No. 3

パキスタン国
母子保健プロジェクト
巡回指導調査団報告書

平成10年4月
（1998年4月）

国際協力事業団
医療協力部

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パキスタン国
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国　際　協　力　事　業　団
医　　療　　協　　力　　部

序　　　文

パキスタン国母子保健プロジェクトは、安全な妊娠・分娩のための母性保健医療の人材育成についての技術協力として、平成８年６月から５年間の協力期間で開始されました。

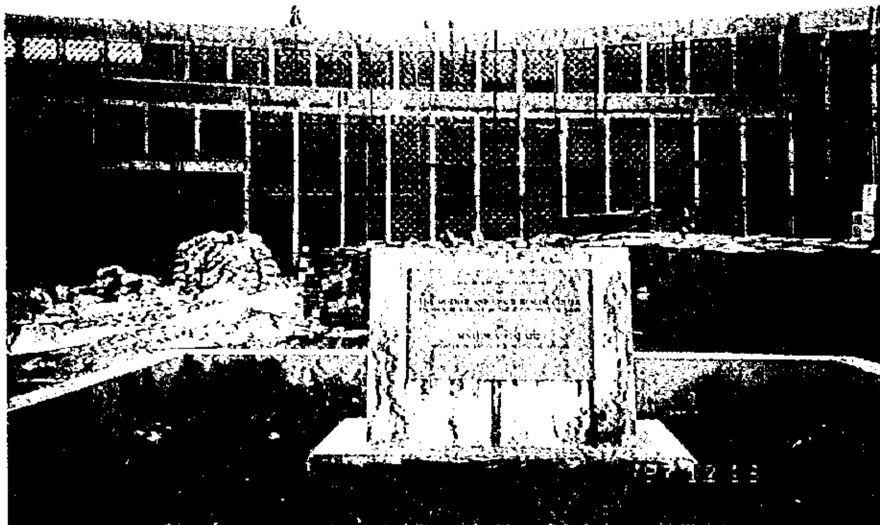
このたび、協力開始後１年あまりの時点で、これまでの活動内容を確認し、本プロジェクトにかかわる専門家とカウンターパートに必要な助言を提供し、また、本プロジェクト当初の目標を達成するために必要な事項をパキスタン側関係者と協議するため、国際協力事業団は、平成９年12月15日から12月21日までの日程で医療協力部長福原毅文を団長として、巡回指導調査団を派遣しました。

本報告書は、上記調査団の調査結果を取りまとめたものです。

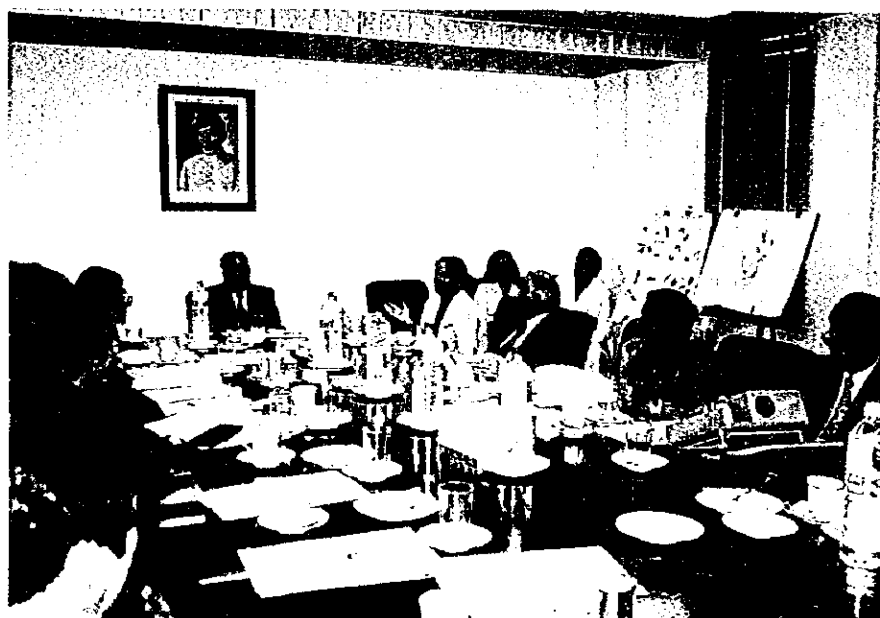
ここに本調査にご協力を賜りました関係各位に深甚なる謝意を表しますとともに、本プロジェクトの実施運営に対しまして、さらなるご指導、ご鞭撻をお願い申し上げます。

平成10年４月

国際協力事業団
医療協力部長　福原毅文

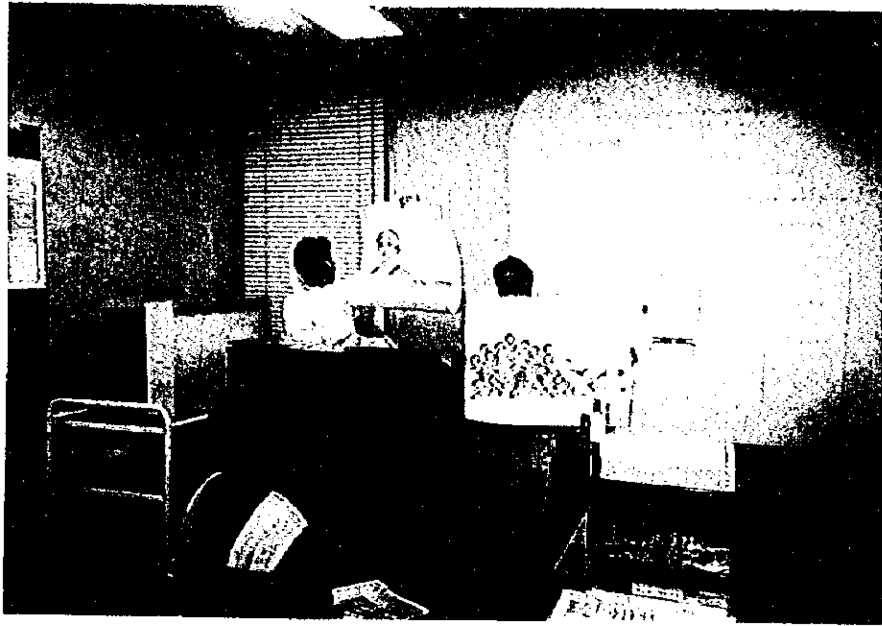


母子保健研修センター入院／手術棟



合同調整委員会

ミニッツ署名



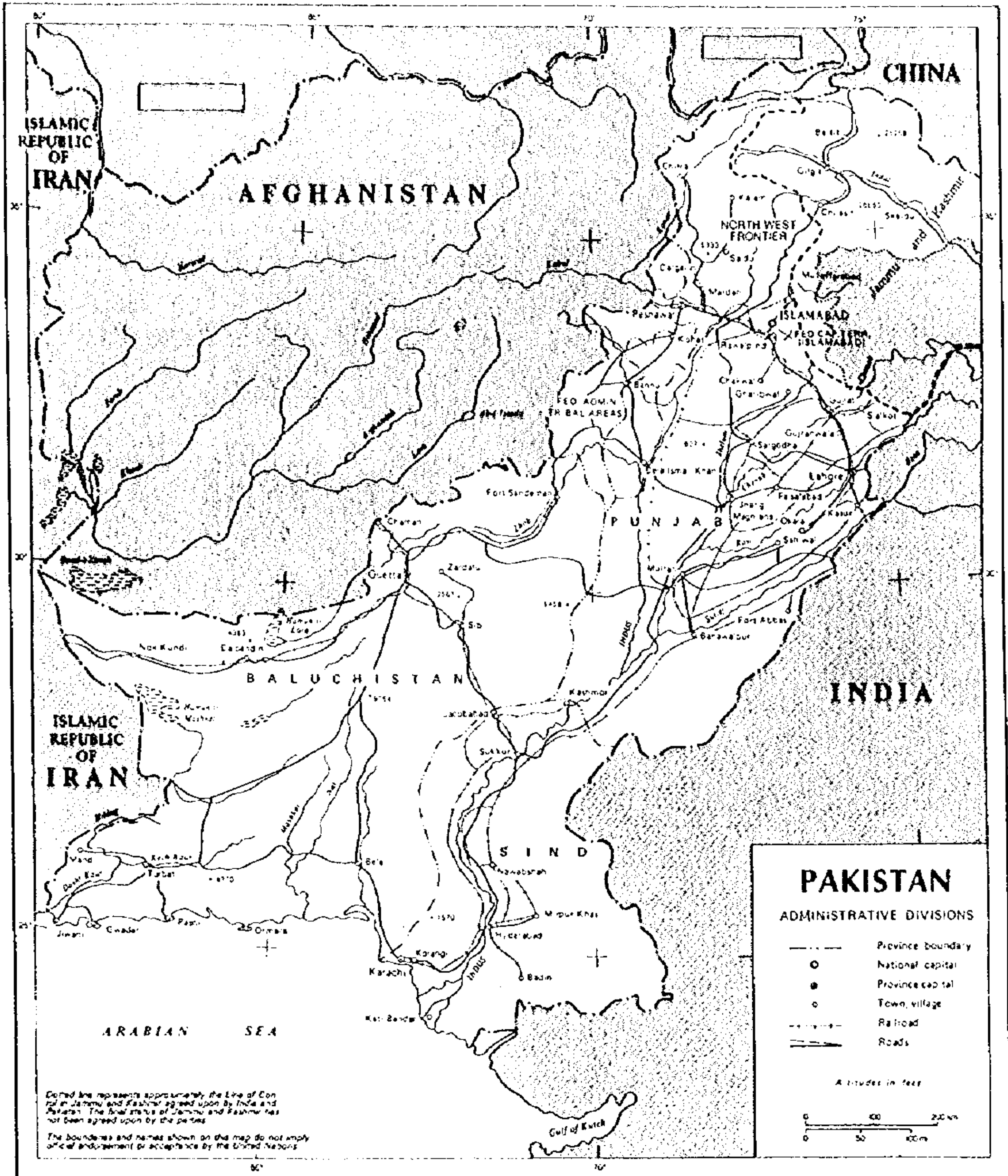
看護婦による母親学級の活動報告

栄養指導のために作成した図表

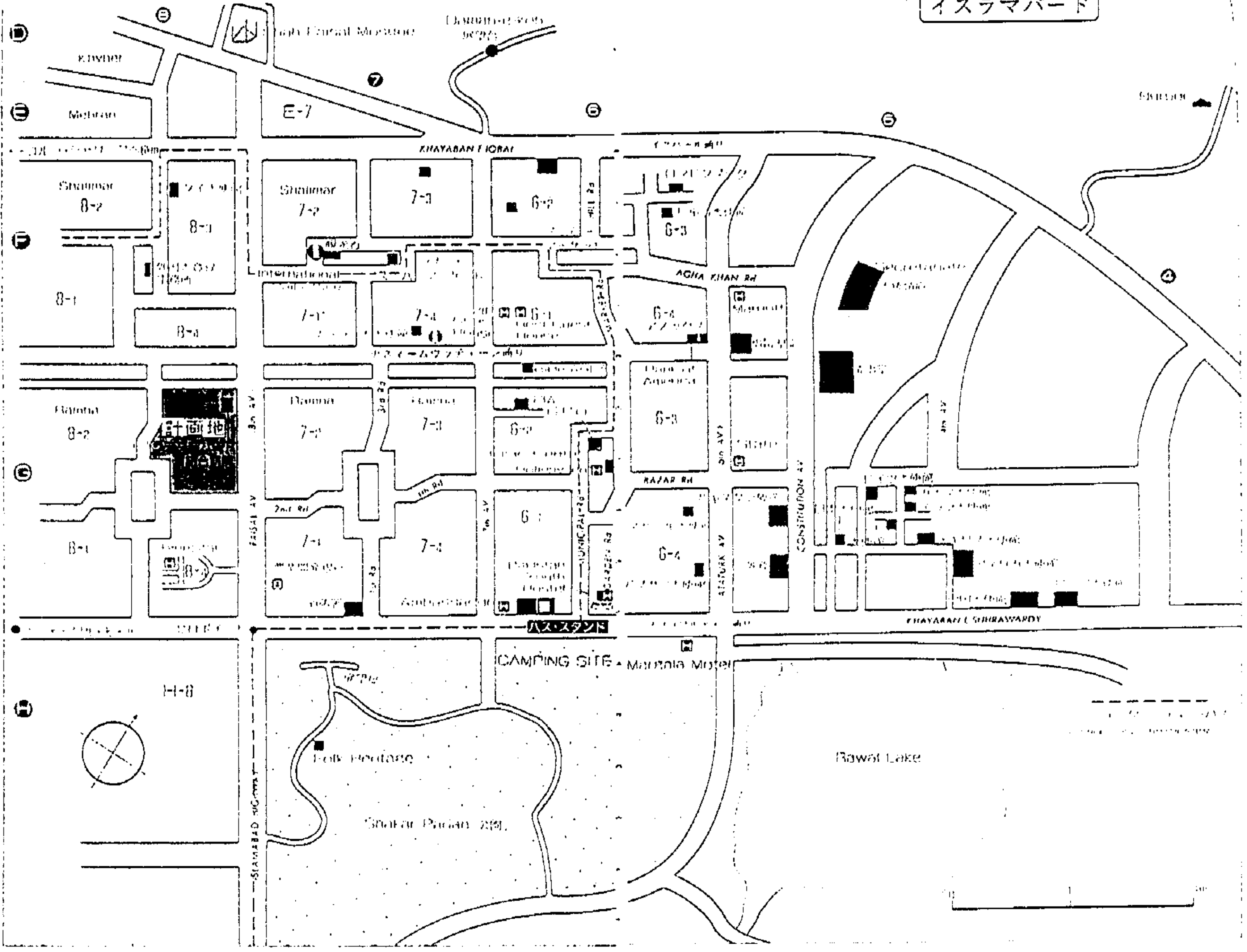
Rural Health Centre

LHWの自宅

地図：パキスタン・イスラム共和国



地図出所） UNDP, Development Cooperation : Pakistan 1993 Report



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１．巡回指導調査団の派遣

１－１　調査団派遣の経緯と目的

１－１－１　背景、経緯

(1) パキスタン国母子保健プロジェクトは「母性保健医療の人材育成による安全な妊娠・分娩の保証」を目標に1996年６月に開始され、これまで、長期専門家４名、短期専門家延べ９名の派遣、３名のカウンターパート研修員受入れ、および機材供与を行ってきた。

本案件に連携して、無償資金協力により、パキスタン医科学研究所（Pakistan Institute of Medical Sciences：PIMS）敷地内に母子保健センターが建設されるが、入院／手術棟が1998年４月、研修／外来棟が1998年11月に完成予定であるため、プロジェクトのこれまでの活動は、プロジェクト基盤整備のための定例／月例会議の開催ならびに妊産婦死亡に関する実態調査リフレッシュトレーニングカリキュラム作りの準備活動を中心に行われてきた。

(2) 1997年９月に、事前調査団当時よりプロジェクトにかかわってきたProject Director（以下、PD）のDr.Musthaqが解任され、新たにPIMS総長であるDr.MahmoodがPDを兼務することになったが、新PDは無償資金協力の設計内容についても無理な仕様変更を要望するなど、これまでのプロジェクトの経緯、方向性を理解していないことが懸念となった。

また、保健省内の機構改革（1996年12月に、それまで独立組織であったPIMSが保健医療局長下へ組み込まれた）、政権交代に伴う関係者の異動により、州組織との連携も十分に機能していない状況も問題となっていた。

その要因として、前PDとPIMS総長の権力抗争があるが、プロジェクトにおいても、保健省への働きかけを含む、パキスタン・イスラム共和国（以下、パキスタン）側の体制づくりが弱かった問題があるといえる。

(3) 1998年４月の１期工事完成を控え、母性保健従事者に対する研修センターとしての母子保健センターの確立が最優先課題であるが、その運営に関するパキスタン政府の1998年度予算の策定が12月に行われることから、保健省責任者ならびに新PDに対し、プロジェクトの方向性（高次医療ではなく、安全な妊娠・分娩の保証のための人材養成を目的とする）および母子保健センターの役割について合意することが必要となり、以下の対処方針により、巡回指導調査団が派遣されることとなった。

１－１－２　対処方針

(1) パキスタン保健省責任者（保健大臣、次官、保健局長）と協議し、母子保健プロジェク

トならびにその実施内容を政府として認知するとともに、これをサポートすることに関して再確認する。

(2) 新PDのPIMS総長ならびにカウンターパート等と協議し、母子保健センターが、母子保健従事者の育成のための研修施設であることを再度確認する。

(3) 各州との連携体制を確認する（各州がリフレッシュ研修のための医療従事者を送ることを確認する）。

(4) 1998年4月に完成する入院病棟についての、運営組織図、人材のリクルートならびにその配置、予算措置について確認する（特に、無償資金協力の基本設計時に、病院の維持管理および医療従事者の研修費用に充てることが合意されている有料個室収入について、会計、使途について確認する）。

(5) プロジェクトデザインマトリックスを見直し、活動計画をより具体的で実現可能なものとする（特に、母子保健センターの運営体制確立に重点を置く）。

(6) Joint Coordinating Committeeを開き、上記事項について同意する。

1－2 調査団の構成

	担当	氏名	所属
団長	総括	福原毅文	国際協力事業団医療協力部長
団員	母子保健	吉武克宏	厚生省国立国際医療センター国際医療協力局派遣協力課長
団員	看護	小西洋子	厚生省国立国際医療センター看護部長室副看護部長
団員	協力計画	大野ゆかり	国際協力事業団医療協力部医療協力第一課職員

1－3　調査日程

日順	月日	曜日	移動および業務
1	12月15日	月	移動　東京（12:55）→イスラマバード（20:15）PK853
2	12月16日	火	09:00 JICA事務所表敬 10:00 日本人専門家との協議（JICA事務所） 15:00 PIMS、母子保健センター視察 16:00 日本人専門家との協議（JICA事務所）
3	12月17日	水	09:00 EAD（経済協力局）表敬訪問 10:00 カウンターパートとの協議（Weekly Meeting）（PIMS） PM　合同調整委員会準備、ミニッツ案作成（プロジェクトオフィス）
4	12月18日	木	09:30 保健省次官表敬訪問 11:00 合同調整委員会（PIMS） 17:00 ミニッツ最終案打合せ（総長室）
5	12月19日	金	08:30 産後学級見学（PIMS） 10:00 看護婦による母親学級の研修内容報告（PIMS） 15:00 ミニッツ署名（保健省） 15:30 JICA事務所報告 日本人専門家との総括打合せ（JICA事務所）
6	12月20日	土	09:00 栄養トレーニングの発表（PIMS） 11:00 Rural Health Unit視察、LHWの家庭訪問（Bharakahu, イスラマバード首都圏地区）
7	12月21日	日	移動　イスラマバード（07:20）→東京（21:10）PK852

1－4　主要面談者

(1) パキスタン側関係者

1) 保健省

Mr.Zheer Sajjad	Secretary
Prof. Ghayyur H. Ayub	Director General
Dr. R. M. Ansari	Joint Secretary

2) Pakistan Institute of Medical Sciences（PIMS）

Prof. Mahmood Ahmed	Executive Director/Project Director（MCH Project）
Dr. Asif Mahmood	Deputy Executive Director
Prof. K. A. Abbas	Prof. of Paediatrics（Children's Hospital）
Dr. Gul N. Rehman	Register/MCH Project Team Member
Prof. Ghazala Mahmud	Consultant Surgeon, Department of Gynae / Obs.
Dr. S. Batool Mazhar	Associate Surgeon, Department of Gynae / Obs.

