Working Towards Millennium Development Goals

Research & Advocacy Fund

Maternal and Newborn Health

The Policy Context in Pakistan

TABLE OF CONTENTS

Authors: Sally Golding, Sarah Hall, Fatimah Shah with thanks to Seema Khan and Dr. Donya Aziz.

LIST OF ABBREVIATIONS

AusAID	Australian Agency for International Development
BC	British Council
CMW	Community Midwives
DFID	Department for International Development
DHQ	Donor History Questionnaire
EDO	Executive District Officer
EmONC	Emergency Obstetric and Neonatal Care
GDP	Gross Domestic Product
GoP	Government of Pakistan
GSEP	Gender, Social Exclusion and Poverty
I-SAPS	The Institute of Social and Policy Services Pakistan
INGO	International Non-Governmental Organisation
LHV	Lady Health Visitor
PAP	Population Association of Pakistan
PMA	Pakistan Medical Academy
PMU	Policy Management Unit
POC	Programme Oversight Committee
PST	Programme Strategy Team
MDG	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NGO	Non-Governmental Organisation
RAF	Research and Advocacy Fund
TOR	Terms of Reference
TRF	Technical Resource Facility
WRA-P	White Ribbon Alliance Pakistan
WHO	World Health Organisation

BACKGROUND

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

The purpose of RAF is to improve MNH practices and supporting policies related to Millennium Development Goals (MDGs) 4 and 5. To do this, RAF supports quality non-clinical research and effective advocacy. RAF has already undertaken three rounds of proposals, and is in the process of announcing the fourth round. To date, most proposals received and funded by RAF have been research-oriented, often with weak links to policy or practice change as it affects MNH.

This document comes from the recognition that opportunities exist to more quickly and collectively bring about change in MNH outcomes for poor and marginalised women and children. RAF recognises the need to place advocacy firmly at the centre of its programme. For advocacy to be effective it must be grounded in the socio-political realities. The document highlights the current MNH policy context in Pakistan to help RAF's grantees and potential grantees in understanding the background and plan effectively to influence change.

POLICY CONTEXT

1 OVERVIEW OF MATERNAL AND NEWBORN HEALTH IN PAKISTAN

The prevalence of poor MNH outcomes in Pakistan is well documented. Despite efforts by the Government of Pakistan (GoP) to respond to international commitments, such as the MDGs, Pakistan lags behind most developing countries in terms of its MNH outcomes. The Pakistan Demographic and Health Survey (PDHS 2007)[1] provides the latest credible statistics on maternal, newborn and child health.

Table 1. Statistics of MNH in Pakistan

Total Fertility Rate (TFR)	4.1 Births per woman
Contraceptive Prevalence Rate (CPR)	22 percent
Infant Mortality Rate (IMR)	78 (per 1,000 live births)
Neonatal Mortality Rate (NMR)	58 (per 1,000 live births)
Under five Child Mortality Rate	94 (per 1,000 live births)
Maternal Mortality Ratio (MMR)	276 (per 100,000 live births)

In addition, among women aged 15 to 49, complications arising out of pregnancy and childbirth are the leading cause of death, accounting for 20 per cent of all deaths for women of childbearing age[2]. Certain areas and provinces have particularly poor maternal and infant health outcomes. Women living in rural areas are at double the risk of dying of maternal causes than women living in urban areas – a maternal mortality rate of 319 and 175 deaths per 100,000 live births respectively.[3] The maternal mortality rate in the province of Balochistan is 785 deaths per 100,000 live births.[4]Evidence also suggests that while the Infant Mortality Rate (IMR) has declined steadily over the last two decades, there has been no parallel decline in neonatal mortality rate (NMR).

The lack of provision of adequate basic health services, trained staff, adequate medical supplies and equipment are direct causes of maternal mortality. The health system in Pakistan suffers from a lack of investment by the national government. According to WHO statistics, Pakistan's investment in the social sector is amongst the lowest in the world, with less than 2% of total government expenditure going to health.[5] This is a result of both limited government revenue, and a lack of political will. The MNH system is also weak, suffering from poor governance in terms of inadequate information and accountability systems, weak linkages and integration between institutions, poor management capacity within decentralised institutions and poor human resource management.

