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Informing Policies, Reforming Practices

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Maternal, Newborn, and Child Healthcare (MNCH) in Pakistan: Bridging the Gap of Community Participation and Voice

Mainstreaming the Model from District Lodhran

INTRODUCTION

The importance of healthcare and nutrition for both mother and child cannot be overlooked in achieving Sustainable Development Goals (SDGs)[1] and reducing maternal and child mortality rates. Poor maternal health can have damaging impact on the family, society, and nation as a whole. According to research, the babies of ill or under-nourished pregnant women are more likely to have a Low Birth Weight (LBW) (Reed 1998: 6; Kramer 1987) and impaired development. LBW children in turn are at greater risk of dying and of suffering from infections and growth retardation, have lower intelligence and higher risk of developing chronic diseases in adulthood (Grivetti 1998)".

In Pakistan, mothers, newborns and children desire improvement in Maternal, Newborn, and Child Health (MNCH) Services as the country has one of the worst maternal and child mortality rates in the world. This is corroborated by the data that Maternal Mortality Rate (MMR) is 170 out of 1,00,000 live births and Infant Motility Rate (IMR) is 69 out of 1000 live births[2]. A provincial comparison indicates that despite being ahead of other provinces, Punjab is still performing low on maternal, neonatal and child health indicators and the situation is even worse in the Southern districts of the province (Table 1).

Province/ District/Indicator	Punjab	Lahore	Lodhran
Skilled Birth Attended Deliveries	38.5	81.7	43.2
<5 Year Mortality Rate per 1000 Live Births	104	62	97
Infant Mortality Rate per 1000 Live Births	82	52	78
Contraceptive Prevalence Rate	29	34.6	45.3

Source: MNCH Profile 2011

The causes of MMR and IMR are manifolds, like absence of nutritional and antenatal care, inadequate number of health facilities, mishandling by

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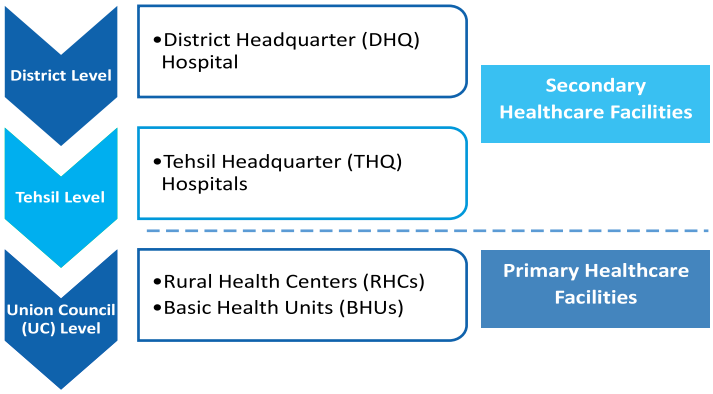
untrained or unskilled birth attendants, etc. However, all of these causes are preventable through providing care by fully competent Skilled Birth Attendants (SBAs)[3] during pregnancy, delivery and in the postnatal period, which can significantly contribute to saving the lives of mothers and newborns.

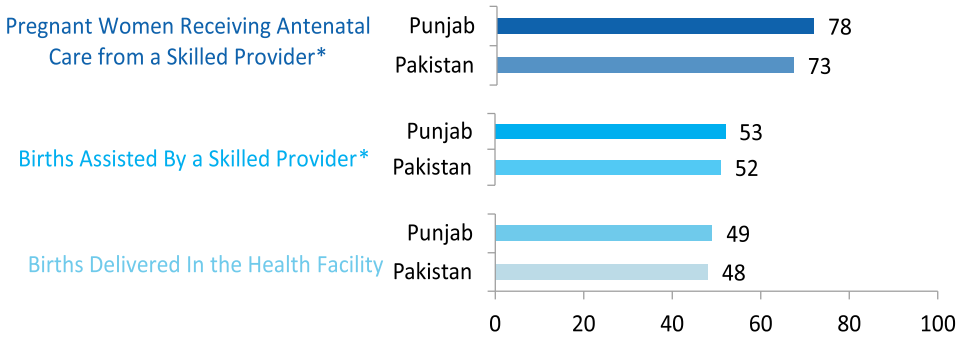
In Pakistan, government took major move towards Primary Health Care (PHC) and improving demand side in PHC (Fig.1) in mid-1990s and deployed trained Lady Health Workers (LHWs) and Community Midwives (CMWs). LHWs provide PHC services with emphasis on Maternal Child Health (MCH), family planning and improvement in nutritional status of mother and children, and improve utilization of health services through referral. Whereas, Community Midwives (CMWs), which meet the international definition of SBAs, are trained in home-based deliveries.[5]

