Pakistan National Maternal and Child Health Programme

Mid Term Evaluation

صحت زندگی

MNCH Program

Government of Pakistan (GoP) launched the Maternal Neonatal and Child Health (MNCH) Programme in 2007 to accelerate progress towards Millennium Development Goals (MDGs) 4 & 5. This was to be achieved primarily through providing emergency obstetric and new-born care services, training and deployment of a new cadre of community midwives and institutional strengthening especially at the provincial and district level. After 3 years into its implementation an evaluation was conducted in (September 2011-September 2012) across Pakistan, steered by the Planning and Development Division. Considering implementation challenges and resource constraints, findings of the evaluation indicate that the Programme focused on two major outputs i.e. emergency obstetric services and community midwives, which have shown marked progress i.e. institutional deliveries and skilled birth attendance. However, management structures have not been strengthened as per the PC-1 and the Programme is lagging behind in provision of comprehensive family planning services and communication interventions for improving MNCH care. It is highly recommended that an integrated approach with a package of MNCH services be adopted. This should be complemented with innovative management and institutional arrangements such as public private partnership, contractual arrangements with NGOs and strengthening community midwives' role in the health system.

Key Recommendations

- Integration of the current MNCH Programme into provincial health sector strategies under the direction of the Provincial Director General (DG) Health
- Prioritise funding around a package of essential MNCH interventions with a strong focus on the district level and below
- The contractual terms of the nationwide outsourced and vertically managed BHUs - through the People's Primary Health Care Initiative (PPHI) - need to be revisited
- Integration and linkages with Population Welfare Departments to address challenges facing implementation of an integrated MNCH Programme
- Public Private Partnerships for services and community mobilization should be strengthened
- Institutionalise the role of CMW into the first level of referral in the catchment area
- A uniform CMW retention policy needs to be approved by the appropriate body followed by implementation

Table 1: Comparison of current situation and targets to be achieved by 2015

Area	Current Status	Mdg Targets
Infant Mortality Rate (IMR)	78 / 1,000 live births	40 /1,000 live births,
Maternal Mortality Ratio (MMR)	276 / 100,000 live births	140 /100,000 live births
Contraceptive Prevalence Rate (CPR)	30%	60%
Total Fertility Rate (TFR)	4%	2.1%
Population Growth Rate	1.7%	1.3%

Source: National Institute of Population Studies and Macro International Inc. Pakistan Demographic Health Survey 2006-2007. Islamabad, Pakistan: NIPS and Macro International 2008.

MNCH Programme: An Introduction

Pakistan faces a daunting challenge in meeting the 2015 targets set for attaining the Millennium Development Goals (MDGs) 4 and 5 (Table 1). This is due to exacerbating factors such as high maternal, neonatal and child mortality, low skilled birth attendance rate, low levels of female literacy, poverty, malnutrition, communicable diseases and inadequate and unreliable access to Emergency Obstetric and Neonatal Care (EmONC) and other Maternal, Neonatal and Child Health (MNCH) services. In 2005, an MNCH strategy was launched by the Prime Minister, followed by the commencement of the MNCH Programme in 2006 which aimed to achieve MDGs 4 & 5 by integrating ongoing initiatives and further strengthening the health system. The overall vision of the Programme has been to improve quality and coverage of MNCH services, especially at primary and secondary levels of the health care system, coupled with community outreach services through integrated system-wide approaches. National in its scope, the MNCH Programme was implemented in 134 districts across 4 provinces, Azad Jammu Kashmir (AJK), Northern Areas, Federally Administered Northern Areas (FANA) and Federally Administered Tribal Areas (FATA). Table 2 illustrates goal, outcome and components of this Programme.

Table 2: MNCH Programme - Goal, Outcome and Components
Goal
To reduce maternal and child deaths and illness by improving the health status of all, particularly of the poor and marginalized
Outcome
To improve the accessibility of high quality and effective MCH services for all, particularly the poor and disadvantaged, through development and implementation of sustainable MCH Programme at all levels of health care delivery system
Components
1. Integrated delivery of MNCH services at district level 2. Training and deployment of community midwives 3. Provision of comprehensive family planning services 4. Strategic communication for MNCH care 5. Strengthening Programme managment

Evaluation of the MNCH Programme

Evaluation of the MNCH Programme was conducted (September 2011-September 2012) across Pakistan and was steered by the Planning and Development Division; the period covered for the evaluation was 2006/2007-2010/2012. Data was collected through various methods including both quantitative and qualitative techniques. Secondary data analysis was distilled from the "Health Facility Assessment" reports and selected field-visits were carried out at provincial and district levels entailing a multiple case-study approach across three different districts to gain a sharpened understanding of MNCH services.