However, the underlying causes of maternal and newborn mortality are socio-cultural structures, which discriminate against women and girls particularly those who belong to poor and marginalised groups. In Pakistan, access to MNH differs greatly between different socio-economic groups. Poverty, ethnic, cultural and religious factors can all have an impact on women's status and their ability to access health care. In fact, a significant barrier to reducing maternal and newborn health mortality rates in Pakistan is the lack of attention paid to the broader social, cultural and political factors at work in particular contexts which affect women's access to health services. RAF sees the following as important factors[6]:

[1] The National Population Census was scheduled to be held in 2008 but has been indefinitely delayed due to security and financial constraints.
[2] Pakistan Demographic and Health Survey 2006-2007, pg.26.
[3] Ibid.
[4] Ibid.
[5] UNICEF, 2008. Countdown to 2015: Maternal, newborn & child survival. Tracking progress in maternal, newborn & child survival. The 2008 report. New York: UNICEF.
[6] Khan, S. et al (2010) *Gender Inequality, Social Exclusion and Maternal and Newborn Health*, Briefing Paper prepared for RAF

- Low prioritisation of girls' education;
- Limited ability to enter waged employment;
- Lack of control over income and assets;
- Lack of decision-making power in the household;
- Limited mobility of women;
- Low levels of participation in public life; and
- High levels of violence against women.

2 NATIONAL PROGRAMMES AND PROGRAMMES RELEVANT TO MNH

For the past 10 years Pakistan's commitment to achieving the MDGs has been the primary driver behind efforts to improve MNH in the country. Prior to the implementation of the 18th Constitutional Amendment (see section below) the Federal Ministry of Health is responsible for policy development, standard setting, regulatory frameworks for drugs and services, development of national plans, inter-provincial coordination, monitoring, evaluation, research, resource mobilisation, and provision of services through vertical programmes such as Lady Health Workers (LHWs) and Expanded Programme on Immunisation (EPI), etc. The mandate of the Provincial Departments of Health is that of policy, intra-provincial coordination, monitoring and evaluation, medical and nursing education and tertiary care service delivery. The Districts administration is responsible for implementation, monitoring and supervision, management of healthcare delivery at and below the District Headquarter Hospitals (DHQs) and implementation of Federal vertical programmes at the district level.

The **National Programme for Family Planning and Primary Health Care** (widely known as the Lady Health Worker (LHW) Programme) was launched in 1994 and employs community based outreach workers to provide essential primary health care services and information at community level. Presently over 100,000 LHWs are employed with 65% population coverage (approximately 90 million). Each LHW is responsible for approximately 1,000 households. The programme contributes directly to MDGs 1, 4, 5 and 6 and indirectly to goals 3 and 7.

The LHW Programme utilises a selection and training criteria to ensure that trained workers are acceptable to and trusted by their communities. The selection criteria states that an applicant must be a local resident, with secondary education, at least 18 years of age, preferably married and have a recommendation by the community. A 2008 report by WHO[7] however, found that the criteria had contributed towards an imbalanced nationwide coverage of the Lady Health Workers, as the entry-level qualifications are too high for some areas, resulting in few or no candidates.

The LHW Programme is the Ministry of Health's flagship Primary Healthcare initiative. The Programme was launched by Prime Minister Benazir Bhutto and survived multiple leadership changes in the politically turbulent 1990s. The successive political and military governments have also allowed the programme to continue.

The LHWs visit women in their homes and have helped increase the uptake of basic health services, e.g. family planning and immunisation at domestic level. However, little change has been observed in antenatal visits or hospital deliveries[8]. It should be noted that over the years the LHWs have, moved away from their primary objective of providing family planning products and counselling services. The traditionally conservative environment in Pakistan, duplication of family planning services by the Ministry of Population welfare, and involvement of LHWs in other programmes and initiatives (e.g. polio campaigns, tuberculosis treatment initiatives, surveys, and the National census) because of

[7] Pakistan's Lady Health Worker Programme, Global Health Workforce Alliance, World Health Organization, Case study 2008
[8] 'Challenges in Access to and Utilisation of Reproductive Health Care in Pakistan' Moazzam Ali, Mohammad Ayaz Batti, Chushi Kuroiwa (2008)

their extensive network and coverage, have contributed towards the dilution of LHW support towards family planning services.

