC and behavior of Antenatal care services and service providers. Observations were carried out in the union council Pattri and Gandawa town, District head Quarter of Jhal Magsi. Government health facilities District heads Quarter Hospital, a BHU, a CD and private health clinics, religious healer, cultural healers and communities in the union council Pattri were focus of the observations. Notes were taken and revised at the end of the day.

Eight focus groups were conducted using a five questions guide between married male and pregnant females separately in the 8 villages of union council Pattri. Focus groups were conducted through trained Female research attendants in local (Balochi language). The focus of the FGDS was to assess the behaviors of pregnant ladies and concerns of males.

In-depth interviews were conducted at three levels including Islamabad; provincial head quarter Quetta and district Jhal Magsi. Standardized in-depth interviews, informal conversational interviews and general interview guide approach were used. The subjects in Islamabad were policy makers from governmental organization and other stakeholders. In Provincial level policy makers, planners and implementers were interviewed. In the District level health mangers, doctor, private health providers and individuals related to maternal health in the community were focused.

Observation and FGDS data was analyzed through content analysis with inductive approach and in-depth interviews were analyzed through both inductive and deductive approaches.

Quantitative survey to assess socio demographic factors, knowledge, attitude satisfaction and other reinforcing and enabling factors was conducted among 513 pregnant females aged from 18 to 40 years. The study was conducted through multistage Random sampling technique in all villages of the union council Pattri. The data was collected through translated and pretested close-ended questionnaire with the help of specially trained female research assistants. The Quantitative results were analyzed but using SPSS version 16, descriptive Chi square and regression were used to test the significance. Trustworthiness of study was assured through triangulation and strength of the generalizability was the mix method of study using both qualitative and quantitative. Language, cultural practices, time and resources appeared to be important limitations.

CHAPTER IV
RESULTS

This chapter includes results of data gathered from different methods for the study. The results in this chapter are based on in-depth interviews, document analysis, observations, focus group discussions and a quantitative cross-sectional survey.

4.1 In-depth interviews

A total of ten standardized in-depth interviews were conducted in this study from federal, province and district.

Table 5: In-depth Interview Key informants

Serial number	Level	Number of interviews
1	Federal (policy makers)	6
2	Provincial (planning and implementation)	10
3	Districts (implementation)	10

The policy process

In Pakistan the policy process was used to take place within a set of steps at the Federal Ministry of Health. There were nine major steps in the policy process right from problem identification, agenda setting and formulation up to implementation and monitoring

The Ministry of Health gathered information from Biostatistics Unit and Health Management Information System (HMIS).

The five-year plans were formulated according policy document. Subsequently, projects were designed which included development as well as recurrent budgets. Public Sector Development Program (PSDP) or the Annual Plan was developed afterwards. The provincial governments bear the responsibility for implementation. Monitoring and evaluation followed these steps

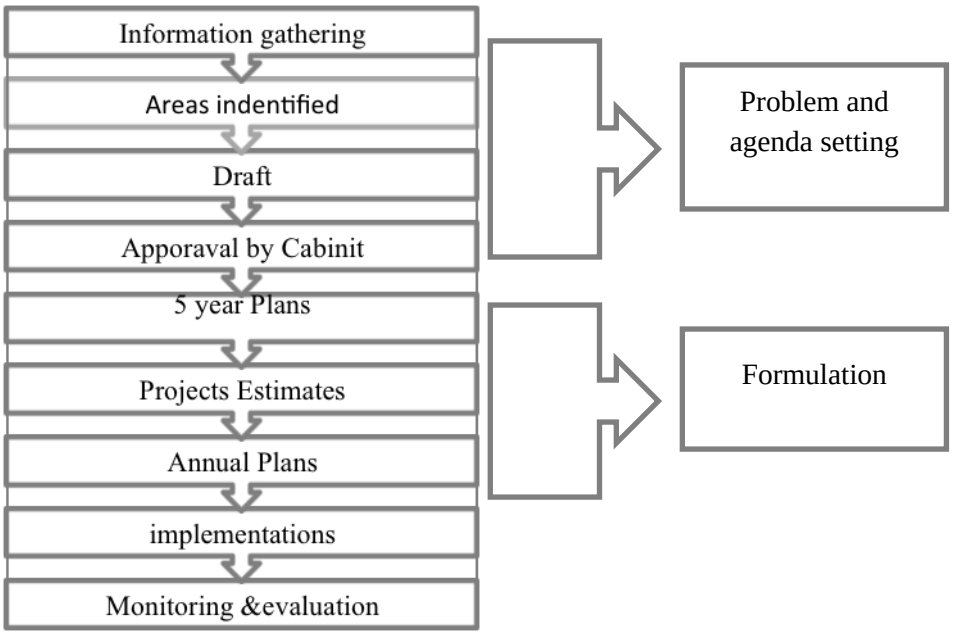

Figure 10: Policy process in Pakistan

4.1.1 Agenda setting and formulation of National health policy 2001

The national health policy 2001 was the third policy in the history of Pakistan and it was introduced after the four years of the 1997 health policy. The agenda of Health Policy 2001 provided an overall national vision for the Health Sector based on "Health for All" approach. Under the new Health Policy, health sector investments were being viewed a part of the Government's Poverty Alleviation Plan; priority attention has been accorded to the primary and secondary tiers of the health sector; and good governance is seen as the basis for health sector reforms to achieve quality health care.

"It was based on Alma Atta declaration that was health for all" key informant 1

But it mostly concentrated on preventive areas to support the coming decentralization of the health system to district level.

As antenatal care services are provided through primary care health services and gender equity is one of the most important aspect of health care for women, and after provision of services awareness is the backbone of the utilization of the services the agenda of the NHP 2001 has specific areas related to primary and secondary health care services along with removal of professional/managerial deficiencies in the district health system. Policy also identifies the areas of gender equity and mass

awareness programs in the public health.

"The policy also emphasizes on the issues of improving preventive programs and curative programs through district health officers." key informant 6 comments

"*In all successive health plans of Pakistan MCH was a priority, every donor that puts money in here have MCH priority, therefore in MDGS they have given a major concerned about the maternal health*" key informant 2 comments

Information gathering

The communication was taking place through two ways. One was for the routine official matters between offices of federal, provincial and districts and second was information generated through HMIS that provided information about disease prevalence and about all the health system. The Ministry of Health gathered information from Biostatistics Unit and Health Management Information System (HMIS); the HMIS system was producing data from primary and secondary health care services at district level. The performance of the HMIS was unsatisfactory, rate of the error was high and the reporting was not regular as well. But province of Punjab had fully organized data management and they were sharing with federal government.

"*Health management information system that generates information at the district in Baluchistan HMIS was blur*" KI 1

Province Role

Provinces were the members of the committee for national health policy making group. After gathering information introductory meetings were being held where all the four provinces had representation. Through those meetings and information problems were identified and census was developed for the agenda setting and the first draft was prepared. This draft was sent to the Planning Commission and the Ministry of Finance where consultations took place and the draft was finalized. The final draft was approved in the federal cabinet after discussion.

However, the facts remained that despite of many coats of sessions, policy development is highly federal with tiny contribution from the major stakeholders.

"The role was important but it was not considered" KI at provincial level

"*The federal they take the situation universally*" KI planning section

The provinces were consulted very less and they use to consult high-level positions and stake holders like district authorities hardly played a role. However, the pharmaceutical industry and medical professionals do participate in the process. Despite the existence of an elaborate process the policy of 2001 was nevertheless planned in a centralized manner without adhering to the process.

On top of this there is conflict of opinion on the extent to which provinces played their roles, as in Pakistan power are shared on the basis of population other provinces feel that the policies were generated on the need of entire Pakistan and that represents the situation of the Punjab province.

"*The Baluchistan is very much different from the other provinces, like infrastructure, scattered population, big area, in that sense the provincial government was not consulted*" KI planning section

Political Involvement

There were no or perhaps an insignificant role was being played by the politicians, legislatures and the policy was not discussed in the Parliament. Other stakeholders like, civil society, and the community at large hardly played any role.

"*by enlarge ministers decision making role in ministries are not interested in substantive elements of policy they are not interested in how policy will impact on peoples life*" KI NGO

"*They do have their role, but I don't think they had any deriving role" KI 1*

4.1.2 Planning

The Federal Ministry of Health in collaboration with the Ministry of Planning formulated and approved health programs and projects; below the provincial level in the district (local) was responsible only for the implementation of plans under the recommendations of the provincial health ministry. Budget for the health department from federal government is released in through development and non-development allocations to the provinces.

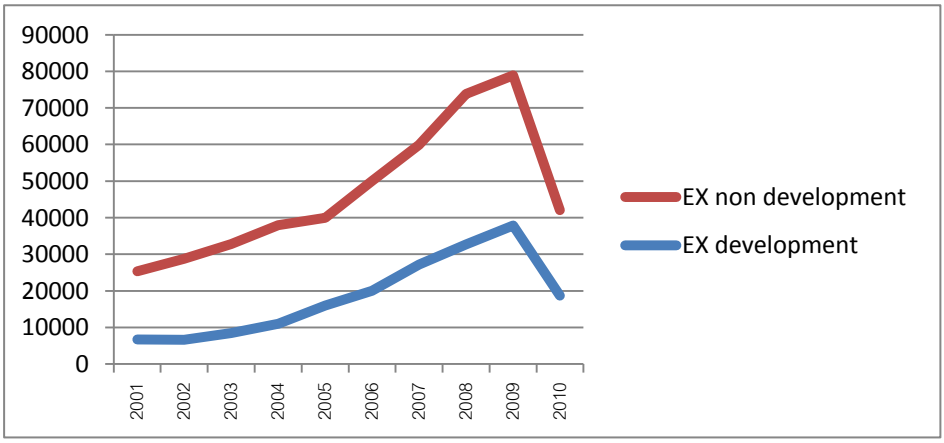

Figure 11: Federal Government expenditure on health

The important institutions engaged in health planning included the Federal Ministry of Health, Planning and development (P&D) Division, National Economic council (NEC), Executive Committee of the National Economic Council (ECNEC) and Economic Coordination committee (ECC) at the federal level. However, the Ministry of Health played important role in health planning in collaboration with the P&D Division. At provincial level, provincial ministries of health in collaboration with the Provincial Development Working Party (PDWP) were engaged in health planning. Below the provincial at district (local) level no planning activities were taken. Districts were responsible only for the implementation of plans, policies and recommendations of the federal and provincial government. Health planning was hardly flexible, participative and integrated with other decision-making processes in Pakistan.

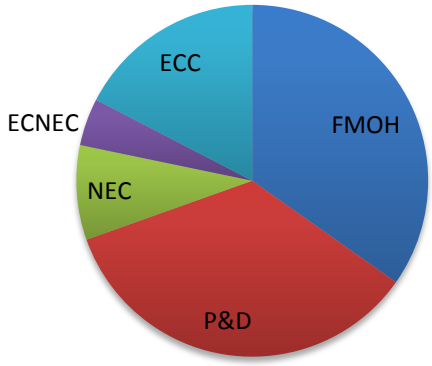

Figure 12: Institutions in Health planning

"*Project actually gets developed and then that project is controlled basically by federal*" KI provincial policy team

First five years plans were generated and the yearly plan followed. The planning was mostly based on biomedical model of health. Pakistan has been making the medium-term 5-year plans by the Planning Commission, which sets priorities for the country.

"As a consequence of the narrowly focused agenda building, planning is mostly directed to the delivery of health care services and increasing the number of clinics, clinical laboratories and physicians" KI NGO

4.1.3 Implementation

After policy 2001 several new projects were launched, some of the projects were upgraded and maternal health services were improved in Baluchistan province to bring the change. But the respondents were not satisfied by the implantation of the policy. Government of Baluchistan was fully committed to implement the new policy, strategic planning was done and it was 2005 that policy implementation started.

"Our observation is implementation is very very ……. Poor, hence slow and it is not being followed" KI 1

"*We started it 2005, but we were not able to implement the policy totally*" KI planning cell

Following are the major achievements in Baluchistan after the implementation of NHP2001; services here mentioned are related to maternal health.

Management cadre

One of the important gain after the NHP 2001 at the provincial level in Baluchistan was to separate the management cadre from general cadre in 2010 though its not fully implemented yet, but now doctors in mangers have extra qualification in public health.

MNCH Project

This federally led project was launched in 2006 in all provinces of Pakistan. This program is designed and implemented as a concerted effort to help achieve the Millennium Development Goals. According to project details this program incorporates seven out of ten key areas. The program aims to reinstate the trust of the communities in the public sector health system and to provide them with quality services. Direct benefits of the program were creation of additional jobs in the public sector, as well as employment opportunities for trained healthcare providers, particularly the community midwives.

The program was supposed to introduce a cadre of community-based health workers, who will meet the international definition of skilled birth attendants. These community midwives (CMWs) will be trained in home-based deliveries, which will significantly increase the proportion of skilled birth attendance in the country.

LHW Program

The lady health worker program (LHW) in Pakistan, created in 1993 is based on lady health workers (LHWs) trained to provide specific, basic primary health-care treatment plus preventive services establishes a milieu of well being, enhance interaction of patients with health-care providers, enable timely treatment, prevention and even screening. Women from local communities, with at least 8 years of formal education, undergo 6 months of training, The Program provides all services under the primary Health Care to the communities at their doorsteps, and each LHW is responsible for a population of about 1000 (i.e. approximately 200 families). This was the program that continued in NHP 2001 and was the core program for the community

development. But the key informants at different positions were not satisfied for the impact of the program.

"Well one major change was the introduction of LHW program" KI 7

People's Primary Healthcare initiative (PPHI)

PPHI was launched in 2006 with the aim to strengthen the primary health care system by rehabilitating the basic health unit and integrating the PHC services all our Pakistan. The initiative is covering the primary health through eight components that include,

- Improvement of basic hygiene
- Adequate supply of drinking water
- Participation of the population
- Health and hygiene education
- Appropriate methods of treatment
- Maternal and childcare, including reproductive health and family planning
- Improvement of nutritional status
- Expanded Program of Immunization (EPI)

4.1.4 Monitoring and evaluation

Health system in the Pakistan have not developed an efficient system of monitoring particularly to monitor regular health system though projects have their own monitoring and evaluation, which are mostly biased also.

"Then the assessments that have been done on the LHW program are so biased" KI NGO

The respondents working at different levels in the health department were of view that there are no institutionalized arrangements for monitoring, especially a set-up with forward and backward linkages.

"Main issue of monitoring and evaluation is lack of resources" KI planning cell

Furthermore, collected data and information from the districts are not properly processed, trained personnel are not available, and site visits of the health projects are

often lacking.

"Our capacity is very deficient at the district level" KI 5

During interviews health professionals and field officers working at district level have disclosed that the Ministry of health has developed particular forms for monitoring and evaluation of health projects, however, in practice this system comprises only paper monitoring, depending solely on the completion of the specified forms.

"In theory there are monitoring committees, supervising teams, but in actual fact it does not happen" KI NGO

They also disclosed that there is no mechanism to ensure that the monitoring forms are completed and returned in time to the appropriate authorities.

"*The LHW will fill up pillow*" KI 4

Monitoring of health system and programs mainly in the rural areas is not regularly conducted, as has already reported for many years. As a result the process of collecting important information does not work properly.

"The problem is that we face difficulties to access the facilities, especially it costs a lot" KI 1

"We have good structure for monitoring and supervision, hierarchy also exist, structure is not functionalized, it's not functioning, DHIS, HMIS is umbrella" KI 3

4.1.5 Policy outputs/change

At present, there are 972 hospitals, 4842 dispensaries, 5344 basic health units and 909 maternity and child health centers in Pakistan.

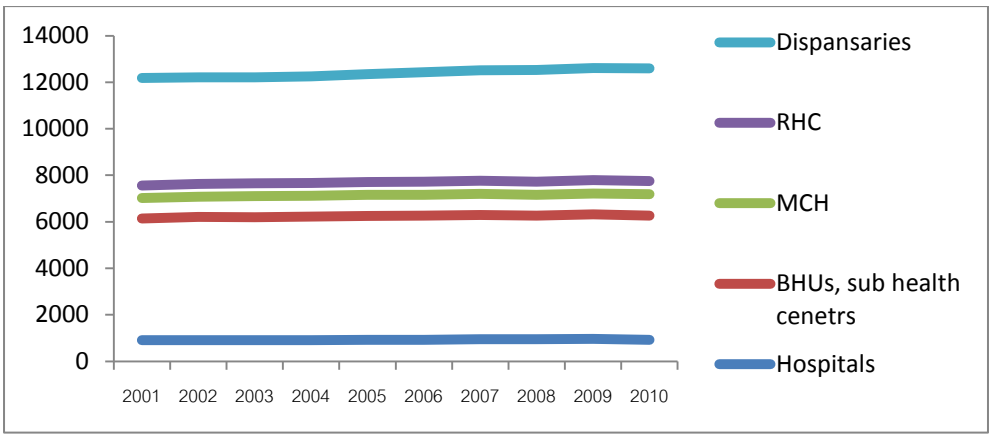

Figure 13: Progress of creating Health facilities

With availability of 144,901 doctors, 10,508 dentists, 73,244 nurses and 104,137 hospital beds in the country by 2010-11,

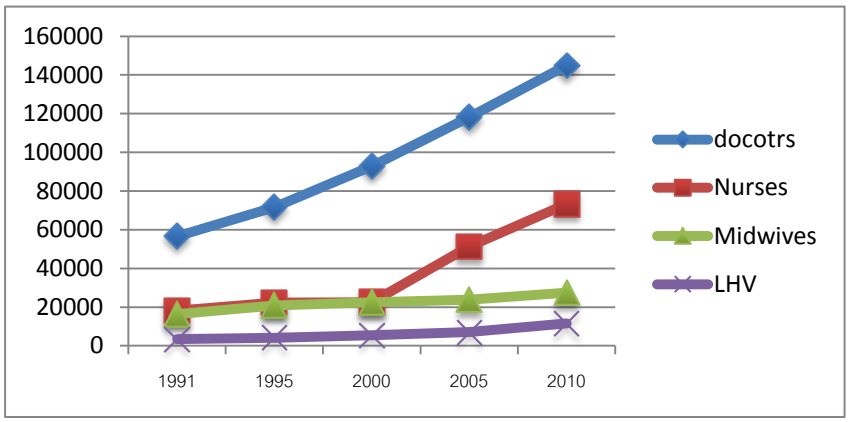

Figure 14: Progress of Human resources

The population and health facilities ratio works out at 1222 persons per doctors, 16,854 persons per dentist and 1701 persons per hospital bed that compares well with the other developing countries.