Findings of the Evaluation

The evaluation focused on five major components (see Table 2) to assess their performance and contribution for achieving the desired outcome of the Programme. Key findings indicate that components 1 and 2 were 'fully' achieved, the 5th component was achieved to "some extent" and there was a failure in achieving the targets of components 3 and 4; as described below:

MNCH services at District level

Commendable achievement of targets have been made in the upgrading of health facilities (71% to 88%), however this has been more focused at the secondary level rather than the primary level. There is a deficit of at least 123 Comprehensive Emergency Obstetrical and Neonatal Care (CEmONC) and 790 Basic Emergency Obstetrical and Neonatal Care (BEmONC) facilities across Pakistan. Due to slow and inadequate budgetary releases, the standard and quality of services has not improved. Furthermore, lack of coordination among various vertical Programmes such as Lady Health Worker (LHW), Expanded Programme of Immmunization (EPI), Nutrition and Population Welfare Department for implementing the MNCH Programme has also resulted in fragmentation of efforts leading to inefficiency and ineffectiveness.

Training and deployment of Community Midwives

The MNCH Programme has made progress in introducing a cadre of CMWs and nursing schools (68 schools approved by the Pakistan Nursing Council) have been upgraded to support training. The utilization of CMWs for conducting deliveries was reported to be very low in Punjab. An average of 1.8 per CMW in one year was carried out with the exception of 20 per month noted in one of the sample districts. Out of a total of 11996 CMWs 45 per cent had been trained and of them about 64 per cent deployed, mainly in Punjab. However, successful delivery of services and referral by CMWs is marred by lack of trust by the community, weak transportation system, social and cultural gaps between CMWs and clients, and out of pocket payments for deliveries. The poorly defined roles and lack of supervision involving Lady Health Workers (LHW), Community Midwives (CMW) and Lady Health Visitors (LHV) has resulted in poor linkages among these three cadres ultimately affecting MNCH care at community level.

Provision of comprehensive Family Planning services

Limited progress has been made in the achievement of this component, mainly due to lack of integration with the Department of Population Welfare (DoPW) which is supposed to provide contraceptives to the MNCH Programme. However, no formal agreement or MoU was signed between MNCH Programme and DoPW. Considering the post 18th constitutional amendment scenario, functional integration between Provincial Health Departments and Department of Population Welfare has not been followed in most provinces.

Strategic communication for MNCH care

Communication and advocacy plans were developed but not satisfactorily implemented due to lack of funds and giving more priority to upgrading facilities. The Programme made efforts to celebrate and highlight

weeks and days to communicate certain messages to the communities, however, use of print and electronic media was almost negligible which can be used effectively for promoting health awareness.

Strengthening Programme management

Various strategic and technical arrangements for managing the MNCH Programme were established, however, the oversight committees did not provide any strategic guidance. Federal and provincial steering committees were operational to some extent but the provincial MNCH coordinating committees and technical coordination committees remained defunct. Programme Management Units (PMU) were fully functional in 134 districts, but most provinces reported a shortage of staff in District Management Units (DMUs). The MNCH Programme was implemented by the federal MNCH cell as a vertical Programme, before the devolution of the Ministry of Health. Thus Departments of Health had limited ownership in this Programme. Currently, the Planning and Development Division is not only managing the MNCH fund releases to provinces/ areas but also playing an important coordination role.

