Pakistan’s maternal and child health policy: analysis, lessons and the way forward

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Abstract

An estimated 400,000 infant and 16,500 maternal deaths occur annually in Pakistan. These translate into an infant mortality rate and maternal mortality ratio that should be unacceptable to any state. Disease states including communicable diseases and reproductive health (RH) problems, which are largely preventable account for over 50% of the disease burden.

The analysis of Pakistan’s maternal and child health (MCH) and family planning (FP) policy covers the period 1990–2002, and focuses on macroeconomic influences, priority programs and gaps, adequacy of resources, equity and organizational aspects, and the process of policy formulation. The overall MCH/FP policy is well directed. MCH/FP has been a priority in all policies; resource allocation, although unacceptably low, has substantially increased during the last decade; and there is a progressive shift from MCH to the reproductive health (RH) agenda. Areas in need of improvement include greater use of evidence as a basis for policy; increased priority to nutrition programs, measures to reduce neonatal and perinatal mortality, provision of emergency obstetric care, availability of skilled birth attendants, and a clear policy on integrated management of childhood illnesses.

Enhanced planning capacity, development of a balanced human resource, improved governance to reduce staff absenteeism and frequent transfers, and a greater role of the private sector in the provision of services are some organizational aspects that need the governments’ consideration.

There are several lessons to be learnt: (i) Ministries of Health need sustained stewardship and well-documented evidence to protect cuts in resource allocation; (ii) frequent policy announcement sends inappropriate signals to managers and weakens on-going implementation; (iii) MCH/FP policies unless informed by evidence and participation of interest groups are unlikely to address gaps in programs; (iv) distributional and equity objectives of MCH/FP be addressed while setting overall national goals; (v) institutional capacity is a vital ingredient in translating MCH/FP policies into effective services.

The suggested strategic directions emphasize, among others, the need for a comprehensive MCH/FP framework; strengthened stewardship in ministry of health; cost-effective strategies to address the gaps identified and doubling of the public sector resource allocation to MCH/FP over the next 5 years. The ability to ensure delivery of quality health services remains the biggest
challenge in the Pakistani health sector. Unless sound policies are backed by well-functioning programs they are likely to become a victim of poor implementation.

Keywords: Maternal and child health; Family planning; Policy analysis

1. Setting and surrounding

An estimated 400,000 infant and 16,500 maternal deaths occur annually in Pakistan. These translate into an infant mortality rate (IMR) and maternal mortality ratio (MMR) that should be unacceptable to any state. The numbers reflect only the years of life lost due to premature mortality. Should the years lived with disability, such as due to malnutrition in children and reproductive morbidity in women be included, the burden of disease (BOD) would be even greater. It is no surprise that in 1996, communicable diseases and reproductive health problems accounted for more than 50% of the total BOD, disease states that are largely preventable or readily treatable [1].

The question that why so little has changed in maternal and child health (MCH) in Pakistan, as well as in other south Asian countries, over the last decades has been a subject of ongoing debate [2]. The purpose of the current review is to analyze Pakistan’s maternal and child health and family planning (FP) policy over the last decade, identify strengths and weaknesses and factors underlying these, and suggest strategic directions to the policymakers. The analysis also offers lessons for other countries at a similar stage in the development of their MCH/FP programs.

2. Approach and methodology

This review broadly covers the period 1990–2002 and analyzes the last three health policies. In addition, it includes a critique of the major national programs on MCH/FP during this period. It also utilizes evidence from health and demographic surveys conducted by independent agencies to assess the status of MCH/FP.

The review has generally preferred the traditional terms maternal and child health and family planning over the broader reproductive health (RH) as it covers the period before as well as after the term RH was formally coined [3] and also because the terms MCH/FP better reflects the reality of health system in Pakistan, while recognizing that a gradual transition is taking place towards RH. In this paper, a mother is defined as a woman of childbearing age who has had at least one pregnancy, while a child represents an individual under the age of 5 years unless referred to otherwise.