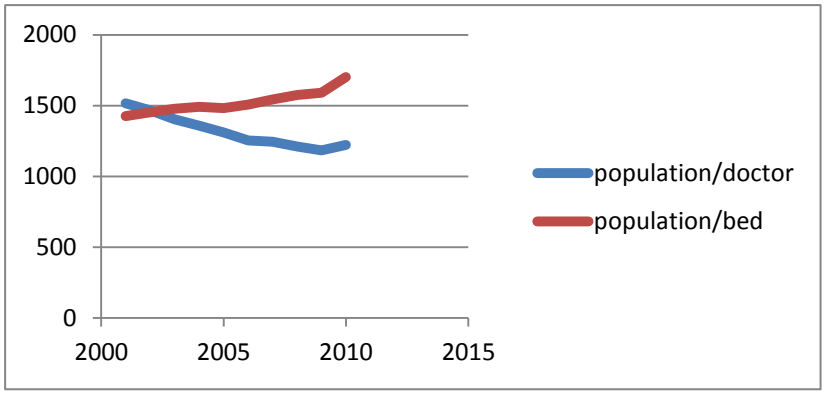

Figure 15: Ratios Per Doctor and Bed

During 2010-11, 35 basic health units and 13 rural health centers have been constructed. While 40 rural health centers and 850 basic health units have been upgraded. Some 4500 doctors, 400 dentists, 3200 nurses and 5000 paramedics have completed their academic courses and 4300 new beds have been added in the hospitals. Some 96,000 Lady Health Workers (LHWs) have been trained and deployed mostly in the rural areas. The total outlay of health is budgeted at Rs.42.0 billion (Rs.18.7 billion development and Rs. 23.3 billion current expenditure) which is equivalent to 0.23 percent of GDP that is 79 billion as compared in 2009-10.

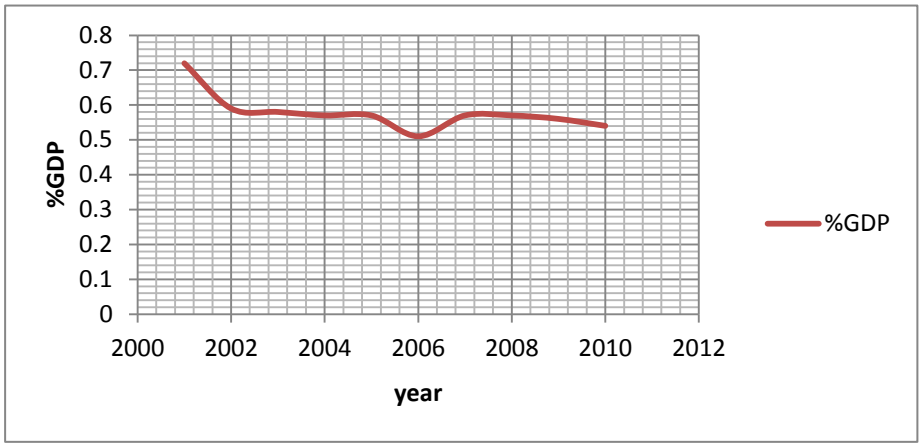

Figure 16: Percent of GDP spent on health

Considering the number of health facilities, staff and indicators there is a change at country level but the in the view of respondents there is a little change in Pakistan for the maternal health services and the changes are not because of government policy.

"Well the indicators speak for themselves that Pakistan is off the track in meeting the MDGs," KI provincial policy Team

And the change that we are noticing is not because of health system. These changes are also related to increase in education, moving of people from rural to urban areas and because of private sector as well

"Peoples per capita has been improved some level of education has improved among women, people have moved from rural to urban areas, better access to facility have improved" KI provincial team

"I see very little change in the health sector" KI 6

"I mean they have done little by their own" KI 4

The respondents were more concerned on the impact of policies in the Baluchistan province as the indicators were not improved as in other provinces of country.

"Baluchistan specifically the indicators are shameful" KI 8

4.1.6 Impediments for policy implementation and changes

According to the respondents the overall implementation in the Baluchistan province is influenced by the political, economic, socio- cultural context and overall health system.

"System is not delivering on what it suppose to deliver" KI Provincial team

Some respondents were also on the same view that we not run our health system regularly and we prefer projects.

"We deliver health services through projects, we are not running a system" KI planning cell

"There is package of nine services at papers but nothing is on ground" KI NGO

Political influence

In Pakistan governments changes frequently and every new government tends to change or decrease its support for health policies and programs initiated by the former government. Such a trend in governments neither provides specific time for the implementation nor for the intended goals to be achieved. It also results in a lack of government support for health programs and a waste of resources.

"After four year they introduced a new policy" KI 3

"So in our culture in our country, political will always, drifting from one place to other" KI 1

Most of the respondent's at all three levels were in view that politicians are not interested in the policy issues at any level of policy process, especially in Baluchistan province; they don't have efforts towards maternal health.

"By enlarge they have their eye on next election, they have eye on some quick wins, in the run up to that, they want to recover their election expenditure and they are looking for procurements" KI NGO

Some of the respondents also considered the political situation in Baluchistan, about three million people are migrated from neighboring country Afghanistan during different wars and they are also burden on our health system.

"There are hundreds and thousands of Afghani people living in different areas of Baluchistan especially in Quetta; if you go to any of our hospitals you will find more than 60% of them" KI planning cell

After the takeover of military government in1998 political situation also hindered the policy implementation as people from other provinces were targeted in the provincial Headquarter Quetta and other parts of the Baluchistan.

"We use to bring people from other provinces after unrest and target killings of people from other provinces refused to come and serve in Baluchistan" KI Planning cell

Financial factors

Respondents produced common impression about financial matters. In Pakistan at federal level resources are divided and decisions are made on the bases of population, Baluchistan has a 6% share in total population and gets share of the financial resources accordingly and we have different geographical situation as compared to other provinces.

"We get money from the federal on the bases of population and share of jobs in the

federal to represent us" KI planning cell

The respondents stated that as the implementation is the responsibility of provinces and province has share from the federal and that money always comes late so they face lot of problems.

"Because mainly the provinces they have 50 % of resources, 50% they are dependent on federal government" KI

"Provincial budget is always short, overall budget actually did not changed" KI planning cell

Respondents in the planning section in the provincial office stated that though federal government provided lot of budget but that for not regular health system, the money was provided for the projects, project finished the budget was also stopped.

"Actually the money was given through, you know major path was through the project and most of the projects were concerned with maternal health," KI 8

According to the respondents these projects initially always had problem with funding from the federal and later on the funding was continued.

"When the projects launched initially there was delay in funding for all the projects, and there is a long chain of getting budget from federal" KI Planning cell

Social development of Balochistan province

Most of the respondents were of view that in Balochistan province social development is one of the major factors to uptake the policy; there is lack of resources including financial, human and infrastructure, education, basic infrastructure and other facilities.

"Our districts are lacking other facilities like education, social interaction, our trained staff avoid to serve in the remote areas because of the non availability of the facilities at the district level" KI 1

"That I feel that why is not education and proper health services" KI NGO

Human Resources

In view of the respondents Baluchistan province always had the problem about sufficient staff to work in both rural and urban areas.

Unavailability of staff

The respondents stated that we are facing deficiency of technical from Managers, gynecologists to LHV.

"Our staff more likely to go clinical side is more attractive as compare to public health" KI planning cell

"The retention was and still the big issue for MNCH, and non-availability we are facing are gynecologists, and other technical staff for MNCH" KI 8

"At the district level two or three persons are doing all the functions" KI at District

"The major problem includes female staff in the periphery, even in district head quarter hospitals" KI District

The respondents also expressed that the staff that is available our system is not able to send them to the rural area.

"That there is excess of female staff in Quetta" KI 8

Capacity of the staff

One of the most important themes emerged from this study was the loos of capacity at every level from managers to supporting staff.

"they are not trained to work on that side, they never have been told about their job description" KI 8

As there is question mark on standard of education in our country, during training or in job there is no training to update and make their knowledge fresh and increase the capacity of human resource.

"We don't strengthen primary healthcare & don't have concept of family medicine" KI 7

"RHC were made every equipment was provided, we were not able to use the equipment, so everything destroyed with time" KI provincial policy team

"We have designed the good packages, we have job description books, but still we don't know about our job" KI 6

Private sector

According to the respondents private sector is one of the most significant impendent to implement maternal health service in Pakistan and Balochistan as well.

"In Pakistan you can find well established private hospitals to private health clinics in the huts" KI 8

Public facilities are struggling to run and on other side private sector is unregulated.

"BHUs don't run, public hospitals are largely dysfunctional, private hospitals are unregulated, the is no regulation of price or quality" KI NGO

Respondents also reported private medical sector on health education that is leading to compromise on the quality of education.

"The other thing that has happened with human resources is that they have opened up private sector to come in medical education sector so the quality of training has really compromised as a result of that" KI 4 in conclusion the results of the in-depth showed that the policy process was conducted mainly at federal level and the important stakeholders did not played any significant role table 6.

Table 6: In-depth Interview themes

Codes/ Aspects	Emerged themes
Agenda setting	Health for All, Province role neglected, politician's role limited,
• Information Gathering	HIMS performance not satisfactory, reporting not regular, MNCH was not considered as separate entity
• Province role	Limited role
Planning	Projects implemented with planning from federal, planning was carried out universally for all the provinces Operational responsibilities from Province
Implementation	Poor. Not implemented totally & properly
Monitoring and Evaluation	Biased Lack of resources Decreased capacity Not regular in rural areas
Change after implementation	Unsatisfactory Other factors (socio-economical development)
Impediments for Implementation	Overall decreased capacity of system
• Political influence	Politicians less interested in Health policy generation and implementation Political instability
• Financial factors	Balochistan always short of budget Projects funded by federal Regular expenditure 50% depends on Federal Delays in realizing budget
• Human Resources	Unavailability of health force Deficient in capacity
• Private sector	Powerful Growing fast No regulating body for private health sector
• Balochistan	Unavailability of staff Staff distribution

4.2 Policy document analysis

Although policy analysis frameworks used in this study focused on areas such as content, process and feasibility of implementation, in this section NHP2001 document analysis was carried out. The document analysis was based on alignment between policy statements and intended out comes using a predefined criteria by (Cheung, et al., 2010; Rütten, et al., 2003) the tool has been used in Australia to analyze different polices. In this framework the tool sorted accessibility, policy background, goals,

resources, monitoring and evaluation, political and public opportunities and evaluations.

A. Accessibility

The policy document were accessible from the Government of Pakistan website and hard copy was available from the offices of the senior managers at the start of the policy implementation as it was the first detailed policy of Pakistan which was covering all the aspects and all level of services provision both in federal provinces. However the documents and its orientation were not accessible to the mangers at district and mangers of the various vertical programs.

B. Policy Background

The policy background encompasses consideration of scientific results, burden of the problem and demand for action. In the NHP 2001 document the scientific grounds of the policy were not established nor the conclusive review of the literature is mentioned however some key areas have problem backgrounds e.g. key Area no 2 and three have back ground of the problem which addresses on inadequacies of primary health care and to remove professional and managerial deficiencies in the district health system respectively. According to the discussion with policy makers at different level the draft during policy formation process had a detailed review of literature from the provinces, which included strategy out lines, statistics and deduction. However the policy document contains an annex, which shows the projected health indicators from 2001 to 2010. Indicators include infant mortality rate, EPI coverage, number of polio cases, and prevalence of preschool malnutrition, low birth babies, contraceptive prevalence rate, MMR, and Lady Health Worker coverage.

C. Goals

The Goals are concrete and stated clearly both in quantitative and qualitatively. The goals are clear in its intent along with detailed mechanism with which they can be achieved and can be measured, example include key area no: 2 inadequacies in primary/secondary health care services. Most of the goals action centers on the improving health of the population through primary and secondary health services

along with improving health care system of the Pakistan. The goals in the policy have time frame targets and projections for a period of ten years.

The external consistency of the goal is drawn from the other countries, which have improved their primary health care, by community works and family health workers to control high rates of MMR and NMR, service utilization and mass awareness programs; examples include Thailand and Sri Lanka.

As in the developing countries the existing services are not utilized international community has suggested to provide services on the target population directly to reduce the burden of the disease, following the strategy NHP 2001 has goals to provide services through LHW and family health workers. The internal consistency was drawn from the providing services to the targeted population.

D. Resources

Although developing countries are short in resources in every sector. The NHP 2001 has addressed resources quite precisely by increasing the percent of GNP 0.5 in 2000 to 0.7 in 2001 and onwards on health expenditure. The policy document has a three year planned PSDP 2001-04 and ten year vision 2001–11 documents and most of the goals have the budget allocation to implement the goal and achieve target.

Human resources are addressed along their capacity building as in Key Area no 2 and 3 by recruiting 100,000 trained lady health workers and removing professional and managerial deficiencies in the district health system respectively.

Organizational capacity has also been addressed by upgrading 58 district 137 tehsil hospitals over a period of 5 years.

E. Monitoring and Evaluation

The policy document addresses the monitoring issues, increasing the capacity of the ministry of health by establishing the policy analysis and research unit. The unit will be responsible for monitoring the progress of the policy implementation in the key areas and will also provide technical facilities to provincial governments. However the policy did not mention about evaluation of the implemented key areas.

F. Public Opportunities

The policy document involves different stakeholders for the implementation of the policy including provincial health departments, in close collaboration with district health setup under the local government structure, and private health sector.

NGO's and civil society organizations are also declared as important stakeholders.

Key area no 7 also demonstrates regulations in the private medical sector including hospitals, clinics, laboratories and private medical colleges.

G. Obligations

According to the policy documents implementation relies on the shoulder of Provincial governments.

However different organizations are also involved in the implementation of the key areas accordingly, trained lady health workers remain the responsibility of Lady health worker program (national program for family planning and primary healthcare), other organizations obliged for implementation of various programs are as follow, ministry of population welfare, foreign assistance will be sought through economic affairs division and planning and development division, women health project, federal cabinet, TV / radio authorities will have duties for the awareness programs.

4.3 Participant's Observation

The observations are based on 6 months period at Gandawa town and union council Pattri. Observations were carried out both in hospital and outside hospital regarding behaviors for both service providers and service consumers.

The actors observed were both health service providers (doctors, nurses, pharmacist, community health workers, technicians, paramedics) and people visiting those health facilities.

The objects that were included in the observation were health facilities. Activities that were observed include behaviors of the health service providers and behaviors of the people visiting the health facilities and health seeking behaviors in the community.

Gandawa tehsil is the district head quarter of the Jhal Magsi; population of the tehsil Gandawa is about 70,000. The town has administrative offices like Deputy Commissioner, District Nazim (political chief), district education office, District Health office, District headquarter hospital, Government High school, office of the district magistrate and uncompleted building of the higher school building. Gandawa town has lot of private health clinics that are run by registered and unregistered medical practitioners. Union Council Pattri has population of 17375, scattered populated in 8 different villages.

The transportation of goods is carried out through buses, vans, trucks camels and Oxcart. People from villages also use camels and oxcart for transportation to Gandawa town along with modern mode of transportation. Local people use oxcart for the transportation of patients to hospital also.

About 70% of the private buildings are made of mud and almost all the Government buildings are made of cement and bricks.

Gandawa town has an ancient market that contains about 100 shops. These shops mostly belong to local residents of Gandawa. There are many restaurants that provide lunch and tea however these are closed by sunset. There are no hotels in the town. However there is a Government rest house that provides services only to high rank government officials. Health facilities in Gandawa tehsil are composed of a DHQ hospital, a RHC and 3 basic health units; one CD and MCH center Table 7. About 6 private health clinics are providing health services by different type of health providers. Which include religious healers, indigenous modes of treatment, homeopathies and modern modes of treatment, which are provided by the hospital staff, and qualified general physicians. Key informant with me was from the union council Pattri, he used to work in the district health office as a drug dispenser now he is working as teacher and providing health services to the villagers as well.

Table 7: Health facilities in Tehsil Gandawa

S NO	Name of UC	DQH H	RHC	BHU	CD	MCH
1	Gandawa	1				1
2	Pattri			1	1	
3	Khari			2		
4	Mir Pur		1			

4.3.1 Utilization of private health services

Availability of services

As a health services provider had invited me and I promised too, so I started my day with breakfast in his health clinic aet 7:30 am, his clinic is one of the famous clinics in the town, his father opened the clinic both are health technicians in DHQ hospital but his father is retired. There were 2 rooms in the clinic. A small medical store was also there.

Patients started coming to his clinic at 8am, and while we were talking he was attending his patients as well. Patients had common problems like fever, pain and respiratory problems and his prescriptions were almost same for every patient.

On asking him about this mode of treatment he said that *"as we are providing services in a situation which is not our duty and hospital also not have proper facilities of X-rays, ultra sound and laboratory services"*

On asking him regarding pregnancy related problems he said, *"Go to the home of lady and inject syntocinon (oxytocin) and the rest is left on traditional birth attendant and Qualified doctors don't bother to do so "*

While he was treating a patient I had an opportunity to talk with a lady she come with her husband their son about 6 year old had some medical problem. I ask her why she don't took her son to hospital where she can find doctor and may get proper treatment she replied me *"we had to buy those drugs from the medical store outside the hospital, and doctor told us to come back next week, as my son was not getting better we were back to hospital after 2 days, and meeting with doctor he said that we should go some big city"*

Most of the patients were getting drugs in the injectable forms and tablets. Patients were buying medicines from the private medical store in the health clinic.

Why our people don't use the government health facilities he replied *"patients even I want to get treatment from the hospital but our hospital don't have the required capacity in every aspect to attract patients and solve their problem"*

While I was sitting with doctor he was consulting an old lady and she had some problem in her abdomen doctor was saying her to wait for the lady doctor, but she argued that she already had consulted her, if he can do anything that will be better. Doctor just gave her some medicine and then she left. After half an hour we found her in the unregistered private health clinic.