Fig.1: Health Care System in Pakistan



However, despite presence of PHC system in the country, the statistics present a poor scenario with only 73% of the pregnant women receiving antenatal care from a skilled provider, 52% of the births assisted by a skilled provider, and 48% of the births delivered in a health facility[6]. The situation is equally worse in Punjab. (Chart 1)

Chart.1: Maternal and Child Healthcare



*Skilled provider includes doctor, nurse, midwife, or Lady Health Visitor
Source: Pakistan Demographics and Health Survey (PDHS) 2012-13

Challenge of Missing Voice and Community Participation:

One of the key reasons for low performance on health indicators is the missing demand-side accountability and

oversight of local services. Communities and health service users lack authority and voice to influence the health service delivery at the district and tehsil levels in Punjab and other provinces of Pakistan.

Government of Punjab has made efforts[7] to establish linkages between community and health workers and to ensure community involvement through representation from local villages by constituting Support Groups[8] and Village Health Committees (VHCs)[9]. In addition, opportunities are also being created for establishing tehsil and District Community Health Councils. However, the community health councils are yet not functional, especially in district Lodhran.

POLICY OPTIONS AND WORKABLE MODEL:

Absence of community involvement in accountability and oversight of the MNCH services makes communities, particularly women, a weaker party at local as well as tehsil and district levels. This situation highlights the need to bridge the gap between service users and service providers of MNCH services at all levels. For bridging the gap between service users and services providers of MNCH services, Institute of Social and Policy Sciences (I-SAPS) implemented an innovative Model of establishing health support committees at Tehsil and District levels. Details of the Model are given below:

MODEL OF TEHSIL HEALTH SUPPORT COMMITTEES (THSCs) AND DISTRICT HEALTH SUPPORT COMMITTEES (DHSCs)

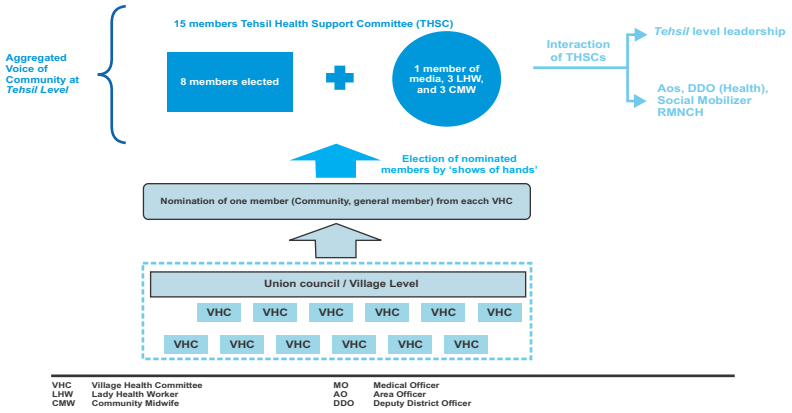
Tehsil Health Support Committees (THSC) has been established in Tehsil Lodhran. The pilot of THSC contributed to improving health services being provided in the tehsil by ensuring maximum involvement of citizens and community members. Active and voluntary involvement of community members and their interaction with PHS providers offers the opportunity to strengthen linkages between service users and service providers of health services.

HOW THE MODEL WAS ADAPTED AND DEVELOPED?