Analysis of resources allocated to MCH is based on the government and donor documents that comprise the major MCH/FP development programs. Government allocation in the recurring budget is not classified under MCH/FP head, thus was not available.

3. Maternal and child health situation, services and system

3.1. Health situation

Pakistan has lagged its neighbors and other low-income countries in terms of health and population outcomes, despite the fact that Pakistan’s GNP of US$ 440 is higher than the average (US$ 410) for low-income countries [4]. Despite improvements in the 1990s, IMR of 83 per 1000 live births [5,6] is higher than the averages for low-income countries and south Asia by 10 and 16%, respectively (Table 1) [4]. Neonatal mortality accounts for 40–60% of all infant deaths and 60% of neonatal mortality occurs in first week of life. The perinatal mortality ranges from 54 in Karachi to 82 in Faisalabad with stillbirths accounting for 25–50% of all neonatal mortality [7].

Women in the reproductive age constitute 23% of Pakistan’s population of 144 million [8]. The sex ratio in Pakistan is adverse to women, 108:100, due to excess mortality among female children and women during childbearing age. It is reported to be 1.7 times higher for girls between the age of 1–4 and about double for women between the ages of 20–29 years [9]. The population is growing at 2.4% annually with
increasing contraceptive use, reaching 27% from 12% in 1991. The total fertility rate is 4.8, down from around 5.4 in early 1990s [5].

The MMR is estimated around 300 per 100,000 live births. Population based studies done in the early 1990s indicate MMR ranging from 281 in Karachi to 673 in Balochistan [10]. WHO and UNICEF in 1996 estimated that one in every 38 women die from pregnancy related causes most of which are preventable. Data from these UN agencies has demonstrated that maternal mortality in many regions of the world is underestimated by a third [11]. In Pakistan, data on abortion is scarce; it is believed that 5–13% of maternal death can be attributed to unsafe abortions [5,9].

There has been no change in the nutritional status of mothers and children during the last decade. A quarter of newborns have low birth weight and percentage of under-five children who are under-weight range between 33 and 45%. Anemia remains prevalent among women (40%) and children less than 5 years (62%) [12]. The poor maternal nutritional status is the result of repeated pregnancies, inadequate food intake due to limited access to food within the household, and poor dietary habits reflecting the low status of women. Pakistan has low prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), but it is a high-risk country due to significant risky behaviors in vulnerable population, making the conditions ripe for an HIV/AIDS epidemic.

3.2. MCH/FP health system

The federal government is primarily responsible for formulating national health policies, while the responsibility for implementation rests largely with the provincial and district governments. The public sector comprises a network of almost 10,000 health facilities ranging from basic health units to tertiary referral hospitals. The MCH organizational setup at all levels is weak in terms of technical capacity and resource availability. For instance, the MCH provincial directorate in the Punjab, a province of 80 million people, has the director as its only professional staff. Family planning services are the responsibility of the federal Ministry of Population Welfare. The segregation of reproductive health services in two ministries has been responsible for duplication of effort and poor coordination. In addition, the problem of understaffing, especially of female health staff, is compounded by the non-availability of funds for monitoring and supervision. The private sector serves nearly 70% of the population and is primarily a fee-for-service system without any regulatory framework.