When she was leaving from the private health clinic with her son I created an opportunity to talk with her about lady docotr experience why she don't wanted to go there,

She replied to me *"she charged lot of money for medicine and treatment but in the evening my daughter in law died"*

4.3.2 Common work force for private and public health sector

The result of observations revealed that skilled persons related to health are providing services in both private and public health sector. In the morning they work in government facilities and later on they are available round the clock to provide private health services at hospitals, health centers, private clinics, medical stores and at the homes. In the villages of the union council Pattri, Traditional Birth Attends and older females of the home provided obstetrical services. Private curative services are provided by health personnel, schoolteachers or by self-experienced individual. Religious healers were also playing the role.

DHQ Hospital Gandawa

In the hospital I went to OPD room and meet doctor he was busy with patients and I went to meet another doctor and medical superintendent and had tea. We talk about hospital situation and patients behaviors and facilities available. The hospital had one ambulance in working condition.

4.3.3 Constraints to service provision

Financial resources

The medical superintendent was very keen to brief about the problems and he was complaining about budget and capacity building of the staff.

"We cannot provide services in the continuum because we don't get the budget on regular basis from the provincial"

Human resources

On provision of maternal health services he was very much disappointed he said *"we don't have educated females in health related professionals and people from other districts don't come here to work"*

Hospital also has Maternal and Child health center (MCH) but in the hospital MCH center don't have separate room and when needed they call the in charge Lady Health Visitor (LHV) of the center usually for filling the documents.

Physical condition of health facilities

The DHQ hospital and other health facilities were not in good conditions and with the unavailability of the staff they were deficient in physical conditions and equipment and logistics.

"Hospital has ten bedded one general ward that is in miserable condition and beds are not clean and medicine store is always short of medicine and the only emergency operation theater room is out of electricity and equipment". A doctor's view working in the hospital

A pharmacist also runs a health clinic in the Gandawa town, some patients were sitting there in the afternoon and while we went to meet him he was treating a patient and according to him *"he is charging nominal fee and patients are charged only for the medicines"*

A senior doctor who also has been working as executive district health officer for 5 years during 2001 when our district became separate and he quotes on reforms

"Whenever we had a change that was limited to the papers we never got any serious attention from the provincial government to change the circumstances locally, in form of promoting health, logistics or funds, we always been short of funds.

Accessibility

The senior managers in the district were on a view that they don't have access to the pregnant mothers and they also don't have the access to health in this area, no awareness programs are launched, health promotion is not there.

He said, *"we don't have access to pregnant ladies and they also don't have access to our health system public or private"* KI 9

On the other side private health system was providing the services in the villages,

"He is just coming from a nearby village, went to help a pregnant lady for delivery" unregistered medical practitioner.

Union Council Pattri

Pattri is one of the nine union council of the District Jhal Magsi, the population of the UC is17, 375 people and consist of 15 villages. About 90% belongs to the Lashari tribe and other casts. People here have occupation of agriculture, animal husbandry and government services.

The population here is mostly divided to clans and sub clans. Strong values and traditions here are the product of tribal system, the culture and traditions of the Baloch have historically been passed down from mother to daughter, and men from father to son. It is a highly male dominant society. Females are not considered as a part of decision. Women don't have independent access to transportation, education, or any awareness more than that taking care of home and if needed work with husband in agricultural fields.

4.4 Focus group discussions

A total of 8 focus groups were carried out in tehsil Gandawa district Jhal Magsi to find out the antenatal utilization among pregnant ladies.

Union council pattri is one of the 4 union councils of Gandawa tehsil. Total population of Gandawa tehsil is 69,713 with a fertility rate of 4.1; approximately 2,858 ladies get pregnant yearly.

Health facilities in Gandawa tehsil include one district head quarter hospital (DHQ), one Rural Health Center, one basic health unit, four civil dispensaries and one MCH in the DHQ hospital.

Focus groups were conducted in union council Pattri, tehsil Gandawa among pregnant ladies and married men separately. Union council pattri has a population of about twenty thousand people and according to EPI micro plan (EPI, 2011) about 712 women get pregnant yearly.

Government health facilities at primary health care level include a basic health unit and civil dispensary; both BHU and CD are under control of PPHI project. BHU has one part time doctor who conducts three days OPD a week; other staff includes a Female medical technician, male medical technician (both positions were not filled at the time of data collection), trained birth attendant (Dai), Lady health visitor and 3 supporting staff.

Characteristics of female respondents

A total of 8 focus group discussions were conducted four were among pregnant females and four were among married man, 24 pregnant ladies participated in female FDGS and 22 men participated in the FDGS. The mean age among female participants was 25 years and range was 18 to 32 years and mean number of children was 5 and range of children was 1 to 9. About 83% of the ladies don't had any education and 16% of them had any type of education. About 25% of the pregnant mothers ever had antenatal care. Out of all members 54% had any pregnancy related perceived problem /complication.

Male focus group discussions

A total of 4 male focus groups were conducted in the different villages of the union council Pattri

Table 8: Socio-demographic characteristics of Male FGDS

General characteristics	Number	Percentage
	Total = 22	
A) Age (years)		
Mean=29.54, SD=7.28, Range=18-45		
B) Income		
Mean=14181.81, SD= 4767.31, Range= 8000-25000		
C) Number of children		
Mean= 4.5, SD= 1.6, Range=2-8		
D) Education		
No formal education	17	77
Primary or high education	5	23
E) Number of wives		
1	13	59
≥2	9	41
F) Occupation		
Farming	13	59
Animal husbandry	6	27
Government servant	3	17
G) Ever took wife to Health facility for ANC		
Yes	7	38
No	15	62

Table 8 shows that mean age of male participant was 29.5 years; mean income was 15000 rupees per month; mean of the number of children was 4.5 about 23% had primary or high education. About 60% were relating to farming and 41% had two wives, 39 of them men took their wife ever to hospital ever for maternal health related problem.

4.4.1 Pregnancy and health care

To understand the concerns and pregnancy and health care, the respondents were asked about importance of health care during pregnancy and male concerns about care during pregnancy.

Female participants were asked about the importance of pregnancy care. The theme emerged was antenatal care leads to relief from health problems during pregnancy.

The respondents realized about the importance when they experienced any problem during pregnancy and got relief after contacting skilled or unskilled birth attendant.

"During my first child I had lot of problems like vomiting, weakness, pain" a pregnant lady says

The severity of the problems also created more importance to utilize the government health facility and got awareness regarding services.

"I had three abortions in the early pregnancies one day I had chance to go with my husband who took his mother to a hospital in other city and he also took me to doctor and doctor told me to visit her early in the pregnancy"

Pregnant ladies in the study area never went to any health facility for antenatal care when they did not have any problem and they viewed, as the people who are sick they should go to the health facility, time they need treatment.

One lady mother of six said *"I never needed a doctor, I don't had any problem during pregnancy we have to suffer small problems and we should ignore them"*

Male respondents were also concerned about the antenatal care when their wives had problem during pregnancy as they thought mostly it's a natural problem and every lady has to produce children, small problems are part of life.

"When ladies get pregnant they have lot of health related problems and it makes problems for us at home"

Some of the respondents believed that pregnant ladies must have treatment on the right time,

"When they need doctor we should take them to health clinic" 28 years male

But some responds viewed that pregnant ladies have more chances to face health problems and it would be better if we prevent them before they occur, but it can be achieved as we understand these problems and we know to prevent them.

"I took her to a lady in nearby hospital, she treat my wife and later on she was feeling better"

4.4.2 Pregnancy related problems

Both male and female respondents mentioned problems about health during pregnancy, problems about health services, accessibility, utilization, and expanses during care, emergency problems.

"During pregnancy I feel very much weak, I feel back pain, I have faced abortion also, cannot do daily routine" female 25 years old

"During pregnancy my wife had health" A male respondent

4.4.3 Pregnancy related Health problems and consults

Most of the pregnant ladies reported their health good and had a healthy pregnancy, but few of them were complaining about weakness and one of them complaint a lot about back pain. Most of them who were complaining about weakness said that they have weakness because of food intake, nausea and vomiting. They also reported about stress of work and loss of rest.

In term of health care during pregnancy women said that they consult mother in law, friend or female family member and take care by them self through indigenous methods or self care. However during sever problems they consulted traditional birth attendant, local private health provider, government health facility in Gandawa town or to some other city depending on the severity of the problem.

"Mother in law called on Traditional birth attendant and doctor (local private health provider) and then my husband took me to Gandawa and later on we went to some other" 29 years old mother

Male respondents also complaint about weakness and other complications for their ladies, they took their ladies to the health service provider on the severity of the problem.

One of them quoted everybody want to get good services for their family health, but we usually work in the fields with our kids and wife, we don't have services at field but we try to get services as near as possible. Then if we don't get relief we go ahead

as much money we can spend. But other hand we must wait little time as some problems finish by time.

Mother in law and traditional birth attendant and local health services providers were doing the job of the health consultants. Initial contact person was mother in law and TBA or some senior experienced lady who used indigenous modes of treatments to help pregnant lady. They frequently contacted local health provider for pain and weakness relief, which provides them services at home for charge.

"I contacted my mother and mother in law they told me about pregnancy and some tips to control my diet and work at home. If I had some problem they used to give me thing which was brought from the near by areas".

4.4.4 Attitude towards existing maternal Health services

Most of the pregnant women and males in the FGDS stated that they have private health services in the community at were private health clinic and hospitals (CD, BHU, RHC and DHQ) in other areas. As there are no labor rooms both in public or private health facilities most of them did not knew about other maternal health services like antenatal and postpartum care. This showed a disintegration and joblessness of the maternal health services. Most of them had no idea about antenatal care during normal pregnancy. This indicated about awareness of the maternal health services.

A lady responded, *"Hospital staff don't talk in a good way"*

The experience of one lady, she shared; *"we met doctor afternoon and we purchased medicine from medical store on doctor prescription we went other doctor private clinic and in the evening we went to Quetta"*

Male respondents were also of same view*, "there is no difference in private and public hospital services, hospital services are slow and expansive also"* a man said

Most of the man thought of negative attitude and unawareness as well, and they don't had much information about services, there was no strong concept of visiting some

health facility when there was no problems as they were not getting good outcomes from the Government health services.

A man said, *"I don't know any thing all about this, and we face lot of problems"*

A school teacher says, *"we use them when we don't have any choice, we not have good experiences with government facilities, some time they don't have staff, some time they don't have medicine, they say its free but when we go there we have buy medicine by our self and ambulance services don't work, so now feel that its better not to use them"*

4.4.5 Past experience

In FGDS with both male and females past experience was one of the major factors to low utilization of government facilities for maternal health. Most of respondents don't have good experience during their last visit for any reason. Some the respondents never visited health facility because of negative past experience learned by others.

Most of the participants had negative impression about government health facilities, they stated that most of the health staff there were unfriendly.

One of the man expressed his feelings *"no lady health provider was there and male doctor prescribed some drugs for my pregnant wife"*

Females also had same opinion and they were also in the view that if they go there they don't get proper treatment and staff of the hospital makes them spend unnecessary money and this leaves bad impression on their decision makers.

"We don't find anybody in the hospital we wait a lot but nobody come to treat me and then afternoon we left for hospital in Gandawa and even there we don't find anybody"

People also avoided visiting health/hospital because of attitude of the staff as well. Most of them said the hospital staff is not friendly but they behaved well in the private clinics. They did not know about the jobs of the staff and who is going to take care of them for maternal health services.

4.4.6 Availability

The health facilities located in the union council Pattri did not had female staff and there were no antenatal care facilities, the district head Quarter hospital was very far where a female doctor or female health technician was available.

Many women could not go for antenatal check-ups as there were no such Facilities in the village they either had to go to the nearest village BHU or to the district hospital, private hospital at Gandawa town, the district headquarter.

"We cannot go because we don't know where is hospital and how far, we can't go alone and husband busy in work we don't know who works there and who we meet, we go there when we have severe problem"

Accessibility and utilization of Government health services

Access to the health facility was influenced through many ways in the study area; most influence was produced by location and cultural norms.

4.4.7 Cultural influence

In community studied females are very much dependent on the males to go other villages or some other place outside their village, if male company they can go.

"If my husband or brothers don't go how do I can go to hospital?" 21 years lady

Most of the participant mentioned that their husbands and parents usually decided for them. They also pointed that they had to ask for permission from their husbands to attend ANC

"We always ask permission to our husbands before we decide" 25 year old lady

The females who living in the village, which had BHU also, could not go alone on of them presented her words in way *"when we go there we don't find any lady"*

4.4.8 Geographical influence

Male respondents were also concerned with accessibility of the health facility as out of their reach. Most of them were complaining about the distance, as they had to walk

about for many kilometers to reach the road and then get a bus or van to reach the facility.

"If have to go the hospital we must start our journey at 5 am early in the morning"

4.4.9 Financial factors

The FGD respondents argued that the majority of respondents were poor. This might be the main reason for the seeking health facilities, which are away from their villages, and cost of unnecessary treatment, transport, and other out-of- pocket costs were mentioned as constraints. Poor basic infrastructures (road, ambulance, health facilities and their equipment), lack of decision making power, lack of women empowerment, inequity, low educational status and less attention to basic women health and basic rights were discussed as the result of poverty.

"Most of the time the reason why we don't use the health facility is because of our economic problems" 33 years old male

"We can't pay all the costs of transport and medication" 31 years old male

"We don't have those costs and stay home and pray from God" 25 years female

4.4.10 Religious factors

Most of the respondents described traditional and religious factors were hindering the use of maternal health services. Most of them mentioned that due to cultural values in the community ladies are not allowed to travel alone without our males and can meet only women in the health facility and they often don't meet don't see lady there. Religious belief was also dominating that God gives health and health problems. Community women also get relief from health problems through a religious man, (mullah for taweez) or husband brings taweez..

A man says *"when we have some illness and its because of God wish and when we sick we lose sins and when God want and we become well, and taweez are verses of Quran, they have more power than human made medicines"*

Different categories were developed according to the content of the FGDs. Main categories of the FGDs were, low educational status, male dominancy, low socio-

economic status, religion and cultural believes and Poor quality of health service, lack of accessibility to health care and past experience, table 9 shows the summery of factors affecting utilization of ANC services.

Lack of awareness was developed as the main (core) category of the study. The selected core category also had three sub- categories; economic, socio cultural and institutional factors, which in turn were grouped in the core category. Many codes were grouped in to each category by making the categories flexible. Most mothers said their husbands were the ones to make the decision for their health related issues. They also said they were not well aware about maternal health care. The different religious, cultural, social and decision-making power factors also had contributed to the present poor access of maternal health care in the study district.

Table 9: Summery of Factors Affecting Utilization of ANC Services

Themes	Aspects
Pregnancy & health care	• No problems during pregnancy no ANC care
Pregnancy and Health problems	• Mostly weakness • Headache • Fainting • Vomiting • Abortion
Health problems and consults	• Family • TBA • Local unregistered health practitioner • DHQH Gandawa • Move to other city
Availability of ANC services	• Less in number • Common workforce for Private and Public health system • Physical conditions not good • Female staff not available • Available staff not competent
Impediments to Accessibility to ANC services	
Attitude	• Negative attitude towards Government health facilities
Cultural	• Women cannot travel alone • Don't have decision making rights • Prefer local traditional modes of treatment
Awareness	• People in community don't know about ANC services
Geographic	• Health centers far • Don't have roads • Don't have transport
Past experience	• Visit due to any problem if don't have good experience next time prefer private facilities
Finical problems	• Travel cost expansive • Medicine cost expansive
Religious factors	• Religious healers • Sickness is from God and will help to get better

4.5 Quantitative survey

The survey was conducted among pregnant ladies at union council Pattri; the results are as follow

4.5.1 Socio-demographic characteristics of pregnant ladies

Socio-demographic results revealed that minimum age of the respondents was 18 and maximum was 35, most of the subjects were in the aged 21 to 25 49.1%, and the mean age was ± 24. Number of children was 1 to 11 with a mean of ± 4.86. Health facilities were located with five to 35 kilometers (km) from the respondent's living place with mean distance of ± 17.7 km. the family income of the most (91%) of respondents was under 10000 Pakistan rupees (Rs) per month, with a minimum of 1500 to 25000 and the mean was ± 6548 Rs (< 75 US $ / month). About 92% of the respondents were uneducated, and about 98% of the respondents were housewives or were related to agriculture with their family. Four hundred and thirty nine (85.6%) never had antenatal care during their current pregnancy or previous pregnancies only 14.4% of them had antenatal visits at least once. About 66.7% of the respondents had any perceived pregnancy related problem table 10.

Table 10: Socio-demographic characteristics of pregnant ladies (n=513)

Characteristics	Number	Percentage
Age		
≤20	84	16.4
21-25	252	49.1
26-30	124	24.2
≥30	53	10.3
Mean ± SD = 24.67 ± 4.11, Min= 18 Max= 35		
Parity		
≤3	83	16.2
≥4	430	83.8
Mean ± SD = 4.86 ± 1.76, Min= 1 Max= 11		
Distance from the health facility (km)		
≤5	100	19.5
10	81	15.8
15	131	25.5
20	60	11.7
30	57	11.1
≥35	84	16.4
Mean ± SD = 17.7 ± 10.45, Min= 5 Max= 35		
Family Income (per month) PKR (1 PKR=92 $)*		
<10,000	467	91
>11,000	46	9
Mean ± SD = 6548.73 ± 3743, Min= 1500 Max= 25000		
Education		
No education	473	92.2
Any education	40	7.8
Occupation		
House wife	503	98.1
Government servant	10	1.9
Ever had Antenatal care from public health facility		
No	439	85.6
Yes	74	14.4
Any perceived pregnancy related Problems or complication during pregnancy		
No	171	33.3
Yes	342	66.7

* PKR= Pakistan Rupee, $= United States

4.5.2 Knowledge

Table 11: Knowledge of the respondents (n=513)

Knowledge group	Number	Percentage
Low knowledge (0-7)	408	79.5
High knowledge (8-14)	105	20.5
Mean ± SD = 4.29 ± 3.50, Min= 00 Max= 14		

Table 11 shows that most of the respondents 408 (79.5%) had low knowledge and 105 (20.5%) had good knowledge.