Cross cutting issues

- **Human resource:** A visible increase in the number of institutional deliveries at MNCH supported facilities has been reported but there is a high dropout rate among facility staff. This is due to delayed or non-payment of salaries, and lack of essential medicines and supplies adversely affecting the continuity and quality of services. Services, which should be available 24/7, are hampered by lack of staff, especially the Women Medical Officers (WMOs) and other specialists including Gynecologists, Anaesthetists and Pediatricians.
- **Capacity building and training:** Training needs of the staff were not assessed properly and trainings that were conducted not recorded or documented – the focus of most trainings was on Integrated Management of Neonatal and Child Illnesses (IMNCI) followed by Emergency Obstetric and Neonatal Care (EMONC) and Emergency Newborn Care (ENC). Staff at 60 per cent of the health facilities has not received any MNCH-related training, whereas the primary health care level staff was mostly neglected.
- **Donor harmonisation:** A number of donors have their own MCH projects which are relevant to the policies, plans and strategies of the government, but based on their own priorities. As a result some donor initiatives have evolved as parallel projects with lack of synergy with the MNCH Programme and duplication of its activities. There is lack of sustainability of interventions and poor documentations of the results of projects.
- **Value for money:** During the evaluation period only 37 per cent of about PKR 20.0 billion has been released, however 87 per cent was actually utilized. As regards 'allocative equity' except for DFID which has aligned its support with the health system, other donors have opted for parallel financing. The current unit cost for training and deploying a CMW is PKR 200,000 and 270,000 respectively. The unit cost per delivery for those deployed is PKR 3750 as opposed to the one envisaged in PC-1 as PKR 400. As regards 'allocative efficiency', most provinces had the needed human resources available at the BHU level; Punjab had the right mix of inputs for Basic EMONC at Tehsil Headquarter hospital, but not at District Headquarter hospital. Pakistan's unit cost for caesarean section (US$ 154) aligns well to the unit costs in countries such as India and Thailand.

Way Forward

- **Coordination and integration**

The current MNCH Programme should be integrated into provincial health sector strategies under the direction of the D G Health. This can be achieved by setting the funding priorities around a package of essential MNCH interventions with a strong focus on the district level and below.

- **Public private partnership**

Public private partnerships arrangements for strengthening services and community mobilization should be tested and implemented. Some of the options that need consideration could be: contracting out, contracting in technical assistance, community management and franchising model, private sector provision of MNCH services and performance based incentives for district and health care providers. The contractual terms of the People's Primary Health Care Initiative (PPHI) need to be revisited, to formally guarantee comprehensive delivery of MNCH services, both at the facility and community levels at BHUs and RHCs.

- **Strengthening of CMW component**

There is need to institutionalize the role of the CMW into the first level of referral in the catchment area where she is expected to work. The working relationship between LHWs and CMWs needs further strengthening through regular supervision and support by Lady Health Supervisor (LHS). A uniform CMW retention and monetary incentive policy needs to be approved and implemented so there is standardization in deployment and retention across provinces and regions. The PNC which is the accreditation and licensing body for CMWs

needs support for standardizing examination system and reviewing the quality of CMWs' training schools.

- **Capacity building and training**

Provinces should now develop basic training and continued support packages for district and facility level staff and ensure these are rolled out across the MNCH network. These trainings should focus on both technical and management aspects according to individual needs and requirements. The facilities also need to be equipped with essential and adequate equipment, medicines and staff to ensure quality EMONC services.

- **Donor harmonisation**

The Government of Pakistan (GoP) needs to proactively harmonise donor activities and harness incoming finances. Financial inputs from donors should be considered a long term investment in strategic MNCH areas, and must not be used to complement public financing of health services. Donors should re-strategise the way they fund provinces, to ensure a district focus on needs and requirements. The facilities also need to be equipped with essential and adequate equipments, medicines and staff to ensure EMONC services.

Recommendations Absorbed So Far

- An integrated PC 1 has been developed for Punjab and Khyber Pakhtunkhwa
- Deployment guidelines for CMWs were developed in line with PC-1. However, the guidelines could not get policy approval following devolution. Currently, only DoH, Gilgit-Baltistan has formally approved the guidelines while other provincial departments (specifically NPPI-Sindh) are informally using some sections of the guidelines
- Retaining and deploying CMWs has remained a challenge for all provinces. With provincial autonomy, provincial programmes are making strategic choices in terms of revising their monetary scale and providing them technical supervision to institutionalize them in to the system
- Punjab has revised contracts for Poverty Reduction Strategy Paper (PRSP); contracting out MNCH services as proposed
- A revised CMW curriculum has been approved by PNC which will ensure improved skills leading to improved capacities of CMW
- Another TA has been launched to develop and provide hands-on support for establishing upgraded examination system
- A TA has been launched for Punjab and Khyber Pakhtunkhwa which has undertaken community mobilization