Over the last decade donor financed projects have supplemented insufficient public sector resources for MCH/FP services. These include the World Bank financed Family Health and Population Welfare Projects, Asian Development Bank supported Health Care Development and Women Health Projects, DFID

### Table 1

<table>
<thead>
<tr>
<th>Bangladesh</th>
<th>India</th>
<th>Iran</th>
<th>Pakistan</th>
<th>Sri Lanka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual growth rate (%) (2001)</td>
<td>2.2</td>
<td>1.8</td>
<td>1.8</td>
<td>2.4</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>3.6</td>
<td>3.1</td>
<td>2.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Female life expectancy (years)</td>
<td>64.7</td>
<td>61.7</td>
<td>71.1</td>
<td>61.5</td>
</tr>
<tr>
<td>IMR per 1000 live births</td>
<td>67</td>
<td>65</td>
<td>36</td>
<td>83</td>
</tr>
<tr>
<td>Prevalence of malnutrition in under 3(%)</td>
<td>47.8</td>
<td>47</td>
<td>10.9</td>
<td>38.2</td>
</tr>
<tr>
<td>EPI coverage (%) (1999)</td>
<td>72</td>
<td>55</td>
<td>99</td>
<td>50</td>
</tr>
<tr>
<td>MMR per 100,000 live births (2001)</td>
<td>600</td>
<td>440</td>
<td>130</td>
<td>300</td>
</tr>
<tr>
<td>CPR (%) (2001)</td>
<td>43</td>
<td>43</td>
<td>56</td>
<td>27</td>
</tr>
<tr>
<td>THE as % of GDP (2000)</td>
<td>3.8</td>
<td>4.9</td>
<td>5.5</td>
<td>4.1</td>
</tr>
<tr>
<td>GHE as % of THE (2001)</td>
<td>36.4</td>
<td>17.8</td>
<td>46.3</td>
<td>22.9</td>
</tr>
<tr>
<td>OOP expenditure as % of THE (2001)</td>
<td>59.7</td>
<td>82.2</td>
<td>50.9</td>
<td>77.1</td>
</tr>
<tr>
<td>Per capita THE in US$ (2000)</td>
<td>14</td>
<td>23</td>
<td>258</td>
<td>18</td>
</tr>
<tr>
<td>Per capita GHE in US$ (2000)</td>
<td>5</td>
<td>4</td>
<td>119</td>
<td>4</td>
</tr>
</tbody>
</table>


### OOP: out of pocket expenditure; THE: total health expenditure; GHE: government health expenditure.
and KfW funded Social Marketing of Family Planning and the multi-donor supported Social Action Program Projects I and II. The latter was meant to support the government’s Social Action Program (SAP). These programs and projects have not brought about the expected improvements due to structural, capacity and procedural issues in their design, implementation and monitoring. In addition, weakening macroeconomic situation, excessively centralized management, frequent transfers of staff, and poor governance to address staff absenteeism reduced increasing donor investment.

Lack of clear human resource policy for MCH services and poor personnel management has also been a major contributor. The human resource imbalances in MCH/FP reflect in non-availability of qualified female staff in PHC facilities and secondary care hospitals on the one hand and lack of skilled birth attendants in the community, on the other.

3.3. Public sector MCH/FP health services

Availability of female providers has increased substantially during the 1990s; however, availability of skilled birth attendants remains low with 80% of pregnant women being delivered without assistance from a skilled birth attendant [5]. Just over 50% and less than a third of women received antenatal and postnatal care, respectively, during their last pregnancy, with major urban rural differences. Basic and comprehensive obstetrical care is provided at various levels of the system, however, it is believed that access to and quality of these services and their utilization are low. An assessment of obstetric services indicated that most facilities do not provide emergency obstetrical care (EmOC) or meet the minimum acceptable level set by WHO [13].

Access to FP services has been enhanced through recruitment of over 70,000 community health workers mainly in rural areas and social marketing of contraceptives through 9000 trained professionals and 34,000 private outlets in urban and peri-urban areas [14]. However, there is still a large unmet need (37%) with more than half of women desiring no more births. Immunization coverage of pregnant women for tetanus toxoid is 48% and of children 50% with large urban-rural and a smaller male–female difference [5].