4.5.3 Attitude

Table 12: Attitude respondents (n=513)

Attitude group	Number	Percentage
Positive attitude (>24)	217	42.3
Negative attitude (<23)	296	57.7

Mean ± SD = 22.93 ± 1.98, Min= 18 Max= 27

Table 12 shows that attitude towards ANC at government health facility was mostly negative 296 (57.7) and 217 (42.3) had positive attitude.

4.5.4 Satisfaction

Table 13: Satisfaction of the pregnant ladies toward public health facility who ever had antenatal care (n=74)

Satisfaction towards ANC	Number	Percentage
Satisfied (>26)	34	45.9
Not satisfied (<25)	40	54.1

Mean ± SD = 25.90 ± 3.68, Min= 21 Max= 34

The satisfaction was assessed among respondents who had antenatal care at government health facility. Most of the respondents 40 (54.1) were not satisfied 34 (45.9) had satisfaction table 13.

4.5.5 Enabling Factors

Table 14: Enabling Factors

Factors	Number	Percentage
Travel cost expansive (n = 513)		
No	201	39.2
Yes	312	60.8
Fee for ANC is Expansive (n = 74)		
No	26	35.1
Yes	48	64.9
How long wait for ANC (minutes), (n = 74)		
≤30	38	51.4
40	21	28.4
≥60	15	20.3
Is it long time (n = 74)		
Yes	31	41.9
No	43	58.1

Table 14 shows the details of enabling factors; about 60% of the respondents viewed that traveling cost for antenatal visit is expansive. The ladies who ever had Antenatal care (n=74) 48 (65%) had a views that medical expenses are expansive for ANC visit, and about 58% of the ladies complained of long time for ANC checkups.

Table 15: Source of information for health facility and ANC

Source of Information	Number	Percentage
Health Personnel (n = 513)		
No	418	81.5
Yes	95	18.5
Family member		
No	359	70
Yes	154	30
Friends		
No	350	68.2
Yes	163	31.8
Television		
No	492	95.9
Yes	21	4.1
Radio		
No	507	98.8
Yes	6	1.2

Table 15 shows that most of the respondents were not getting any information for health services and ANC. Health personnel are providing information to 95 (18.5%)

of respondents. About 30% and 31.8% of the respondents were getting any information from their family and friends respectively. Only 4.1 % and 1.2% of the respondents were getting information from the TV and Radio.

4.5.6 Social support

Table 16: Social supports Husband

Social support from husband	Number	Percentage
Providing information		
No	312	60.8
Yes	201	39.2
Encouragement		
No	354	69.0
Yes	159	31.0
Advice		
No	308	60.0
Yes	205	40.0
Providing money		
No	207	40.4
Yes	306	59.6
Accompany you to get the service		
No	7	1.4
Yes	506	98.6

Table 16 shows that 39% (201) of the respondents were getting information from the husband, 31% (159) of the respondents had encouragement by their husbands, and 40% (205) had advice by their husbands, 59% and 98.6% of the respondents were getting money and accompanied by their husband respectively.

Table 17: Social supports by Mother in law

Social support	Number	Percentage
Providing information		
No	175	34.7
Yes	335	65.3
Encouragement		
No	135	26.3
Yes	378	73.7
Advice		
No	153	29.8
Yes	360	70.2
Providing money		
No	328	63.9
Yes	185	36.1
Accompany to get service		
No	416	81.1
Yes	97	18.9

Table 17 reveals that most of the respondents 65.3% (335) were getting information from mother in law, 73% and 70% of the respondents were encouraged and advised by their mother in law respectively. However 36.1% of the mothers in law were providing money and 19% accompanied daughter in law to get the services.

Table 18: Social supports from Friends

Social support from friends	Number	Percentage
Providing information		
No	394	76.8
Yes	119	23.2
Encouragement		
No	211	41.1
Yes	302	58.9
Advice		
No	198	38.6
Yes	315	61.4
Providing money		
No	447	87.1
Yes	66	12.9
Accompany you to get services		
No	369	71.9
Yes	144	28.1

Table 18 shows that 23 % of the respondents were getting information from their friends. About 59% and 61% of the respondents were encouraged and advised by their

friends respectively. Only 13% of the respondents got money from their friends, and 28% of the respondents accompanied by the friends to get services.

Table 19: Social supports by neighbor

Social Support by neighbor	Number	Percentage
Providing information		
No	352	68.6
Yes	161	31.4
Encouragement		
No	277	54.0
Yes	236	46.0
Advice		
No	277	54.0
Yes	236	46.0
Providing money		
No	466	90.8
Yes	47	9.2
Accompany to services		
No	249	48.5
Yes	264	51.5

Table 19 shows that 31% of the respondents were getting information from the neighbor, 46% of the respondents had encouragement and advice from their neighbor. Only 9.2% had money and 51.5% of the neighbor accompanied the respondents.

Table 20: Why don't have ANC (n = 439)

Reason	Number	Percentage
Not necessary		
No	147	33.5
Yes	292	66.5
Costly		
No	98	22.3
Yes	341	77.7
ANC so far from home		
No	162	36.9
Yes	277	63.1
Don't know about ANC services		
No	133	30.3
Yes	306	69.7
Have to wait too much		
No	137	31.2
Yes	302	68.8
Nobody accompany to Government health facility		
No	417	95.5
Yes	22	5.0
Don't know where to go		
No	74	16.9
Yes	365	83.1

Table 20 shows the number and percentages of the respondents who never had antenatal care (n=439) about 66% of the respondents thought that ANC is not necessary, 77% had view that its costly and 63% thought facilities are far, 70% did not knew about services and 83% did not knew where to go, 68% did not had ANC because of long waiting times, and only 5% did not went because nobody accompanied them to go government health services.

4.5.7 Factors associated with ANC

Table 21: Factors associated with Antenatal cares Practice

Factors	**Antenatal care Practice**				**p-value**
	No= 437 (85.6%)		**Yes= 74 (14.4%)**		
N= 513	N	%	N	%	
Age					.807
<20	69	82.1	15	17.9	
21-25	217	86.1	35	13.9	
26-30	107	86.3	17	13.7	
>30	46	86.8	7	13.2	
Parity					< .001
<3	57	68.7	26	31.3	
>4	382	88.8	48	11.2	
Distance from the health facility (km)					< .001
≤5	82	82.0	18	18.0	
10	66	81.5	15	18.5	
15	114	87.0	17	13.0	
20	42	70.0	18	30.0	
30	57	100	-	-	
≥35	78	92.9	6	7.1	
Family Income					< .001
<10,000	414	88.7	53	11.3	
>11,000	25	54.3	21	45.7	
Education					< .001
No education	423	89.4	50	10.6	
Any education	16	40.0	24	60.0	
Occupation					.001
House wife	434	86.3	69	13.7	
Government servant	5	50.0	5	50.0	
Perceived pregnancy related Problems					< .001
No	107	62.2	64	37.4	
Yes	332	97.1	10	2.9	

Table 21 shows association of factors with Antenatal care, table shows that number of children, family income, and distance from the health facility, education, occupation, and perceived complications were highly associated p-value < 0.001 with antenatal care utilization at government facility. However age was not significantly associated p-value 0.807 with antenatal care utilization at health facility.

Table 22: Knowledge and practice of ANC at Government health facility

Knowledge	Antenatal care				p- value
	No		Yes		
	Number	%	Number	%	
Low knowledge	408	100.0	-	-	< .001
High knowledge	31	29.5	74	70.5	

The table 22 shows that knowledge about antenatal care was significantly associated (p-value < .001) with high utilization of antenatal care.

Table 23: Attitude and practice of ANC towards Government health Facility

Attitude	Antenatal care				p- value
	No		Yes		
	Number	%	Number	%	
Negative attitude	243	82.1	53	17.9	.009
Positive attitude	196	90.3	21	9.7	

The table 23 shows that attitude towards ANC at government health facility was significantly p-value= .009 associated with ANC in negative manner.

Table 24: Association of travel cost expanses (n=513)

Factors	Antenatal care				p- value
	No= 437 (85.6%)		Yes= 74 (14.4%)		
	Number	%	Number	%	
Travel cost expansive (n = 513)					< .001
No	148	73.6	53	26.4	
Yes	291	90.3	21	6.7	

Table 24 shows that travel cost is significantly associated p value < .001 with ANC for utilization.

Table 25: Association of Source of information

Factors	Antenatal care Practice				p-value
	No= 437 (85.6%)		Yes= 74 (14.4%)		
N= 513	**Number**	**%**	**Number**	**%**	
Source of Information					
Health Personnel (n = 513)					< .001
No	392	93.8	26	6.2	
Yes	47	49.5	48	50.5	
Family member					< .001
No	359	100	-	-	
Yes	80	51.9	74	48.1	
Friends					.688
No	301	86.0	49	14.0	
Yes	138	84.7	25	15.3	
Television					.211
No	423	86.0	69	14.0	
Yes	16	76.2	5	23.8	
Radio					.312
No	433	85.4	74	14.6	
Yes	6	100	-	-	

Table 25 shows that information from health personnel (p-value < .001) and family (p-value < .001) are significantly associated with ANC utilization.

Table 26: Association of reinforcing factors (N= 513)

Factors	Antenatal care Practice				p-value
	No= 437 (85.6%)		Yes= 74 (14.4%)		
	N	**%**	**N**	**%**	
Social Support					
Husband information					< .001
No	302	96.8	10	3.2	
Yes	137	68.2	64	31.8	
Husband encouragement					< .001
No	346	97.7	8	2.3	
Yes	93	58.5	66	41.5	
Husband advice					< .001
No	285	92.5	23	7.5	
Yes	154	75.1	51	24.9	
Husband providing money					< .001
No	203	98.1	4	1.9	
Yes	236	77.1	70	22.9	

Table 26: (Continued) Association of reinforcing factors (N= 513)

Factors	Antenatal care Practice				p-value
	No= 437 (85.6%)		Yes= 74 (14.4%)		
	N	%	N	%	
Husband accompany you to get the service					< .001
No	-	-	7	100	
Yes	439	86.8	67	13.2	
Mother in law providing information					.858
No	153	86.0	25	14.0	
Yes	286	85.4	49	14.6	
Mother in law encouragement					.314
No	112	83.0	23	17.0	
Yes	327	86.5	51	13.5	
Mother-in-law advice					.001
No	143	93.5	10	6.5	
Yes	296	82.2	64	17.8	
Mother in law providing money					.857
No	280	85.4	48	14.6	
Yes	159	85.9	26	14.1	
Mother in law accompany to get service					< .001
No	403	96.9	13	3.1	
Yes	36	37.1	61	62.9	
Friends providing information					.009
No	346	87.8	48	12.2	
Yes	93	78.2	26	21.8	
Friends encouragement					.094
No	174	82.5	37	17.5	
Yes	265	87.7	3712.3		
Friends advice					.001
No	182	91.9	16	8.1	
Yes	257	81.6	58	18.4	
Friends providing money					< .001
No	393	87.9	54	12.1	
Yes	46	69.7	20	30.3	
Friends accompany you to get services					.144
No	321	87.0	48	13.0	
Yes	118	81.9	26	18.1	
Neighbor providing information					.740
No	300	85.2	52	14.8	
Yes	139	86.3	22	13.7	
Neighbor encouragement					.443
No	234	84.5	43	15.5	
Yes	205	86.9	31	13.1	
Neighbor advice					.443
No	234	84.5	43	15.5	
Yes	205	86.9	31	13.1	

Table 26: (Continued) Association of reinforcing factors (N= 513)

Factors	Antenatal care Practice				p-value
	No= 437 (85.6%)		Yes= 74 (14.4%)		
	N	%	N	%	
Neighbor providing money					
No	397	85.2	69	14.8	No
Yes	42	89.4	5	10.6	Yes
Neighbor accompany to services					
No	216	86.7	33	13.3	No
Yes	223	84.4	41	15.5	Yes

Table 26 shows that social support from the husband is significantly associated p-value < .001 with ANC utilization at government facility. Mother-in-law advice and accompany p-value .001 and < .001 respectively are also highly significant. The table also reveals that social support from the friend is also highly significant with antenatal care utilization at government facility.

Table 27: Binary logistic regressions of the factors leading to use of ANC

Variables	p-value	OR	95% CI	
			Lower	Upper
Distance from health facility	.995	4.96	2.8	8.53
Education	< .001	12.9	6.31	25.48
Parity	< .001	3.63	2.08	6.30
Family income	< .001	6.52	3.43	12.52
Occupation	.577	6.29	1.77	22.29
Perceived problems/complications	< .001	19.85	9.85	40.03
Attitude towards government health facility	< .001	2.03	1.18	3.94

Table 27 shows results from the binary logistic regression model also reveal the strong association of education, parity, and family income, perceived problems and attitude with antenatal care utilization at government health facility. However distance and occupation were not significant in the binary logistic model.

CHAPTER V
DISCUSSION

The overall objectives of the study were to analyze the policy process formation, implantation; utilization of the services provided after the implementation of NHP, 2001 and to generate a policy proposal for ANC at district level for the Province of Balochistan. The chapter produces the outcomes of the preceded chapters and matches the connection among the findings. It compares the differences of the findings with theoretical and realistic evidences from the assessments of countrywide and worldwide findings.

Pakistan, from 1947 to 2011, has produced three health policies. The first policy came in 1990, followed by polices in 1997, and 2001. In June 2004, the federal government published a report on Health Sector Reforms. In May 2005, a Medium Term Development Framework for 2005-2010 was developed.

The first National Health Policy of Pakistan (1990) declared high commitment to health by announcing intention to increase governmental health expenditures up to 5% of the GNI. This policy aimed to provide universal health coverage to the people in accordance with the slogan health for all concepts (HFA). The policy also introduced several programs like maternal and child health care, immunization and nutrition (Pakistan, 1990).

The 1997 policy was based on the concept of health for all, with the aim of making health services more responsive to current health needs. Several health programs were also included in policy including maternal and child health program (Pakistan, 1997).

National health policy 2001 is broader, as it strives for preventive and pro-motive measures in health, rather than relying entirely on curative care. It also proposes to overcome the urban bias in health care. The NHP2001 has identified ten key areas, and they include: reducing communicable diseases; promoting preventive care; removing rural-urban bias, gender and income biases; improving the quality of primary health care; and regulating the private sector. A major shift to address

inequities has been taken by setting a goal of removing three areas of inequities, namely: urban-rural; gender; and income differences (Pakistan, 2001a).

5.1 The Policy Process

5.1.1 Agenda setting and formulation

Under the new local government Ordinance, NHP 2001 was built as a part of the Government's Poverty Alleviation Plan; priority attention has been accorded to the primary and secondary tiers of the health sector; and good governance is seen as the basis for health sector reforms to achieve quality health care. The agenda was influenced by the health for all slogan and strengthening the health system to support the district government system. These results of this study are also supporting the evidence to local government system, and empower the community as was based on Alma Atta declaration.

Development of Millennium Development Goals (MDGs) set by UN and other international agencies in the year 2000, also influenced the agenda NHP2001. Pakistan is a signatory to the MDGs. Eight of these broadly stated goals and 18 specific targets to be achieved by the year 2015, six are directly related to health. This policy has used a focused approach through identification of ten priority areas in the health sector with the understanding that interventions in these would bring about a major improvement in the overall health status of the population of Pakistan including women (Nisar, 2010; Rizvi & Nishtar, 2008).

Although women's health is being concentrated over prioritizing of gender equity as one of the key areas, it is only presented as an insulated theme rather than being an component in all policy areas and strategies (Rizvi & Nishtar, 2008).

The NHP 2001 focuses on health through identification of gender equity, reproductive health, such as provision of reproductive health services, increase in number of nurses, creation of women hospitals and nutritional supplementation, openly proves that the effort has been enormously narrow with emphasis on pregnancy and child birth among married women (Siddiqi, 2004). Policy also suggests human resource approaches particular to women health needs such as enrolment and training of Lady Health Workers (LHWs), improvement in working conditions of doctors, nurses and

paramedics (N. Rizvi & Nishtar, 2008).The ‘Health for All’ is a governmental obligation that has always been impeded by problems with human resources. Similarly in a wealthy health system, the accessibility of ‘the right people, in the right places, with the right skills’ is a fundamental task. This is because having the right health workforce depends on sound, long-term policies, based on good information and people’s political will to make it happen.

5.1.1.1 Information for policy agenda

Developing evidence-based agenda requires support on various forms of information. It comprises supportive the context for intervention and local preferences. Often, information on context-society, local customs, past, resources, and constraints—requires collection of new data that may be either quantitative or qualitative. Numerous benefits increase when decisions in public health are based on sound scientific evidence. Whereas evidence must be considered beside community belief, opinion and local consideration (Laurie, 2005)

A countrywide facility-based health management information system occurs till 1992. Parallel to the former community based information system, information system of vertical programs like EPI, TB, AIDS, and Malaria etc. also exist, but non of them is integrated in NHIMS. The source of data comes from FLCF’s, not from provincial hospitals, federal hospitals and private sector (EMRO, 2007).

It is designed to provide information on service related indicators, information on the status of the instruments and equipment’s. Although the available information from current HMIS is very comprehensive, the quality and reliability of information is quite low due to various factors that include lack of refresher trainings, non-availability of tools and no proper mechanism to improve quality of information.

The source of information for the NHP 2001 were Several population based surveys that include the Pakistan Integrated Household Survey, Demographic and Health Survey, Household Income and Expenditure Survey and others that provide information on health status, utilization and limited information on household expenditure on health.

At that time the health department of Baluchistan also had HIMS to give feedback to the province and then to federal. But the HIMS was not working in all districts of the Baluchistan during 2001.

Regular reporting coverage in the districts during 2010, which were upgraded in 2004 with a more integrated and comprehensive district health information system (DHIS), ranged from 31% to 91% and reporting regularity was 68% on whole. Data report also admits that antenatal services are very disappointing as only 15% of the pregnant women were registered by the health facilities in Baluchistan province in 2010 (DHIS, 2010).

5.1.1.2 Provincial role in agenda setting

Policy formulation is one of the gears of pre-decision segment of the policy process, and is the development of policy substitutes for dealing with problems on the public agenda (Dye, 2002). Government bureaucracies, interest group offices, legislative committee rooms, meetings of special commissions and policy planning organizations are the platforms of the policy formulation.

