Maternal and Child Health: A Health Policy Perspective

TheNetwork
for Consumer Protection

EXECUTIVE SUMMARY

Pakistan is among the 189 countries that made a commitment to achieve Millennium Development Goals (MDGs) by 2015. With a decade left to achieve these social targets, performance so far suggests the need for immediate and far-reaching measures in the social policy arena, particularly the health system of the country. At least three of the eight MDGs are directly aimed at maternal and child health (MCH) and well being, while the other five have a strong impact on MCH. The UN Millennium Project working on MDGs has pointed out that to reduce maternal mortality dramatically all women must have access to high quality delivery care.

Due to its strong linkages with the health systems, improving and sustaining MCH in Pakistan is a broad policy agenda, closely linked to the macro development of the country. There is also a clear need to integrate determining factors of breastfeeding and drinking water.

Researchers have concluded that existing health system in many countries simply cannot cater to future needs, i.e. to achieve MDGs. In this scenario, a comprehensive, evidence based health policy may be the best step to improve the overall health system, of which MCH is an integral part.

On the basis of review of various documents and research papers and the need for integrating MCH with the broader policy agenda, this paper discusses the role of the Ministry of Health in Pakistan in formulating an evidence based policy with active engagement of civil society and the initiative of a 'National Health Policy Framework' launched by TheNetwork. Besides it discusses TN contribution regarding safe drinking water and breastfeeding - both important elements in determining the health of mother and child. Recommendations made in this paper include:

Integration of MCH program into the broader health system; making health system fully functional at all levels; ensuring availability of EmOC and IMCI; taking action regarding determinants of MCH including literacy, poverty, social justice etc.; developing a comprehensive and evidence based National Health Policy with a proactive approach by the Ministry of Health.

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"Vertical interventions can supplement mainstream MCH initiatives, but cannot replace a well functioning national health care system."

1.0 INTRODUCTION

Pakistan is among the 189 countries that made a commitment to achieve Millennium Development Goals (MDGs) by 2015. With a decade left to achieve these social targets, performance so far suggests the need for immediate and far-reaching measures in the social policy arena, particularly the health system of the country.

At least three of the eight MDGs[1] are directly aimed at maternal and child health (MCH) and well being, while the other five have a strong impact on MCH. As per the MDGs, Pakistan has committed to reducing maternal mortality to 120 for every 100,000 live births, down from its current high level of 533. Likewise, the Government has committed to: reducing infant mortality to 40 in every 1,000 live births from the current rate of 85; and reducing mortality of children under age five to 47 in every 1,000 live births from its current rate of 109.

Pakistan's figures are part of a global phenomenon. It is estimated that over 10 million children under the age of five die every year worldwide, four million of them in their first year of life. Pakistan, where 65,000 children under age five die annually, is included in the list of six countries where most of these deaths occur. Likewise, maternal mortality worldwide stands at over 5 million a year, with another 8 million mothers facing life long consequences of pregnancies and deliveries. Pakistan, with maternal deaths at 26,000 annually, is among the thirteen countries which account for two-thirds of the global maternal mortality ratio.[2]

These numbers have been raising concerns regarding the possibilities of achieving high and sustainable levels of maternal and child health. While skilled birth attendants and similar community based health workers are important for primary health care, evidence indicates that their impact on maternal mortality is limited due to the fact that a great majority of obstetric complications that kill cannot be predicted or prevented.[3] Therefore, such vertical interventions can supplement mainstream MCH initiatives, but cannot replace a well functioning national health care system. Naturally, health care systems need to be further tuned towards MCH interventions, such as the relatively simple interventions collectively known as Emergency Obstetric Care (EmOC), delivered at the health center or district hospital level. Improving and sustaining MCH in Pakistan is therefore a broad policy agenda, closely linked to the macro development of the country as well as the evolution of its health system.

1. MDGs include eradication of extreme poverty and hunger; achievement of universal primary education; promotion of gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability and; development of a global partnership for development.
2. WHO, UNICEF and UNFPA, 2004. Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA. [Geneva: WHO]
3. Maine, D. 1991. Safe Motherhood Programs: Options and Issues. UN Millennium Project 2005. Who's got the power? Transforming Health Systems for Women and Children. [Task force on Maternal Health and Child Health]

2.0 SOCIO-ECONOMIC AND HEALTH CONTEXT

The health of mothers and children in Pakistan cannot be seen in isolation. It is related to the prevailing social, economic and political order of which the health system is a part. For instance, unstable political processes in Pakistan have seriously undermined the empowerment of women in national decision making, while also allowing primary health care delivery in the country to deteriorate through lack of political accountability.