3.4. MCH services and the private sector

The provision of MCH services in the private sector has traditionally focused on provision of delivery care through over 800 maternity and general hospitals [15]. Recent data indicate that trained and untrained TBAs conducted 56% deliveries. In addition, there is an increasing trend to seek antenatal (43%), postnatal (45%) and family planning care (39%) from private providers. The coverage of the non-governmental organization (NGO) programs is limited with 1% of women seeking FP services from NGO clinics [5]. The lack of information on various aspects of the private sector, including the cost and quality of MCH/FP services, has precluded its in-depth analysis.

Pakistan is a signatory to the internationally agreed Millennium Development Goals (MDGs) [16]. Of the eight broadly stated goals, four are directly related to RH. Government of Pakistan would need to significantly improve its performance in the health sector to achieve RH related MDGs by 2015 (Table 2).

4. Analysis of maternal and child health and family planning policy

4.1. Macroeconomic scenario and its influence on MCH/FP policy

The economic growth in Pakistan has followed a downward trend with the real GDP growth falling from over 6% per annum in the 1980s to around 4% during the 1990s [17]. A sharp rise in interest payment on public debt and a commensurate fall in expenditures over this period are responsible for the sluggish performance. These macro economic imbalances, coupled with governance failures and government’s inability to channel limited resources effectively towards pro-poor activities, have resulted in a rise in the incidence of poverty in Pakistan [18]. The brunt of the cuts in development expenditures has fallen largely on the social sectors—health and education, and has been the major influencing factor in shaping MCH policy and its implementation in the 1990s. It is fair to state that given the unpredictability of the macroeconomic situation, the Ministry of Finance often has the last word in determining what gets financed in the National Health Policy. While there is paucity of reliable information
Table 2
Trends in key maternal and child indicators

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under five mortality</td>
<td>140</td>
<td>111</td>
<td>110</td>
<td>47</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>120</td>
<td>105</td>
<td>83</td>
<td>40</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>N/A</td>
<td>340</td>
<td>530</td>
<td>120</td>
</tr>
<tr>
<td>12–23 months immunization coverage</td>
<td>25</td>
<td>49</td>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>6.2</td>
<td>5.4</td>
<td>4.8</td>
<td>120</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>11.8</td>
<td>23.9</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Unmet need of family planning</td>
<td>28</td>
<td>37.5</td>
<td>33</td>
<td>–</td>
</tr>
<tr>
<td>Pre-natal consultation</td>
<td>30</td>
<td>36</td>
<td>54</td>
<td>–</td>
</tr>
<tr>
<td>Post-natal consultations</td>
<td>N/A</td>
<td>11</td>
<td>90</td>
<td>–</td>
</tr>
<tr>
<td>Births attended by skilled birth attendants</td>
<td>N/A</td>
<td>18</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>HIV prevalence among 15–24-year-old pregnant women</td>
<td>N/A</td>
<td>&lt;0.1</td>
<td>&lt;0.1</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Pakistan Integrated Household Surveys.

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on whether the increase in poverty has lead to an increase in rates of malnutrition, available data at the very least indicate that trends in critical nutrition indicators such as childhood malnutrition and maternal anemia have hardly changed [2]. The evidence pointing to the association between increasing poverty and debt with maternal and childhood malnutrition from other parts of the world is well documented [19], and there is little reason to doubt that Pakistan will be any different. While the influence of the macroeconomic scenario on the health profile of a country is obvious to most, the reverse—contribution of health to the economic development of a country has not been evident to many policymakers. This has been unambiguously articulated in the report of the WHO’s Commission on Macroeconomics and Health [20]. Health is the basis for job productivity, the capacity of children to learn at school, and their capability to grow intellectually, physically and emotionally. Investing in RH today is an essential input to poverty reduction, economic growth and long-term development of the country.