The study results concluded that provincial role was not much considered and decisions were made on the federal level. The provinces were consulted very less and they use to consult high-level positions and stake holders, district authorities hardly played a role.

Earlier, The health agenda was set and the FMOH builds policy decisions. Bureaucrats and medical professionals play a major role in setting health agenda and making policy. Inside the ministry of health physicians among the government servants play a dominant role due to their health-related experience and abilities. Doctors are taught to find the solution to a health problem mostly in medical diagnosis and cures. They tend to find results to each health problem in harmony with the biomedical model of health. The gist of NHP's 1990, 1997 and 2001 clearly show that the main focus in inventing the health policies was on clinical health care (M. Khan, M. Van, 2007).

5.1.1.3 Political Role

The health policy process does not take place in a political vacuum but is embedded in a political and administrative context (Gill, 1994).In Pakistan the NHP2010 was not discussed among political organizations and in the parliament. Through different offices and ministries the draft was provided to cabinet, which approved it after a discussion.

The importance of political role can be assessed through Kingdon's three-stream approach; politics stream refers to noticeable and unseen participants. Noticeable participants may be inside government or outside of government, they have planned interests and climax a specific problem and use the mass media to get attention. For example new president and prime minters may be powerful agenda setters because the newness of their position produces the room for them. The hidden participants the specialists of the community of academics, researchers, consultants, who work less on getting issue to the agenda and more on proposing alternative options for the solving problems that do get on agenda (Gill, 1994; J. Kingdon, 1984).

In numerous unindustrialized countries, the influence of the political context upon the health system and the health of the people are ignored when health policies are analyzed. Individual approach to consider of public health policy is to think it of an answer of a political system to powers gotten to accept upon it from the environment. Powers produced in the environment, which mark the political system, are viewed as inputs. The environment is any condition or circumstance defined as external to the boundaries of the political system. The political system is that group of interrelated structures and process which function authoritatively to allocate values for society. Out puts of the political system are authoritative value allocations of the system and these allocations constitute public policy (Thomas, 1972).

Results of this study revealed that the demands for maternal health were generated from the environment and support also was not generated to influence the political system, rather forces were generated by the ongoing reforms. The outputs were not in the policy to consider in a politically generated atmosphere. The Participatory

observations revealed that there was no local awareness for the health policies and their accountability.

5.1.2 Formulation

Planning is a systematic approach to attaining explicit objectives for the future through the efficient and appropriate use of resources, available now and in the future (Green, 2007).

The Federal Ministry of Health in collaboration with the Ministry of Planning formulated and approved health programs and projects; below the provincial level the district (local) level was responsible only for the implementation of plans and recommendations of the provincial health ministry.

On provincial level, provincial ministries of health in association with the PDWP are involved in health planning. Underneath the provincial at district (local) level no planning activity is carried out. Districts are reliable only for the implementation of plans, policies and endorsements of the federal and provincial government. Health planning is barely flexible, participative and combined with other decision-making processes in Pakistan (Bjorkman, 1986; Green, Rana, Ross, & Thunhurst, 1997).

Lots of findings from the previous studies have noticed that health planning in Pakistan has mainly contained the construction of planning documents, and the preparation of formal documentation for short-term measures (Bjorkman, 1986; Green, et al., 1997; Shaista Alam, 2003).

During 2002-2003 and 2003-2004 annual plans were also attentive on growing the quantity of BHUs, RHCs, hospital beds, physicians and nurses and deprived of any consideration to rise the number of public health professionals in the country (GOP, 2002, 2003; Siddiqi, 2004). But while developing a health plan for a province, whether federal or district level needs to take account of the existing and potential roles of these agencies at all stages of the planning process to empower the existing health system.

5.1.3 Implementation

Political scientist Gerston defines implementation as “the implementation represents the conscious conversion plans in to reality” and is the “follow – through” component of the public policy making process (Larry, 2004).

In Pakistan the implementation is the responsibility of provinces at district level. Though the constitution of Pakistan consider health sector a provincial subject but health care delivery is traditionally been administrated by the federal and provincial governments with districts mainly responsible for implementation. The curative and rehabilitative services are being provided mainly at the secondary and tertiary services. Preventive and promotive services are mainly provided through various national programs, and community health workers interfacing with the communities through primary health care facilities and outreach activities (EMRO, 2007).

In Pakistan politics, economic and socio-cultural context strongly influence the implementation process. Governments are changed frequently and every new government tends to change or decrees the support on their own values not the values. Such trends never leave policies implemented properly by shortage of time and changes in agendas. It also results in lack of government support for health programs and waste of resources (A. Khan, 1996).

Documents analysis revealed that human and financial resources were listed in the policy document. Like other areas of Pakistan some of the big projects were launched in Baluchistan province that are as follows,

Creation of management cadre

One of the important gain after the NHP 2001 at the provincial level in Baluchistan was to separate the management cadre from general cadre in 2010 though its not fully implemented yet, but now doctors in mangers have extra qualification in public health.

MNCH Program

The program aims to reinstate the trust of the communities in the public sector health system and to provide them with quality services. Direct benefits of the program were

creation of additional jobs in the public sector, as well as employment opportunities for trained healthcare providers, particularly the community midwives.

LHW Program

The lady health worker program (LHW) in Pakistan, launched in 1993 is based on lady health workers and it was continued as do so by policy 1997, trained to provide specific, basic primary health-care treatment plus preventive services establishes a milieu of well being, enhance interaction of community with health-care providers, enable timely treatment, prevention and even screening.

People's Primary Healthcare initiative (PPHI)

PPHI was launched in 2006 with the aim to improve the health system strengthening by rehabilitating the basic health unit and integrating the PHC services all our Pakistan. The initiative is covering the primary health through eight components.

Pakistan with accessibility of 144,901 doctors, 10,508 dentists, 73,244 nurses and 104,137 hospital beds in the country by 2010-11, 96,000 Lady Health Workers (LHWs) have been trained and deployed mostly in the rural areas, the population and health facilities ratio works out at 1222 persons per doctors, 16,854 persons per dentist and 1701 persons per hospital bed compares well with the other developing countries (WHO, 2010b).

The projects defined above are being implemented by a wide web of primary, secondary and tertiary health care facilities, supported by various cadres of trained health service and information providers. Yet, a breakdown to interpret these policy commitments into the desired improvement in MNH outcomes rests on the projects. Dearth of investment in the health system, together with inadequate basic health services, untrained staff; insufficient medical supplies and equipment continue to hamper progress on improving MNH outcomes. Policy desires to be executed effectively, advocacy efforts should focus on the execution of policies and practices and mounting up evidence-based interventions where the need is greatest.

These changes are also related to increase in education, moving of people from rural to urban areas and because of private sector as well (N. Rizvi & Nishtar, 2008).

5.1.4 Monitoring and evaluation

The policy document addresses on the monitoring issues, increasing the capacity of the ministry of health by establishing the policy analysis and research unit. The unit will be responsible for monitoring the progress of the policy implementation in the key areas and will also provide technical facilities to provincial governments.

Health systems in the Pakistan have not developed an efficient system of monitoring particularly to monitor regular health system though projects have their own monitoring and evaluation, which is also biased (Green, et al., 1997; Kelley Lee, 1998; Luby et al., 2004).

The KIs working at different levels in the health department were of view that there are no institutionalized arrangements for monitoring, especially a set-up with forward and backward linkages.

Implementation is not based in terms of getting results and nobody is answerable for bringing results in the system. All person assumes office does his/her job without reflecting the results for which he/she is responsible. So there is lack of accountability for results and lack of accountability to the people. The agreed monitoring mechanisms are being ignored (Lashari, 2004).

Besides, together data and information from the districts are not appropriately managed, the reason behind seems that competent personnel are not available, and site visits of the health projects are often lacking at every level (GOP, 2003; Green, et al., 1997)

Monitoring of health system and programs mainly in the rural areas is not regularly conducted, as has already reported for many years. As a result the process of collecting important information does not work properly.

5.2 Impediments for policy implementation and changes in Balochistan

Implementing a policy is a job of various organizations and various actors at different levels, in Pakistan programs health professionals, civil servants and bureaucrats functioning at the federal, provincial and district levels play different functions allowing to their qualifications and professional capabilities.

According to the studies communication gaps delay the flow of evidence from upper to lower level actors particularly in understanding specific objectives of the planned health projects before implementation (Kelley Lee, 1998).

According to the respondents the overall implementation in the Baluchistan province is influenced by the political, economic, socio- cultural context and overall health system.

Implementation schedules for women's health programs and nutrition programs are not based on a systematic approach (GOP, 2003; M. M. Khan & Van den Heuvel, 2007), some respondents were also on the same view that we not run our health system and we prefer projects.

5.2.1 Political influence

Political system of Pakistan till 1998 was not quite stable and governments changed frequently and the each government not giving enough time for the policies to be implemented according to their frameworks tabled the new policies.

But after the takeover of the military in 1998 and September 11 incidents brought many changes to the political system. Pakistan was the centered by the international community to carry out their ambitions. The government poverty alleviation program influenced the agenda of the policy and MDGs. Political role was not considered as political wing was concentrating with international community and during the implementation the political leadership was busy with pressure of peace and results from the international community.

Baluchistan province was also suffering from unrest because of national and local political problems. Many skilled persons were forced to leave the province those belonged to other provinces. Baluchistan province tribal anarchies also influenced the implementation in some areas of the province.

Most of the respondent's at all three levels were in view that politicians are not interested in the policy issues at any level of policy process, especially in Baluchistan province; they don't have efforts toward Baluchistan.

5.2.2 Financial factors

The implementation of a policy requires that resources come from wherever necessary to enact the relevant program(s) and "that the economic structure, social institutions, and political processes will be shaped to protect and maintain that commitment"(Merilee S. Grindle & Thomas, 1989; Watt, et al., 2005).

Implementation is obviously affected by wherever the funds are derived from to carry out policy, and who controls them. Financial control is usually protectively protected by the federal in order to execute, if essential, national policy and preserve power at the central level (Gill, 1994).

The study revealed the implementation is the responsibility of provinces and province has share of 50% from the federal and that money always comes late so they face lot of problems.

Results of the study also stated that though federal government provided lot of budget but that for not regular health system, the money was provided for the projects, project finished the budget was finished also.

And because of communication gaps projects initially always had problem with funding from the federal and later on the funding was continued.

The capacity of the center to pay for a particular part of public expenditure is a powerful pull for lower level authority to follow central policy schemes. Therefore in a federal influenced policy the national government may exercise selected control over even fairly autonomous provinces by providing economic support for particular programs (Gill, 1994).

5.2.3 Social development of Baluchistan province

Rivaled with other provinces of Pakistan, and Pakistan taken as a whole, Baluchistan’s economic and social development appears to face particularly overwhelming tasks. The province starts from a relatively low level in terms of social achievements such as health, education and gender equity markers, economic development and physical infrastructure (Pakistan, 2010).

Provincial capital city Quetta is only the urbanized city and due to lack of facilities in rural areas human resources prefers to stay in Quetta.

Baluchistan province social development proved to be one of the major factors to uptake the policy; there is lack of resources including financial, human and infrastructure, education and other facilities.

Lack of infrastructure and other facilities technical staff avoids traveling and performing their duties leading to unavailability of staff hence impediment to implementation

The study results also proved that though there are some developments in health indicators in Baluchistan these are because of tiny changes in education and better socio economic situation.

5.2.4 Human Resources

In view of the respondents Baluchistan province always had the problem about sufficient staff to work in both rural and urban areas. Realizing the problem related to human resource government of Baluchistan established Human Resource directorate in 2001 to remove the provincial deficiencies (GoB, 2010).

5.2.4.1 Unavailability of staff

The respondents stated that they are facing deficiency of technical from Managers; gynecologist to LHVs and still health staff likes to prefer curative services.

Unavailability of staff was also related to local female participation, education and lack of interest and awareness seems reason behind.

Poor infrastructure of public health facilities mostly FLCFs contribute to mal-distribution as it drives providers away from rural and peri-urban areas to larger towns and bigger facilities. It has been shown that a large number of FLCFs don’t have electricity, water and are not accessible through roads (Nishtar, 2010).

The respondents also expressed that the staff that is available our system is not managing to send them to the rural area.

5.2.4.2 Capacity of the staff

In a responsive health system education, training, and capacity building should be the centerpiece of a policy. Numerous problems need to be addressed in the area of undergraduate and postgraduate schooling, working education and field education. Each of these has to be relevant to the needs of respective health professionals (Nishtar, 2010).

One of the most important themes emerged from this study was the loos of capacity at every level from managers to supporting staff.

As there is question mark on standard of education in our country, during training or in job there is no training to update and make their knowledge fresh and increase the capacity of human resource.

5.2.4.3 Private sector

The private health sector is very much revenue placed and the profitable portion of the overall health sector, the important role being played by the private sector in Pakistan implies that health policy cannot be made without linkages with this sector (Lashari, 2004; Nishtar, 2010).

According to the respondents private sector is one of the most significant impendent to implement maternal health service in Pakistan and Baluchistan as well. Public facilities are struggling to run and on other side private sector is unregulated.

Respondents also reported private medical sector on health education that is leading to compromise on the quality of education.

The document analysis of the policy was qualitative in nature by using a tool initially generated by Rutten in 2003 to analyze the role of policy and evidence in health promotion later on Cheung modified the criteria to assess the policy for chronic care program in Australia (Cheung, et al., 2010). The tool may be viewed as a checklist.

The current study also used the same criteria to analyze the policy document. The document was fulfilling most of the objectives. Considering the history of Pakistan health system and generation of three policies in 10 years the tool identified many opportunities for improvement of the policy generation of Baluchistan province after

the devolution of the ministry of health to provinces. Opportunities included accessibility, policy background, goals, monitoring and evaluation, public opportunities.

It is important for the implementers at the gross root level to understand the complex interactions of the policy as they work in different government health programs and organizations. They produce feedback and guidelines to improve the content of the future police (Smith-Merry, Gillespie, & Leeder, 2007). The province of Baluchistan is the underdevelopment province where health services providing mangers have less experienced health management cadre needs to be involved more in the accessibility and health policy research.

5.3 Utilization of Health services

5.3.1 Health seeking behaviors and utilization of the services

District Jhal Magsi has more than 85% of rural area, with low literacy rate and underdeveloped infrastructure, and a low-income district (Pakistan, 2010). Women's deprived societal situation, which is often connected to the financial worth positioned on familial roles, aids to poor health, inadequate diet, early and frequent pregnancy, and a sustained series of dearth. Pakistan, where women are less educated and receive less evidence than men, and have less power over decision-making and family resources, they are also less proper at recognizing health problems or seeking care (Sabeena, 2011).

About 14% of the subjects had antenatal care and qualitative results are support the low utilization of the pregnant mothers in the Pattri union council. According to the HIMS/DHIS report 2010 only 15% of the pregnant women were registered (DHIS, 2010). Most of the pregnant women complain about pregnancy related health problems and according to PHDS 2007 about 60% of the pregnant ladies had perceived complications or problems and 58% in the study subjects of PAIMAN project (Council, 2010).

Participants of the study preferred private services for their maternal health needs, the consultation started from mother in law to a doctor in the private health clinic figure 17.

Local studies and international literature also have well matching figures about utilization of government services and that was throughout the last decade, in 2004 about 10% to 40% of the pregnant ladies contacted government health facility (DHIS, 2010; EMRO, 2007; MICS, 2004; NIPS, 2008).

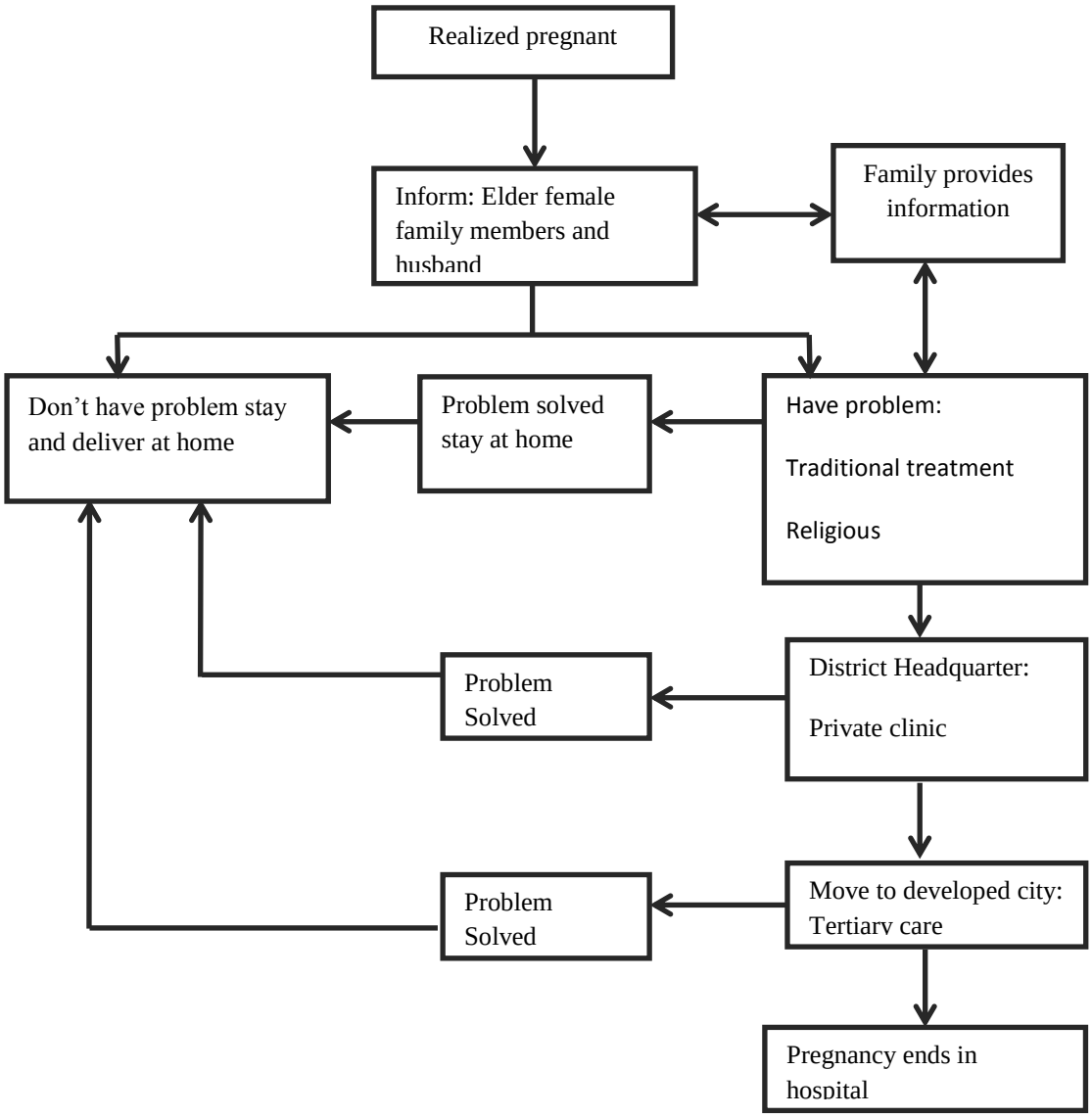

Figure 17: Antenatal care seeking behavior

5.3.2 Barriers to the ANC utilization

In the developing world lots of factors are contributing to the low utilization of ANC services, even though these services can be delivered through LHV program in the community and it's the part of their job description as well in Pakistan.