Pakistan's flagship **Maternal, Newborn and Child Health Programme** (MNCH) was launched in 2005. Presently the MNCH programme coordinates the efforts of various federal and provincial bodies in close collaboration with donor and private sector programmes with the aim of improving maternal, neonatal and child health indicators in Pakistan. The focus of the MNCH Programme has been two-fold: to coordinate, improve, and promote primary health service delivery to end users; and to elicit tangible behaviour changes that will improve the acceptance, demand for and utilisation of those services.

The Programme is in the process of deploying a new cadre of Community Midwives (CMWs) with the aim of increasing the proportion of skilled birth attendance in under-served communities (population of approximately 100 million), and thus positively affecting the Maternal Mortality Ratio (MMR) through early detection and timely referral of obstetric and newborn complications.

The MNCH Planning Commission's Performa[9] (PC-1) proposes the training of 12,000 CMWs in collaboration with programme partners. CMWs undergo two years of training and are deployed to their Union Council of residence where linkages between the District Evaluation Committees (DEC), CMWs, LHWs, Lady Health Visitors (LHVs), and the community will ensure consistent service delivery and a sound referral system. Presently approximately half of the CMWs have been trained.[10] Deployment for community midwives with funding from UNFPA is now in progress in Two districts of Khyber Pakhtoonkhwa, Punjab and Azad Kashmir, deployment in two districts of Sindh is also in progress with the help of Norway – Pakistan Partnership Initiative.

At present deliveries in most of Pakistan's rural areas are carried out by **Traditional Birth Attendants** (TBAs). Although not classed as part of an official programme, these unskilled women are integral parts of the communities they serve, due either to conservative social practices or the absence of skilled attendants. While TBAs enjoy acceptability in their communities, they usually employ unhygienic practices and are often unable to refer complicated cases in a timely manner. In the 1990s there was a global effort to impart institutional training to TBAs spearheaded by international agencies such as UNICEF. Although it was found that the training of TBAs had a positive effect on neonatal mortality, there was little or no improvement of maternal mortality ratios. In many studies it was found that the TBAs eventually reverted to their old practices. It may be beneficial to impart some training to TBAs as a stop-gap initiative while other cadres such as Community Midwives are still in the process of being trained and deployed in the field.

Other programmes of either direct or indirect relevance to MNH are:

- Women's Health Project
- National Nutritional Programme
- National Expanded Programme on Immunisation (EPI)
- Polio Eradication Initiative
- President's Emergency Polio Campaign
- National Programme for Control of Diarrheal Diseases (CDD)

[9] A GoP-issued document prepared for publicly-funded projects. The document usually defines the regulations governing the project, its scope, mandate, budget, the sponsoring agency, executing agency, operational maintenance and the concerned government ministry/department.

[10] Table: Programme Progress To date (2006-2010), pg: 3, National Programme for Maternal Newborn and Child Health (2006-2012) Government of Pakistan's Initiative for Millennium Developments Goals 4&5 (March 2011) referenced at http://www.mnch.gov.pk/library/Program%20Documents/Govt%20of%20Pakistan%20Initiative%20for%20MDGs.pdf

- Integrated Management of Childhood Illness (IMCI) Strategy
- Acute Respiratory Infections (ARI) Control Project

3 NATIONAL POLICIES & ACTS RELEVANT TO MNH

The GoP has also introduced a series of health policies that have a direct impact on MNH:

3.1 POLICIES:

- **1990 National Health Policy** - Pakistan's first National Health Policy was adopted in 1990 which envisioned universal health coverage through skilled and trained providers.

- **2001 National Health Policy** - The current National Health Policy was framed in 2001 and identified health sector reforms and governance as a crucial element for effective poverty alleviation through strengthening the primary and secondary tiers of health services.

- **2002 Population Policy** – Following the 2001 Local Government elections, the 2002 Population Policy was the first Federal Programme which envisioned devolution of some administrative control from the Federal Government to the Districts. The salient features of the policy include promotion of women's health; integration of reproductive health services with family planning; broader participation of the private sector; improved social marketing; induction of male mobilisers at a Union Council level; and inclusion of mainstream reproductive and sexual health issues into family planning services.