4.2. Policies, and programs on MCH/FP

The period 1990–2002 has seen the change of five successive governments of various shades of democracy and the announcement of three health policies. The health policies of 1997 [21] and 2001 [22] were non-participatory exercises and have not been implemented. The 1990 policy [23] was partially implemented through recruitment of 70,000 lady health workers (LHWs). Paradoxically, the most powerful “policy instrument” in Pakistan has been the medium-term 5-year plan by the Planning Commission, which sets priorities for the country. In addition, the government announced several policy statements on MCH/FP. Of note has been the Reproductive Health Package of 1999 [24], which was a joint document of the Ministries of Health and Population Welfare. The Ministry of Population Welfare announced its Interim Population Sector Perspective Plan 2012 in 2002 [25]. Table 3 provides an overview of the priority areas and evolving changes in priority in MCH/FP as envisaged in the policy documents over the period 1990–2002. It also identifies gaps and shortcomings in the policies. The analysis indicates growing awareness of the increased burden of morbidity and mortality among women and children with an incremental expansion of the agenda focusing on MCH/FP in early 1990s to RH in the latter half of the decade.

4.2.1. Priority areas and gaps in MCH/FP policies

The child health priority areas include immunization, infant health care, childhood diarrhea and acute respiratory infections. All policies and programs have emphasized maternal health, safe motherhood, and availability of female staff. In addition, RH, HIV/AIDS, and sexually transmitted infections have received increasing emphasis, a reflection of the
## Table 3: Priority areas and gaps in MCH/FP in national policy documents, period 1990–2002

<table>
<thead>
<tr>
<th>MCH area</th>
<th>Key policy strategies for maternal and child health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health</td>
<td>Immunization</td>
</tr>
<tr>
<td>Maternal health</td>
<td>Availability of trained personnel for attending births (LHVs and public health nurses) and LHWs/TBAs</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutrition in medical education</td>
</tr>
<tr>
<td>Family planning</td>
<td>Made mandatory as of health care involvement of private practitioners in FP</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Not specifically referred to</td>
</tr>
<tr>
<td>Reproductive health</td>
<td>No mention</td>
</tr>
<tr>
<td>Universal coverage</td>
<td>Health care cover to entire population</td>
</tr>
<tr>
<td>Financial risk protection</td>
<td>Health insurance schemes</td>
</tr>
<tr>
<td>Targeting poor and vulnerable</td>
<td>Overall policy did not have specific focus—for food supplementation targeting of poor in urban and rural areas targeted</td>
</tr>
<tr>
<td>Gaps</td>
<td>Limited focus on emergency obstetrical care, and HIV/STI Likel or no implementation in areas of nutrition and social protection mechanisms</td>
</tr>
</tbody>
</table>
growing awareness internally of their influence on the nation’s health.

Despite increasing emphasis, several gaps have remained: (i) lack of an overarching comprehensive MCH framework; (ii) aspects of nutritional status have been overlooked; (iii) underestimation of neonatal and perinatal mortality’s contribution to the infant mortality; (iv) ensuring provision of emergency obstetric care has received inadequate priority; (v) lack of financial risk protection mechanism for the mother and child; (vi) the government continues to implement ARL, CDD, EPI and IMCI all at the same time. The latter has been piloted for several years with no influence on policy; (vii) strategic thinking for developing a balanced human resource is lacking; (viii) the policy on the role of the private and the NGO sector in the provision of MCH/FP services and the potential for partnerships between the public and private segments of the health sector has been superficially addressed.

4.3. Resource allocation and expenditure

4.3.1. Health sector expenditure

Expenditure in the health sector in general and MCH in particular is not well documented. Estimated total expenditure on health (THE) in Pakistan is US$ 18 per capita of which the total government health expenditure (GHE) is US$ 4 per capita [26]. This compares unfavorably with the figure of US$ 34 per capita for a package of essential health services as proposed by WHO [20]. Table 1 compares GHE and THE in relation to selected health system performance indicators for Pakistan and regional countries. As a percentage of GDP, GHE was 0.7% in early and mid 1990s, decreasing to 0.5% in early 2000s [27]. For comparison, the corresponding figure for all low-income countries between 1990 and 1998 was 1.3% of GDP.