Availability

Primary care in the Union council Pattri is provided by two health units' a basic health Unit and a dispensary. The dispensary, provides ambulatory curative care and maternal and child health services and a LHV or LHW; and the Basic health Unit, contributing basic in-patient care in addition to the dispensary's services, and staffed by a larger number of more qualified staff, a doctor and paramedical health workers.

Lot of studies has shown the association between availability of the health resources and their utilization (M. A. Magadi et al., 2000; Nielsen et al., 2001). The current study showed shortage of health services and workers in the villages and in existing services health workers were not available.

According to the senior managers in the district, BHU's are less in number, but in the existing health facilities number of health personnel especially female staff are not available.

Absenteeism of the staff was also an important factor emerged during the qualitative study. Female staff are bit reluctant towards their duties in the rural are, mostly they don't come to duties and managers also not force them to their duties, or if they come they leave before time (Nishtar, 2010).

Awareness

Knowledge is to know something by studying, exercise, education; it is the experience of things and wisdom (Saseendran, 2004). NHP 2001 neglects the prevention and control aspect of non-communicable diseases; it does not specifically refer to health publicity in relative to public health and maternal health utilization (Ronis & Nishtar, 2007).

In Baluchistan of the female literacy rate is 10% and the literacy rate in the study district was 5% and change in literacy rate from census 1998 was 2% to 2004-05 (MICS, 2004). Education among the pregnant ladies was low and was significantly associated with utilization in this study, women with education has more awareness about ANC services and importance leading to more utilization (Nielsen, et al., 2001; Simkhada, et al., 2008; Smith Greenaway, Leon, & Bake, 1993). A study Pakistan in

a qualitative study reported education as a key factor in getting information and utilization of ANC (Zubia, 2005).

Most of the pregnant ladies had low knowledge in this study and statistical analysis showed very tight association with antenatal care utilization, and other studies also revealed that women more knowledge and with high exposure were more likely to receive antenatal care in the neighboring country India and in the national studies(Council, 2010; Navaneetham, 2002; Paredes, Hidalgo et al., 2005; Sabeena, 2011; SINGH et al., 2011). In the community studied respondents who did not had ANC 70% thought that it's not necessary, 66% did knew about ANC services and 83% did not knew where to go.

Mass media has a strong social and cultural impact upon society. It helps to form public opinion, which is often translated into action over time. A study conducted reported that after education exposure to media was highly significant (Saseendran, 2004; SINGH et al., 2011). Pregnant ladies in the study had very much less exposure to TV and radio for the information of ANC 4% and 2.1% respectively.

Subjects that had information about ANC from a health personal had significant association with uptake of ANC coverage, the results are consistent with PAIMAN project, project used LHW workers for the intervention to increase maternal health services utilization (Council, 2010).

Awareness regarding maternal health also leads to birth control and birth spacing, overall fertility in Pakistan is 4.1 and Baluchistan that rate is further higher due to strong cultural and religious beliefs.

Lot of national and international studies has reported parity as on of the most significant barriers to ANC utilization (Ciceklioglu & Soyer, 2005; Erci, 2003; M. A. Magadi et al., 2000; Overbosch, Nsowah-Nuamah, van den Boom, & Damnyag, 2004; Paredes, et al., 2005). The quantitative results also showed statistical significance of parity with utilization of ANC. In Qualitative study the respondents also expressed high number of children and more health complications.

Accessibility

Prenatal care access is defined as the potential ability of a woman to enter prenatal care services and maintain care for herself and fetus during the prenatal period (Phillippi, 2009). Many studies have found that ANC utilization is influenced by accessibility of the services. Present study considered Geographical, financial and cultural factors to analyze.

Geographical Access

The degree of access of communities to roads and transport is an important reflection of their development status. Road and transport is an important mark of mobility, education, employment and health. It also indicates connections to the outside world. In those where access to roads and transportation is poor or non-existent, it is very difficult to deal to with health.

In quantitative and qualitative study distance was significantly associated with utilization of the services in both designs. The study subjects living in less than 5km had more antenatal care. In the qualitative study the distance emerged as important theme for the utilization of ANC,

In other studies distance was significantly associated with ANC utilization (Glei, 2003; M. A. Magadi, Madise, N. J Rodrigues R.N, 2000). Qualitative studies also reported that distance to services or physical approach were hurdles to the ANC services utilization (GRIFFITHS & STEPHENSON, 2001; Mathole, 2004; L. Myer, Harrison, A., 2003). A study of the conducted urban squatter settlement in the Pakistan largest city also reported transport association to ANC use (Sabeena, 2011; Zubia, 2005).

Financial Factors

Scarcity of financial proceeds and transportation pose economic barriers to a women-seeking ANC. In this study respondents highlighted the financial problems important. In the Quantitative survey family income was significantly associated with ANC use (Ruhul Amin, 2010).

In the observations and focus group discussions financial problems emerged as important factor also.

Financial costs for services including transportation and medical were major factors prohibiting services utilization in the different both qualitative and qualitative studies from Pakistan and international studies (Adamu & Salihu, 2002; GRIFFITHS & STEPHENSON, 2001; Mathole, 2004; L. Myer & Harrison, 2003; L. Myer, Harrison, A., 2003; Overbosch, et al., 2004; Zubia, 2005).

Cultural and religious factors

The male dominates Baloch culture, females have more restrictions as compare to the male, and male elders in the family make decisions. Females have less mobility in the society and exposure to outside world. Women have less autonomy and cannot travel alone in the community studied (Jejeebhoy & Sathar, 2001).

A study conducted in Pakistan reported 79% of women in Baluchistan had accompanied mobility, compared to just 39% of Punjabi women, whereas Punjabi women more commonly reported unaccompanied mobility (Zubia, 2005)

As described earlier that Baloch culture is male dominant society and household heads are always men. They also pointed that they had to ask for permission from their husbands to or head of the household attend ANC, a study from Nepal showed negative association with ANC in male dominant commune (Matsumura, 2001).

Baloch communities live joint family system and international studies have revealed that family size and structure have significant influence on the ANC use (Matsumura, 2001).

Muslims in the rural areas have more belief on the religion and that belief also influenced the uptake of ANC in the community. A study conducted in the Nigeria reported the “God’s Will” as the strongest factor in non-utilization of the services (Adamu & Salihu, 2002).

Attitude towards ANC at Government health facility

Chountoumadi defines as "Attitude expresses the perception of a person towards a human being, an object or a condition, which is developed by the person's experiences and defines his or her reactions" (Saseendran, 2004). Attitude contains three parameters: emotions, knowledge and the way of acting and all three parameters can change (Joy, Carter, & Smith, 2000; Soderhamn et al., 2001).

Health behavior can be defined as an activity started by a individual who considers himself to be healthful, for the determination of preventing disease or detecting disease in an asymptomatic stage." Whereas sickness behavior is defined as "any activity started by a person who senses illness, for the determination of defining the state of his health and of finding appropriate solution." Finally, sick role behavior "is the activity undertaken by those who consider themselves ill for the purpose of getting well (Rosenstock, 2005; Simkhada et al., 2008).

To understand behaviors we must consider how health services are used and why health services are used. Though maximum studies of utilization do not cover why people use health services, one area of research can be identified to understand health and illness behavior as a function of personal characteristics; "variables affecting the perception of symptoms" (Kasl, 1966).

In the rural areas like the study site where social status is low, infrastructure is underdeveloped, available health services are located at far distance, The findings thus, must be known to relevance the situation confronting the person who must decide whether to seek preventive or detection services before the appearance of events that he interprets as symptoms.

In this study the perceptions of the individuals emerged as an important barrier towards the use of antenatal care services. The quantitative survey revealed statically significant negative association towards government health facilities. Both male and female respondents among focus group discussions and in observations exposed negative attitude toward government health facilities.

The negative attitude may be result of characteristics of health care services Mathole (Mathole, 2004) his study found poor quality of care and negative association. The quality of the antenatal care in services not attracting the pregnant mothers for maternal health services in the rural areas of the Pakistan (EMRO, 2007).

Most of the patients were getting drugs in the injectable forms and tablets. Patients were buying medicines from the private medical store in the health clinic.

Other qualitative also reported the perception of the pregnant ladies as a barrier to the utilization of ANC care. A study from South Africa suggested that most women saw little direct benefit from ANC and did not visit again (L. Myer & Harrison, 2003)

Pregnant ladies in the study area never went to any health facility for antenatal care when they did not have any problem and they viewed, as the people who are sick they should go to the health facility, time they need treatment. Past experiences of the males respondents was also reported in the study as when they had to hospital their experiences were not good.

Female respondents also had same opinion and they were also in the view that if they go there they don't get proper treatment and staff of the hospital makes them spend unnecessary money and this leaves bad impression on their decision makers.

Some studies highlighted that the complications experienced during pregnancies had a positive effect on ANC (Matthews, 2001; Paredes et al., 2005)use in the current study about 60% of the pregnant women complained about pregnancy related problems and showed significant association with ANC use.

The private health sector in Baluchistan exists in every village, and includes people from every class of the society also play an important role. Other studies also support the evidence that in terms of health care during the obstetric period, private antenatal care is regularly chosen for problems and checkups (Matthews, 2001), but private delivery care is not adequate and of standard quality rather hinders the accessibility during maternal health emergencies.

Influence of family and society support toward ANC utilization

World health Organization defines ANC as "The aim of antenatal care is to assist women to remain healthy, finding and correcting adverse conditions when present, and thus aid the health of the unborn. Antenatal care should also provide guidance to the woman and her partner or family, to help them in their transition to parenthood" (Simona, 2005). In the study area people live in big families and during motherhood ladies family circumstances create significant effect on utilization.

Studies has revealed that Personal and family problems also emerged as important issues that contributed to lack of antenatal care (Lia-Hoagberg et al., 1990). Families who offered the social support to the pregnant ladies had more antenatal visits (Erci, 2003; Oakley, Hickey et al., 1996). Results of the quantitative study in current survey showed significant association of social support from mother in law for ANC use through advising, and accompanying to services. A qualitative study from Pakistan also reported the same evidence (Zubia, 2005).

Different studies have shown positive association of the community characteristics exerting a strong direct positive influence on women's decision to seek maternity care including the percentage of women in a community who delivered a child in a health facility (Stephenson et al., 2006), neighbors and their behaviors (M. A. Magadi et al., 2003; Montgomery & Hewett, 2005) and the presence in the community of a health worker providing prenatal care (Gage & Calixte, 2006). However in this study neighbors don't showed any significant effect. The community health worker relation was significantly associated with ANC uptake. Friend's economical support, providing information and advice were also associated with utilization of ANC.

Social support has been defined by Cobb (S. Cobb, 1976) as "information leading the subject to believe that he is cared for and loved,,,,, esteemed and valued,,,,, that he belongs to a network of communication and mutual obligation". The relationship among societal encouragement and health is well known (Bloom, 1990). The support from the society influences health outcomes straightforwardly by offering access to information or by boosting motivation to involve in adaptive behaviors.

In this study the social support from the husband was a strong factor towards the utilization of ANC services. The social support variables were included providing money, encouragement, providing information, and accompany to get the service. International literature show significant association of support from partner and family members with maternal health services uptake (Hildingsson et al., 2008; Tarkka & Paunonen, 1996).

5.4 Recommendations for the Policy Proposal

The results of the current study show that amendments are necessary if we really want to implement health policies in Baluchistan Province to improve ANC services. Based on the results, many imperative suggestions can be recommended (Appendix H and table 28).

Policy proposal for ANC needs to be rewritten for the new roles of ANC personnel vis-à-vis families and communities, appropriate training programs developed, backed up by supportive supervision and monitoring systems. Programs need new protocols to revise the number of recommended ANC visits, to refocus service content, and to strengthen links between ANC providers, communities, and referral facilities.

To achieve the above stated goal the government of Baluchistan should adopt the following policy objectives to reform and increase ANC services coverage.

1. Provide and Deliver a basic package of quality Essential maternal Health Services
2. Develop and manage competent and committed maternal health care providers
3. Generate reliable maternal health information to manage and evaluate ANC services
4. Adopt appropriate health technology to deliver quality maternal health services
5. Finance the costs of providing basic ANC care to all pregnant mothers in Baluchistan
6. Reform the maternal Health Administration to monitor, evaluate and make it accountable to the public

Province of Baluchistan health system is facing many challenges with regard to human rescuers, financial resources, and basic infrastructure. There is a need of multidimensional and multi-sectorial approach through long-term and consistent interventions.

Table 28: Recommendations regarding policy formation

Stages	Recommendations
Agenda setting	• Elected politicians in the provincial assembly and political leaders of different ethnic groups should take part in the policy process by discussing the maternal health problems on different forums from masses to the legislatives. • Appointed officials from public health including all the levels of administration, from district officer of health to secretary of health, with the help of elected politicians should put maternal health problems on the agenda to be acted on without delays.
Policy formulation	• Public health officials should formulate alternative polices to deal with certain areas like, to increase capacity of the health personal and health system to maternal health problems. Alternative polices should also be built for the private health sector to provide good quality care.
Policy Adoption	• Maternal health policy should be adopted with a support of majority in the provincial legislative assembly and by the consensus of the bureaucrats and public health mangers. • Adoption of the health management cadre last year is an example of judiciary courts intervention forcing the provincial government to adopt the policy. If needed courts should be convinced to come in and help in adoption of maternal health policy by provincial government.
Policy implementation	• Administrative units that mobilize financial and human resources should implement an adopted policy. This can only be done when district health systems can carry out planning and would have authority to mobilize financial and human resources. • The interventions should be implemented mostly through regular programs in the health system.
Policy monitoring and evaluation	• Policy monitoring and evaluation should be carried out timely in all aspects. Monitoring and evaluation and accounting units of the government should conclude whether executive groups, legislators, and courts are in obedience with constitutional necessities of a policy and attaining its objects.

Table 28: (Continue) Recommendations regarding policy formation

Stages	Recommendations
Policy Adaptation	• Inspecting and assessment units report on regular bases to agencies answerable for formulating, adopting, and implementing policies that poorly written regulations of maternal health system, insufficient resources, inadequate training of the health personnel that require revision or change.

CHAPTER VI
CONCLUSION AND RECOMMENDATIONS

The history of providing health to the people in Pakistan through planned polices is not very much old. In Pakistan health policies emerged from 1990 and within period of ten years three policies to provide health to the people of Pakistan were introduced. The last policy was introduced in 2001 after the takeover of military in 1998.

The newly elected cabinet approved local ordinance in 2001 and many portfolios had reforms to implement the local ordinance. The aim of the local ordinance was to empower the people at gross root level and alleviate the poverty. On the other hand at international level politics diverted to coup with terrorism as the nucleus was the neighboring country Afghanistan and Pakistan became one of the important stakeholders in war against terrorism.

Throughout the history of Pakistan, health to the nation has been mostly provided through curative health model and preventive components have not considered, as they should be, to improve public health in the country. Currently 37% of population is living in urban areas and 63% are living in rural areas.

The study has emphasized on the policy generation, implementation and its utilization in the community. Maternal health indicators are not so much impressive, maternal deaths in Baluchistan province is three times of the national figure, and antenatal care coverage values are lower than other provinces or national level marks. Government health system is providing 30% of health services and 70% are provided by private health sector. Current study has found that in rural areas demand lot of more efforts to provide health accordingly.

6.1 Policy process

The study results have shown that during agenda setting the important stakeholders did not played any significant role. The agenda was based on poverty alleviation program through local government ordinance. Most of the policy focused on the building infrastructure, increasing human resources, and increasing managerial

capacities in the rural and urban areas. Maternal health improvement was considered as of part of health system strengthening at primary and secondary level, by providing projects like LHWs and midwives through LHW program and NMNCH projects. Pakistan commitment with international community for MDGs also had influence on agenda to build multiple goals requiring multi sectorial involvement.

The study results showed that the health information system designed to provide information on service related indicators, information on the status of the instruments and equipment's. Although the available information from current HMIS is very comprehensive, the quality and reliability of information is quite low due to various factors that include lack of refresher trainings, non-availability of tools and no proper mechanism to improve quality of information.

Despite of having long consultative meetings, provincial committees results showed that the policy was made by the federal considering the circumstances universally for all Pakistan though provinces were very much different in socio-cultural and development, especially Baluchistan province.

During agenda setting elected representatives of people did not played any significant role, the policy was not discussed in the parliament only draft was sent to the cabinet for approval.

On provincial level, provincial ministries of health in association with the PDWP are involved in health planning. Below the provincial level at district (local) no planning activity is carried out. Districts are reliable only for the implementation of plans, policies and endorsements of the federal and provincial government. Project actually gets developed and then that project is controlled basically by federal, and the provincial portion of course is stated separately in the PC1, and then again problem of consultation comes in while planning the project consultation with the provinces is very limited, and other factors are also there in to create problem, like the federal unit of any project they want to keep some key area with them like if there are some consultancy, or hiring of consultancy, they want to keep it with themselves so they can hire by their own as what they want, and then let's say about MNCH project or

national program, their procurement is completely under the federal people, so whatever they want to give province they have to accept it.