Then, it has been well established that poverty affects vulnerable sections most, particularly women and children, and social development including health is the first target of poverty. Globally, more than half of all child mortality happens due to malnutrition, a socio-economic phenomenon driven by poverty.[4] Similarly, high unemployment affects disposable income in control of women and further contributes to poor health indicators - Pakistan's present rate of over eight percent unemployment (16.5% women and 6.7% men) does not afford much hope for improving health indicators. Furthermore, existing inequities in health have far reaching effects on health of the mothers and children when these are based on gender in particular. Inequity, too, has political-economic roots, which cannot be addressed simply by targeted vertical interventions, but require a holistic approach.

Likewise, education of mothers has proven to be an important determinant of maternal and child health, while schooling for girls results in healthier, better educated children, fewer maternal and child deaths, greater economic opportunities, and enhanced well being of families.[5] The extremely low rate of female literacy in Pakistan (37.7%),[6] and low women enrolment in higher education, it is clear that educational interventions also need to be made with a health perspective.

These political, economic and social issues further complicate the problems within the country's health sector, which is not being able to deliver. Although primary health care is supposedly free of cost, it is not easily accessible.[7] The prevailing poverty, illiteracy and unemployment are barriers to access to health care. Rather, catastrophic health situations and their costs push the population further into the trap of poverty, while the absence of social safety nets and risk pooling mechanisms at a national level further aggravate the situation. Due to these multiple factors, the state of maternal and child health is not impressive.

In order to reverse the dismal situation regarding child health, some programs had been initiated with donor support as a response to major diseases responsible for infant and child mortality: acute respiratory infections, diarrhea and malnutrition. These programs include: Acute Respiratory Tract Infection (ARI) Control Program; Integrated

"Prevailing poverty, illiteracy and unemployment are barriers to access to health care."

4. WHO, 2005. World Health Day toolkit 2005 (www.who.int.com)
5. ibid
6. SPDC, 2004. Social Development in Pakistan - Annual Review. Combating Poverty: Is Growth Sufficient?
7. Bhutta S, Jafarey S N, Midhat F. "Safe Motherhood: A situation Analysis and Recommendations for Evidence based Approaches." Maternal and Child Health in Pakistan. Edited by Zulfiqar A Bhutta. Oxford 2004.

Table 1: Key Maternal and Child Health Indicators of Pakistan

Indicator	Value	Sources
Total Fertility Rate	5.1	(WHR 2003)
Contraceptive Prevalence Rate	27.6%	
Unmet needs of Family Planning	30%	
Births Attended by skilled attendants	20%	
Exclusive Breastfeeding in the first 4 months	16%	
Low birth weight	30%	(8th 5 yr Plan 98)
Malnourished children <5yrs	42%	(8th 5 yr Plan)
Stunted (Height/Age)	40%	
Wasted (Weight/Height)	14.9%	
Immunization coverage (12-23 months)	27%	PIHS 2000-01
Incidence of Diarrhea for children <5 yrs	12%	PIHS 2000-01
Polio cases	4*	(Jan-Mar 05, WHO)
Adequate drinking water supply	60%	
Annual Growth Rate	2.5%	(WHR 2003)
Population completed primary or higher	38%	2000-01 PIHS
Female literacy rate	32%	PIHS

*Source: World Health Report, WHO, 2003; Pakistan Human Condition Report, 2003. * As reported by WHO officials.*

Evaluation of different vertical programs reveals shortcomings in planning and implementation except for LHW program.

Management of Childhood Illness (IMCI); Control of Diarrheal Diseases Program (CDD); and Expanded Program of Immunization (EPI).

The National ARI Program was launched in 1989. A review of the program was conducted by WHO and UNICEF in 1997, identifying: serious lack of funding, lack of coordination with other child survival programs, inadequate training for lady health workers and general practitioners in the private sector, ineffective monitoring systems, lack of mass awareness about seeking timely care and insufficient planning and support at provincial and district levels.[8] The CDD Program had been launched in Pakistan in 1989, and an evaluation of the program in the mid-nineties found poor compliance with the guidelines. Recently the CDD program has been merged into the Family Planning and Primary Healthcare Program (LHW program). An evaluation of this program is underway, while a previous evaluation shows some encouraging signs within the limits of a vertical program.[9] The LHW Program, initiated following the National Health Policy of 1990, manages 70,000 LHWs (out of a targeted total of 100,000), covering 60% of the country's population.

The IMCI Program, initiated on a pilot basis in 1998, is aimed at improving health workers case management skills, health systems to deliver IMCI, and family and community practices. In April 2001, the evaluation of the program concluded that it is often unwise and some-

8. Zaidi A K, Khan T A, Akram D S. "Early Childhood and Survival in Pakistan". Maternal and Child Health in Pakistan. Edited Zulifiqr A Bhutta. Oxford 2004.