Dr. Shamsa Zafar	MCH Team Member, Department of Gynae / Obs.
Ms. Mumtaz Begum	Nursing Superintendent, Children's Hospital
Ms. Nasim Sohail	Head Nurse, Department of Gynae / Obs.
Ms. Neelofer Ghani	Charge Nurse, Children's Hospital
Ms. Anis Fatima	Charge Nurse, Department of Gynae / Obs.
Ms. Nasreen Bajwa	Dietitian, Islamabad Hospital
Mr. M. Zaheer Adnan	Social Welfare Office
Mr. Arshad Mahomood	Pegion, Children's Hospital
Mr. Jalil Ahmed Malik	Driver, Children's Hospital

3) Economic Affair Division

Dr. R. M.Ansari	Joint Secretary

4) Islamabad Capital Territory (ICT)

Dr. Muhammad Azhar Khan	District Health Officer
Dr. Amirzada Khan	Assistant District Health Officer

5) JICA MCH Project Local Staff

Mr. Badar Mohamood Malik	Secretary & P. A. to Chief Advisor
Mr. Ahmed Waseem Ashraf	Secretary
Mr. Ghulam Mastafa	Driver
Mr. Hameed Gul	Driver

6) JICA MCH Project Temporary Staff

Dr. Sofia Nilofer Sheikh	Researcher for Referral Level Hospital Survey
Ms. Athar Sayed	Sociologist & C/P for JICA Nutritionist
Mr. Waheed Ullah	Computer Operator
Mr. Muhammad Saleem Abbasi	Computer Operator

7) その他

Dr. Shahina Qureshi	Consultant Paediatrician (Oncology)

(2) 日本側関係者

1) 在パキスタン日本国大使館

久保田　実	特命全権大使
児嶋　秀平	一等書記官
山田　耕士	一等書記官

2) JICAパキスタン事務所

中川　和夫	所長
戸塚　真二	所員

3) プロジェクト派遣専門家

仲佐　　保	長期専門家	チーフアドバイザー
成瀬　　章	長期専門家	業務調整
千歳　万里	長期専門家	栄養学
金川　修造	短期専門家	小児科

4) その他

道券　康充	UNDP Programme Officer
富澤　隆一	青年海外協力隊員（イスラマバード小児病院配属、医療統計）
友野　康宏	㈱日本設計　主任技師
梅田　典夫	飛島建設パキスタン事務所長

2. 調査結果

新しく交代したPDをはじめ、プロジェクトカウンターパート、先方政府関係者に、プロジェクトの目的を再確認するとともに、無償資金協力により建設される母子保健センターの研修センターとしての機能が確立できるよう、必要な組織、人員、予算配置等を確認し、プロジェクトの今後の活動計画を協議することを主目的として1997年12月15日から21日まで派遣された。

本調査団は、各関係者との協議を中心に活動し、主な結果は以下のとおりである。

(1) 日本人専門家との協議、PIMS、母子保健センター視察（12／16）

当初予定されていた保健省への表敬訪問が、次官の都合により18日に変更されたため、初日に日本人関係者でプロジェクトの現状、問題点についての打合せを行った。

リーダーよりプロジェクトの活動実績についての報告がなされ、無償資金協力による母子保健センター建設前のフェーズとして、これまではトレーニングの内容を検討するための調査を行ってきたこと、パキスタン側が主体となって調査をしてきたことで、カウンターパートが育ってきていること等が説明された。

また、本プロジェクトの実施体制、母子保健センターの組織、人員、予算の仕組みや問題点についての検討を行った。

調査団側からは、母子保健センターにおける研修計画と研修部門の組織について、具体化することが、重点課題であることを指摘した。

(2) 経済協力局表敬（12／17）

母子保健センターへのスタッフと予算措置について申し入れた。また、無償資金協力とプロジェクト方式技術協力は別であり、プロジェクト方式技術協力は研修による人材養成が目的であることを説明した。

(3) カウンターパート（Weekly Meetingメンバー）との協議（12／17）

PDであるPIMS総長は、冒頭挨拶において、本プロジェクトが研修を主目的としていること、高次医療ではなくPHCにかかわる人材育成が重要であることを表明し、母子保健センターに対する予算措置や人員配置は問題なく対応することを説明した。

本調査団派遣の直前に、PIMS総長が無償資金協力の２期工事の入札立ち会いで来日した際、国内委員長よりプロジェクトの目的を改めて確認した成果があったといえるが、来日以前はこのような発言を行ったことがなかったため、現場のカウンターパートらにとって驚きだったようである。

調査団からは、研修の計画、実施体制、組織等について質問しつつ、研修実施には、募集選考、計画策定、評価管理、さらに、視聴覚教材を含む研修手法開発等の専用スタッフが必要であることを強く指摘し、研修部門の組織人員の具体化を申し入れた。

(4) 保健省次官表敬（12／18）

PIMSと保健省の関係、母子保健センターの位置づけ、地方政府との関係について協議を行った。

母子保健センターでの研修の計画立案は同センターが行い、保健省はPIMSから提出される案を承認する立場であることが確認された。なお、PIMSについては、将来、再度独立組織になる可能性があることも言及された。

人員配置については、半数近くはPIMS内での配置替えとなるが、追加の人員は保健省が措置することを確認した。

また、地方政府との関係について、保健省は機構上の権限はないが、母子保健センターに研修生を送る際の経費、地方で研修を行う場合の施設や医師等指導者について、地方政府が負担することに同意した。

なお、当日の新聞に発表された国家保健政策について照会したところ、同政策に基づいて今後次期５カ年計画が策定されること、特に女性の健康が重点課題のひとつである等の説明を受け、英文ドラフトを入手した。

この国家保健政策には、本プロジェクト活動と密接に関連するリプロダクティブヘルス、PHC、人材育成等が重点課題として取り上げられており、プロジェクトにおいて分析を深めるとともに、母子保健プロジェクトを国家政策のなかで位置づけていくための保健省に対する働きかけが必要である。

(5) 合同調整委員会（Joint Coordinating Committee）（12／18）

PIMS総長より冒頭挨拶と無償資金協力の進捗状況を含むプロジェクトの全体説明がなされた後、妊産婦死亡調査およびデータ分析結果の報告、活動計画の報告、研修計画についての報告がなされた。

活動計画報告以外は、パキスタン側カウンターパートが資料の作成、OHPを使っての発表を行い、プロジェクト活動を主体的に担っている様子が見受けられた。

研修計画については、まだ内容面で不十分な点が多く、特に研修手法や評価手法については、今後検討が必要である。

合同調整委員会には、パンジャブ州、イスラマバード首都圏地区（ICT）からも参加しており、イスラマバード首都圏地区医務官からは、母子保健センターが草の根レベルの母子保健従事者の研修を行うことを評価する発言がなされた。

パンジャブ州からは、研修生の募集、選考についての質問があり、それについては、今後、各州との検討の会議がもたれることになった。

(6) ミニッツ署名（12／19）

保健省次官、PIMS総長と団長は、以下の合意事項に署名した。

1）保健省は母子保健センターが母子保健従事者に対する国の研修センターの役割を果たすことを確認し、次期5カ年計画に盛り込むこと。

2）PIMSが母子保健従事者に対する母子保健センターでの研修を計画立案すること。また、同センターに適切な研修部門を設置すること。

3）母子保健センターでの円滑かつ効果的な研修実施については、保健省とPIMSが管理監督を行うこと。

4）母子保健センターの研修に必要な人員と予算の配置は、保健省とPIMSが行うこと。

5）保健省とPIMSが、地方政府とイスラマバード首都圏地区が技術面および予算面で研修に協力することを確保する。

なお、調査期間中、母子保健センターの名称を「母子保健研修センター」とすることを提案していたところ、保健省側から非公式ながら、支障がない旨の回答がなされたので、プロジェクトの目的をより明確にするためにも、名称の変更が望まれる。

(7) その他

1）産後学級見学および看護婦による母親学級の報告（12／19）

合同調整委員会において発表の機会のなかった看護婦の活動については、別途、報告会を開催した。

調査や研修実施にあたり、看護婦たちは主力となって活動しているにもかかわらず、合同調整委員会のメンバーに入れないこと、Weekly Meetingにおいても成果の発表は医師が行ってしまうこと等から、看護婦たちは医師に対して強い不満をもっており、今回、個別ながら、調査団への報告の機会を作ったことで、多少なりともインセンティブになったと思われる。（しかしながら、総長主催昼食会でのパキスタン側出席者は医師ばかりで、プロジェクトカウンターパート以外の臨床医も含まれていたなど、意識のギャップは根深いものがある。）

2）栄養トレーニングの発表およびフィールド視察（12／19）

PIMSで活動の説明を受けたのち、イスラマバード郊外のRural Health Unitの視察を行った。また、Lady Health Workerの家庭訪問では、農村の生活の様子が垣間見れたとともに、家庭訪問調査を通じて、カウンターパートや栄養の専門家とフィールドのLHWらとの人間関係づくりが進んでいることが見受けられた。

附 属 資 料

① ミニッツ

② National Health Policy（Draft）および関連新聞記事

③ プロジェクト活動報告（英文）

④ カウンターパートとの協議議事録

⑤ 合同運営委員会議事録

⑥ プロジェクトサマリー（1997年11月28日付）

⑦ 今後のプロジェクトの方針（1997年10月付）

⑧ 母子保健プロジェクト改訂PC－1（1996年6月）

⑨ PIMSからの予算、人員配置要求資料

① ミニッツ

MINUTES OF MEETING

BETWEEN
THE JAPANESE ADVISORY TEAM
AND
THE AUTHORITIES CONCERNED OF
THE ISLAMIC REPUBLIC OF PAKISTAN
ON
THE JAPANESE PROJECT-TYPE TECHNICAL COOPERATION
FOR THE MATERNAL AND CHILD HEALTH PROJECT IN PAKISTAN

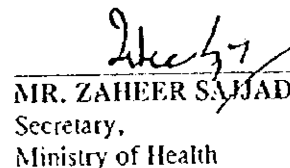
The Japanese Advisory Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Takefumi FUKUHARA, Managing Director, Medical Cooperation Department, JICA, visited the Islamic Republic of Pakistan from December 15 to 21, 1997 for the purpose of advising the activities concerning the Japanese Project-Type Technical Cooperation for the Maternal and Child Health Project in Pakistan (hereinafter referred to as "the Project"), and discussing the future implementation plan of the Project.

During its stay, the Team exchanged opinions and had a series of discussions with the authorities concerned of the Islamic Republic of Pakistan about the activities and implementation of the Project.

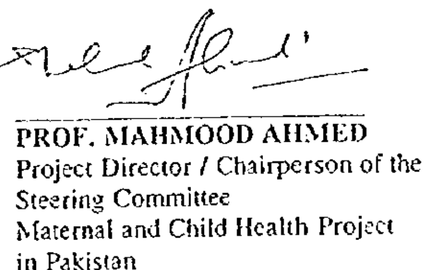
As a result of the discussions, both sides agreed upon the matters referred to in the document attached hereto.

Islamabad, 19th December, 1997

DR. TAKEFUMI FUKUHARA
Leader, Advisory Team,
Japan International Cooperation Agency



MR. ZAHEER SAJJAD
Secretary,
Ministry of Health



PROF. MAHMOOD AHMED
Project Director / Chairperson of the Steering Committee
Maternal and Child Health Project in Pakistan

I. JOINT COORDINATING COMMITTEE MEETING

The Joint Coordinating Committee Meeting of Maternal & Child Health Project was held on Thursday the 18th of April, 1997 at 11:00 a.m. in the Conference Room of Executive Director/Project Director's Office, Pakistan Institute of Medical Sciences, Islamabad and discussed important related matters.

AGENDA

The Agenda of the meeting was as follows :

No.	Item	Presenter
1.	Self Introduction of Participants	
2.	• Introductory Address • Overall Plan of the Project and Future Perspective	Prof. Mahmood Ahmed Executive Director/Project Director, PIMS, Islamabad
3.	Maternal Health Studies	Dr. Gul N. Rehman Registrar, Children's Hospital, PIMS, Islamabad
4.	Maternal Mortality Data	Dr. S. Batool Mazhar Associate Surgeon Department of Gynae/Obs, PIMS Islamabad
5.	Activity Plan	Dr. Tamotsu Nakasa Chief Advisor MCH Project
6.	Training Plan	Prof. Ghazala Mahmud Consultant Surgeon Department of Gynae/Obs, PIMS, Islamabad
7.	Discussion	
8.	Closing Remarks	Prof. Mahmood Ahmed Executive Director/Project Director, PIMS

PARTICIPANTS

Participants of the Joint Coordinating Committee Meeting were :

PAKISTANI SIDE :

No.	Name	Designation
1.	Prof. Mahmood Ahmed	*Executive Director/Project Director, PIMS, Islamabad*
2.	Dr. Asif Mahmood	*Deputy Executive Director, PIMS, Islamabad*
3.	Dr. Rashid Manzoor	*Representative Deputy Secretary, Economic Affair Division*
4.	Dr. Shahina	*Representative Director General Health Services, Punjab*
5.	Mr. Matiullah Khan	*Joint Secretary, F & D, Ministry of Health*
6.	Dr. Azhar Khan	*District Health Officer, ICT*
7.	Dr. Shafiq ud Din	*Representative Chief Health, Ministry of Planning*
8.	Prof. Ghazala Mahmood	*Consultant Surgeon & Head, Department of Gynae/Obs, PIMS, Islamabad*
9.	Prof. Khawaja Ahmed Abbas	*Professor of Paediatrics, Children's Hospital, PIMS, Islamabad*
10.	Dr. S. Batool Mazhar	*Associate Surgeon, Department of Gynae/Obs, PIMS, Islamabad*
11.	Dr. Gul N. Rehman	*Registrar, Children's Hospital, PIMS, Islamabad*
12.	Dr. Shamsa Zafar	*Department of Gynae/Obs, PIMS, Islamabad*
13.	Dr. Sofia N. Sheikh	*Research Physician, MCH Project*

JAPANESE SIDE :

No.	Name	Designation
1.	Dr. Takefumi FUKAHARA	*Leader of JICA Advisory Team*
2.	Dr. Katsuhiro YOSHITAKE	*Member of JICA Advisory Team*
3.	Ms. Yoko KONISHI	*Member of JICA Advisory Team*
4.	Ms. Yukari ONO	*Member of JICA Advisory Team*
5.	Dr. Tamotsu NAKASA	*Chief Advisor, MCH Project*
6.	Mr. Akira NARUSE	*Project Coordinator, MCH Project*
7.	Ms. Mari CHITOSE	*Nutrition Expert, MCH Project*
8.	Dr. Shuzo KANAGAWA	*Paediatrician/Short Term Expert, MCH Project*
9.	Mr. Koji YAMADA	*First Secretary, Embassy of Japan*
10.	Mr. Shinji TOTSUKA	*Deputy Resident Representative, JICA Pakistan Office*
11.	Mr. Mahmood Jilani	*Chief Programme Officer, JICA Pakistan Office*

II. AGREEMENT

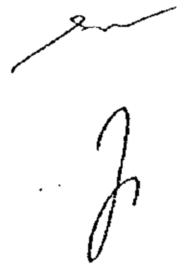
1. Ministry of Health agree that the MCH Centre will be recognized to play a role as a National Center for Training of health care providers relating to Maternal and Child Health (MCH) and will reflect it in the next National Five Year Plan (1998-2003).

2. PIMS will design appropriate training models/ programmes for all levels of health care providers for training in the MCH Centre. As well they will develop a proper training department in MCH Centre.

3. Ministry of Health and PIMS will supervise the MCH Centre and coordinate for smooth and effective implementation for training of health care providers.

4. Ministry of Health and PIMS will allocate necessary staff and budget especially for training in order to run the MCH Centre properly.

5. Ministry of Health and PIMS will ensure that the Provincial Governments and Islamabad Capital Territory authorities *(Ministry of Interior, Government of Pakistan)* cooperate technically and financially in this project as required for training of health care providers.



② National Health Policy（Draft）および関連新聞記事

DRAFT

National Health Policy

Ministry of Health
Government of Pakistan

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1. Introduction

A National Health Policy was formulated in 1990 to form the basis for the development of the country. It aimed to address the basic problems in the health sector by strengthening the health care system on the basis of Primary Health Care (PHC) and bringing about the needed reforms in all areas of health.

However, there is now a need to revise and update this policy due to many reasons. The previous policy did not adequately cover all areas of PHC, specially in view of renewed HFA strategies. There is a lack of focus on the district health system which is the foundation of health care delivery in the country. Many priority health areas have not been given proper emphasis. The same is true for new and re-emerging health areas like chronic and non-communicable diseases. Many sections require updating as the status of the health programmes has changed a great deal in recent years. There is also a need for a more action oriented approach in the policy guidelines. Practical approaches for community and private sector participation and intersectoral collaboration need to be highlighted. The newly elected Government has promised some basic reforms in the health sector in its manifesto that need to be incorporated in the policy.