4.3.2. Government expenditure on MCH/FP

In absolute terms total public expenditures have quadrupled since 1987/1988, in real terms and keeping inflation in view, government health expenditures appear to have remained constant on a per capita basis [27]. The expenditure by the federal Ministry of Health has risen by 50%, specifically due to federally funded LHWs program and increased expenditure on key preventive program related to MCH/FP. The World Bank estimates that MCH services account for a share of total cost at primary level ranging from 6 to 17%, and 1 to 3% at secondary care level [1].

In line with government’s health and population policy, the GHE related to all preventive and population welfare programs has increased by seven and almost 12-fold, respectively, since 1987. Much of this increase was financed by external donor support and includes funds allocated under SAP [28]. The enhanced allocation has been used to finance outreach program for provision of MCH/FP services including antenatal care, training of TBAs, health education, expanding family planning provision through public sector and social marketing programs, training of female paramedics, and immunization of women and children. Interventions such as training of TBAs continued to be part of government policy despite evidence to the contrary [29,30], due to lack of enthusiasm among policymakers to update policies based on best available evidence. Critical areas of MCH where investment has not increased include enhancing availability of 24 h emergency obstetrical care, interventions for improving nutrition of mothers and children, management of reproductive tract infections, and development of referral systems for emergency care.

4.4. Equity aspects of MCH policies

In health, societal averages typically disguise as much as they reveal. Distributional aspects of health status and services are often captured through assessment of poverty, health inequality, and health equity. While all three are similar in some ways they are different in others [31]. Health policies and programs in Pakistan have often set ambitious targets. What has been missing is a concern about distributional aspects of health status and services. Equity in health can be considered from two standpoints—service provision and financing of health care. While some information is available on the inequities that prevail in service provision through the various surveys, lack of data on financing of health care, especially its equity aspects is a major informational gap. Despite being ranked 62nd by the World Health Report 2000 [32], there is anecdotal evidence to the existence of
major inequalities in “fair financing” of health care in Pakistan.

The distribution of MCH/FP indicators across income quintiles provides some insight into the importance attached to equity aspects in the national health policies (Table 4). Health indicators are poor in the lowest income quintiles and in rural areas [33]. This pattern concurs with the rising level of poverty, which has recently been estimated at 32.6% for the overall country with urban and rural levels of 24.2 and 35.9%, respectively [18]. Difference in access to health facilities is of some importance in explaining the variation in health status. IMR and child mortality rates are lower for villages where there is a community hospital, dispensary, clinic or any health facility [33].

Universal health coverage was one of the targets of the 1990 health policy. The 1997 and 2001 health policies, have not addressed equity and distributional aspects. None of the policies have suggested strategies for addressing health inequalities. The reasons include: (i) health equity issues have only assumed greater significance over the last decade; (ii) donor agencies have pushed governments to improve efficiency without focusing on equity; and (iii) health sector technocrats and policymakers are generally unaware of the importance of pro-poor health policies and strategies. The interim poverty reduction strategy of the government of Pakistan through its enhanced socio-economic development agenda outlines government’s vision for reducing poverty and thereby inequalities [17]. It is too early to predict whether it will have an effect on health equity.

4.5. Stakeholder analysis of MCH policies and programs

Stakeholders, whether within the governments, donors, international agencies, or in the community can influence MCH/FP programs. Not much research-based information is available on the participation of different stakeholders in policy formulation and program implementation. Two studies have undertaken a stakeholder analysis in the context of Health Sector Reform [34,35]. Extrapolating the findings of these to MCH/FP, the situation that emerges is illustrated in Fig. 1.