9. ibid

times impossible to separate IMCI from health sector reforms. During the evaluation it emerged that a functioning health system, supervision, training and ownership are needed for the success of IMCI.[10]

The results of these vertical interventions echo similar impacts elsewhere in the world: while such programs are useful for bringing some positive changes in public health, they fundamentally rely on women and children having access to a high quality health care delivery system.

The UN Millennium Project has pointed out that to reduce maternal mortality dramatically; all women must have access to high quality delivery care, consisting of: a skilled birth attendant[11] at delivery, access to Emergency Obstetric Care (EmOC), and a functional referral system. Virtually all pregnancy complications can be successfully treated when EmOC is universally accessible and appropriately utilized. The UN recommends a minimum of one comprehensive emergency obstetric care facility[12] and four basic emergency obstetric care facilities[13] per 500,000 population. Unfortunately, ensuring the functionality of basic health care and referral system has not been a priority in Pakistan, resulting in lack of linkage between first level, secondary and tertiary care facilities. Likewise, EmOC has not been prioritized in the country. An analysis of EmOC services conducted by the Government of Sindh and UNICEF identified severe deficiencies, showing that twenty four hours coverage for complicated cases was provided only at tertiary level hospitals, and that extreme shortage of supplies marred provision at all levels of care.[14]

Besides the three elements of access to high quality delivery care, appropriate utilization is also an important area of concern, pointing towards the issue of three delays based on cultural, social, and economic factors.[15] These are: (a) delay in taking decision to seek care; (b) delay in reaching to the appropriate facility; and (c) delay in receiving treatment at the facility. These delays may be reduced through strengthening the referral system. But above all, traditional understanding of these delays some how ignores issues of equity and poverty. For instance, first delays is not solely due to the absence of husband at the moment or due to the cultural behavior of the family but it is also dependent on the other two delays. The family may decide not to seek emergency care because nearest facility may not be functioning. Paying for transport and for treatment might throw the family into debt that would lead to poverty.[16] It is obvious that irrespective of information or awareness level of a family these are systematic issues that need to be appreciated in context.

According to a study, analysis of 10 countries with different MMR, level of human development, and GDP per capita shows that in every country maternal death is associated with poverty.[17] This

"All women must have access to high quality delivery care"

10. UNICEF and Ministry of Health, Government of Pakistan. 2002. "Process Evaluation of Early Implementation phase of IMCI in Two Pilot Districts of Pakistan." [Islamabad: Abdur Rahman Associates]

11. A skilled attendant is an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, child birth and the immediate postpartum period, and in the identification, management and referral of complications in women and newborn (Revised definition by WHO; the International Confederation of Midwives; and the International Federation of Gynecology and Obstetrics, 2004).

12. Basic emergency obstetric care with performing surgery and blood transfusion; from: UNICEF, WHO, and UNFPA. 1997. Guidelines for monitoring the availability and use of obstetric services [New York: UNICEF]

13. To administer parenteral antibiotics, oxytocic drugs, anticonvulsants for pre eclampsia and eclampsia; perform manual removal of retained products and to perform assisted vaginal delivery (UNICEF, WHO, and UNFPA, 1997).

14. Bhutta et al. "Safe Motherhood: A situation Analysis and Recommendations for Evidence Based Approaches", Maternal and Child Health in Pakistan. Edited by Z A Bhutta. Oxford 2004.

15. UN Millennium Project. 2005. Who's Got the Power? Transforming Health Systems// for Women and Children. Task Force on Child Health and Maternal Health

16. Maine D, Larsen M. 2004. "Blaming the victim? The literature on Utilization of Health Services". Background paper prepared for UN Millennium Project Task force on Maternal and Child Health. [New York: United Nations]

17. Graham, W. J. et al. 2004. "The Familial Technique for Linking Maternal Death with Poverty". Lancet 363 (9402): 23-27.

evidence emphasizes the need for comprehensive efforts targeted to reduce poverty and inequity with a view to achieve maternal and child health. Moreover, estimates show large disparities between rich and poor seeking MCH services. This indicates that the poor have little access and affordability to avail services, thus not only remaining poor due to disease and disability, but also deepening their poverty due to that very factor.Table 2 provides information about disparities between rich and poor in developing countries regrading utilization. According to these figures, in case of delivery, 90 percent of the services are being utilized by top 20 percent quintile.The table shows disparities in all five types of services.