The new health policy aims to improve the health status of the nation by providing universal coverage of quality health care through an integrated PHC approach. Good governance will be the cornerstone of health sector reforms with special emphasis on strengthening the district health system. Existing health facilities and programmes will be strengthened and upgraded. Human resource development will be rationalized. The private sector will be given greater responsibility for health services delivery. Communities will be empowered to take an active role in the health system, which will be decentralized. Health care planning will be based on scientific research. The health sector will be better regulated, and made more responsive to the current and future challenges. The vulnerable and disadvantaged groups in society will be given priority as recipients of social uplift programmes. The policy document provides an overview of the health sector in the country, and gives guidelines for action in all priority health areas, with a vision upto the year 2010.

2. Health and Demographic Situation Analysis

Pakistan, in the past five decades has achieved impressive economic growth of about 6% in the GDP, and Substantial progress has been made in the agriculture sector, which has exceeded the population growth rate. However, social indicators in general, and health and demographic indicators in particular have lagged behind those countries of comparable economic level as also most of the lower income countries.

Pakistan started with a very weak base in the health sector in 1947. At the time of Independence, the country inherited very poor medical facilities (one medical college, 78 doctors, widespread malnutrition, unsanitary environmental conditions and a high prevalence of communicable diseases).

The rate of expansion of health facilities and health manpower remained very sluggish for many years, because of the low priority given to the health sector, which led to extremely inadequate and inequitable distribution of health facilities in both urban and rural areas.

In the first 25 to 30 years after independence, hospitals, medical colleges, and curative health care development received priority. This resulted in the establishment of 830 hospitals with 86,921 beds, 75,000 doctors and 6,000 PHC units by 1996. The Primary Health Care and Preventive Services remained neglected and were under-funded. The situation changed in the late 70's when basic rural health programme received a greater focus and was substantially expanded after the famous Alma-Ata Declaration in 1978. Currently, almost all the urban population and 70% of the rural population within a 5 kilometer radius have a health outlet. The current position of health facilities and personnel is as follows :-

Table-I. **Health Facilities**

Type of Facility	Upto 1978	5th Plan 1983	6th Plan 1988	7th Plan 1993	1996-97
Hospital	536	626	710	799	830
MCH	748	794	998	849	864
RHC	200	302	417	485	542
BHU	554	1,982	3,454	4,663	5,147
Beds	42,469	52,161	64,471	80,047	86,921
Bed/ Population	1,804	1,708	1,610	1,509	1,610

Source: Planning and Development Division

Table-2: **Health Personnel:**

Health Personnel	Upto 1978	5th Plan 1983	6th Plan 1988	7th Plan 1993	1996-97
Doctors	8,041	20,865	42,862	63,003	75,000
Dentists	781	1,222	1,772	2,402	3,000
Midwives	3,106	6,031	12,866	18,641	21,304
Nurses	3,892	7,348	14,015	20,245	24,810
LHVs/FMTs	341	1,144	2,697	3,920	4,250
TBAs	-	15,000	30,000	45,000	50,000
LHWs	-	-	-	-	45,000

Source: Planning and Development Division

However, there are geographical imbalances in the distribution of health facilities in the rural and the urban areas, availability of health personnel and curative vs preventive measures.

To maintain the expansion of health facilities, the financial allocation for the health sector has been rising significantly. Public expenditure, both development and non-development, has increased steadily.

Table-3 shows the financial allocation of the health sector during the different Plan periods.

Table-3: **Financial Outlays of Five Year Plans** **(Rs. Billion)**

Type of Facility	Upto 1978	5th Plan 1983	6th Plan 1988	7th Plan 1993	1996-97
Development	0.076	4.584	10.368	14.77	32.5
Rural Health Programme	0.007	1.25	3.798	6.305	9.0
G. Prevention	0.069	0.744	6.57	8.466	8.9
NON-Development	5.405	25.00	40.0	61.066	70.00

Source: Planning and Development Division

Per capita expenditure on health increased from Rs.3.52 monthly in 1978 to Rs.160 in 1997-98. A number of national level health programmes funded by the Federal Government also have been undertaken for several years. These programmes include: Malaria Control; EPI/CDD, Nutrition; ARI; Prime Ministers' Programme for Family Planning and Primary Health Care; AIDs Prevention; and T.B. Control.

All efforts in the past made through the Five Year Plans have improved the health status of the population, as reflected in the following table :-

Table-4. **Health Indicators**

INDICES	Upto 1978	5th Plan 1983	6th Plan 1988	7th Plan 1993	December 1998
Infant Mortality Rate	120	110	100	95	86
Crude Death Rate	14	12	10	9.1	8
Maternal Mortality Rate	600-800/ (per 100,000)	600-800	500-700	400-600	350
Life Expectancy					
• Male	54 Years	55	57	61	63.6
• Female	53 Years	54	56	60	63.3

Source: Planning and Development Division

In spite of steady improvements, the present health system has not adequately met the requirements of the population. Pakistan's health indicators present a very dismal picture as compared to countries at the same economic level. The health status of the nation after 50 years of independence is characterized by a population growth rate of around 2.8 percent, infant mortality rate of 86 per thousand live-births and maternal mortality rate of 350 per 100,000 live-births which is one of the highest in the world. The major killers of children are diarrhea and pneumonia, in women of child-bearing age complications of pregnancy, in adults accidents, and cardiovascular diseases and cancer in the elderly. Infectious diseases remain a severe burden, while dental caries and gum diseases are increasing. Drug abuse has emerged as a public health problem, while malaria and tuberculosis continue to be potential threats. Poor maternal nutrition status results in the high incidence (about 25 percent) of low birth weight babies. Protein-energy-malnutrition is prevalent in the vulnerable population, while micro-nutrient deficiency disorders e.g. iron deficiency anemia in children and women of child bearing age and iodine deficiency disorders completely over-shadow all other nutritional problems.

3. Health Policy Guidelines upto 2010

The Government of Pakistan is committed to achieve the goal of Health For All through PHC. It aims to create a platform for social change to improve the quality of life of the people, through this approach. The new health policy is based on a concept of health with its physical, mental and social dimensions, where health is an important indicator of quality of life and national development. All important aspects of the health care system have been addressed under the framework of the new policy.

The 2010 vision for the health sector development is one of comprehensive and quality health care for all segments of the society. The burden of ill health from preventable causes would be greatly reduced. The capacity of the health care system to deal with new and emerging health threats would be adequate to ensure public safety. The available health facilities would be distributed in an equitable manner. In addition to a strong PHC programme, a highly organized and well equipped tertiary level care will be available at affordable prices. The ultimate goal of all health programmes would be to ensure basic services and promote a better quality of life for attaining maximum

national development. The achievements expected by the year 2010 through the implementation of the new Health Policy initiatives are given in Table -5 :

Table 5 **Targets for Years 1998, 2003 and 2010**

INDEX	1998	2003	2010
Infant Mortality Rate	86	40	20
Maternal Mortality Rate	350	200	90
Life Expectancy	62	65	69
Percentage of children below 01 year fully immunized	65	90	100
Percentage of expectant mothers fully immunized against tetanus	60	80	100
Eradication of Polio	-	Year 2000	-
Trained personnel attending pregnancy and child birth (percentage)	20	70	100
Percentage of low birth weight babies	25	10	05
Oral Rehydration Therapy use (percentage)	70	90	100
Iron Deficiency Anemia			
• Women	40%	20%	5%
• Children	30%	20%	5%
Goitre Prevalence Rate (GPR)	15%	10%	1.0%
Doctors	75,000	133,000	142,200
Dental Surgeons	3,000	6,000	15,000
Nurses	24,810	35,000	50,000
Paramedics	115,000	170,000	215,000
Traditional Birth Attendants (TBAs)	50,000	60,000	65,000
Community Health Workers (Female)	45,000	75,000	100,000

The major objectives of the policy are as follows:

- to address the health problems in the community, by providing promotive, preventive, curative and rehabilitative services to which the entire population has effective access
- to bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support
- to improve the utilization of health facilities by bridging the gap between the community and health services.
- to expand the delivery of reproductive health services including family planning both in urban and rural areas of Pakistan
- to gradually integrate existing health care delivery programmes like EPI, malaria control, nutrition and MCH within the PHC.
- to improve the nutrition status of mothers and children and reduce the prevalence of malnutrition
- to promote proper inter-sectoral action and coordination at all levels.

The main strategies of the policy are as follows:-

- strengthen the district health system to deliver the essential elements of PHC and provide the necessary support mechanism in terms of training, and logistics to effectively supervise the performance of health workers at all levels
- ensure satisfactory staff levels at RHC's/BHUs and promote the deployment of female workers as a human resource capacity building for the district health system
- introduce the necessary directives to develop and support decentralization strategies in the organization, planning and management of the national health system.
- improve the functions of the referral system to ensure equitable accessibility to emergency, secondary and tertiary health care services
- ensure direct and effective community involvement and bring about coordination and collaboration between health and other government sectors and NGOs
- introduce alternative approaches to financing health care through the involvement of the private sector and the national health care schemes
- integrate all vertical programmes in to PHC at the operational level to create an effective district health services system based on comprehensive PHC
- deliver reproductive health services including family planning in all health activities and at the household level through home health care
- promote innovative control strategies for the prevailing communicable diseases such as tuberculosis, viral hepatitis and acute respiratory infections (ARI) and diarrhoeal diseases, and undertake the control of major prevalent non-communicable diseases
- planning would be decentralized to the grass-roots level and community would be given active participatory role

4. Setting Priorities

The ultimate aim of this health plan is to improve the levels of health in the population. The first priority will constitute a concerted effort on the most serious health problems, from the prospective of mortality and morbidity indicators. In Pakistan the recorded high infant & child mortalities are due mostly to diarrhoeal diseases, acute respiratory infections, immunizable diseases and malnutrition. These conditions are prevalent because of the high rate of poverty, large families and contaminated environments, as well as inadequate health services system, while the high maternal mortality is due to preventable complications occurring during pregnancy, labour and the post-partum period. Primary health care is considered to be the key intervention for achieving health for all. To attain the best outcome during this planning period, several priority programmes have been delineated to constitute the thrust of district, provincial and national health services delivery. A package of managerial support is also considered to ensure their successful implementation. A second priority to be addressed by this plan is the risk of population trap. The promotion of extensive reproductive health services including family planning through a comprehensive package of community and family based PHC health services will be the key for realizing this objective.

Another realization of the health sector is that poverty constitutes the underlying cause of ill-health, and for a considerable proportion of the people, survival acquires the greatest urgency. In such situations there is little that the health interventions can do to improve health. To address the poverty related high morbidity and mortality, the Ministry is aiming to launch an integrated community based, intersectoral, total development programme of Basic Minimum Needs. It will address the comprehensive needs of the community such as food, water, shelter, health, education and income through social and income generating activities. This will lower child and maternal mortality, decrease fertility and improve other indicators of quality of life. A forth priority is the process of developing policies and intervention plans for involving the private sector so that it can play a significant part in the health sector. Specific innovative operational strategies are considered in this plan.

5. National Health Development: Planning for PHC

5.1 Structural Reforms in Health Care System

The intended health reforms will include the development and capacity building of the health services infrastructure i.e., facilities, human resource, management, information system and logistics. This will improve the support to health services and the interaction between the different levels of care on the one hand and the community on the other.

To improve the efficiency of the health care system there will be a re-organization at all levels to bring about close coordination between all programmes, between federal and provincial departments, between different levels of health care and between the community and the health care system.

The following are some principal features of this intervention:

- The principle of equity will be strictly followed to ensure universal provision of PHC services
- Planning would be decentralized to the grass-roots level and the community would be given an active participatory role;
- District planning and implementation cells would be established on priority basis - DHOs/ADHOs, health managers and administrators will be trained through short/refresher courses on planning and implementation.
- Planning will be need-based, realistic and participatory, keeping in view the situation, cost analysis, disease patterns and the environment.
- Planning would be based on reliable data and information. For this, the Planning Cells will be linked effectively with the Health Management Information System(HMIS).
- Planning would be based on "Create facilities, and reduce liabilities" lines. The recurring budget will be correlated with the development budget.
- A Standing Committee will be formed for coordinating external assistance

5.2 Management Reforms

- Good governance will be the basis for strengthening the foundation of health services at all levels
- District health management and leadership in support of PHC will be strengthened through training of district and tehsil health management teams, working under the supervision of the District Health Authorities.
- Decentralization of administrative, management and financial responsibilities to the district level will be carried out.
- Proper resource allocation and efficient use of resources will be promoted
- Proper management training will be provided to health functionaries.
- The Provincial and District Health Development Centers will function as focal points for in-service training of health workers, with assistance from the Health Services Academy.
- Packages of services will be clearly defined for all levels of care to ensure good quality health care
- Role of line departments and health related sectors in PHC will be clearly defined and functional linkages established.
- Operational procedures in the Health Department will be revised and made more practical and efficient. Problem solving approaches will be introduced.
- Participation of non-physicians in health management will be promoted in areas where they have special expertise.

5.3 Strengthening the District Health System

The District Health System (DHS) consists of different levels of health care, namely families, community, Health Houses, BHUs/RHCs, THQHs and DHQHs. In addition, there are private practitioners, NGOs, CBOs etc. The DHS will be supervised by the District Health Authorities (DHAs) comprising health professionals, elected members and community leaders. The DHO will be the incharge of running the health facilities in his district, with the district management team and tehsil management team. Packages of services and standards of care will be developed for each level of care and each level will be staffed and equipped accordingly. Home and self health care programmes will be focused at the household level. The community health workers will be trained as multi-purpose workers to deliver essential services at the community level and form a link between the community and the health system. The packages of services will be based on PHC which will include :

- Health Education
- Promotion of food and proper nutrition
- Safe water and basic sanitation
- Reproductive health and child health (including MCH and family planning)
- Immunization against major infectious diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

The BHUs/RHCs will be First Level Care Facilities. The THQH will function as the first referral level, backed up by the DHQH. The District Health System will be decentralized with greater delegation of financial and administrative powers to local level. District management will be largely dependent on HMIS and community involvement. The poorly functioning FLCFs will be selectively privatized, and DHQHs will be given autonomy to improve their functioning. The DHDCs will be focal points of district level training and monitoring activities. The DHS will coordinate with other line departments in strengthening services like water supply, waste disposal, industrial safety and protection from environmental hazards.

5.4 Integration of Different Priority Health Programmes

Programmes like EPI, Malaria, and AIDs, will be integrated with the PHC delivery system, and the resources will be transferred from Federal Health Ministry to the Provincial Health Departments. This will reduce duplication of resources in the federal and provincial health departments, improve the coverage and quality of the services, reduce cost of health delivery and optimize scarce resources, avoid duplication of training and facilitate the accountability of health providers. This approach will require an integrated organizational set-up and training of multi-purpose workers.

The Federal Ministry of Health and Provincial Health Departments will be re-organized under PHC for coordinated planning and integrated service delivery through the existing health infrastructure. A Task Force will be set up to work out the modalities of the structural re-organization.

5.5 Decentralization

Decentralization brings decision making closer to the communities and facilitates their involvement in the process of health development. The following steps will be taken to implement the concept of decentralization:

- Roles and responsibilities at each level will be clearly defined.
- Appropriate resources will be allocated at each level so that it can perform well.
- Necessary structural reforms will be brought about.
- Codes and regulations will be modified to bring them in line with revised roles and responsibilities.
- Peripheral levels will be given control over budgets and programme implementation.
- Peripheral levels will be allowed to hire and fire staff, determine staffing patterns, and establish incentives for good performance.
- Prospective target setting at the central level will be relinquished and substituted with retrospective monitoring of results.

5.6 Consolidation of the Existing Primary Health Care Network

- Proper staffing, equipment, supplies especially medicines, and functional referral systems will be ensured
- Gender imbalance will be removed by increasing the strength of female health workers at all levels.
- The efficiency of female workers will be maximized through continuing training and skill development for service delivery and motivating community to utilize static health facilities.
- The community health workers and other PHC staff will be trained as multipurpose workers to function effectively in an integrated health services delivery model.
- The referral system will be strengthened by establishing a national referral policy that defines clear referral pathways and protocols, with checks and balances.
- All health outlets will provide family planning services. There will be close coordination between all programmes offering family planning services.
- Dental care will become a regular component of the health care system.

5.7 Intersectoral Coordination, NGOs and Community Involvement

This government encourages public involvement in the whole range of development activities including health. To render this initiative meaningful the health plan is promoting the establishment of the necessary structures for community organization and their involvement in significant decision making in the planning, implementation ,and management of health development activities. Functional linkages and mechanisms will be developed for community involvement and inter-sectoral collaboration through:

- District Health Authorities (DHAs)
- Health Committees and Women's Committees
- Functional linkages between different community health workers (e.g. LHWs, VBFPWs, TBAs)
- User charges/cost-sharing in health care
- Financing NGOs/CBOs for health services
- Leasing of FLCFs to NGOs/CBOs
- Defining the role of line departments in PHC
- Establishing a community based health care referral support network with the assistance of CBOs, community workers and through special schemes like Health Cards

5.8 Health Manpower

- A National Training and Monitoring Cell will be set up in the Health Department.
- There will be separation of Management from Technical positions with appropriate training for each area.

- Need based in-service and education programmes will be carried out. Integrated training programmes will be developed for multipurpose workers.
- Rapid expansion in the output of paramedical/auxiliary staff will be done by increasing admission, opening new training institutions and upgrading established institutions. Local and female candidates will be encouraged to join.
- Admission capacity in the existing nursing schools will be increased to achieve the target of one nurse to 6 beds. Specialized training in nursing will be promoted. Training facilities for public health nursing will be created.
- Current dental services are negligible. Departments of dentistry in medical colleges, hospitals and PHC facilities will be upgraded to provide dental services to the entire population.
- Undergraduate medical and nursing/paramedical education will be consolidated and the curriculum will be redesigned towards community oriented medical education to produce a health worker who will be a health care provider for PHC with the potential to become a specialist.
- A grading system based on training levels will be introduced for health professionals.
- Admission in medical colleges will be limited to maintain a balance between supply and demand of doctors.
- System of examinations will be made transparent, reliable, objective and valid to encourage better learning.
- Training of TBAs will continue. They will be fully utilized as a cadre and will be involved in family planning programmes and linked with the LHWs.
- Domiciling midwifery will be introduced to promote safe motherhood.
- All training curricula for health workers will be standardized. Training will be extended to all cadres of health workers and private practitioners and will form the basis for their grading.
- Job descriptions for all categories of health workers will be developed.
- Post graduate training institutes will be set up in existing hospitals capable of undertaking such programmes.
- The postgraduate education as a continuation of undergraduate education will be carried out in all medical colleges. The output of specialists will be increased.
- A percentage of top students in professional colleges will be provided opportunities for specialization.
- Integration of family planning and health at service delivery level i.e. district level and linkage of two cadres of community workers, i.e. LHWs and VBFPWs will be done.
- Family Physicians will be promoted as a specialty.
- Specialists in basic sciences and community medicine will be accorded priority and provided incentives.
- The employment of doctors on a contract basis to serve in rural areas will be supported and consolidated with some incentives.
- Comprehensive laws will be introduced to ban unauthorized practice of medicine.
- Newly graduating doctors will be provided loans through Health Foundations to set up their practice.