- **2000 National Reproductive Health Services Packages (NRHSP)** – Joint effort of Federal Ministries of Population Welfare and Health

- **Ten Year Perspective Development Plan 2001 – 2011**- shift towards preventive services through primary health care.

- **2005 National Maternal, Newborn and Child Health (MNCH) Strategic Framework**[11] – This envisions the provision of MNCH services to all by coordinating the existing programmes and services; development and implementation of sustainable provincial and district programmes focus on skilled birth attendance; and focus on the poor and disadvantaged. The MNCH Strategic Framework sets the guidelines for the MNCH program.

- ***Draft* 2010 National Population Policy** - The Draft 2010 National Population policy emphasizes the need to place population stabilisation and fertility transition in the context of demographic opportunities and challenges centre stage in Pakistan's Poverty Reduction Strategy Paper (PRSP-II)[12].

3.2 ACTS

The failure to translate policy commitments into the desired improvement in MNH outcomes also reflects a gap between policy and implementation and a failure to successfully tackle broader gender, social exclusion and poverty (GSEP) issues that impact on MNH. The GoP has sought to tackle some of the broader GSEP issues that may indirectly affect MNH, particularly those relating to women's rights and empowerment, via legislation:

[11] http://www.mnch.gov.pk/library/Program%20Documents/National%20MNCH%20Program%20Communication%20Strategy%20Framework.pdf
[12] http://www.finance.gov.pk/poverty/PRSP-II.pdf

- **The Women Protection Act 2006** – This law was enacted in 2006 to correct the interpretational and implementation issues related to laws pertaining to adultery and rape in Pakistan (Hudood Ordinance 1979). The faulty interpretation of the law required women who had been raped to provide four witnesses to the incident. The failure to provide such witnesses was taken as an admission of adultery and women could be imprisoned for years with few options for legal relief. The Women Protection Act also changed the procedure for registering a case of adultery, requiring the accuser to provide two witnesses of the incident to a Magistrate before the accused can be charged with the crime. Furthermore, the Act calls for punishment in cases of wrongful accusation.

- **The Protection Against Harassment of Women at the Workplace Act 2010** – The Act broadly defines harassment as any unwelcome sexual advance, request for sexual favours or other verbal or written communication which causes interference with work performance**.** The law imposes minor and major penalties and entrusts an inquiry committee to take cognizance of complaints.

- **Domestic Violence (Prevention and Protection) Bill 2009** – This Bill was passed by the National Assembly in 2009, but was not passed in the required time period by the Senate. The Bill is presently pending with a Mediation Committee of the Parliament. The Domestic Violence Bill seeks to prevent violence against women and children with a network of protection communities and protection officers with prompt criminal trials for suspected abusers. The Bill generally defines domestic violence as all intentional acts of gender based or other physical or psychological abuse committed by an accused against women, children or other vulnerable persons with whom the accused person is or has been in a domestic relationship. The Bill makes sexual harassment or intimidation punishable by 3 years in prison, a 500,000 Rupee fine, both.

- **The Anti-Women Practices Bill 2008** – This Bill is presently pending in the National Assembly for final consideration. The Bill intends to amend the Pakistan Penal Code to criminalise and make punishable certain malicious social practices which lead to the exploitation of and discrimination against women. Practices such as the giving of daughters to settle feuds and disputes (Swara and Wanni), forceful marriage of women, marriage of women to the Quran, interference in a woman's right to inherited property, are to be made illegal and punishable.

- **The Reproductive Healthcare and Rights Bill 2009** – This Bill is pending with the Health Committee for approval before being sent back to the National Assembly for final consideration. The Bill aims to provide quality reproductive health through short and long term efforts, such as the professionalisation of obstetric care and improvement of the reproductive health system, particularly in the primary health care sector.

- **The Compulsory Immunisation Bill (Draft)** – This draft Bill is an initiative of the Pakistan Institute of Legislative Development and Transparency (PILDAT). The draft Bill to make immunisation compulsory for all will be presented to the Members of the national assembly in the upcoming session in March 2011[13].