Table 2: Utilization of health services by lowest 20% quintile and highest 20% quintile in developing and transitional countries

Intervention	Bottom 20% quintile	Top 20% quintile
Medical treatment of fever	25%	44%
Delivery attended	32%	90%
Respiratory infection	37%	49%
Full immunization	39%	61%
Any antenatal care	59%	89%

Adapted from Chart: UN Millennium Project 2005

"Besides making the health system functional, reducing poverty would enable wider sections to afford health care."

On the basis of these figures it is clear that, besides making the health system functional, reducing poverty would enable wider sections of society to seek and afford health care in the event of illness. However, reducing poverty is a complex task, as demonstrated by successive attempts by the Government, relying mostly on economic growth rate. But studies have shown that it is the level of equality that determines incidence of poverty; there is now ample evidence that growth without distribution cannot reduce poverty. Thus, equality has positive relationship with poverty reduction, and therefore with accessibility and affordability of health care through a vicious cycle. For instance, inequality measured by the Gini coefficient shows that while a one percent decrease in inequality is likely to reduce poverty by 8.5 percent, a one percent increase in per capita income is expected to reduce poverty by only 3.6 percent.[18]

18.SPDC. Social Development in Pakistan. Annual Review. Combating poverty Is growth sufficient? SPDC. 2004

3.0 THE POSITION OF THENETWORK

3.1 Health Policy

As discussed above, efforts to improve maternal and child health depend upon overall functioning of the health system.[19] Researchers have concluded that existing health systems in many countries simply cannot cater to the future needs, i.e. to achieve MDGs. There are three major flaws in the present health systems in such countries. First, availability, accessibility and utilization of key health interventions are impossible through existing fragile and fragmented system. Second, catastrophic costs of seeking care are further deepening poverty. Third, failing to become a core social institution, the health system intensifies exclusion, reduction in citizens' voice, and inequity.[20-21-22] Pakistan's health system is subject to all these factors, so achieving MCH targets would greatly rely on how policy makers perceive the existing system and whether they have political will to change it.

Moreover, for an equitable health system, redistribution should be taken care of.[23] In this regard, interventions targeted at the poor and marginalized should be the first step not the only step. An equitable and rights based system can ensure that strategies regarding maternal and child health be implemented, and so MCH should not be an isolated or vertical program; rather, it must be part of an implement-able national health policy.

A comprehensive, evidence based health policy can be the best step to set a vision in this regard. Successive health policies, plans, and reform commission reports since independence, have been mostly non-participatory.[24] Therefore, it is imperative that for the ownership and implementation of policies in their true sprit, civil society and other stakeholders be involved. Indeed, the Ministry of Health is and must be in the driving seat of formulation, planning and implementation of the policy. However, it is equally true that best expertise in that area exists outside the domain of MoH. That is academia, research organizations and individual researchers, civil society organizations, and so on. The role of such elements is crucial, at least from developing a demand for the policy. As a response to such a need, TheNetwork for Consumer Protection (TN) has initiated a process of consultation on National Health Policy.

In addition, TN proposes that the welcome focus of Government on MCH must take into account some critical determining factors: safety of drinking water, and the promotion and protection of breastfeeding practices.

3.2 Water, MCH and Health Policy

60% of infant deaths are caused by water-borne diseases in

"MCH should not be an isolated or vertical program; rather, it must be part of an implement-able national health policy."

19. All the activities whose primary purpose is to promote, restore or maintain health (WHO)

20. Travis, P, S Bennett et al 2004. Overcoming Health Systems Constraints to Achieve the Millennium Development Goals". Lancet 364 (9437): 900-06.

21. Xu, K., D. B. Evans et al. 2003. "Household Catastrophic Health Expenditure: A Multi-country Analysis." Lancet 362 (9378): 111

22. UN Millennium Project 2005. Who's Got the Power? Transforming Health Systems for Women and Children. Task Force on Child Health and Maternal Health.

23. Mackintosh and Tibandebage. 2004. In UN Millennium Project 2005. Who's Got the Power? Transforming Health Systems for Women and Children. Task Force on Child Health and Maternal Health.

24. Lashari, T. "Pakistan's National Health Policy: Quest For A Vision". TheNetwork for Consumer Protection, Islamabad.

"The focus on MCH must take into account some critical determining factors: safety of drinking water and protection of breastfeeding practices."