- Steps will be taken to address the shortage of trained teachers especially basic science teachers.
- Full time medical faculty will not be allowed private practice, and will be compensated with other incentives.
- Institutional practice after regular working hours will be allowed to specialists working in public sector hospitals on the basis of profit sharing with the hospital.
- Doctors admitted against seats reserved for rural and backward areas would be under obligation to serve for a specified period in that area, failing which they would not be eligible for government jobs.

- A Committee will be constituted at federal level to develop a comprehensive career structure for health professionals to attract competent people to public health sector.
- Proper training facilities and opportunity for upward movement in all medical and para-medical categories will be provided.

5.9 Supervision, Monitoring and Accountability

- The PHDCs and DHDCs will function as monitoring and evaluation cells.
- Proper supervision, monitoring, and evaluation of health services will be emphasized and made regular part of health programmes.
- A Health Institutions Database will be established and updated annually.
- Concept of accountability will be based on clear assignment of responsibilities, proper training, adequate authority, objective and supportive supervision, and timely feedback for corrective action as well as reward for good performance.
- Supervisory checklists will be implemented at all levels.
- The ACR system will be strengthened and made more transparent and participatory.
- Quality assessment and assurance of PHC services, in relation to set standards, will be made an integral part of health services management.
- Modern record keeping and audit systems will be introduced.
- Community will have a direct role in management and supervision of health care system through CBOs, DHAs, Health Committees etc.

6. Human Resource Development for Health

6.1 Community Oriented Medical Education (COME)

The government has acknowledged the growing need to ensure the relevance of medical education to the requirements of the national health care system and community needs. To address these challenges the programme of community oriented medical education is to be introduced in medical, nursing and paramedical institutions/colleges as an effort to ensure the coherence between policies and programmes on the one hand and the production and utilization of trained medical staff on the other. This educational reform will consider the following:

- relevant educational settings;
- a curriculum based on national health needs;
- emphasis on disease prevention and health promotion;
- lifelong active learning;
- competency based learning;
- teachers trained as educators;
- integration of science with clinical practice;
- selection of entrants for non-cognitive as well as intellectual attributes;
- coordination of medical education with health care services;
- multi-professional training; and
- continuing medical education.

6.2 Pakistan Medical and Dental Council (PMDC)

The Pakistan Medical and Dental Council (PMDC) will be made an independent institution with the responsibility of regulating the profession through:

- Registration
- Setting standards and prescribing curricula
- Laying down qualifications and experience levels for appointment as teachers and examiners
- Determining equivalence of foreign qualifications.
- Guarding professional ethics and discipline.
- Monitoring medical and dental practice through licensing.
- Revision of medical and dental curricula towards community oriented education.
- Regulation of medical and dental education in the private sector.
- Formulation of legislation in the health sector.

6.3 Nursing and Paramedical Staff Development

The Nursing Profession in the country has developed gradually since independence of Pakistan. It faces a lot of issues that need to be addressed. They are related to standard of nursing education, supply of adequate nursing and para-medical workforce, employment opportunities, career structure, nursing leadership, research etc. There is an acute shortage of female paramedics specially in rural areas

The nursing and paramedical institutions will be strengthened, a better career structure will be laid down, working conditions will be improved, training and higher education will be emphasized, and nursing leadership will be developed. Federal and provincial nursing units will be strengthened through provision of budget, equipment and support staff. Nursing education will be brought at par with other professional training programmes. Male nurse and nurse aids training programmes will be started. New schools of public health will be established to remove the shortage of paramedics. The training of para-medics will be rationalized. It will be made more broad based to reduce the categories of paramedics. HMIS and research for nursing development will be promoted.

Community oriented nursing and paramedics programmes will be introduced. Steps will be taken to encourage employment of female health workers in rural areas, including better pay scale, safe accommodation, career development opportunities and close link with other female workers and supervisors.

7. Social Action Programme Project (SAPP)

The central focus of SAPP-I was on strengthening policy-making and management capacity of the line departments and increasing expenditures, especially under the non- salary portion. SAPP-II will maintain its focus on the same four sectors (PHC, Population Welfare, Water and Sanitation and Basic Education) and the themes which emerged in SAPP-I. The programme will be expanded to include nutrition, TB control and first referral level care. It will seek to improve social services through realistic planning, restructured expenditures on programmes to ensure quality; cost effectiveness, access to the poor and females.

The Government's intent for SAP II is to continue with the main agenda of SAP I, but to focus on improving the quality of basic services, increasing community involvement, strengthening monitoring mechanisms, promoting the provision of services by NGOs and the private sector, and building gender equity. An important element of SAP II will be to undertake health sector reforms to bring systematic changes in the entire health sector. The main agenda of health sector reform will be:

- Strengthening the organization, structure, management, and implementation of health services at the primary health care level;
- Improvement of referral services at primary, secondary and tertiary levels;
- sustainability and improvement of utilization of health services at the peripheral level (i.e. BHUs, RHCs and FWCs); and
- Enhancement of the roles of the private sector, NGOs and the community.

8. Priority Health Programmes

8.1 National EPI Programme

The Programme aims to protect children by immunizing them against tetanus, measles, poliomyelitis, diphtheria, pertussis and childhood tuberculosis and mothers against tetanus.
The routine immunization coverage will be expanded through fixed centers, outreach teams and Lady Health Workers. Surveillance will be strengthened. Special immunization days and campaigns will be conducted. The hepatitis B vaccine will be integrated into routine immunization. Adequate supply of vaccines and logistics will be ensured and Programme will be strengthened at district level.

8.2 Prime Minister's Programme for Family Planning and Primary Health Care

The Prime Minister's Programme for Family Planning and Primary Health Care aims at extending outreach services to communities, at their door steps, through the Lady Health Workers (LHWs). These LHWs are a vital link between the community and the health facilities. They provide essential health services like reproductive health, MCH, health education, treatment of minor ailments, and referral of high risk cases to the health facilities.

The main Programme strategies will include improvement in the quality of services, expansion of coverage by selecting 100,000 LHWs, better management, cost sharing through community and private sector involvement and strengthening family planning and reproductive health components. There will be an integration of all primary health care services to provide comprehensive health care to the population at large and the disadvantaged groups in particular. Urban PHC will be given more emphasis to address the health needs of the under served urban population especially those in Katchi Abadies and socially deprived areas. Collaboration between Department of Health and Local Bodies run health facilities will be improved. Family planning and health services will be integrated at district level and LHWs and VBFPWs will be linked. Steps will be taken for ownership of the Programme by the communities.

8.3 Maternal and Child Health

MCH services will be given priority in the health care system. A broad package of services will be offered, including prenatal care, safe delivery, family planning and care of all health needs of women and children. This will be accomplished through creating MCH Units in the Ministry of Health at federal and provincial level, strengthening the priority health programmes geared towards health of women and children, training of female health workers (doctors, nurses, LHVs, midwives, TBAs, Lady Health Workers etc.), strengthening emergency obstetric care at FLCFs, health education and community organization, advocacy for the health of women and children in the context of international obligations like Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination Against Women, and Health for All. Women and

children with special needs will be given priority in health care. Mother and child will be considered one unit for purpose of service delivery. Caring practices for young children will be promoted, specially the girl child. The role of family and community in MCH will be maximized. Women will be empowered through health education. Effective partnerships will be built with all related sectors for provision of MCH services. Multi-sectoral Women's Health Advisory Committees will be formed at federal and provincial level. Leadership of women will be promoted in the field of women's and children health and social development. Research and database formation in this area will be taken up on priority basis. Special MCH programmes geared towards community based institutions, schools etc. will be implemented. District health system will be made women friendly.

8.4 Reproductive Health

Reproductive Health (RH) deals with all aspects of the reproductive system and its functions. In the context of Primary Health Care (PHC), reproductive health includes pre-natal care, safe delivery, post-natal care, family planning, nutrition of females, breastfeeding, STDs/AIDS, RTIs, treatment of infertility and diseases of the female reproductive system. Government of Pakistan is taking steps to implement a Reproductive Health Programme and integrate it into the PHC system. All THQHs and DHQHs will be made functional to provide reproductive health services and the concerned staff will be provided proper training.

8.5 National ARI and Diarrhoeal Disease Control Programmes

These Programmes aim to reduce mortality due to acute diarrhea and pneumonia respectively in infant and young children, promote the use of ORT in all health facilities and at the household level and rationalize the use of antibiotics and other drugs in ARI cases. CDD & ARI Control Programme strategies will include integration into PHC and shift towards the integrated management of childhood diseases approach. This strategy will ensure more accurate identification of illnesses, more appropriate treatment, speedy referral and provide complete management of all the major illnesses. The Programmes will also develop relevant training programme for PHC workers, and strategies for home health care.

8.6 Malaria Control Programme

The Programme aims to keep malaria at low levels in the country so that it does not become a major public health problem.

Malaria control strategies will be :

- Highly selective indoor insecticidal spray in rural areas on epidemiological basis, and mosquito larval control under urban/peri-urban situation.
- Strengthening the case detection mechanism particularly the Passive Case Detection.
- Quick diagnosis and prompt treatment of cases.

- Promote alternative vector control methods such as biological and environmental management.

8.7 National Tuberculosis Control Programme

The revised T.B. Control Programme aims to reduce the mortality, morbidity and transmission of T.B. and to prevent drug resistance. Strategy for T.B. control will be the introduction of Directly Observed Therapy of Short duration (DOTS). The Programme will be integrated with the PHC delivery system. After initial implementation in selected demonstration sites, expansion of the Programme will take place district by district, with full coverage by 2000/2001. An organizational framework will be established for the implementation of the revised Programme. A regular supply of anti-TB drugs will be ensured. The NGOs and private sector will be involved in the Programme.

8.8 National AIDS Control Programme

The Programme aims to prevent HIV transmission and reduce morbidity associated with HIV/AIDS. Strategies for HIV/AIDS prevention will include: promotion of safe blood transfusion, interruption of STDs transmission, establishment of an AIDS surveillance and monitoring system, training of various categories of health staff, social behavioral research studies, and developing and strengthening a Programme management structure at federal and provincial level.

8.9 Nutrition

Improving nutrition of the people will be seen as an objective of the development planning in its own right; and a whole range of sectoral policies and programmes will be drawn.

Objectives

The objectives of the nutrition policy will be:

- To prevent malnutrition in the preschoolers.
- To reduce anaemia in pregnant and lactating mothers, preschoolers and children of all ages.
- To reduce prevalence of low birth weight
- To significantly reduce occurrence of new cases of Goiter in areas where it is pandemic and reduce it's prevalence in preschoolers and teenagers
- To generate mass awareness about appropriate nutritional practices
- To reduce 3rd degree malnutrition
- to universalize iodized salt.

For this purpose a systematic approach will be adopted, based on the nutritional and income distribution implications of food production and supply policies, food distribution policy and public health policy.

The main focus of nutrition policy will be on.

- Capacity and capability to address nutrition issues at various levels
- Control of nutrition implications of Infectious Diseases.
- Mass Awareness regarding improved nutritional practices especially of vulnerable groups.
- Eradication of specific diseases of nutritional origin, e.g., Iron Deficiency Anaemia, Iodine Deficiency Disorders etc.
- Incorporating nutrition interventions into different levels of the health care system and training health workers in nutrition.
- Inclusion of element of nutrition in all development programmes of the related sectors.

Specific Measures

a. A plan for social marketing for micro nutrients e.g., iodized salt and ferrous sulfate will be drawn and executed to boost private sector involvement

b. A Nutrition Foundation will be set up to extend nutrition services and coordinate the activities of existing NGO's and involve new NGO's, and set up Women Groups in the villages to deliver nutrition services.

c. Local Government/Municipal Corporations of big cities will also be involved extensively in the delivery of nutrition services.

d. A detailed plan of action for activating private sector investment in production and marketing of iodized salt will be chalked out on cost effective basis. Iodized salt would be made available to the entire population. This would reduce overall prevalence of goiter and eventually eliminate iodine deficiency disorders

e. Legislation will be formulated and enacted for:-
   - banning the use of non-iodized edible salt through legislation
   - regulation on manufacture and marketing of breast milk substitutes

f. Mass awareness campaign will be launched regarding national nutrition problems and healthy nutritional practices, and knowledge of food and nutrition will be incorporated in information and education programmes

g. An effective system will be established to check adulteration to improve food quality control. An inter-ministerial National Council of Food Quality Control under the Chairmanship of Minister for Health, will be instituted for the purpose. Intersectoral technical advisory committees for nutrition will be constituted at federal and provincial level.

h. Aneamia would be reduced through fortification and iron supplementation.

i. Food supplements will be provided selectively to vulnerable groups through programmes like World Food Programme.

j. Applied nutrition programmes will be organized in schools, communities etc.

8.10 Mental Health

Mental health is emerging as a public health problem. New Mental Health Act will be formulated to provide respectable care and treatment for the mentally ill. The central strategy would be adopting an indigenous approach to mental health, intersectoral collaboration, integration of mental health and substance abuse in Primary Health Care, education of public to create awareness about mental illness, strengthening of resource centers, conducting epidemiological studies and encouraging community participation. The programme will include: training of primary health care providers, establishing resource centers at teaching hospitals and psychiatric and detoxification centers at DHQ Hospitals, setting up monitoring and evaluation systems, and preparing training and teaching modules. Special facilities will be established for mentally handicapped. Crisis intervention and counseling services will be created for victims of abuse, torture and trauma. Large mental hospitals will be re-organized and upgraded. Ways and means will be devised to achieve proper mental development of children through parental guidance, school education etc. Mental health services will be integrated with social services

8.11 Oral and Dental Health

Dental care will be made a regular component of the health care system. Focal points will be set up at federal and provincial level. Physical facilities for dental care will be upgraded and adequate number of dentists, dental hygienists and other auxiliaries will be trained and provided an adequate career structure. Public education and awareness will be given priority.

8.12 Health Promotion and Health Education

Health Promotion and Health Education will be an essential component of all health services. Systematic and well planned health promotion and health education activities will be undertaken to empower the community to work for the promotion of its own health.

The main focus will be on research based, audience targeted, issue centered, high profile and high impact interventions with demonstrated sustainability, and strengthening of health promotion and health education infrastructure. All channels of communication will be used. Interpersonal communication and community participation will receive focus. Capacity building activities will be undertaken. Advocacy campaigns will be launched. Inter-sectoral Federal and Provincial Communication Advisory Groups will be formed.

8.13 School Health Programmes

Comprehensive school health programme will be implemented to address the health needs of children and adolescents. The main components of the school health programme will be:

- Health education as a component of school curriculum.

- Health services to the school population through the existing PHC and community health services.
- Ensuring a safe school environment through proper training of school population and providing safeguards.

The main strategies will be proper teacher training, involvement of parents and communities, and laision with the Health Department facilities.

9. Non Communicable Diseases

While infectious diseases continue to be the major causes of morbidity and mortality in the country, there has been a steady rise in the prevalence of non-communicable and chronic diseases in recent years. This is largely attributable to the unhealthy lifestyle e.g., smoking, high fat diet, lack of exercise, stress and environmental pollution. This calls for concerted efforts for the prevention and control of these diseases.

A comprehensive programme for the prevention and treatment of non-communicable diseases will be developed. Focal points for the prevention and control of various non-communicable diseases will be designated. An integrated approach with the full involvement of the community and a promotional campaign for a healthy life style will be adopted to reduce the incidence of cardiovascular diseases, diabetes, cancer etc. Diabetes, cardiovascular diseases and cancer control programme, in line with WHO's recommended ***INTER HEALTH PROGRAMME***, is a cost effective approach which will be implemented. Local research in prevalence and causes of non-communicable diseases will be promoted to devise suitable interventions and control strategies. Financial assistance will be provided to poor patients suffering from chronic and debilitating diseases through the Zakat Fund and social welfare organizations.

9.1 Cardiovascular Diseases

An effective awareness programme for the prevention and control of cardiovascular diseases will be started with a mass media campaign. It is aimed, with the involvement of the community, to reduce the percentage of the hypertensive population as well as the number of smokers and thus consequently reduce the incidence of heart diseases. Training of specialists, doctors, nurses, and dietitians will be started. The population will be encouraged to undergo regular medical check ups for blood pressure etc. regularly. Sufficient facilities will be created to make possible early detection of cardiovascular diseases and their treatment.

9.2 Prevention and Treatment of Blindness

Many forms of blindness are due to preventable disease. In the majority of cases blindness is preventable, if diagnosed and treated in time. An assessment survey will be done to find out the magnitude of the problem, and prepare a national programme for prevention and treatment of blindness. Care of eyes and treatment of common eye diseases will be part of PHC. Facilities will be provided for specialized treatment, surgery and cornea transplantation.

9.3 Prevention and Treatment of Diabetes

This is a serious health hazard and its prevalence is increasing. There is no data on its incidence and therefore, a survey will be done to assess the prevalence of this disease in order to devise and implement a comprehensive strategy for the prevention and treatment of diabetes.

9.4 Cancer Control Programme

The main aim of cancer control programme would be prevention, early diagnosis, effective and efficient treatment of potentially curable diseases.

Cancer is largely a life style disease. One-third is preventable, and another third is curable through early detection and treatment e.g. breast, cervix and oral cavity tumors etc. The programme for cancer control will include: mass education concerning risk of cancer from tobacco and alcohol, dietary modifications, vaccination against hepatitis B, early diagnosis and treatment, research, education and training of public and health professionals, in-service and postgraduate training in clinical oncology. Establishment of one Co-60 unit for each 2 million population is envisaged. Oncology will be promoted as a specialty and laboratory facilities will be upgraded. A national cancer registry will be established.