3.3 POLICY IMPLEMENTATION

The policies outlined above are being implemented by an extensive network of primary, secondary and tertiary health facilities, supported by various cadres of trained health service and information providers. However, a failure to translate these policy commitments into the desired improvement in MNH outcomes remains. Lack of investment in the health system, alongside inadequate basic health services, trained staff, inadequate medical supplies and equipment continue to hinder progress on

[13] http://pakobserver.net/detailnews.asp?id=81082

improving MNH outcomes. Policy needs to be implemented effectively, with this in mind, advocacy efforts should focus on the implementation of policies and practices and scaling up evidence based interventions where the need is greatest

4 IMPLICATIONS OF THE 18TH CONSTITUTIONAL AMENDMENT

Until recently, MNH and broader health policy had largely been within the purview of the national government, which would have constituted the primary target for RAF-funded advocacy efforts. However, in April 2010, Parliament passed the 18th Amendment to the Constitution, which aims to considerably increase provincial autonomy, as well as to devolve authority and responsibility for micro-level social sector policies and service delivery to the provincial level. Pursuant to the Constitutional amendment many federal ministries and programmes (including the Ministry of Population Welfare and vertical programmes housed in the Ministry of Health) are to be devolved entirely or partially to the provinces. Although the 18th Amendment envisioned a broad stroke approach to devolution, various issues have surfaced in the past nine months and an Implementation Committee headed by the Ministry of Inter-provincial Coordination, has been constituted to clearly define the roles of the Federal and Provincial Governments and resolve any issues that have arisen during the devolution process.

RAF will continue to monitor developments closely. RAF envisages that the Amendment will have important implications for the way in which health policy and practice is developed and implemented in the future, and consequently, for the kind of advocacy work it may support. The changes to the individual Ministries are outlined below:

4.1 DEVOLUTION OF MINISTRY OF HEALTH

The Ministry of Population Welfare, along with its administrative and service delivery staff has already been devolved to the provinces. The Implementation Committee for the 18th Amendment has begun a consultative process over the devolution of the Ministry of Health, which has been delayed until May 2011. The National Assembly Standing Committee on Health has already begun its own consultative process in preparation for the Committee's meeting with the Chair of the Implementation Committee. The Federal Government has retained the authority to regulate the medical profession, including medical training, as well as medical research. It is still unclear what additional mandates the Federal Government will retain.

4.2 VERTICAL PROGRAMMES (INCLUDING MNCH)

It is clear that a majority of the vertical programmes run by the Federal Ministry of Health will be devolved entirely to the Provinces. These include the LHW Programme, EPI Programme, MNCH Programme, National AIDS/HIV Programme, Stop Tuberculosis, Malaria Rollback Programme, National Nutrition, National Blindness Prevention Programme, National Hepatitis Programme, etc. Prior to the 18th Amendment the Federal Government was responsible for the policy development and financing of these programmes, while District Governments were responsible for implementation.

Once the Vertical Programmes are devolved to the Provinces, the Provincial Governments will assume the role once played by the Federal Government. In the immediate future the policies and programme cycles already in place will most likely continue; however the Provinces may find difficulties in allocating budgets for these programmes in the long run. The vertical programme expenditures for the remainder of this Financial Year (ending June 30 2011) will be borne by the Federal Government. Provincial Governments have already raised concerns over their ability to provide budget allocations for the next year. It remains to be seen how the Federal Government will respond to the Provinces' demand for finances.

4.3 ROLE OF PROVINCIAL GOVERNMENTS

In the post 18th Amendment context, the Provincial Governments will be responsible for setting the policies, targets, and budgets for health. Vertical Programmes, which until now bypassed the Provincial Government, will now be housed in the Health Departments and will be answerable to the Provincial Legislatures. Thus members of the Provincial Assemblies will assume the role of overseeing these programmes, while the Provincial administration will be responsible for implementation, monitoring, and evaluation. The implications of the change of role of Provincial governments for MNH programmes are explored in further detail under the themes below.

The Provinces have not been involved directly with policy formation and oversight of the federally run vertical programmes, yet it is important that their policy priorities and implementation reflect best practice and the national experience thus far. This scenario provides both a challenge and an opportunity for RAF and its potential grantees. Holding provincial governments to account on their commitments, funding allocation and implementation of MNH services will be vital.

Please refer to RAF's Approach to Advocacy – Guidance for Applicants & Grantees for more information on how RAF seeks to bring about a change in MNH policies and practices in the given policy context.