The study results revealed that Pakistan national health policy 2001 was implemented mostly through projects to provide maternal health services. Major example of the maternal health services includes LHW program, National maternal and Neonatal child health program and PPHI. In Pakistan politics, economic and socio-cultural context strongly influence the implementation process. In Balochistan province management cadre has be established 2011 as separate group in the health force of the province. Governments are changed frequently and every new government tends to change or decrees the support on their own values not the real values. Such trends never leave policies implemented properly by shortage of time and changes in agendas. It also results in lack of government support for health programs and waste of resources leading to problems in policy implementation. Study respondents stated that changes after implementation are because of overall social development not particular of the policy. As compared to other provinces the development indicators in Balochistan are not so much changed and because of that we see little change.

The results of the study has shown that health systems in the Pakistan have not developed an efficient system of monitoring particularly to monitor regular health system though projects have their own monitoring and evaluation system. Monitoring of health system and programs mainly in the rural areas is not regularly conducted, as has already reported for many years. As a result the process of collecting important information does not work properly. Implementation is not based in terms of getting results and nobody is answerable for bringing results in the system. All persons assume office does his/her job without reflecting the results for which he/she is responsible. So there is lack of accountability for results and lack of accountability to the people. The agreed monitoring mechanisms are being ignored.

6.2 Impediments to Implementation of the NHP2001

According to the study communication gaps delayed the flow of evidence from upper to lower level actors particularly in understanding specific objectives of the planned health projects before implementation in the Baluchistan province and is influenced

by the political, economic, socio-cultural context and overall health system. Implementation schedules for women's health programs and nutrition programs are not based on a systematic approach.

The incidents of 9/11/ 2001 brought considerable changes in the international politics and in the front line countries that are fighting against terrorism. As one of neighboring country of Afghanistan, Pakistan has suffered a lot in development, financial and human loss. The politicians have been concentrating more on fighting against on terror. This war increased more burdens on already troubled economy with low GDP growth and high debt. On the other hand Baluchistan province also had insurgency from the start of the 20th century. Baluchistan province tribal anarchies also influenced the implementation in many areas of the province. Most of the respondents at all three levels were in view that politicians are not interested in the policy issues at any level of policy process, especially in Baluchistan province, they don't have efforts toward Baluchistan.

Financial resources are one of the most important factors that affect policy implementation study has revealed that development budget does not increased considerably to implement the NHP 2001. Baluchistan province don't had health infrastructure, less human resources, low literacy and a large geographical area. The study demonstrates that no special measures were taken to implement the maternal health policy regarding on ground situation in Baluchistan province.

More than 65% of province Baluchistan is rural, with 18% literacy rate and basic infrastructure is lacking in most of the province. Population density is 19/ square Kilometer. Most of the medical and public education institutes are in provincial head quarter Quetta and only the urbanized city. After getting education majority of the health related personnel prefers to stay in Quetta. MNCH project has established midwifery schools and public health schools on regional bases in interior of the province. But the project is facing shortage of human resources in interior Baluchistan.

The study explored that traditionally rural areas are deficient in human resources this is because low number of health personal related to maternal health service and of

preference to stay in Quetta or the people mostly like to stay in their home districts. Throughout the last decade security has been a major problem to stay and work in other areas, and dependency of females on males, female health workers cannot go the outreach areas. The study respondents also elaborated the capacity of the available staff, as they don't get refresh courses, proper training and proper information about their job description. Pakistan health system in Baluchistan is providing routine antenatal care services in primary care level through LHW, LHV and midwifes but the study disclosed that available staff don't have access to the to pregnant ladies.

About 70% of the health services are provided through private health sector in Pakistan and mostly it is for fee in all over Pakistan. Baluchistan also has private sector even in rural areas. Private services are provided by the health personal working with government also and in rural area includes limited number of doctors, nurses, and paramedics, LHV, midwifes, LHW, and unregistered health practitioners. Local cultural and religious mode of healers is also providing health services. As government does not regulate private sector the private sector has grown remarkably during last decade.

6.3 Utilization of ANC by pregnant women

In Baloch culture pregnancy is believed to be a natural process and pregnancy has its own traditional norms and values. In the community studied pregnancy is confirmed after missing menstrual periods for three consecutive months with signs of like and dislike of food, vomiting in the morning and frequent urination. After confirming pregnancy, pregnant women seek advice for food, health care and problems related to pregnancy from elderly women in family, neighbor and friends. Female relatives play an important supportive role throughout pregnancy. The extended family and community apply an important influence on health practices related to pregnancy. When they face some problem the health seeking starts from the female family member to private health services in the village to tertiary hospitals in the urbanized city depending on the resources and severity of the problem. According to information from ministry of Health Baluchistan only 15% of the pregnant women were registered for ANC in 2010 and current study revealed that 14% of pregnant ladies had antenatal care in the community studies. The study identified some barrier

to utilize the services.

The facilities were not available properly with shortage of health staff, equipment's and medicine, were under utilized for ANC services. Pregnant ladies and man in the community had low knowledge and information about routine ANC and services provided. Facilities were not accessible to three quarters of the population. Women are usually not allowed to visit a health facility or health care provider alone or to make the decision to spend money on health care.

Transportation also proved to be an important factor as roads and proper transport was not available and maternal health medical treatment and travel costs were expansive for the people. The community had negative attitude regarding government maternal health services, people believed that government services are not efficient as compare to private sector, even though health personnel is same in private and public provider.

Being part of the government's Poverty Alleviation Plan, the health policy has to realize and reflect that poverty could not be alleviated only through restoration of economic growth, but health status of the population has a role to play in economic development.

6.4 Summery of gaps identified

- Baluchistan province local socio-cultural and ground situation is understudied.
- There are different barriers to access of MNH services in Baluchistan province
- The quality of maternal health care delivered desires to be upgraded
- There is poor management system
- Authority and responsibility demands special consideration.
- Human resources lack capacity and need trainings.
- ANC services need improvement.
- There are issues due to inadequate financial resources
- Socio-cultural and gender issues need more attention

After the 18th constitutional amendment there is a window of opportunity to generate truly representative health policy, based on local socio-cultural and on ground

situation, for government of Baluchistan to strengthen maternal health system. The exact real image of policy means that the policy commitment should be based on core health issues of pregnant mothers and their babies of people of Baluchistan that the skills are satisfactorily directed, resources must be existing according to all goals and finally that implementers take the responsibility and ownership with impetus and pledge for policy activities.

Women's health cannot be improved without addressing every issue, and without moving from the traditional culture of birthing to a modern system of maternal and child health services. It is the need of time to produce evidence and information. The health department should understand the needs and culture of the Baluchistan people and especially women before making any maternal health related decision. Getting the information will guide policy makers to create interventions right on the need of the pregnant women.

6.5 Further research

The current study results showed that existing health system of Baluchistan has weaknesses in many aspects and lot of future studies need to be conducted for detailed review of maternal and child health policy before making future decisions.

- To assess referral and communication system at various health facility levels for maternal and neonatal health.
- Altered examples that can be up taken for improving utilization of maternal health services at public health facilities.
- Requirement of operative research for implementing at least service delivery criteria concentrating on maternal and neonatal health including its improvement, scalability and sustainability.
- Comprehensive evaluation of assorted vertical / parallel maternal health programs as regards practical integration at various services delivery facilities i.e. primary, secondary, and tertiary.
- Evaluation of capacity and skills of maternal health care providers.
- Evaluation of deployment and barriers to move right person to the right place.
- Evaluation of financial fund flow mechanisms for maternal health.
- Evaluation of alternate financial fund flow mechanism models for addressing

equity in maternal health in the context of Baluchistan.

- Viable models for improving nutritional status of mothers and newborns.
- Producing nutrition interventions and their incorporation at the PHC level.
- To carry out interventional studies increasing male participation in maternal health utilization.

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APPENDICES

APPENDIX A

IN-DEPTH INTERVIEW QUESTIONNAIRE GUIDELINES WITH POLICY MAKERS

Serial No	Interview Checklist	Coding
i	Interview Checklist	Interview
ii	ID of the respondent	ID
iii	Organization and duration (years & months)	ID
A	**Policy process and implementation**	
1	What do you think about the magnitude of the maternal health situation in Pakistan? Especially in context of Antenatal care in the rural areas of the Pakistan?	Problem identification
2	What do you think about agenda regarding maternal health in national health policy process 2001espicically with slogan health for all? Probe: • Ensure participation of locals in programming • Did the NHP2001 receive sufficient attention from the political/bureaucratic level? What mechanisms exist to seek participation of major stakeholders?	Characteristics
3	How would you describe the features of the National health policy 2001? Probe: • Based on ANC (maternal health) needs of the pregnant mothers • Clear policy goal & objectives and consistency In your view why the issue of ANC (maternal health) can come on to the agenda? • Efforts and influence by donor organizations such as the WHO and World Bank etc.	Objectives / Goals
4	Were the local, cultural and individual influences considered, as the implementation of the policy was responsibility of the provinces?	Policy Formulation & Decision making Process

Serial No	Interview Checklist	Coding
B	**Policy Implementation**	
5	What changes were made in the organizational structure of the system to effectively implement the policy? Probe • Functional unit at MOHP with critical number of human resources to steer the implementation • What line of planning was provided to the provinces • Were rural areas of Pakistan had platform (capabilities) for adoption (especially in case of Balochistan)	Policy implementation objective at federal level
6	What changes were made in human resources at central and local levels for effective implementation? Probe: • Existence of clear human resource policy specifying the number and type of staff required at each facility • Defined roles of the federal, provincial and district governments	Human resource management
7	What changes were made in planning and financing system after NHP 2001? Probe: • Need-based plans developed and implemented • Budget released by the federal to the province at least	
8	What changes are made in financing and expenditure system? Probe: • Provincial Health ministry's responsible for their budgets • Timely release of central budget • Authorities to re-allocate funds as per the local needs • If changes are not made so far which are the critical areas of financing that need to be addressed immediately?	Planning and Financing Mechanisms

Serial No	Interview Checklist	Coding
9	How was the communication between Federal and provinces? • Functional system of communication with provincial government • Communication channels and feed-back system • Consistency and completeness of the information What is the communication mechanism between province & district? • New system of communication developed • Agreed communication channels and frequency	Information and Communication
10	How is the supervision & monitoring of the programs at provincial level? • Regular system of monitoring and supervision from the province and district health office • System of regular monitoring of health plans and programs by provincial government and district health offices	Supervision and monitoring
11	What were the major problems encountered during policy implementation? Probe: • Lack of clear policy and implementation plan • Inadequate financial and human resources • Lack of capacity in deferent areas • Lack of appropriate organizational structure • Political problem • Reluctances of central level to transfer authority	Issues for policy implementation
12	Do you have anything more to add? Please have your comments?	Opinion

APPENDIX B

IN-DEPTH INTERVIEW GUIDELINES FOR IMPLEMENTATION AT PROVINCIAL LEVEL

Serial number	Interview Checklist	Coding
i	Interview Checklist	Interview
ii	ID of the respondent	ID
iii	Organization and duration	ID
A	**Policy process**	
1	What is the role of provincial health department in NHP policy generation? Probe • Problem Identification • Agenda setting • Policy formulation	Policy process
2	Was your organization consulted in developing NHP 2001? If yes, could you please share your experiences?	Problem identification
3	Does provincial health departments are considered as important stakeholders in the policy process?	
4	Does the policy addresses the health service organization and management needs of district health office specially related to Balochistan province situation. Probe the following: • Emphasizes on planning and management at provincial and local level • Ensure smooth functioning of local health facilities • Ensure participation of locals in identifying health • Needs, planning and implementation of health program	Policy characteristics

Serial number	Interview Checklist	Coding
B	**Policy implementation**	
8	What is the role of provincial governments regarding implementation of NHP 2001? Probe • How planning is carried out for services deliveries? • Who participates in planning? • What is the basis of planning? • Who sets service targets for health programs? • Does the plan give any special focus to remote areas? • If yes, how is it different than the whole province plan? • What difference have you noticed in planning practices before and after NHP 2001?	Policy planning
9	What organizational changes were made at provincial level following NHP 2001 regarding Maternal health especially for antenatal care for planning and health services delivery	
10	Was the required financial resource ensured during planning? If not, what alternative mechanisms were adopted to finance the planned activities?	Financing for the plan
11	What changes are made in financing and expenditure system? Probe: • Guidelines available on budget • Provincial Health ministry's responsible for their budgets • Timely release of central budget • Authorities to re-allocate funds as per the local needs • If changes are not made so far which are the critical areas of financing that need to be addressed immediately?	Financing
12	Lack of adequate and qualified staff in the health facility is a major problem in Balochistan province. What changes were made to increase human resource management in the province and facility level after NHP 2001? Probe:	Provincial Government's Mandate and Practice in Human resource Management

Serial number	Interview Checklist	Coding
13	What capacities were needed at provincial and local level for the proper implementation of NHP 2001? • Administration and Management skills, • Need-based participatory planning, Resource mobilization and proper accounting skills, • Monitoring skills for health services, • Were the above capacity needs assessed and measures implemented? If not, how could it be done?	Capacity Development
14	What is the communication mechanism between federal health ministry and provincial ministries and provincial to district health office? • New system of communication developed • Agreed communication channels and frequency • Consistency and completeness of the information	Information and Communication
15	In your opinion does NHP 2001 received sufficient attention from the politicians and bureaucrats? What mechanisms exist to seek participation of relevant stakeholders at provincial levels?	Political Commitments, Participation
16	How is the supervision & monitoring of the programs at provincial level? • Regular system of monitoring and supervision from the province and district health office • System of regular monitoring of health plans and programs by provincial government and district health offices	Supervision and Monitoring System
17	What effects did the socio- economic and armed conflicts made in NHP2001 implementation? Probe: • Planned activities were partially implemented	Socio-economic and political environment
18	Could you briefly share with us on the implementation status of the planned activities at district and below levels? Status	Implementation status

Serial number	Interview Checklist	Coding
19	What were the major problems encountered during policy implementation? Probe: • Lack of clear policy and implementation plan • Inadequate financial and human resources • Lack of capacity in deferent areas • Lack of appropriate organizational structure • Political problem • Reluctances of central level to transfer authority	Issues for policy implementation
20	In your opinion what are the important factors for successful implementation of NHP 2001 in Balochistan? Probe: • Need of clear policy and implementation plans • Stable elected government • Need of increased health budget • Availability of health workers in health facilities • Local management of health facilities and programs	Policy reform proposal
21	Do you have anything more to add? Please have your comment?	Opinion

APPENDIX C

FOCUS GROUP GUIDE LINES WITH MARRIED MALES AT COMMUNITY LEVEL

1. What is your opinion about health concerns of a lady when she is pregnant in our community?
2. What are concerns of you people about government health care facilities?
3. Do you feel any change in maternal health services deliveries from last ten years to till now, what changes?
4. Utilization of government maternal health services? As they are free.
5. In your view what are the major problems in our community that prevent us using government health services and how these can be make better?

APPENDIX D

FOCUS GROUP GUIDE LINES WITH PREGNANT LADIES REGARDING ANTENATAL CARE AND ITS UTILIZATION

1. In your view what is the importance and need of the antenatal care?
2. Where would you like to go for antenatal services? Why?
3. What problems you people face after you get pregnant and how you manage them?
4. What social and cultural support you get for antenatal care?
5. In your view what are main barriers for antenatal care utilization? How and Why?

APPENDIX E

CRITERIA FOR DOCUMENT ANALYSIS

A		**Accessibility**
	1	The policy document is accessible
B		**Policy Background (source of) health policy**
	1	The scientific ground of the policy are established
	2	The goals are drawn from a conclusive review of literature
	3	The source of health policy is explicit I. Authority (one or more persons, books, scientific articles or source of information) II. Quantitative or qualitative analysis III. Deduction (premises that have been established from authority, observation, intuition, or all there)
	4	The policy encompasses some sets of feasible alternatives
C		**Goals**
	1	The goals are explicitly stated
	2	The goals are concrete enough (quantitative where possible and qualitative where not) to be evaluated later
	3	The goal is clear in its intent and in the mechanism with which to achieve the desired goals, yet does not attempt to prescribe in detail what the change must be
	4	The action centers on improving the health of population
	5	The policy is supported by evidence of external consistency in logically drawing a health out come from the goals of policy out come
	6	The policy is supported by internal validity in logical drawing a health out come from the goals and policy outcome
D		**Resources**
	1	Financial resources are addressed
	2	Human resources are addressed
	3	Organizational capacity is addressed

E		**Monitoring and Evaluation**
	1	The policy indicated monitoring and evaluation mechanisms
	2	The policy nominated a committee or independent body to perform the evaluation
	3	The data for evaluation, collected before, during and after the introduction of new policy
	4	Other factors that could have produced the change (other than policy) identified
	5	Criteria for evaluation are adequate or clear
F		**Political opportunities**
	1	Co-operation between political levels involved (federal, province, health) has either worsened or improved
	2	Support from other sectors (economy, science) has either worsened or improved
	3	The political climate has either worsened or improved
	4	Co-operation between public and private organizations has either worsened or improved
G		**Public Opportunities**
	1	The population supports the action
	2	Multiple stakeholders are involved
	3	Primary concerns of stakeholders recognized and acknowledge to obtain long-term support
H		**Obligations**
	1	The obligations of the various implementers are specified - who has to do what?
	2	The action is part of health professionals' duties
	3	Scientific results are compelling for action
	4	Health professional obliged to the population to act in this area

APPENDIX F

RESEARCH QUESTIONNAIRE

Utilization of antenatal care service among pregnant ladies in reproductive age in district Jhalmagsi, Balochistan

ID NO. ----------

Ward No ……

Date of data collection……/……. /…….