9.5 Burns and Injuries Prevention

There is evidence from available records that injuries are a growing problem in Pakistan and the burden of this disease is going to grow in the coming years. Between 1960-1994, there has been a tremendous increase in injuries and related risk factors. The present wave of sectarian and ethnic violence is another compelling reason to recognize that injury is an emerging public health problem.

Major causes and risk factors for injuries will be studied, health education programmes will be carried out, health care services will be improved, a database will be established and advocacy will be carried out for appropriate legislation. A well organized ambulance service and chain of trauma centers will be provided.

9.6 Senior Citizens

Early detection and appropriate treatment of diseases of the elderly will be provided to ensure their good health and maximum independence. Social support and terminal care of elderly will be ensured. Senior citizens will be provided free anti-diabetic and anti-hypertensive drugs and domiciliary care. Separate beds and dispensing windows in hospitals will be established. Geriatrics will be included in medical curricula. Proper home-care and self-care will form the basis for elderly health services. Arrangements will be made for the institutional care and other services for the elderly.

9.7. Rehabilitation Services

- Public awareness about health risks and prevention from disabilities will be carried out.
- An organizational framework will be developed and equipped for rehabilitation of patients with any disability.
- Doctors, social workers and teachers will be trained in this specialty
- Special beds will be provided in hospitals
- The subject will be added in medical and paramedical curricula
- Research will be carried out in this field.
- Social support will be provided to the disabled to make them self reliant and independent.

10. Curative Care and Upgradation of Hospitals

- Along with strong PHC programme the secondary, tertiary and specialized hospital care will be strengthened and upgraded to provide a reliable backup medical and referral support, research and training base, and lead the nation in the high tech movement.
- The specialized centers will be equipped with latest technologies. Incentives will be provided to competent and highly qualified professionals in the country, including overseas Pakistanis , to contribute to the health sector development in the country.
- All hospitals will be equipped and staffed according to the level of care and properly managed to ensure good quality of care
- No emergency will be denied care due to inability to pay. Medico legal status and paying capacity will be dealt with subsequently after resuscitation and shifting the patient into hospital wards. This policy will be widely publicized to the public.
- A paging system will be introduced in each hospital to trace staff on duty.
- The telephone exchanges of major hospitals will be improved according to requirements.
- Alternate arrangements for power generation will be made available for operation theaters and other essential areas of hospitals.
- A round the clock functional ambulance system will be established. Private sector will be encouraged to provide these services on affordable charges.
- All hospitals will be provided with dead body carriages.
- All hospitals will comply with essential drugs and supplies lists, schedules and procedures.
- Infection control and blood safety will be ensured.
- Medical audit system will be introduced.
- Modern computerized record system will replace the outdated manual system.
- Hospital management boards will be formed.
- Filter clinics offering PHC services will be set up around tertiary care and teaching hospitals.

11. Referral System

- National guidelines will be developed for a strong referral system, in which the referral pathway will be well defined and protocols will be established. It will include incentives for proper utilization of the system like preference for admission, less cost to the patient etc. Also, penalties for by-passing the referral system will be levied (e.g., additional charges) to discourage improper use of health facilities.
- The THQH will be the first level referral facility for all emergencies including obstetric cases and will be linked with FLCFs through proper transport and other communication facilities. The DHQH will be the next higher referral level and will have departments in all specialties.
- All public and private health facilities will be graded and linked through the referral network. The Health Institution Database will facilitate this networking. The community health workers will form an important link in this network.

12. Basic Minimum Needs Programme (BMNs)

The WHO assisted Basic Minimum Needs Programme has shown great success and cost effectiveness in its initial phase. It is a multi-sectoral development programme that aims to alleviate poverty through a self-help approach and hence has a positive impact on the health and social indicators of the participating communities. It will be replicated on a large scale in a phased manner throughout the country. Through this Programme different government sectors will join hands to provide technical and financial assistance to communities for:

- Income generating projects
- Provision of health and social services
- Training and capacity building

The community will share the cost, participate actively, and ensure the success and sustainability of the Programme. Interest free loans will be provided to communities for implementing projects, to recover cost, earn profit and pay back loans.

A BMN National High Council will be constituted which will be headed by the Prime Minister of Pakistan. There will be a Poverty Alleviation Commission headed by the Federal Minister of Health, with membership from different ministries. It's Secretariat will be set up with sections of Planning, Training, Accounting, Monitoring/Evaluation and Auditing. At the operational level, District Support and Tehsil BMN Teams will be formed (from Social, Livestock, Agriculture and other related sectors) to plan, coordinate and implement activities. The Programme will be implemented in phases with increasing coverage to the entire population by the year 2010.

13. Environmental Health

The Health Department will assume an active role in environmental health efforts related to it's jurisdiction.

- The Lady Health Workers of the PHC programme will work in the community for promotion of basic sanitation and safe water supply.
- The District Health Department will coordinate with all related departments in the district to promote environmental health, including vector control, safe disposal of waste, basic sanitation, safe water supply, food hygiene etc.
- The Health Department will enforce necessary legislation for promotion of safe environment e.g., Pure Food Ordinance, Anti-smoking laws etc.
- The Health Department will launch a multi-media health education campaign to create awareness about environmental health
- Special programmes like " Healthy Cities," "Health Villages," "Active Life Styles," will be launched to address the health issues of rapidly growing urban and semi-urban centers with many environmental health problems.

14. Traditional Medicine

The following actions will be considered:

- The role of PMDC will be expanded to regulate traditional medicine.
- The National Council for Traditional Medicine will be strengthened and traditional medicine will be covered under the Drug Act for which appropriate legislation will be carried out.
- Special Cells for Traditional Medicine will be established at federal and provincial level.
- Traditional medicine will be upgraded to meet the national needs in terms of its education and treatment facilities. Entry qualifications will be fixed, curricula will be standardized, training institutions will be affiliated with Universities and special beds will be provided in hospitals. Research in this field will be promoted.
- A pharmaceutical lab at the Federal level will be established for research and making of drugs based on indigenous medicine.
- Orientation courses will be conducted on various systems of medicine to bridge the gap of knowledge and develop linkages in terms of public health.
- Training of collectors and drug dealers on post-harvest treatment of crude drugs will be imparted through short courses to maintain purity and quality of herbal drugs for marketing.
- Marketing of non-allopathic products will be regulated by incorporating it in the Drugs Act.

15. Drug Abuse Control

The problem will be addressed through strengthening and expansion of detoxification and rehabilitation facilities, creating public awareness, mobilizing community support, training of manpower, monitoring of incidence and prevalence of drug dependence, initiating drug prevention and treatment programmes for the target groups, in addition to measures which will be taken to control production/supply and illicit trafficking. Drug testing laboratories will be established in the health sector for quick and reliable results. A Center of Excellence for Conducting Research in Preventive Treatment and Rehabilitation of Addicts and specialized treatment and rehabilitation centers in all Provinces will be established.

16. New and Emerging Health Challenges

Continued research and surveillance will be conducted to study the occurrence and emergence of new health challenges in order to formulate plans for their prevention and control. The surveillance system will be an integral part of the HMIS. Special attention will be given to check cross border spread of health hazards. Exchange of information will be promoted to facilitate control measures.

17. Epidemic/Disaster Preparedness

A National Epidemic/Disaster Preparedness Plan will be developed, based on early warning system and close surveillance. The plan will have provision for investigation, public awareness, coordination of relief efforts and development of an information base for planning.

18. Health Management Information System (HMIS)

The new Health Management Information System (HMIS) was implemented in 1992 and is currently functional in 85 districts of the country. The strategy for strengthening the HMIS will be to redesign the existing Bio-Statistics Cell, Ministry of Health as the National Health Information Resource Cell and to modify the scope of work from virtually a static (information storing center) to a more dynamic information resource unit. It will have strong elements of supervision, field interaction, information use and feedback. Similar efforts will be made at the provincial level. Surveillance system will be strengthened. All health information systems will be integrated into one national database for close monitoring and better use of information. The HMIS will be expanded to cover more levels of health care and a wider range of health areas for comprehensive national coverage.

19. Pharmaceutical Sector

A comprehensive drugs policy will be implemented throughout the country:

19.1 Policy Implementation

- Free medical treatment will be provided for common diseases and emergencies.
- Regular supply of very essential drugs will be ensured at all levels of care according to prescribed lists and schedules, so that services can be provided to maximum number of people at minimum cost.
- Drugs procurement, distribution and quality assurance systems will be simplified, strengthened and streamlined and made more efficient to ensure proper selection efficient procurement, satisfactory storage, up to date inventory, prescription, monitoring and dispensing.
- The Drug Control Organization will be strengthened for effective implementation of the Drug Law and National Drug Policy.
- A self regulatory body will be established from within the Pharmaceutical sector which will provide for a consultative group at the federal and provincial level for :

  a) Dialogue between Government, industry, private sector, PMA and consumers, on prices;
  b) Developing guidelines on prescribing and dispensing drugs:
  c) Acting as a peer review board.
  d) Continuing education for retailers and other group

  Local manufacture as well as export of drugs will be promoted.

19.2 Provision of Essential Drugs

- A list of very essential drugs will be provided for each level of health facility for free of cost provision. The National Essential Drugs List will be updated at regular intervals and all bulk purchases in the public sector will be made from the National Essential Drug List. (NEDL)
- Training and education of medical professionals in the public health sector will be done on concept and need for prescribing drugs from the EDL.
- An in-depth feasibility study will be done to understand and assess actual demand for essential drugs in accordance with the health needs on the basis of technical, economic, and market information and analyses of existing situation.
- PHC providers will be trained in the principles of essential drugs and in the basic skills of inventory management.
- Sale of drugs without prescription will be restricted by strict enforcement.

19.3 Rational Use

- Rational use of drugs will be promoted at all levels, i.e., prescriber, dispenser and consumer through various interventions, i.e., regulatory, administrative and educational
- A comprehensive educational programme shall be carried out for the public on the use/misuse of drugs.

19.4 Procurement Process and Distribution System

- Drug requirements for each facility will be carefully worked out annually. The drug procurement will be at provincial level and distribution will be directly to district level.
- Introduction of community pharmacy services and stream-lining of the drug distribution system will be done.
- A system of checks and balances will be introduced to minimize leakage of funds and a security system will be put in place to prevent pilferage of drugs.
- Some portion of the drug procurement, storage and distribution system will be contracted out to the private sector.
- Different models of drugs supply will be implemented to increase the participation of the private sector in drug supply to government facilities, while maintaining oversight and responsibility for assurance of drug quality, selection and availability.

19.5 Quality Assurance

- The system of Quality Assurance, i.e., licensing, inspections and laboratory services will be strengthened and streamlined.
- Appointments of qualified professional pharmacists, (a Chief Pharmacist at the provincial level and a Director Pharmacy at divisional level) will be made. A competent field work force of Drug Inspectors will be trained to monitor the distribution and quality of drugs. Good storage and pharmacy practices will be introduced at sale and distribution level
- Central Drug Laboratory, Karachi and Drug Testing Laboratory will be upgraded and new labs will be established at Provincial Headquarters.
- A computerized poison, drug and adverse reaction information center will be established.
- A nation wide recall system will be developed in the event of hazardous product being identified.
- Drug surveillance will be carried out to ensure quality of drugs and eliminate spurious and substandard drugs to safeguard public health, and research will be conducted to enable the pharmaceutical sector to meet the national demands.
- Good Manufacturing Practices will be brought in line with international standards and will be enforced..
- Prices of drugs will be rationalized and stabilized.

19.6 Purchase and Maintenance of Medical Equipments

- Committees will be formed at provincial and divisional level for short listing.
- Purchases will be through competitive tendering.
- Provision for maintenance and servicing will be incorporated within the purchase contracts.
- Local capacity building will be promoted.
- Maintenance workshops will be established at divisional levels and hospitals with appointment of technical staff.
- Tax concessions will be provided for import of essential medical equipment.
- When sophisticated equipment is obtained for an institution, the previous equipment will be transferred to a lower level facility, if appropriate, to prevent wastage of resources.

Private sector involvement will be encouraged through joint ventures.

20. Vaccine Production

The local vaccine production capability will be strengthened and expanded as a national goal. The need as well as production and supply strategies for vaccines for use in the country will be carefully determined to make them viable and cost effective.

Restructuring of vaccine production will be considered as part of an overall Government of Pakistan effort to re-establish a sustainable financial and management structure for all components of the National Institute of Health (NIH), Islamabad. A detailed implementation plan will be developed. The following options will be considered for vaccine production :-

- Create an autonomous production unit under 100% ownership of NIH.
- Create a completely independent vaccine production company in partnership with the private sector in which the Government retains a significant share.

Investment in physical infrastructure will be supported by investment in the underlying staff skills, management system, and organizational structures of vaccine production.

To maintain access to new technologies and have long term role in vaccine production, the GOP will develop new forms of collaboration with the private sector vaccine producers. The production capacity will be increased in terms of both quality and number of vaccines to meet the country's requirements. Quality of vaccines will be ensured by complying with international standards for Good Manufacturing Practices. The vaccine production unit will be operated at full capacity to sustain required production levels. To establish credibility as a country importing and producing vaccines, Pakistan will restructure and upgrade it's national quality control system for biological products.

21. Health Legislation

The following legislation will be developed/amended to implement the government's commitments to Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Health for All (HFA) etc.

- Universal Iodization of Salt
- Marketing of Breast Milk Substitutes
- Food Fortification
- Pure Food Ordinance (to be amended)
- Maternity Benefits
- Child Right to Survival and Development
- Prohibiting Juvenile Smoking
- Mental Health Act.
- Regulation of private sector
- Traditional Medicine Act
- Drug Act

22. Health System Research

Health research in Pakistan has remained a neglected area. This will be given due importance. Research climate will be promoted in all academic institutions. Institutionalization of Health Systems Research (HSR) will be done through the establishment of HSR centers and field experimental areas in provincial health directorates and at the federal level to promote and facilitate research in health delivery systems, so that health planning is based on scientific research.

Health systems research will be made an essential component of all projects. In-service training of health professionals in health systems research will be promoted. The Pakistan Medical Research Council will provide leadership and guidance for health systems research and it will be made an effective focal point for research in all relevant segments of the health sector throughout the country, as well as for transfer of technology. A mechanism will be developed through which results of research are applied/utilized in relevant programmes.

23. Public Sector Financing System

23.1 Government Incentives for Financing

The presently available package of incentives will be publicized and all DFIs will be permitted to lend to the health sector. The rules of business will be formed by the Commission proposed for regulating private sector. Selected nonprofit institutions will be supported to cover recurrent expenditures, including a strong preventive and MCH component, with concentration on reaching the under served.

23.2 Third Party Health Insurance

The possibility of expanding the existing health insurance system is fairly limited. In rural areas, low purchasing power and poor availability of health services make widespread health insurance unlikely in the medium term. In urban areas, the most easily registered groups are already covered (government employees under the entitlement programme and lower-income employees under the ESSIs). These schemes will be strengthened for more effective implementation. Re-imbursement to government employees for health expenditure according to fixed schedules will be the predominant mode of health coverage of government employees.

23.3 Employees Social Security Institutions (ESSIs)

ESSIs are well established and have a service network that will provide a base for a national health and social insurance system covering a large segment of the population. Their scope and jurisdiction will be broadened. Additional groups that will be enrolled include higher-wage industrial employees, lower-grade government employees, self-employed persons, indigent people registered with the Zakat Fund , and employees in smaller firms (5-10 employees). These scheme will become a major social support institution for low wage earners and indigent population.

24 Private Sector

- An appropriate legal and regulatory frame-work will be established to improve the quality of small scale private health care and discourage unauthorized practice in allopathic and traditional medicine and to eliminate inadequately equipped facilities. A Commission will be set-up for this purpose. The PMA and other professional organizations will be actively involved. Standards of care will be fixed and enforced.
- Accreditation of private hospitals and clinics will be carried out.
- Balance will be created between public/private health care responsibilities.
- The private sector will be encouraged to participate in preventive and promotive services and the public sector will offer only limited curative health services in urban areas.

- Functional linkages will be developed between the PHC programme and NGOs/CBOs/Private Sector and effective mechanisms for community involvement will be promoted (e.g., Health Committees, DHAs, BMNs). Community participation will be based on self-reliance. The Community will be involved in identifying its needs, as well as implementing and evaluating programmes.
- Private sector work in rural areas will be encouraged with incentives through the health foundation.
- Family Planning services will be strengthened in the private sector.
- Retail pharmacies will be strengthened for quality drugs at affordable prices.
- Public Hospitals staff will be allowed to undertake institutional practice only.

25. National Health Care Scheme

It will be an alternate health care financing and management mechanism based on public-private partnership that aims to:

- Improve the quality and utilization of services
- Decrease the cost of care to the public and the government
- Extend essential health care to all

The Main Components of the NHCS

- District Health Authorities (DHAs) with representation from Government departments and the community, to supervize the management of the district health system.
- Autonomy to selected District Headquarters Hospitals run by Hospital Management Boards, under the supervision of DHAs, with authorization to levy user charges.
- Contracting of selected First Level Care Facilities (FLCFs) to private physicians, NGOs or existing staff, to deliver standard package of services at user charges, under the supervision of CBOs.
- National Health Cards for families in rural and under-served urban areas, to provide essential health services at nominal charges (and free for poor families) through privatized health facilities.

The NHCS will be implemented in the existing district health system, with necessary adjustments and redefinition of roles and responsibilities. Under this scheme, the Government will be responsible for overall policy formulation, regulation, technical guidance, provision of essential resources and key health sector development functions. The Government will monitor the health system through the DHAs, who will be directly responsible for district health management. The District Health Management Team (DHMT) headed by the District Health Officer (DHO) will perform it's functions under the supervision of DHA. The autonomous District Headquarters Hospitals (DHQHs) will also be supervised by the DHAs. The DHAs will

select and organize CBOs to oversee the management of first level care facilities and serve as intermediary institutions for the National Health Card Scheme. Selected FLCFs will be contracted out to staff member and qualified private parties, to deliver standard packages of services at user charges and participate in the National Health Card Scheme. The DHQHs will serve as referral facilities for this scheme, according to established terms, conditions and procedures.

The main features of the proposed National Health Care Scheme are the active role of community representatives in the management of health system along with government officials, empowerment of health facility administration for timely decision making to improve the efficiency of health facilities, financial incentives to health professionals for improving performance and quality of care, increased responsibility of individuals and families for health care, enhancing the resource base for the health system by pooling together public and private sector resources and manpower, and developing the private health sector along with strengthening the public health sector.