Pakistan.[25] Drinking water is therefore critical to ensure good health.[26] However, a recent survey of water samples, by Pakistan Council of Water Resources (PCWR), suggests that water quality in major cities of Pakistan is quite poor. Out of samples taken from Islamabad, Rawalpindi, Lahore, Peshawar, Quetta and Karachi the percentage of contamination was 78, 94, 31, 69, 48, and 61 respectively.[27] The situation in rural areas is more alarming. Despite the fact that contaminated water is main reason for diarrhea, gastroenteritis, Hepatitis in children and adults, access to potable water remains outside of the domain of Ministry of Health, the question then arises in the context of health as to how the Government of Pakistan would be able to ensure safe drinking water with a view to save children from dying. The answer lies in a development-focused health policy that mobilizes multi-sectoral action to improve health status on sustainable grounds. TheNetwork for Consumer Protection has presented a draft regarding the need for a safe drinking water policy.

3.3 Breastfeeding, MCH and Health Policy

In Pakistan, the prevalence of exclusive breastfeeding is alarmingly low; only 16% of mothers exclusively breastfeed their children up to four months. The World Health Assembly passed a resolution in 2001 advocating exclusive breastfeeding for six months.[28] The main hindrances in breastfeeding practices include hospital practices, unethical promotion of breastmilk substitutes, and barriers to breastfeeding in the work place.

An assessment of these barriers shows that, except for hospital practices, the remaining two lie outside the influence of the Ministry of Health. Once again, therefore, the crucial question is whether to continue with cosmetic efforts utilizing all type of resources to enhance the level of exclusive breastfeeding in isolation, or to work for a multi-sectoral action as part of development agenda. One positive step in this direction is the promulgation of "Protection of Breastfeeding and Child nutrition Ordinance 2002", although progress on implementation is slow.

3.4 Consultation on Health Policy

The discussion in this paper provides ample evidence that maternal and child health cannot be separated from the national health system. There are also significant factors outside provision of health care, that impact maternal and child health; meaningful interventions can be carried out from outside health sector. Furthermore, a comprehensive health policy that encompasses the development agenda is the key to achieving the goal of mother and child health. The focus must shift, therefore, from vertical programs and limited interventions, towards overall

25. TheNetwork. Need for a National Drinking Water Policy. IUCN website http://www.edu.iucnp.org/edu/water.htm.

26. Sustainable access to an improved water source, urban and rural including any of the following sources for drinking purpose: piped water, public tap, borehole or pump, protected well, protected spring or rainwater (Drinking undrinkable, TheNetwork, 2005. Original source: Millennium Declaration of UN).

27. ibid

28. Breastfeeding and Young Children Nutrition, www.thenetwork.org.pk (accessed on March 30, 2005)

health system interventions. That could be materialized by addressing all aspects of health: availability, accessibility, affordability, equity and poverty. Civil society has a crucial role to play in this regard particularly in activating the demand for an implementable National Health Policy, which has remained weak with little voice being raised by stakeholders.

Having understood the importance of demand side of health policy, an initiative has been launched by TheNetwork to formulate a "National Health Policy Framework". This framework is expected to be developed through close collaboration of research organizations and individuals, academic institutions, and NGOs.

4.0 RECOMMENDATIONS

Maternal and child health may be improved to achieve MDGs through a targeted set of interventions, as well as a consistent, integrated, health system agenda.

4.1 MCH INTERVENTIONS

- Mother and child health program should be integrated into the broader health system, with the Ministry of Health in the driving seat;
- The overall health system needs to be made fully functional at all levels, including a functioning system of referrals, through deliberate consultations and a demonstration of political will;
- Presence of more skilled birth attendants needs to be ensured;
- Presence of Emergency Obstetric Care (EmOC) at first and second level care facilities needs to be ensured, as the key to reducing maternal and neo-natal mortality through unexpected events;
- Integrated Management of Childhood Illness (IMCI) should be introduced throughout the health sector in Pakistan, based on its evaluated success in other developing countries.

4.2 REDUCING POVERTY THROUGH EQUITY MEASURES

- Without addressing the issues of affordability and equity, a sustainable level of improved health outcomes is impossible to achieve. Therefore, poverty needs to be addressed by creating equity within society through various measures, including literacy, income and asset distribution, employment generation, access to justice, distributive justice, empowerment of women,

"Civil society has a crucial role to play in this regard particularly in activating the demand for an implement-able National Health Policy."

and social safety nets. These actions hardly require new resources at this stage but they certainly require political will. The countries and states at per capita level similar to Pakistan and with low GDP rates have done the same.

- Implementation on Breastfeeding ordinance and ensuring provision of safe drinking water are only two ways which,if fully ensured, can help reduce maternal and child mortality and morbidity in large numbers.

4.3 Comprehensive and Participatory National Health Policy

- These interventions can be ensured through a comprehensive and participatory National Health Policy linked to over all development. In this regard Ministry of Health has to play its proactive role in order to achieve broader support from rest of the social sector. ■