Communicating with different stakeholders to create understanding, confidence and trust is often at the heart of successful MCH/FP programs. The expressed needs, perceptions and behaviors of its beneficiaries enhance the likelihood of the programs’ success. Policymaking in MCH/FP has often been done without the involvement of the true representatives of the civil society. The result is that after nearly four decades of the start of the Population Welfare Program, the misconceptions and fears of the communities regarding the use of contraceptives are not allayed. Three decades after the start of the Poly-immunization Program, the target coverage continues to swing up and down, as the parents are still not convinced of the benefits of immunization.
Experience in Pakistan has shown that stakeholders such as the government and the donors have a lot to do with the success of a program. The achievements of the LHWs Program in the 1990s were due to the firm political commitment and will of successive governments backed by availability of resources. On the other hand, the Social Action Program continued to survive despite its less than expected performance due to continued donor support, as it was the principal instrument of donor investment in the social sectors. However, once the major donor lost interest it was stopped and the unutilized funds disbursed to the government to meet its widening fiscal deficit and for drought relief.

4.6. Management and organizational aspects of MCH/FP system

Perhaps the most convincing argument to the question that despite increased investment in MCH, why the government did not get the value for money, resides in the existing weaknesses of the management and organization of MCH/FP system. Several cross-cutting MCH/FP system issues have policy and programmatic implications, including the following.

(i) Weak policy and planning capacity for MCH at the federal and provincial levels. Inadequately functioning information system and limited use impede evidence based policy development.

(ii) Segregation of reproductive health services under two ministries is responsible for duplication of effort, system inefficiencies, poor coordination, and a constant battle for turf.

(iii) Provincial health departments have not shown themselves to be great implementers of MCH/FP programs. Devolution of powers and responsibility to the districts has so far not brought about the expected improvements in the performance of the district health system.

(iv) Many MCH/FP Programs are implemented vertically and often do not talk to each other. The result is that MCH Directorates in the provincial DOH have remained weak and coordination poor.

(v) Lack of clear policy in the development of human resource for MCH/FP services and poor personnel management practices has been a major contributor to poor performance.

(vi) In the absence of a clear policy and regulatory framework for the for-profit sector, commercial interests are taking priority over social goals. The
less than 1% coverage by NGOs is too small to have any significant impact on the MCH/FP services.

5. Lessons learnt

Several lessons can be learnt from the foregoing review, which have been substantiated by relevant experiences from countries of the region. The major ones being as follows.

(i) Any MCH/FP policy is as good as the planning and implementation capacity of its stewards, the Ministries of Health and their MCH/FP units. Unless policies are translated into appropriate programs, put into operation and evaluated, they only retain academic value. Institutional capacity and good governance is vital in translating policies into effective services. When this capacity is inadequate and governance poor, increased resource allocation even to the right programs, may lead to little actual provision of services [36].

(ii) Poor countries, especially those facing economic crunch, have difficulty protecting the already meager health sector allocations. Ministries of Health need better stewardship and well-documented evidence to minimize cuts by the proverbial scissors of the Ministries of Finance. One reason for the impressive performance of the health system in Sri Lanka has been that the share of public sector spending is stable at 50% of the total per capita health expenditure since the 1980s [37], despite the effect of the civil strife on the country’s economy. The relative success of the LHWs Program in Pakistan can be attributed to the financial protection it has received despite the unstable economic situation.

(iii) Frequent policy announcement reflects the lack of trust in preceding governments. More importantly, it sends inappropriate and confusing signals to the health managers and providers and weakens on-going implementation. The Government of India recently announced the National Health Policy, 2002 [38], almost two decades after its last health policy. In Bangladesh, there is no formal National Health Policy. A set of guiding principles committed to health for all using a primary health care approach has been adopted. Priority is given to ensuring universal accessibility to and equity in health care, with particular attention to the rural population.

(iv) MCH/FP policies unless informed by evidence and participation of relevant interest groups are unlikely to address important gaps. The result is that years are lost before important issues receive the government’s attention and resources. The role of research is well illustrated by two rural MCH/FP projects in Bangladesh, the Matlab Project and the Extension Project that informed changes in the national policy process in the 1980s and subsequently guided the implementation of revisions in the Ministry of Health’s program. Taken together these projects and their contribution to the Third-Five Year Plan constituted a research paradigm that has been termed “implementation-based policy development” [39].