Role of Government in National Health Care Scheme (NHCS)

The NHCS will be sponsored by the Government who will retain the ultimate responsibility for its planning, implementation, monitoring and evaluation. The specific functions of the Government will be:-

- Providing legal and regulatory framework
- Formulating policy guidelines and plans at national level for NHCS
- Establishing standards for care/services package for all levels
- Enforcing rules and regulations
- Providing allocated budget to DHAs
- Serving as appellate authority
- Human resource development/technical guidance
- Financial backstopping for those unable to pay for health care
- Provision for essential drugs and supplies
- Monitoring and evaluation
- Other key health sector development functions

25.1 District Health Authority (DHA)

The DHA will be a multi-sectoral district level body, with representation of Government officials, community leaders and elected officials, possessing the authority and expertise to coordinate and supervise important district health management functions, under the NHCS.

Membership

1.	Chairman (Technical expert) (to be nominated by the Chief Minister)	Chairman

2.	District Health Officer	Secretary/Executive Member
3.	Elected Representative/MPA (to be nominated by the Chief Minister)	Member
4.	Additional Deputy Commissioner (general) of the concerned district	Member
5.	District Population Welfare Officer	Member
6.	Nominee of the local Pakistan Medical Association	Member
7.	Representative of the Municipal Corporation/Committee	Member
8.	Representative of the District Council	Member
9.	Representative of DHQH/THQH (to be nominated by DHA)	Member
10.	Nominee of RHC/BHU (to be nominated by DHA)	Member
11.	Representative of Trade/ Industry (to be nominated by DHA)	Member
12.	Notable of the District having social/ community services background and enjoying good reputation in the area (to be nominated by the Health Minister)	Member
13.	Any person can be co-opetd by the Chairman of the DHA	Member

Mode of Work

The DHA will be provided office space, logistic support and running expenses for its functioning. It will conduct regular meetings according to fixed quorum. The DHA will submit regular reports of the NHCS progress to the Provincial Government.

Role of DHA in National Health Care Scheme

- Management of the district health system
- Maintenance and supervision of district health budget
- Ensuring the observance of rules and regulations

- Serving as a link between the public and the private sector
- Selection/organization of CBOs to supervise the FLCFs and National Health Card Scheme
- Supervision of functioning of CBOs
- Coordinating training of health personnel
- Promoting institutional development and local capacity building
- Adapting service delivery to suit local needs
- Mobilizing/generating resources for health system development
- Mobilizing political and community support for improvements in the health system
- Ensuring efficient use of resources
- Ensuring timely action to solve problems
- Ensuring sustainability of the health programmes
- Ensuring effective collaboration between all related departments and stakeholders for smooth functioning of the health system
- Preventing political interference in health management
- Establishing transparent procedures for district management
- Ensuring equity and social justice in the delivery of health services
- Ensuring quality of care

Implementation Strategy

- The DHA will be established as an autonomous legal entity. It will be given financial authority as well as operational autonomy to manage all health activities.
- A cooperative agreement will be signed between the DHA and the Provincial Health Department to:
  - define the relationship
  - establish obligations and objectives
  - agree on monitoring procedures and evaluation criteria

25.2 Hospital Autonomy

The Government hospitals will be given financial and administrative autonomy starting with the DHQHs. Hospital Management Boards (HMBs) will be constituted, representing hospital staff/communities/ philanthropists etc., for overall policy formulation and management of the hospital. Sub-committees will be formed to run the day to day affairs of the hospital. The government will provide a non-lapsable fund to the facility. The hospital will be authorized to collect user charges, with the approval of the DHA, and establish a share system for the staff, who will be on contract employment with the HMB.. The staff will be permitted to do evening practice in hospital premises, according to standard service charges approved by the DHA, and will contribute a proportion of their earning to the Hospital Fund. The DHA will supervise the functioning of the hospital to ensure that the established standard of care is maintained. The established operational procedures will be required to be displayed at appropriate locations for better enforcement. Internal and external audits will be conducted.

Membership of Hospital Management Board

The board will consist of the following :-

• Hospital Administrator/Medical Supdt.	Member/Secretary
• Two Senior Doctors of the hospital(on rotation)	Members
• A retired doctor belonging to the area	Member
• Two representatives of philanthropic associations	Members
• An accounts specialist	Member
• Representatives of doctors community (PMA)	Member
• Govt. representative	Member
• Representative of citizens	Member

- ♦ Other members can be co-opted as per need (i.e., Nursing, paramedics, other line departments etc.)
- ♦ The Chairman will be selected on a yearly basis from amongst the members, by the members.

Functions of Hospital Management Board (HMB)

- Supervising hospital functioning
- Managing the budget
- Maintenance of the hospital
- Establishing operational procedures and guidelines
- Personnel management
- Public relations
- Liaison with DHA
- Fund-raising
- Contracting of services
- Quality assurance
- Preventing external interference in hospital management

Implementation Strategy

- The HMBs will be established as autonomous legal entities. Financial authority will be given to the Boards to disburse and control funds. Operational autonomy will be given to the HMBs to manage all hospital activities: establish user fees (subject to the approval of the DHA), contract with hospital staff, establish fee sharing systems, etc.:
- A cooperative agreement will be signed between the HMBs and the DHA where established or the Provincial Health Department to:
    - ♦ define the relationship;
    - ♦ provide agreed funds and undertake agreed activities;

- establish mutual obligations and objectives;
- agree on monitoring procedures and evaluation criteria

25.3 Role of Community Based Organizations (CBOs) in NHCS

The DHA will form a Sub-committee consisting of the Member of the Provincial Assembly, District Health Officer and District Social Welfare Officer to select and organize CBOs for participation in the NHCS. Those CBOs will be eligible for selection who belong to the same catchment area and are willing to work voluntarily. All members will have to be at least matriculates or equivalent. Local community leaders with good reputation, ex-servicemen and females will be encouraged for membership. The LHWs will be active members of the CBOs and the Medical Officer of the FLCF will be its Secretary. The CBOs will be provided training on all related aspects of the NHCS, as well as community development, management of FLCFs, budgeting/financing, and local project development for income generation.

Specific functions of the CBOs will include:-

- Supervising FLCF management
- Distribution and supervision of FLCF budget
- Maintenance of infrastructure and logistics
- Serving as intermediaries in the National Health Card scheme . In this context their functions include:-
    - Maintaining population profile
    - Selling cards to community
    - Negotiating with participating health care providers
    - Supervising the scheme
    - Liaison with referral facilities and DHA.
- Recommending transfers, promotions, appointments, disciplinary action etc. of FLCF staff to competent authority
- Conducting health education sessions in community
- Liaison with and support LHWs
- Raising funds for health facilities
- Submitting FLCF performance reports to DHAs
- Ensuring the observance of rules and regulation
- Adapting service delivery to suit local needs
- Ensuring efficient use of resources
- Ensuring timely action to solve problems
- Establishing transparent procedures for FLCF management
- Ensuring equity, quality care, non-interference and community involvement in FLCF service delivery

Mode of Work of CBOs

CBOs will be provided office space, logistic support and running expenses for their work. They will hold regular meetings and constitute sub-committees for FLCF management and other functions

25.4 FLCFs Management by CBOs/NGOs Under NHCS

To improve the management of FLCFs and quality of care the community will be given greater control in running them.

The FLCF will receive the allocated budget from the Government, through the CBO. The Medical Officer incharge of the FLCF will be responsible for management and budgeting functions, under the supervision of CBO. The CBO will ensure that standard package of services is delivered through the FLCF according to the required quality. The DHA will oversee the CBO.

The poorly functioning FLCFs will be contracted out to the hospital staff or other qualified parties like NGOs, private health care providers, CBOs etc.

Characteristics of Contracted FLCFs

They will function on the basis of public private partnership. Government will retain ownership of the facility and the other party will be responsible for its maintenance. The Government will initially provide the budget at the ratio of full, 75%, 50%, 25% and nil over five years. Similarly, services of staff will be gradually transferred to the contracted party over four years. The facility will be authorized to collect user charges fixed in consultation with CBO/DHA and a share system will be established for the staff from user charges. Operational procedures will be established/displayed at appropriate locations for better enforcement . Facility performance will be evaluated annually and a yearly contract will be awarded by Government, based on performance. Health Foundation will assist the facility by providing loans/grants if required. Preventive services will be ensured at nominal charges. The poor patients will be covered through Zakat Funds by the Government.

The facility can also participate in National Health Card Scheme. Functions will include:

- Registering patients (at least 500-1000 families)
- Maintaining records/paperwork/accounts
- Establishing referral links
- Collaborating with CBOs

Implementation Strategy

- BHUs/RHCs will be let out under a contract agreement with the District Health Authorities. Medical Officer in charge will be given first preference for the contracts. The facility service

contracts will be supervised by the DHA. The Provincial Planning Officer, Health, will assist in developing and implementing supervision and monitoring guidelines and procedures. Contracts will be for a period of two years, reviewed annually, and renewable, based on achievement of agreed objectives. Facility will raise funds from user fees and receive government allocations which will be reduced in succeeding years.

25.5 National Health Card Scheme

This will be a Government sponsored prepaid, managed health care scheme for rural and under served urban areas, to be supervised by DHA through CBOs. The CBOs will serve as 'intermediary' institutions to:

- Sell Health Cards to families in the areas
- Negotiate/contract with privatized health facilities
- Manage/supervise the scheme at local level

Basic health units participating in the scheme in their local areas will register 500-1000 card holders. They will:

- Provide a standard package of services during contracted hours
- Provide referral to selected/contracted facilities
- Maintain records/accounts/paperwork
- Be allowed to do private practice outside of contracted hours

Cards will be sold in the catchment area of the health facility and participating providers. A card holder will be entitled to services only with the registered provider. The Scheme will be initiated at Union Council/Tehsil level and will be extended to other levels gradually. Unit of membership will be families and not individuals to prevent the risk of adverse selection of clients. Estimated membership cost could be Rs.300/- per family per year to be paid to the Government. The final figure may be decided subsequently. Families below the poverty line, widows and destitutes will be given free cards through 'Zakat Funds'. Services to be provided to enrolled families will include:

- A basic package of essential services, free to the card holder, subsidized by government
- Additional services(curative, referral, emergency) on the basis of co-payments/ deductibles to the card holder, subsidized by the Government

Re-imbursement to the participating providers will be per person and according to the services provided. Administrative costs will be covered by the Government. The suggested cost of additional services is estimated as follows:

• Per capita annual fee	Rs.80 per year
• Additional Fee for Vaccination (for children under 5 years)	Rs.20 per year
• Ante Natal Care	Rs.400 per pregnancy

- Delivery attendance — Rs.600 each
- Contraceptive advice and management — Rs.30 per woman per year

These figures could be given as a flat rate or weightage according to the location of the practice, for example:-.

- Urban areas, large, tehsils, District Headquarter and above — 80%
- Rural area with road, electricity, piped water and school — 100%
- Rural area with some of the above — 120%
- Areas with none of the above — 150%
- Sparsely populated areas — 200%

Implementation Strategy

The Health Card Scheme will be implemented initially in 2-3 Union Councils or Tehsil level in each Province, under the proposed DHAs. Union/Tehsils will be selected for implementation where there is an effective CBO which can serve as the intermediary institution. A referral system will be established from FLCFs, Tehsil/District hospitals and the Tertiary hospitals and a system of fees and payments for referrals will be developed. CBO, DHA and provincial personnel will be trained in the National Health Card approach and in the operational and technical requirements.

26. Financial Requirements (1998-2003)

It is difficult to place precise price tags on long term projects and new initiatives but an estimated value of Rs.105 Billion has been worked out for a package of health care for the next five years. A larger share of this budget has been allocated to the priority areas of Preventive Programmes (27 billion), National Health Care Scheme (20 billion), the Basic Minimum Needs Programme for poverty alleviation and social development (17 billion). The Drugs and Logistics Supplies have also received a larger share (09 billion). The complete breakdown of the budget is given in Table-6:-

Table 6 **Financial Requirements (1998-2003)**

	Rs. in Billion
Preventive Programme (including FP)	27.0
Non-Communicable Diseases	5.0
Health Manpower Development	5.5
Health Infrastructure	6.5
Specialized Care	5.5
Nutrition	3.0
Drugs and Logistic Supplies	9.0
Vaccine Production	0.6
BMN Programme	17.0
National Health Care Scheme	20.0
Health Foundation/NGO Collaboration	1.6
Health System Research	0.7
Traditional Medicine	1.0
Health Management Information System (HMIS)	1.0
Environmental Health	0.6
Prevention and Control of Drug Abuse	1.0
TOTAL :	**105.0**

ABBREVIATIONS

PHC	Primary Health Care
HFA	Health For All
EPI	Expanded Programme of Immunization
ARI	Acute Respiratory Infections
TB	Tuberculosis
AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Virus.
DHO	District Health Officer
ADHO	Assistant District Health Officer
HMIS	Health Management Information System
FLCF	First Level Care Facility
NGO	Non Governmental Organization
CBO	Community Based Organization
DHA	District Health Authority
MCH	Maternal and Child Health
BHU	Basic Health Unit
RHC	Rural Health Centre
DHQH	District Head Quarter Hospital
THQH	Tehsil Head Quarter Hospital
DHS	District Health System
PHDC	Provincial Health Development Centre
DHDC	District Health Developments Centre
ACR	Annual Confidential Report
LHW	Lady Health Worker
VBFPW	Village Based Family Planning Worker
TBA	Traditional Birth Attendant
STD	Sexually Transmitted Diseases
RTI	Reproductive Tract Infection
LHV	Lady Health Visitor
DOT-S	Directly Observed Therapy of Short Duration
BMN	Basic Minimum Need
CRC	Convention on the Rights of the Child
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
WHO	World Health Organization
SAP	Social Action Programme
SAPP	Social Action Programme Project
ESSI	Employees Social Security Institutions
PMDC	Pakistan Medical and Dental Council
NEDL	National Essential Drug List
PMA	Pakistan Medical Association
ORT	Oral Rehydration Therapy

Health policy okayed

The News, 1997.12.18

By our correspondent

ISLAMABAD: Introducing a comprehensive diseases prevention programme, the government announced on Wednesday an ambitious National Health Policy on which a huge amount of Rs 105 billion will be spent in next five years.

The policy provides free health services and legislation for universal ban on juvenile smoking. The federal cabinet which met with Prime Minister Nawaz Sharif in the chair approved the National Health Policy (NHP).

Giving details about the policy, Federal Health Minister for Makhdoom Javed Hashmi said the NHP is in line with the ruling party's pledge for improving health services and providing better health care services to the people.

Hashmi said huge funds will be allocated by the government for implementing this policy as donors have not yet been asked to assist these programmes. Donors, however, will be welcomed to contribute in this regard.

He said under the National Health Care Scheme (NHCS), the government will issue National Health Cards (NHC) for families in rural and under-served urban areas to provide essential health services at nominal charge (free for poor

Continued on Page 8

Partyless LB polls likely in February

By our correspondent

ISLAMABAD: In its late night second session on Wednesday, the cabinet decided in principle to hold local bodies elections in all provinces after the presidential polls.

Cabinet sources told The News that these polls are likely to be held in February next year.

"Final dates for the local bodies elections will be decided in one of the cabinet meetings in January," a cabinet member told The News. Prime Minister chaired the

Continued on Page 8

Cabinet okays health policy

Continued from Page 1

families) through privatised health facilities.

The focus of this policy, he said, will be on diseases prevention programme for which Rs 27 billion will be provided in next five years. The NHCS will get Rs 20 billion, while Rs 20 million will be incurred on Basic Minimum Needs (BMN) programme.

He said the NHP will have five dimensions: Health sector reforms; new initiatives to fulfill the government commitments; review and consolidation of ongoing projects under SAPP-II; strengthening of the pharmaceutical sector; and health legislation.

"We will bring the health services at the door step of the poor people, and the direction of providing health services is being moved towards poor rural population," said Hashmi. He said several new programmes are being started: Prime Minister's poverty eradication programme, women health and family planning programme, tuberculosis prevention programme, schools health programme, nutrition programme, vaccine production and national health card scheme.

He said Rs 5 billion will be spent on non-communicable diseases, Rs 5.6 billion on health manpower development, Rs 6.5 on health infrastructure, Rs 5.5 on specialised case, Rs 3 billion on nutrition, Rs 9 billion on drugs and logistic supplies, Rs 0.6 billion on vaccine production, Rs 1.6 billion on health foundation and NGO collaboration, Rs 0.7 billion on health system research, Rs 1 billion on traditional medicine, Rs 1 billion health management information system, Rs 0.6 billion on environmental health and Rs 1 billion on prevention and control of drug abuse.

He said the system of indirect assistance will be abolished and the people will get medicines direct.

Claiming that the prices of about 25 medicines have been decreased because of the government efforts in the recent months, he said, the policy will give a broader health spectrum. "We will introduce a system by involving community at the district level so that nobody should dare to misuse its powers."

The Minister said the government will ensure that nobody should increase prices over and above the announced control list. He said the policy will guarantee supply of standard medicines, besides providing loans to fresh medical graduates for starting practice.

"The private sector will be encouraged to extend health services," he said, "a number of hospitals and health centres will be privatised." He said under this policy a poverty alleviation programme has been formulated. "The government will provide easy credit running small projects to overcome unemployment. This will improve the economic and health conditions of the beneficiaries."

Every 9th or 10th Pakistani is carrying Hepatitis B, therefore the government has decided to check this deadly disease through vaccination, he said, the government has to assist the people to help check this disease.

On experimental basis, he said, the government has given autonomy to three hospitals in the country, and decentralised their services so that they can make their own decisions. "If the experience proves a success the programme will be expanded."

About the major objectives of the policy, he said the policy will consider health as a developmental issue, address fundamental issues like poverty and population growth which inhibit a lasting change in health status. It will develop sound strategies for investment by the private sector to enhance the capacity of the system to deliver health care to all, introduce alternative approaches to financing health care through the involvement of the private sector and the national health card schemes.

The policy will address the health problems in the community, by providing promotive, preventive, curative and rehabilitative services to which the entire population has effective access. It will ensure community participation through creation of awareness, change of attitudes, organisation and mobilisation of support, improve the utilisation of health facilities by bridging the gap between the community and health services.

The new policy will expand the delivery of reproductive health services including family planning both in urban and the rural areas of Pakistan. It will integrate existing health care delivery programmes like EPI, malaria control, nutrition and MCH within the Primary Health Care (PHC) and improve the nutrition status of mothers and children and reduce the prevalence of malnutrition.