PART 1 predisposing factors, Socio-demographics

1. Age of respondent…years.

2. Education level?

☐ No formal education ☐ Primary school☐ Secondary school certificate

☐ Higher secondary school certificate ☐ Graduation and above

3. Occupation:

☐ House wife ☐Government service ☐ Private service

4. Family Income……..Rupees/month

5. How many children do you have (do not include this pregnancy)? (Please specify number) …….

Knowledge about Antenatal care:

S.NO	Statements	Yes	No	Don't know
1	Complete Antenatal Care means at least four times of visit			
2	The first visit should be done within first three month			
3	Second visit should be done within six month			
4	Third visit should be done within eight month			
5	Fourth visit should be done within nine month			
6	Antenatal care is the care of pregnant women during their pregnancy			
	Following are the benefits of Antenatal care:			
7	ANC can prevent complications during pregnancy			
8	Those who attend ANC will receive information regarding supplementary food and exercise.			
9	Receive information about labor pain and delivery, lactation and family planning.			
10	Pregnant women will receive tetanus toxoid during Antenatal care to prevent tetanus			
11	Antenatal care is an opportunity to inform pregnant women about danger signs and symptoms			
12	Blood test during Antenatal care is necessary to assess anemic status of pregnant women			
13	Mother attended will know a fetal well being			
14	Medicines that are given during ANC are useful for preventing anemia in pregnancy			

Attitude towards utilization of Antenatal care in Government Health Facility

S.NO	Statement	Agree	Undecided	Disagree
1	You feel that ANC will give you a good health during pregnancy at government health facility			
2	You think you feel peaceful when you visit Antenatal care with your husband or your family at government health facility			
3	You are afraid of blood testing at Antenatal care at government health facility			
4	You think waiting time is too much long during ANC visit at government health facility			
5	You think ANC will give you useful information at government health facility			
6	You feel safe when you go for an Antenatal care visit at government health facility			
7	If you have no complication during pregnancy you will go for to Antenatal care at government health facility			
8	You feel shy when health personnel examine your abdomen at government health facility			
9	You think you feel comfortable when you meet other pregnant women during Antenatal care visit at government health facility			
10	You think it is wastage of time to wait too much for ANC visit at government health facility			

PART 2 ENABLING FACTORS:

1. How far is the hospital from your home? ... Km.

2. Is the travel cost from your house to the hospital expensive?

☐ Yes ☐ No

3. Do you think that the medical fee you pay for ANC service is expensive? **(For those who did not have ANC, go to part 3)**

☐Yes ☐ No

4. How long have you been waiting for each ANC service in average? ……. Minutes

5. Do you feel its long time for waiting?

☐ Yes ☐ No

Please tick (√) in the relevant box to identify your satisfaction level towards statements scale: (For those who did not have ANC, go to part 3)

S.NO	Satisfaction towards Antenatal care Service	Satisfaction level				
		Very satisfied	Satisfied	Neutral	Unsatisfied	Very unsatisfied
1	Waiting time for ANC service is acceptable					
2	The ventilation inside the hospital is good					
3	The service area/rooms can be easily found					

S.NO	Satisfaction towards Antenatal care Service	Satisfaction level				
		Very satisfied	Satisfied	Neutral	Unsatisfied	Very unsatisfied
4	Health providers are very good at explaining about ANC services					
5	Health providers are very competent and skillful.					
6	Available medicines regarding ANC are of good quality					
7	Available Equipment's to examine the patients are enough					
8	Health Providers behavior towards the patient is good					
9	All the patients are treated as equal					
10	The waiting room is spacious and bright					

PART 3

Sources of information: select one answer. (Multiple answer)

1. You get information about ANC from

☐ Health personnel ☐ family member ☐ Friends

☐ Television ☐ Radio

Social support: Multiple choices answer

1. How does your husband support you to get ANC?

☐ Providing Information ☐ encouragement ☐ advice

☐ Providing money ☐ accompany you to get the services

2. How does your mother-in-law support you to get ANC?

☐ Providing Information ☐ encouragement ☐ advice

☐ Providing money ☐ accompany you to get the services

3. How does your friend support you to get ANC?

☐ Providing Information ☐ encouragement ☐ advice

☐ Providing money ☐ accompany you to get the services

4. How does your neighbor support you to get ANC?

☐ Providing Information ☐ encouragement ☐ advice

☐ Providing money ☐ accompany you to get the services

5. How does community support you to get ANC?

☐ Providing Information ☐ encouragement ☐ advice

☐ Providing money ☐ accompany you to get the services

PART4 ANC VISIT:

1. Did you ever get ANC services in your previous (including this) pregnancies at government facility?

☐ 1. Yes

☐ 2. No (if No then go to question no 3)

2. If yes, how many times did you ever get ANC services?

- First three months ……times
- Four to six months ……times
- Seven to nine months ……times

3. If no ANC, why

☐ Not Necessary

☐ Costly

☐ ANC service center is so far from home

☐ Don't know about ANC

☐ Have to wait too much

☐ Nobody accompany to hospital

☐ Don't know where to go

4**.** Did you have any complication during latest pregnancy?

☐ Yes

☐ No

APPENDIX G

BUDGET

No	**Activities**	**Total Amount (Baht)**
1	Traveling cost	80,000
2	Stationary	10,000
3	Research assistants salaries	60,000
4	Accommodation and food	20,000
5	Refreshments	10,000
6	Others	5000
Grand Total		**185,000**

APPENDIX H

DRAFT OF ANTENATAL CARE POLICY FOR BALOCHISTAN PROVINCE

Vision

The vision of antenatal care policy to contribute in maternal health and improve health of mothers in Balochistan province, Pakistan

Goal

The goal of antenatal care policy is to increase ANC coverage by eradicating the barriers to access to inexpensive, basic health services for every mother in Balochistan province

Policy Objectives

The provincial ministry of health should recognize low utilization of the maternal health services where available. The ministry of health should also recognize that districts have varied needs and expectations regarding antenatal care and provincial ministry should support and facilitate the districts in implementation of their strategies by providing relevant financial and technical resources to ensure that basic ANC services are available to every pregnant mother. The policy is intended to strengthen the maternal health system at primary secondary and tertiary level.

Policy proposal for ANC needs to be rewritten for the new roles of ANC personnel vis-à-vis families and communities, appropriate training programs developed, backed up by supportive supervision and monitoring systems. Programs need new protocols to revise the number of recommended ANC visits, to refocus service content, and to strengthen links between ANC providers, communities, and referral facilities.

To achieve the above stated goal the government of Balochistan should adopt the following policy objectives to reform and increase ANC services coverage.

1. Provide and Deliver a basic package of quality essential antenatal care Services
2. Develop and manage competent and committed antenatal care providers
3. Generate reliable maternal health information to manage and evaluate ANC services

4. Adopt appropriate health technology to deliver quality antenatal care services
5. Finance the costs of providing basic ANC care to all pregnant mothers in Balochistan
6. Reform the maternal Health Administration to monitor, evaluate and make it accountable to the public

Province of Balochistan health system is facing many challenges with regard to human rescuers, financial resources, and basic infrastructure. There is a need of multidimensional and multi-sectorial approach through long-term and consistent interventions.

Women in Balochistan are part of a male dominant society where cultural values are backbone of the society. Women autonomy is limited, the literacy rate is low, financially they are dependent on family, and they cannot travel alone as a result the access of the women is limited to health services. Unviability of good quality health services, basic infrastructure, travel costs and medical expanses also influence the utilization of services.

The proposed policy deals direct with problems affecting antenatal care, such as transportation and communication systems, dissemination of information on safe birth planning, and management and quality of health services. Such collaboration will require setting up common objectives and an agreed strategy, within the context of provincial health policy about partnerships.

Another area for policy clarification is that around CMWs. Programs for training CMWs have had mixed reviews and more and more countries are altering their policies to emphasize the deployment of skilled birth attendants. But this takes time to implement, and in the meantime, existing LHWs and TBAs continue to influence families about care, especially in decisions about having ANC.

ANC care providers should be close to the community, and understand women and communities' perspectives on ANC, barriers to and facilitators of ANC. Their position in the health system will provide the opportunity to feed information from the community to the referral level, and vice versa. They could also advocate for the

resources they and the community need because of their ability to facilitate an investigation and explore community perceptions and actions. Such unfamiliar roles for personnel as advocates and researchers, linking ANC systems to referral care, would need development. However backing up in policy.

Policy objectives and Actions for ANC By Provincial Government and District Health departments

1. Provide and Deliver a basic package of Essential ANC Services

The government should provide a minimum of basic package at primary secondary and tertiary care levels for ANC though out province. The existing and proposed health interventions related to maternal health should be integrated in to the regular health system. . Though national health programs have their advantages – mainly in terms of quickly rolling out essential services - they must be devolved to provincial/district level to assure their eventual sustainability via ownership at local level. Their integration into minimal essential health package could serve such a purpose providing an opportunity for community involvement, contribution, participation and oversight. Changes in ANC with regard to involvement of the family and partnerships in the community need to be facilitated. Balochistan health system has a major strength in the form of management cadre in public health, Lady health workers and increasing number of community mid wives in outreach areas. Government health personnel should access the community through outreach services from BHUs or RHCs to make a permanent social network with women involving their families and community this will make understand their cultural values and health seeking behaviors. The mangers should be able to conduct planning on district level to implement policy more accurately.

Proposed actions

- The proposed policy is providing different intervention of ANC health services for both primary healthcare and for above levels of maternal healthcare in the province of Balochistan. Basic health services for ANC will be implemented at primary care outlets including out reach services, referral and emergencies. The proposed intervention is based on standard of care,

human resource requirement, and appropriate health technology, financial out lays, essential drug list and public private partner ship.

- All the services providing intervention through federal projects for ANC will be integrated in the regular health system.
- Provincial health authorities will ensure appropriate staffing, adequate operational resources to deliver the services and adequate provision of essential medicines and medical supplies of MCH center in RHC and BHU.
- Planning and implementation will be carried out at district level for the intervention at local level.

2. Human Resource Development and Management

Health system in Pakistan is mostly composed of curative services and development of the human resources concentrated on doctors, nurses, CMWs, Lady Health workers and LHVs they are mostly trained to provide curative services. Public health has been mostly neglected especially in rural areas leading to shortage of the health personal in out reach areas for maternal health. The service structure for health workers are poorly defined it, favors tenure over competence, largely ignores technical capacities and does not allow incentives or rewards for performance.

There is no organized system for continuing medical education for any ANC health providers who are also largely unsupervised and at times ill equipped with newer knowledge/skills to tackle emerging problems. This holds true for management cadres as well. The types and number of services delivered by a primary health care facility for ANC services currently depend solely on the number and categories of health providers present at that facility. The main reason cited for a non-functional BHU is almost always the absence of a doctor and unavailability of the competent female staff. Consequently providers deliver the types and standards of services that are most beneficial to them and not necessarily the types and standards of services required of them, or of the facility, or demanded by the maternal health conditions.

Health authorities have yet to be convinced that Basic ANC services at PHC services can be successfully provided and delivered by midwives and allied health

professionals making up local teams with the relevant staffing complement and skills mix.

Proposed Actions

- The newly created management cadre in Balochistan will take the charge of district health, only doctors from the management cadre will be appointed as EDOH.
- District health authorities will forecast human resource needs for maternal health services based on local requirements.
- District health departments will promote in-service trainings for community midwifes and lady health workers on continuous bases to increase the competency and create a friendly atmosphere between ANC services providers and pregnant mothers and community.
- District health authorities will appoint and retain relevant cadres of appropriate health personal with special focus on staffing primary care outlets and on recruiting women. District health departments will track human resources for maternal health professionals by establishing a database for doctors, nurses, mid wives and lady health workers working in BHU's and RHC's across each district.
- Provincial and district health authorities will initiate campaigns to promote the permanent roles that midwives and LHW play significant role in providing and delivering effective ANC services to the pregnant mothers.
- District health departments will also launch campaigns to encourage the female to join profession of community midwifes and lady health worker.
- The districts health departments also encourage communities to come forward and propose local professionals whom the community trusts and considers worthy of being a staff member of the local BHU or RHC for maternal health services.

3. Generate reliable health information to manage and evaluate health services

Pakistan health information system currently in use is fragmented and vertical, they used to respond and serve primarily the health programs that created them or are inaccurate.

The gathered data is not processed and analyzed locally leading to decrease in validity and decrease in local decision-making. The capacity of the district mangers is severely deficient to analyze the data and make decisions on the bases of information generated locally.

Newly created DHIS has the data from all the three tires of Pakistan health system is more informative and replaced the old health management information system that gathered the data from primary and secondary health facilities.

Proposed Actions

- Provincial and district health authorities will establish data flow protocols and facilitate the use of appropriate technologies for increasing the efficiency of the information system.
- Provincial and district capacity to utilize the information for evidence-based decision-making will be enhanced appropriately for maternal health services.
- Provincial health authorities will require that maternal health plans to be funded by government and reports of maternal health programs and monitoring and evaluation that is funded and considered by the government would be based on the use and analysis of data at local level provided by the DHIS.
- The district health departments will increase the capacity for the data analysis through make special teams for data analysis at local level.

4. Infrastructure and appropriate health technology for delivering quality services

Maternal health facilities across Balochistan are variable in the way they are built, set up and equipped. Infrastructure of MCH center is suffering from a not fit for purpose. Lack of appropriate, relevant and functional medical equipment in MCH centers further limit performance. Unsafe blood transfusions and poor laboratory standards are also a challenge.

Proposed Actions

- MCH centers and labor rooms will be developed in BHU and RHC under the supervision of CMW or trained TBA. The out reach centers will also be

supervised by the MCH centers. The MCH will also collaborate with local private health provider. The MCH teams will go into the villages and conduct regular sessions with pregnant ladies in groups.

- District health authorities will provide the required maternal health technologies including drugs, diagnostics, and equipment to facilities according to the recommendations of basic maternal health services and ensure continuous supply/replacement of each item to assure service quality and safety.

5. Enhancement of maternal health budget and provision of social safety nets

The overall health spending in Pakistan is very low level even when compared with other low-income countries. The total annual health expenditures are Rs. 186 billion (USD 3.1 billion or nearly USD 19 per capita) or about 1.9% of the national GDP. Of these the government spends nearly Rs. 60 billion (0.6% of the GDP, USD 6 per capita), while much of the remainder are out of pocket payments by citizens at points of care. These latter payments are mostly for curative care and over 80% of all health spending goes for treatments and only 16% for prevention services. This disproportion in spending hides the fact that the proportion of household income that is spent on health increases with poverty with poorer households spending more on health. Health expenditures also account for 52% of all catastrophic spending by households in Pakistan, depicting the inequity of how health is paid for. Finally, donor funding is around Rs. 3.6 billion (USD 60 million annually or USD 0.4 per capita) annually and accounts for about 2% of national health spending. The official donor assistance that is allocated to health is around 8%. At these levels, Pakistan lags other low-income countries where donor assistance averages about 14% of health spending. By providing a basic set of essential maternal health services, the Balochistan government will free up disposable income for households that they can apply to their other needs.

Proposed Actions

- Provincial and district governments will allocate budgets for the health on the basis of per capita costs as determined by costing out the delivery of newly contextualized package of basic maternal health services.

- Provincial and District governments will jointly decide on the types and levels of funding for maternal health services to feed in to the development of financing schemes that will ensure equitable access to maternal health care services by poor and vulnerable pregnant mothers.
- Provincial and district governments will account for the output and financial performance of maternal health programs as discrete entities irrespective of their funding configuration.

6. Monitoring and Evaluation

Maternal health care services in Pakistan are available from public and private providers, but the types, quantum and quality of services don't always meet pregnant mother's needs. The provision of essential maternal health services remains the responsibility of government but the reforms envisioned under the National Health Policy of 2001 which focused almost entirely on the public sector, did not produce improved maternal health outcomes in Balochistan province. Delivery of those services is increasingly being delegated to the non-governmental organizations and private providers as a strategy to improve the effectiveness and efficiency of services under the supervision of the federal government. All of innovations are dependent upon the presence of a strong monitoring and evaluation framework at every tier of the health system strengthening programs to achieve the above objective.

Proposed Actions

- An intensive effort to strengthen the maternal health systems at district level will be undertaken particularly for undertaking robust monitoring and evaluation activities. This will also include an institutional effort to facilitate research and development activities.
- The district health departments will be responsible for continues monitoring and evaluation under the existing framework in the provincial level.
- District and provincial health governments will assist their maternal health authorities to undertake maternal health reform to enable them to monitor and evaluate maternal health services professionally in a atmosphere free of political interference and be more accountable to the communities they are serving.

- On provincial level, the only ANC indicator will be used to monitor progress in Safe Motherhood is coverage: the proportion of women who complete at least one ANC visit, and the number who complete four visits.
- The number of women completing four visits will be used as a proxy for the proportion who has a safe birth plan before their delivery date.
- On the district level indicators will be knowledge of safe birth messages by pregnant women, husbands and mothers-in-law, the proportion of communities that have had awareness-raising inputs, and their response, e.g. activities in support of referral. This will be monitored through meetings with staff, the public, and community organizations.
- Information about the collaborative partnerships formed in support of safe motherhood is important. ANC managers will also scrutinize the performance of referral systems, the perceived quality of delivery care, and costs.
- At operational level, managers will need information on implementation, i.e. specific service activities, as well as the associated financial, administrative, logistic and human resource issues.
- Monitoring of human resource issues will cover new training and job descriptions, ANC policy, service protocols and changes in staff performance.
- The outcomes of the new approach to ANC will be seen in statistics on the proportion of women who get ANC from skilled birth attendants, and who use referral facilities when they experience complications, given of course that these are accessible, affordable and of good quality. The new approach to ANC will show its benefits most clearly and gratifyingly at this level.

BIOGRAPHY

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MPH (health development systems): Chulalongkorn University, Thailand, 2009

FCPS (Pathology): five years supervised training completed (2003 to 2008), College of Physicians and Surgeons Pakistan

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Work Experience:

NGO Coordinator: Balochistan AIDS Control Program (program is funded by World Bank), Quetta Pakistan, from 1st June to 30th January

Medical Officer on Training: 2003-2008

Supervised by fellow of royal collage of Pathologists for the training of fellowship in pathology and clinical attachment in different specialties of medicine,

Sheikh Zayed Hospital, Lahore, Pakistan

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During five-year period I supervised the management of laboratories and assisting the head of departments in management and teaching activities.

Medical Officer / incharge Basic Health Unit: 2001- 2003

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Research work:

Dissertation for the requirement of fellowship, on Prostatic Carcinoma, at Lahore, Pakistan

Thesis for the requirement of MPH, risk factor association for HCV among females in reproductive age at Quetta

Research paper on HIV risk factors association, published in the journal of Chulalongkorn University