The innovation has been adapted from the *Maapay* model[10] of "*Tehsil* and District School Councils" successfully implemented in education sector in Punjab.[11] This is a bottom-up voice aggregation model which provides institutional platform for vertical feedback and decision support to district health management. Through Tehsil and District Health Support Committees the voices of communities is transformed into need-based demands that are shared at relevant forums at district and tehsil levels. The high level committees help to inform and support decision makers for improvement in quality of health services.

The first step towards establishing the Tehsil Health Support Committee has been engagement with Male Health Committees and Female Health Committees already existing at village level in the focus tehsil. The members of Tehsil Health Support Committee (THSC) are elected from the Male and Female Village Health Committees already existing at community level. Each THSC consists of 15 members including representatives from general community, local media, CMWs and LHWs.[12]

Fig.2: Formation of Tehsil Health Support Committee (THSC) in District Lodhran



Members of THSCs and DHSC are linked up with the officials of health department in tehsil Lodhran. The high level committees are mandated to liaise with relevant government officials in their efforts for health reforms and raising voice for action and improvement in health services. The highlight the issues of greater importance and needing attention from health official/government authorities besides ensuring that administrative, policy and political actions are taken to address these issues.

POLICY RECOMMENDATION FOR MAINSTREAMING THE MODEL

Government of Punjab under its Integrated RMNCH programme has introduced opportunities for establishing health councils at tehsil and district levels, however, these forums are not functional currently. THSC established under the pilot initiative in district Lodhran demonstrates the practicality and effectiveness of such community forums. Considering the utility of THSC it is recommended that these forums should be mainstreamed in the existing systems. Government should capitalize on the lessons and materials produced under this model to make the tehsil and district community health councils functional. By mainstreaming this model the government will ensure that its policy is practically implemented.

References and End Notes

[1] *Goal 3: Ensure Healthy Lives And Promote Well-Being For All At All Ages*, Available at: http://www.un.org/sustainabledevelopment/health/, Accessed on: Nov 1st, 2015

[2] *Pakistan Economic Survey 2013-14*, Ministry of Finance, Government of Pakistan

[3] *Multiple Indicator Cluster Survey (MICS) Punjab 2011*, Bureau of Statistics Punjab, Government of Punjab

[4] Health care workers trained in pregnancy, delivery and newborn care-school-councils-lack-training/

[5] "*Functional Integration of Primary Health Care in Punjab*", Health Sector Reforms Program, Government of the Punjab, [Available at: http://www.phsrp.punjab.gov.pk/pmdgp/Concept-Paper-on-Integrated-PHC.pdf, Accessed on July 6th, 2015]

[6] *Pakistan Demographics and Health Survey (PDHS) 2012-13*, National Institute of Population Studies (NIPS), Islamabad, Available at: http://www.nips.org.pk/abstract_files/PDHS%20Key%20Findings%20FINAL%201.24.14.pdf, Accessed on: October 29, 2015.

[7] "*Functional Integration of Primary Health Care in Punjab*", Health Sector Reforms Program, Government of the Punjab, [Available at: http://www.phsrp.punjab.gov.pk/pmdgp/Concept-Paper-on-Integrated-PHC.pdf, Accessed on July 6th, 2015]

[8] Support groups under Chief Minister's Initiative for Primary Healthcare (CMIPH)

[9] Village Health Committees (VHCs) under Punjab Integrated Primary Health Care Model (PIPHCM)

[10] Consumer Rights Commission of Pakistan (CRCP). 2015. *Maapay Model: Parent Voice for Quality Education (A model of District and Tehsil School Councils). CRCP. Islamabad.*

[11] This model was implemented in education sector by CRCP in association with Ilm Ideas. The initiative was initially implemented in districts Jehlum and Gujrat. After successful execution of the project in pilot districts it was scaled up and also replicated in districts MandiBahuddin and Gujranwala.

[12] Compared to *Maapay* Model the THSC Model was strengthened by ensuring participation of media and local service provider i.e. CMWs and LHWs.