Hashmi said, "After implementation on the policy, the health indicators of Pakistan will improve significantly in the next five years, with a decrease in infant mortality from 86/1000 live births to 40/1000 live births. Maternal mortality rate will come down from 350/100,000 live births to 200/100,000 live births, and low birth weight babies from 25% to 10%".

"The life expectancy will increase from 62 years to 65 years and the percentage of children below 7 years (who are fully immunised) from 65% to 90% while Polio is expected to be eradicated by the year 2000."

Changing the health picture

The Rs 105 billion National Health policy announced Wednesday incorporates two key features. The first is the National Health Card Scheme, also part of the PML(N) manifesto, and the second, its focus on a wide-ranging disease prevention plan, for which Rs 27 billion is to be provided over the next five years.

That the government has shown its commitment to implementing its manifesto pledge by initiating the Rs 20 billion Health Card Scheme is a welcome step. The scheme aims at giving health cover to the most deprived sections of society, at nominal charges or without cost. Whereas in theory, the Card Scheme should play a major part in improving the quality of health care, in reality a great deal will depend on how it is implemented.

At present, myriad problems afflict the health-care system. Government hospitals are in such a bad state of disrepair that adequate medical care is almost impossible to obtain for those unable to pay for private consultation. Another aspect of the problem, apart from the non-availability of medicines or facilities, is the attitude of the staff, who often fail to show concern about the fate of the hapless patients who line hospital corridors or occupy the wards.

For the Health Card Scheme to be effective, this attitude will need to be altered. This is a far more difficult task than drafting a policy. More motivation, proper supervision and firmer accountability of staff must also be introduced. The challenge for Pakistan's health planners is to devise ways to introduce a much-needed element of humanity within a health-care system which, at present, is sorely lacking. The initiative on this front needs to begin at the medical college level; the appointment of carefully chosen supervisory staff may also help protect the main idea behind the Health Card Scheme, of providing improved health care to the poor. A proper monitoring of this is all the more important within the privatised or semi-privatised health-care system the government hopes to put in place.

The extensive disease prevention plan and other facets of the health policy, too, have evidently been well thought-out. There is no doubt that preventive medicine and greater focus on reproductive health are essential parts of any health policy in a developing country. But it is the manner in which these schemes are enforced which will determine their impact, and their success in improving Pakistan's position on the revealing health facilities provision charts which will show it at the bottom of countries even in South Asia.

THE MATERNAL & CHILD PROJECT

IN

THE ISLAMIC REPUBLIC OF PAKISTAN

Report
Presented at the visit
of the
Japanese Advisory Mission

DECEMBER, 1997

PAKISTAN INSTITUTE OF MEDICAL SCIENCES
ISLAMABAD

CONTENTS

1. Operational Plan of the Project & the Future Perspective — Prof. Mahmood Ahmed, Executive Director/Project Director

2. Maternal Health Studies — Dr. Gul N. Rehman

3. Maternal Mortality Data — Dr. S. Batool Mazhar

4. Activity Plan (Project Design Matrix) — Dr. Tamotsu Nakasa

5. Training Plan — Prof. Ghazala Mahmud

6. Internal Meeting with the Counterparts of MCH Project *(December 17, 1997)*

7. Joint Coordinating Committee Meeting *(December 18, 1997)*

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PAKISTAN INSTITUTE OF MEDICAL SCIENCES
ISLAMABAD

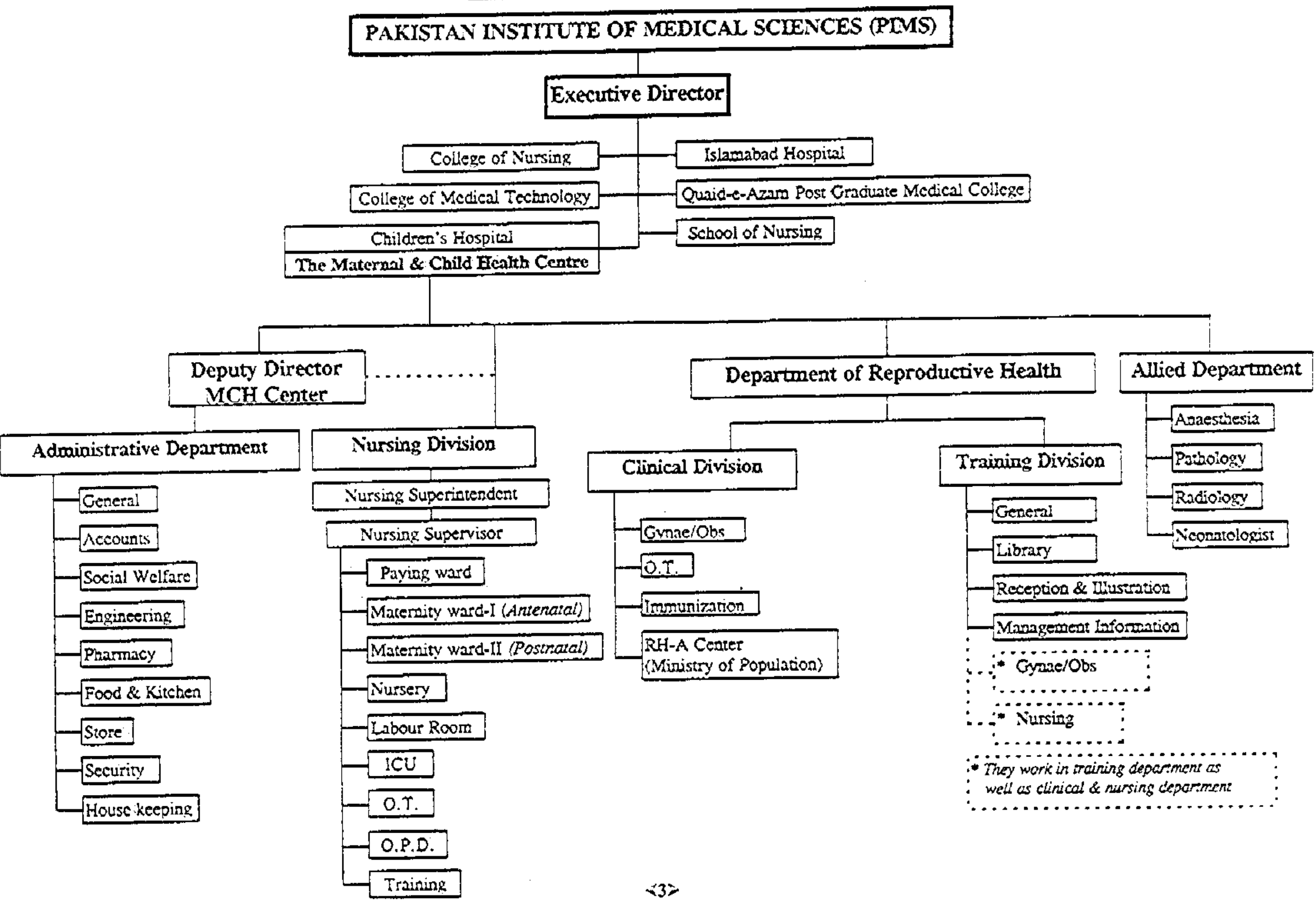
MOTHER AND CHILD HEALTH CENTRE

OPERATION AL PLAN

Organizational Chart	Annexure - A
Budget for 03 Months (April ~ June, 1998)	Annexure - B
Budget for 01 year	Annexure - C
Expected Income Generation	Annexure - D
Staff Requirement	Annexure - E

Annexure-A

ORGANIZATIONAL CHART



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Annexure-B

BUDGET FOR THREE MONTHS (APRIL ~ JUNE, 1998)

S. NO.	HEAD OF EXPENDITURE	AMOUNT (RS. IN MILLION)
01	Pay & Allowances	3.533
02	Repair & Maintenance	-
03	Commodities & Services	9.545
	(1) Personnel T.A.	0.013
	(2) Transportation of Goods	0.013
	(3) POL Charges	0.025
	(4) Conveyance	0.003
	(5) Postage & Telegram	0.003
	(6) Telephone & Trunk Calls	0.125
	(7) Gas Charges	0.125
	(8) Water Charges	0.125
	(9) Electricity	3.000
	(10) Office Stationary	0.125
	(11) Printing	0.125
	(12) Linen & Liveries	0.250
	(13) Rent & Taxes	0.013
	(14) Rent of Accommodation	0.250
	(15) Training, Seminars & Examination	1.000
	(16) Advertisement	0.100
	(17) Patients Diet	0.750
	(18) Drugs & Medicine	3.000
	(19) Others (General Store/Misc.)	0.500
04.	Stipend	0.105
05.	Entertainment	0.012
	GRAND TOTAL	13.195

<4>

ANNUAL RECURRING BUDGET

S. NO.	HEAD OF EXPENDITURE	AMOUNT (Rs. in Million)
01	Pay & Allowances	14.200
02	Repair & Maintenance	4.600 *
03	Commodities & Services	40.820
	(1) Personnel T.A.	0.050
	(2) Transportation of Goods	0.050
	(3) POL Charges	0.100
	(4) Conveyance	0.010
	(5) Postage & Telegram	0.010
	(6) Telephone & Trunk Calls	0.500
	(7) Gas Charges	0.500
	(8) Water Charges	0.500
	(9) Electricity	10.000
	(10) Office Stationary	0.500
	(11) Printing	0.500
	(12) Linen & Liveries	1.000
	(13) Rent & Taxes	0.050
	(14) Rent of Accommodation	1.000
	(15) Training, Seminars & Examination	3.350
	(16) Advertisement	0.200
	(17) Patients Diet	2.500
	(18) Drugs & Medicine	18.000
	(19) Others (General Store/Misc.)	2.000
04.	Stipend	0.420
05.	Entertainment	0.050
	GRAND TOTAL	60.090

Note : * Budget for Repair & Maintenance will be claimed during 3rd year after commissioning of MCH Centre

Annexure "D"

EXPECTED INCOME GENERATION

SUMMARY

NET EXPECTED INCOME TO HOSPITAL : RS. 2,85,21,128.00 (28,521 Million)

TO BE ACHIEVED AS UNDER :

Phase - 1 : (1st year), 25% of the Total Expected Income Rs. = 71,30,282.00 (7.130 Mil.)

Phase - 2 : (2nd year), 50% of the Total Expected Income Rs. = 1,42,60,564.00 (14.260 Mil.)

Phase - 3 : (3rd year), 75% of the Total Expected Income Rs. = 2,13,90,846.00 (21.391 Mil.)

Phase - 4 : (4th year), 100% of the Total Expected Income Rs. = 2,85,21,128.00 (28.521Mil.)

(DETAIL ATTACHED)

DETAILS OF EXPECTED INCOME GENERATION

Major Items	Assumption	Income (Rs.)
Registration & Examination Fee	200 patients/day x 25 Rs x 24 Days x 12 months (33% FREE) *	9,64,800.00
Procedure in OPD Ultrasound (General/Private Patients)	40 patients/day x 50 Rs x 24 Days x 12 months (33% FREE) *	3,85,920.00
CTG (General patients)	10 patients/day x 50 Rs x 24 Days x 12 months (33% FREE) *	96,480.00
CTG (Private patients)	05 patients/day x 100 Rs x 24 Days x 12 months	1,44,000.00
DELIVERY FEE (General)	(33% FREE) *	
SVD : Fee	07 patients/day x 500 Rs x 24 days x 12 months	6,75,360.00
Theatre Charges	07 patients/day x 125 Rs x 24 days x 12 months	1,68,840.00
Assisted (OLFD) :		
Fee	02 patients/day x 700 Rs x 24 days x 12 months	2,70,144.00
Theatre Charges	02 patients/day x 250 Rs x 24 days x 12 months	96,480.00
LSCS : Fee	02 patients/day x 2000 x 24 days x 12 months	7,71,840.00
Theatre Charges	02 patients/day x 500 Rs x 24 days x 12 months	1,92,960.00
Anaesthesia Charges	02 patients/day x 500 Rs x 24 days x 12 months	1,92,960.00
DELIVERY FEE (Private)		
SVD : Fee	02 patients/day x 2300 Rs x 24 days x 12 months	13,24,800.00
Theatre Charges	02 patients/day x 700 Rs x 24 days x 12 months	4,03,200.00
Assisted (OLFD) :		
Fee	02 patients/day x 3400 Rs x 24 days x 12 months	19,58,400.00
Theatre Charges	02 patients/day x 1100 Rs x 24 days x 12 months	6,33,600.00
LSCS : Fee	02 patients/day x 6000 Rs x 24 days x 12 months	34,56,000.00
Theatre Charges	02 patients/day x 2000 Rs x 24 days x 12 months	11,52,000.00
Anaesthesia Charges	02 patients/day x 2000 Rs x 24 days x 12 months	11,52,000.00
OPERATION FEE (General)	(33% FREE) *	
Minor/D&C :		
Fee	05 patients/day x 500 Rs x 24 days x 12 months	4,82,400.00
Theatre Charges	05 patients/day x 125 Rs x 24 days x 12 months	1,20,600.00
Laparoscopy Diagnostic :		
Fee	01 patient/day x 500 Rs x 24 days x 12 months	96,480.00
Theatre Charges	01 patient/day x 125 Rs x 24 days x 12 months	24,120.00
Laparotomy :		
Fee	01 patient/week x 2000 Rs x 4 weeks x 12 months	64,320.00
Theatre Charges	01 patient/week x 500 Rs x 4 weeks x 12 months	16,080.00
Anaesthesia Charges	01 patient/week x 500 Rs x 4 weeks x 12 months	16,080.00

OPERATION FEE (Private)		
Minor/D&C :		
Fee	02 patients/day x 2300 Rs x 24 days x 12 months	13,24,800.00
Theatre Charges	02 patients/day x 700 Rs x 24 days x 12 months	4,03,200.00
Laparoscopy Diagnostic :		
Fee	01 patient/day x 2300 Rs x 24 days x 12 months	6,62,400.00
Theatre Charges	01 patient/day x 700 Rs x 24 days x 12 months	2,01,600.00
Laparotomy :		
Fee	01 patient/month x 6000 Rs x 01 month x 12 months	72,000.00
Theatre Charges	01 patient/month x 2000 Rs x 01 month x 12 months	24,000.00
Anaesthesia Charges	01 patient/month x 2000 Rs x 01 month x 12 months	24,000.00
BEDS		
General ward, 60 beds (Approx. 80% occupancy)	48 beds x 100 Rs x 30 days x 12 months =	17,28,000.00
Poor/Entitled patients, 30 beds (FREE) * (100% occupancy)	30 beds x 00 Rs x 30 days x 12 months =	-
Paying ward, 35 beds (Approx. 80% occupancy)		
Semi private	14 beds x 300 Rs x 30 days x 12 months =	15,12,000.00
Private	14 beds x 750 Rs x 30 days x 12 months =	37,80,000.00
INVESTIGATIONS :		
(Blood C/P, Urine R/E, Blood Sugar, Blood Group)		
General Patients	100 patients x 40 Rs x 3 tests x 24 days x 12 months (**33% FREE)***	23,15,520.00
Private patients	15 patients x 60 Rs x 3 tests x 24 days x 12 months	7,77,600.00
X-Ray Pelvimetery General Patients	01 patient x 150 Rs x 1 test x 24 days x 12 months **(33% FREE)***	28,944.00
Private Patients	01 patient/week x 300 Rs x 1 test x 4 weeks x 12 months	14,400.00
DIET CHARGES :		
General Patients, 60 beds (Approx. 80% occupancy)	48 patients x 10 Rs x 30 days x 12 months	1,72,800.00
Poor/Entitled Patients, 30 beds (100% occupancy)	30 patients x 10 Rs x 30 days x 12 months	1,08,000.00
Paying Ward, 35 beds (Approx. 80% occupancy)		
Private/Semi private	28 patients x 50 Rs x 30 days x 12 months	5,04,000.00
GRAND TOTAL	**Rs. 2,85,21,128.00 (28.521 Mil.)**	

NOTE : * **33% FREE = Entitled Patients/Poor Patients =**

(1) Entitled Patients : Federal Government Employees are entitled to free treatment

(2) Poor Patients : Patients who are dependant on Zakat Fund

Annexure-E

STAFF REQUIREMENT

GRADEWISE BREAKDOWN

S. NO.	BPS	REQUIRED AS PER PC-I	EXISTING AVAILABLE	NEW REQUIREMENT
1.	20	02	01	01
2.	19	03	-	03
3.	18	06	01	05
4.	17	43	11	32
5.	16	11	04	07
6.	15	02	-	02
7.	14	74	-	74
8.	12	02	-	02
9.	11	13	01	12
10.	10	02	-	02
11.	9	30	06	24
12.	8	01	01	-
13.	7	09	02	07
14.	6	18	04	14
15.	5	18	05	13
16.	4	02	-	02
17.	2	28	-	28
18.	1	62	-	55
TOTAL		326	43	283
House Officer		10	-	10
GRAND TOTAL		336	43	293

SUMMARY

Regular Staff	:	326	
House Officers	:	10	
TOTAL	:	336	(DETAILS ATTACHED)

DETAILS OF STAFF REQUIRED

S. No.	Name of Posts	BPS	Req. as per PC-I	Existing/ Available	New Required	Remarks
1.	Consultant Neonatologist	20	01	-	01 *	*
2.	Professor/ Consultant Gynae/Obs	20	01	01	-	
3.	Associate Professor Gynae /Obs	19	01	-	01	
4.	Associate Professor Anaesthesia	19	01	-	01	
5.	Training Coordinator	19	01	-	01	
6.	Assistant Professor Gynae/Obs	18	01	01	-	
7.	Assistant Professor Pathology	18	01	-	01	
8.	Assistant Professor Radiology	18	01	-	01	
9.	Assistant Professor Anaesthesia	18	01	-	01	
10.	Deputy Director (Admin.)	18	01	-	01	
11.	Nursing Superintendent	18	01	-	01	
12.	Registrar	17	01	01	-	
13.	Medical Officer	17	06	06	-	
14.	Resident	17	22	02	20	