(v) Distributional and equity aspects of priority MCH/FP problems have escaped the attention of policymakers and public health practitioners alike. Governments need to incorporate distribution objectives along with the national goals they set for themselves. The recent Indian National Health Policy, 2002 [38], comprehensive in its own right, recognizes inequity in the provision of services as a priority. Although national policy goals have been clearly stated, distributional goals have not.

6. The way forward

While acknowledging that the direction of the national policy as being appropriate, MCH/FP remains high on the list of unfinished agenda in Pakistan. The shortcomings alluded to need be addressed by developing a longer-term vision and delineating effective implementation and good governance modalities if the government aims at achieving the RH related Millennium Development Goals. Without creating false impressions about the scope of the challenge Pakistan faces, we strongly believe that there exists a favorable environment both, externally and internally, which could be a catalyst for a rapid turn around.
The international environment is encouraging for social development and reducing poverty. In Pakistan, the newly established political structures including development of district governments appear to have injected enthusiasm to address problems being faced by the population. Pakistan could harness international goodwill and support, and strategically use the new political zeal by articulating sound policies, ensuring effective implementation, good governance and monitoring progress. The suggested strategic directions shall enhance the likelihood of achieving the desired goals.

(i) Comprehensive MCH Framework comprising:
(a) outline of a long term vision and objectives in line with MDGs; (b) strategic areas of interventions that are cost-effective; (c) partnership between public and private sector; (d) multi-sectoral approach including attention to girls’ education; and (d) means to measure progress towards MCH/FP related goals.

(ii) Current stewardship within MOH has successfully provided the much needed leadership in key preventive programs. This approach needs to be sustained for MCH/FP programs and replicated at provincial and district levels through intelligent use of information for decisions, building coalitions and partnerships, and greater accountability.

(iii) Address gaps in MCH programs: (i) effective programs to address nutritional deficiencies; (ii) access to good quality EmOC and referral services in the rural and hard to reach areas; (iii) unified policy on child health through an integrated program; (iv) emphasis on reducing neonatal and perinatal mortality; and (v) behavior change interventions targeting men and women for reducing population growth and safer sex.

(iv) Strengthen institutional capacity of MCH/FP Provincial Directorates with skilled staff and make them more responsive and accountable for improving access, quality and equity of MCHFP services.

(v) Evolve a strategic plan to correct the human resource imbalances that addresses availability of skilled birth attendants in communities, female paramedical staff in PHC facilities, trained nurses physicians for provision of emergency obstetric and child care in rural hospitals. The plan should also consider the human resource needs of the private and NGO sector.

(vi) Improvement cannot be achieved without doubling public sector resource allocation over the next 5 years and sustaining it over time.

(vii) Opportunities to work closely with the private and NGO sector to harness their potential in the field of RH are essential. The partnership should support areas in which NGOs and the private sector have comparative advantage, including skilled birth attendant’s development, social marketing and awareness raising and behavior change.

(viii) Increased roles of research in MCH/FP for providing evidence that feeds into policy and program implementation is essential. Policy-makers should orient themselves to the need for informed decisions, researchers should develop innovative means of approaching them and government should set aside 1% of funds allocated to all development programs for research.

While this paper has extensively reviewed the MCH/FP policy in Pakistan, it seems appropriate to close the discussion by emphasizing, that the ability to successfully implement programs, sustaining good governance and ensure delivery of good quality health services remains the biggest challenge in the Pakistan. Unless sound policies are backed by appropriate strategies and interventions, action plans, trained and motivated managers and care providers, functioning information system, and a smooth flow of resources to each district of the country, they would become a victim of poor implementation.

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