15.	House Officer	-	10	-	10	
16.	Assistant Training Coordinator	17	01	-	01	
17.	Assistant Anaesthetist (Medical Officer/Resident)	17	05	-	05	
18.	Assistant Pathologist	17	04	-	04	
19.	Pharmacist	17	01	01	-	
20.	Admin Officer/ Personnel Officer	17	01	01	-	
21.	Accounts Officer	17	01	-	01	
22.	Warden	17	01	-	01	
23.	Computer Operator	16	01	-	01	
24.	Head Nurses	16	06	02	04	
25.	Medical Technologists	16	02	-	02	
26.	Superintendent Medical Store	16	01	01	-	
27.	Dietician	16	01	01	-	
28.	Stenographer	15	01	-	01	
29.	Supervisor (Admin.)	15	01	-	01	
30.	Assistant Librarian	14	01	-	01	
31.	Charge Nurses	14	70	-	70	
32.	Supervisor Housekeeping	14	01	-	01	
33.	Incharge Communication/ Electricity	04	01	-	01	

34.	Boiler Supervisor	14	01	-	01	
35.	Stenotypist	12	02	-	02	
36.	Supervisor CSSD	11	01	-	01	
37.	Assistant	11	01	01	-	
38.	Cashier/ Accountant	11	01	-	01	
39.	Computer Data Entry Personnel	11	01	-	01	
40.	Security Supervisor	11	01	-	01	
41.	Reception Officer	11	04	-	04	
42.	Boiler Operator	11	04	-	04	
43.	HVAC Technician	10	02	-	02	
44.	LHVs/Midwife	09	10	-	10	
45.	Lab Technician	09	04	-	04	
46.	Radiographer	09	04	-	04	
47.	O.T. Technician	09	08	06	02	
48.	Immunization Technician	09	02	-	02	
49.	ECG Technician (Lady)	09	02	-	02	
50.	Head Dispenser	08	01	01	-	
51.	Store Keeper	07	02	-	02	
52.	Telephone Operator	07	06	02	04	
53.	Head Cook	07	01	-	01	
54.	Anaesthesia Technician	06	08	01	07	
55.	Sterilization Technician	06	03	-	03	

56.	Dispenser	06	03	-	03	
57.	Ward Master	06	03	03	-	
58.	Sanitary Inspector	06	01	-	01	
59.	Dark Room Assistant	05	02	-	02	
60.	L.D.C.	05	05	05	-	
61.	A.C. Unit Operator	05	03	-	03	
62.	Chiller Operator	05	04	-	04	
63.	Gas Cylinder Operator	05	02	-	02	
64.	Electrician	05	02	-	02	
65.	Plumber	04	02	-	02	
66.	Aya	02	10	-	10	
67.	Ward Boy	02	10	-	10	
68.	Cook	02	08	-	08	
69.	Chowkidar	01	08	-	08	
70.	Naib Qasid	01	04	-	04	
71.	Sanitary Worker	01	37	07	30	
72.	HVAC Helper	01	02	-	02	
73.	Masalchi	01	03	-	03	
74.	Bearer	01	04	-	04	
75.	Dish Washer	01	04	-	04	
	GRAND TOTAL		336	43	293	

* : Physician Neonatology (BPS-19) already working at Children's Hospital. Post in BPS-20 may be filled if required in future, promoted against this post.

Note : Ministerial staff (Assistant, Stenographer, Stenotypist, LDC), Ward Master, Telephone Operator, Head Dispenser, Dispenser, Aya, Ward Boy, Chowkidar, Helper and Sanitary Worker are available with PIMS and will be transferred to MCH Centre. Remaining staff will be recruited/promoted as per rules.

MATERNAL HEALTH STUDIES

Type of studies

1. **Referral Level Hospital Survey (RLHS)**
   ☞ Prof. Ghazala Mahmud, Dr. S. Batool Mazhar, Dr. Sofia N. Sheikh

2. **Health Facility Survey (HFS)**
   ☞ Dr. Gul N. Rehman, Dr. T. Nakasa, Ms. Nilofer Ghani, Ms. Gul Freen

3. **Household Survey for Maternal & Child Mortality Survey (HHS/MCMS)**
   ☞ Dr. Gul N. Rehman, Dr. T. Nakasa

4. **Qualitative Research (QR)**
   ☞ Dr. Gul N. Rehman, Ms. Akiko Udayama, Madam Mumtaz, Ms. Nilofer Ghani, Ms. Gul Freen

5. **Workshops**
   ☞ All Japanese team & All Pakistani Counterparts

6. **Nutrition Education**
   ☞ Dr. Gul N. Rehman, Ms. Athar Sayed, Ms. Misa Nishida, Ms. Mari Chitose

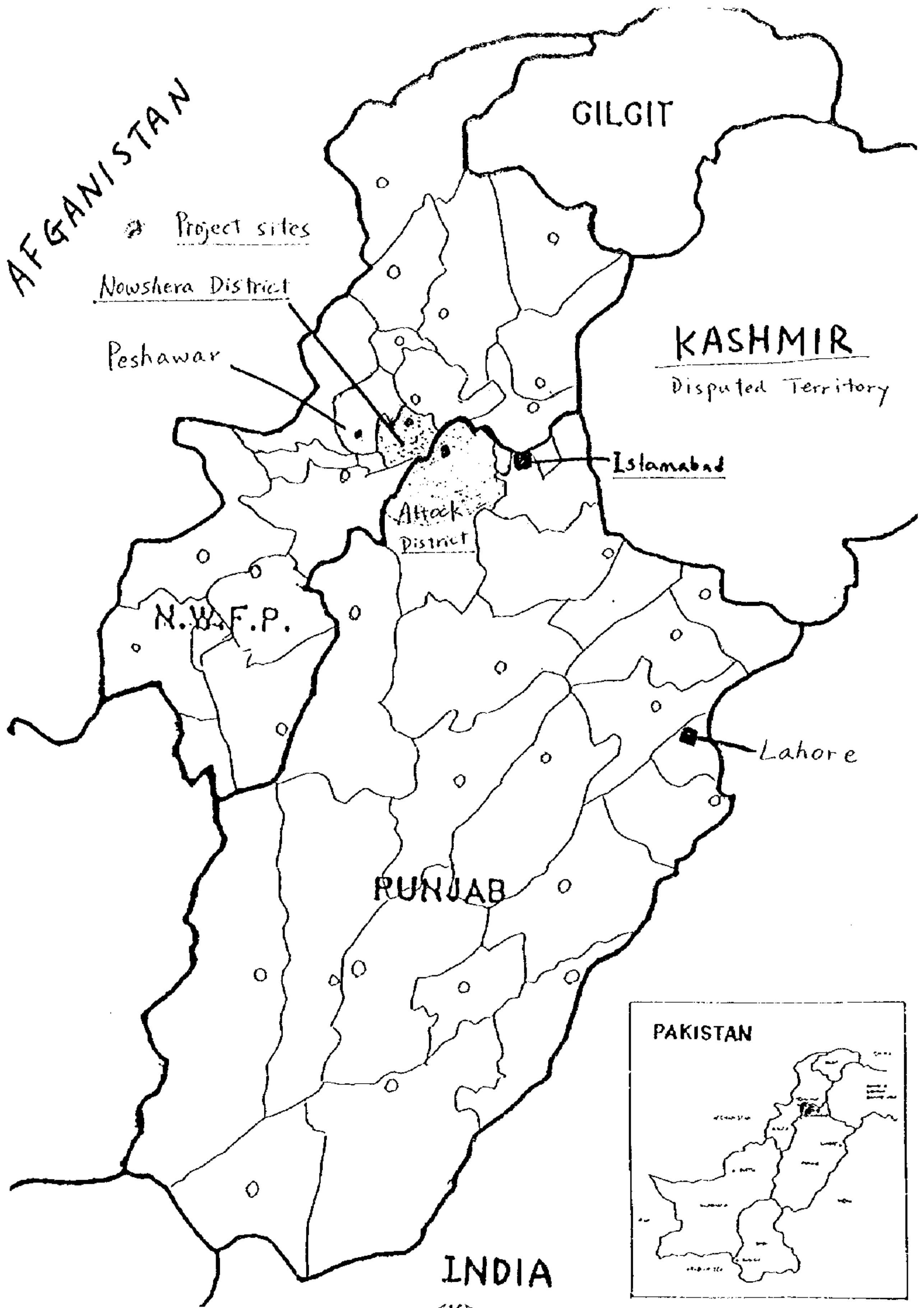
7. **Maternal Health Education**
   ☞ Ms. Akiko Udayama, Ms. Fumiko Kudo, Ms. Nilofer Ghani, Ms. Nasim Sohail

RATIONALE FOR MATERNAL HEALTH SURVEYS :

1. For **SITUATION ANALYSIS**
   1) Community - MMR, CMR, Community Perceptions
   2) Health Personnel
   3) Health Facility

2. To Collect **BASELINE DATA** for evaluation & re-evaluation

3. To develop **INTERVENTIONS** and Plan of Action based on the results
   1) Health Education - Community & Health Personnel
   2) Training
   3) Improving Referral
   4) Supporting facilities



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PAKISTAN DATA

I) General Data :

- Total Population of Pakistan — 137 million
- Total Fertility Rate — 6.0
- Total Births per year — 5.5 million
- Low Birth Weight Babies — 25 %
- Infant Mortality Rate — 95/1000 live births
- Maternal Mortality Rate — 270 ~ 670 /100,000 live births

SUMMARY OF RESULTS

1. Lack of Awareness - Community (Women)
2. Social constraints / barriers (Decision making)
3. Logistic Problems (Distances, Transport, Economics)
4. Most deliveries are conducted at home by untrained personnel (TBAs etc.)
5. Health workers LHWs, TBAs, LHV, Lady Drs., Drs. etc.
   - Not appropriately trained
   - Not practising standardised case management
6. Health Facilities are not working to their full capacity
7. "Capacity Building" at some level facility needed e.g., Blood, equipment (BHU, RHC, THQ)
8. Maximum mortalities occur at home and some in big hospitals
   - Delayed care seeking
   - Late and inappropriate referral
   - Patients are not brought in time

I. REFERRAL LEVEL HOSPITAL SURVEY (RLHS)

(Conducted By : Prof. Ghazala Mahmud, Dr. Batool Mazhar, Dr. Sofia Sheikh)

OBJECTIVE :

- To assess maternal mortality in referral hospitals.
- To find the causes/risk factors responsible in the hospitals and community perceptions about these maternal deaths.

SITE : 7 big Hospitals of Rawalpindi & Islamabad
(PIMS, FGSH, RGH, HFH, CDA, CGH, DHQ)

DURATION : Dec. 1996 ~ Dec. 1997

DESIGN :

- Prospective study
- Retrospective analysis of maternal deaths
- Verbal autopsy from relatives
- Nearmiss case study

STATUS : On going

AUDIT :

Data Collected	:	✓
Preliminary Analysis done	:	✓
Results Presented already	:	✓
Final Analysis	:	

2. HEALTH FACILITY SURVEY (HFS)

(Conducted By : Dr. Gul Rehman, Dr. T. Nakasa, Ms. Gul Freen, Ms. Nilofer)

OBJECTIVES :

- To find the capacity of health facilities for dealing with obstetric cases.
- To assess the capabilities/training status of health personnel for providing maternal health care.

SITE : ICT, Attock, Nowshera

DURATION : Aug. 1996 ~ Dec. 1996

DESIGN :

- A cross sectional descriptive
- Random selection

STATUS : 81 health facilities surveyed (BHU, RHC, THQ, DHQ)

ICT	:	16/16
Attock	:	38/70
Nowshera	:	27/42

(Random Selection)

AUDIT :

Date Collection	:	✓
Date entry	:	✓
Data Analysis	:	✓
Results presented	:	
Menu Script	:	

3. HOUSEHOLD SURVEY FOR MATERNAL & CHILD MORTALITY (HHS/MCMS) :

(Conducted By : Dr. Gul N. Rehman, Dr. T. Nakasa (Drs. & LHVs, Rawalpindi)

OBJECTIVES :

- To estimate Maternal & Child Mortality in the project area.
- To ascertain the perceived causes of maternal deaths in the community.
- To find KABP among mothers - nutrition, health care, pregnancies.
- To evaluate the use of family planning options.

SITE : ICT, Attock, Nowshera

DURATION : Dec. 1996 ~ May 1997

DESIGN :

- Two stage random selection of households
- Socio-demographic data about household
- In-depth interview of ever married women
- Verbal autopsy of dead women and children from sisters/mothers
- Questionnaire about health care seeking practices

STATUS : ICT Completed
Attock - planned
Nowshera - plan prepared

AUDIT :

ICT

Data Collected	:	✓
Data Entry	:	✓
Preliminary Analysis	:	✓
Data Cleaning	:	
Final Analysis	:	
Results Presentation	:	
Write up	:	

4. QUALITATIVE RESEARCH :

(Conducted By : Dr. Gul N. Rehman, Dr. T. Nakasa, Ms. Mumtaz, Ms. Nilofer, Ms. A. Udayama)

OBJECTIVES :

- To find the KABP about obstetric care among women, TBAs, LHWs and community.
- To evaluate the number of deliveries and related complications managed by TBAs and LHWs.

SITE : ICT, Attock (Kanyal village, BHU Kanyal, PM Programme)

DURATION : Oct. 1996 ~ Jul. 1997

DESIGN :

- Observation method
- In-depth interviews
- Focus group discussions (Pregnant/lactating women, mothers-in-law, husbands, TBAs and LHWs)

STATUS : ICT Completed
Attock - Completed

AUDIT :

Data Collected	:	✓
Preliminary Analysis	:	✓
Data Cleaning	:	✓
Final Analysis	:	
Results Presentation	:	
Write up	:	

5. WORKSHOPS :

(CONDUCTED BY : All Japanese team & Pakistani team)

OBJECTIVES :

- Workshop on exchanging opinion about maternal health situation in Pakistan **(Obstetricians)**
- Workshop on sharing knowledge & experience about maternal health through participatory method **(NGOs/Social Scientists)**
- Workshop to know the maternal health situation in DHQs **(Administrators/Drs./Nurses)**
- Workshop to create awareness about maternal health **(Nurses)**
- Workshop to ascertain the role of training institute for Family & Reproductive Health, MCHC **(National Level)**

SITE : PIMS

DURATION :

- Workshop - 1 : Aug. 1996
- Workshop - 2 : Aug. 1996
- Workshop - 3 : Sep. 1996
- Workshop - 4 : Jul. 1997
- Workshop - 5 : Apr. 1998

DESIGN :

- Presentations and discussions

STATUS : Workshop 1 ~ 4 completed in PIMS
Workshop 5 - Planning & preparation

AUDIT :

Results of discussion during workshops used for preparing/planning of various studies and training activities.

6. NUTRITION EDUCATION PROJECT :

(Conducted By : Dr. Gul Rehman, Dr. T. Nakasa, Ms. Athar, Ms. M. Nishida, Ms. M. Chitose)

OBJECTIVES :

- To create awareness about diet to prevent/improve anemia.
- To change behaviour to prevent/improve anemia.

SITE : (ICT Area)

- Pind Begowal - Intervention Area
- Mera Begowal - Intervention Area
- Shahdara - Partial Intervention
- Tarlai - Control Area

DURATION : Oct. 1996 ~ Oct. 1998

DESIGN :

- Phased study
- Training of LHWs (PM Programme) for Nutrition Health Education through participatory approach
- Applying methodology for pregnant women in community.
- Control & Intervention Areas

STATUS : On going

AUDIT :

Data Collected for phase 1 & 2	:	✓
Preliminary Analysis of phase 1 & 2	:	✓
Data Cleaning	:	✓
Final Analysis	:	
Results Presentation	:	
Write up	:	

7. MATERNAL HEALTH EDUCATION :

(Conducted By : Ms. F. Kudo, Ms. A. Udayama, Ms. Nilofer, Ms. Nasim)

OBJECTIVES :

- To create awareness about reproductive health issues among pregnant women and families.

SITE : PIMS

DURATION : Mar. 1997 ~

DESIGN :

- Antenatal & Postnatal classes, discussions

STATUS : On going

AUDIT :

Curriculum agreed upon	:	✓
Time table prepared	:	✓
Material developed	:	✓
Classes conducted	:	✓

STUDIES CONDUCTED

No.	Studies/ Surveys	Status	Data Collection	Data Entry	Preliminary Analysis	Data Cleaning	Analysis	Results Presented	Write Up
1	RLHS	Partially Completed	✓		✓			✓	
2	HFS	Completed	✓	✓			✓		
3	HHS/ MCMS	Partially Completed	✓	✓	✓				
4	QR	Completed	✓		✓	✓			
5	Workshop	Partially Completed							
6	Nutrition Program	On Going	✓		✓	✓			
7	Health Education	On Going							

MATERNAL MORTALITY DATA

Total Number of Maternal Deaths : 123

1) Household Survey : 75
(March 17 ~ April 30, 1997)

2) Referral Level Hospital Survey : 48
(January ~ October, 1997)

MATERNAL MORTALITY DATA :

Date	Duration	Survey	No. of Maternal Mortalities	MMR *(per 100,000 live births)*
Mar 17 ~ Apr 30, 1997	Last 29 years	Household Survey	75	300 ~ 400
Jan ~ Oct, 1997	10 months	RLHS	48	299
Jan ~ Oct, 1997	10 months	PIMS	15	830

COMPARISON :

Total Number of Maternal Deaths : 123

CAUSES	HOUSEHOLD SURVEY	RLHS
Direct Causes	57 (76%)	38 (79.16%)
Indirect Causes	10 (13.3%)	9 (18.75%)
Unknown	8 (10.6%)	-
Incidental Causes	-	1 (2.08%)

HOUSEHOLD SURVEY :

HAEMORRHAGE *(n=43)* :

- Antepartum Haemorrhage : 10 = 25%
  - Placenta Previa : 3 = 30%
  - Abruption Placenta: 4 = 40%
  - Unknown : 3 = 30%
- Postpartum Haemorrhage : 25 = 62.5%
  - Primary : 22 = 88%
    - *Retained Placenta : 7 = 28%*
    - *Atony : 15 = 60%*
  - Secondary : 3 = 12%
- Abortion : 5 = 12.5%
- Surgical : 3 = 6.97%

DIRECT CAUSES :

- Haemorrhage : 57.30%
- Sepsis : 8.00%
- Anaesthesia : 1%
- Hypertensive Disorders : 6.66%
- Obstructed Labour : 2.66%
- Indirect : 13.33%
- Unknown : 10.66%

INDIRECT CAUSES *(n=10)* :

- Chest Pain/MI ? : 4 = 40%
- Hepatic Failure : 1 = 10%
- Chronic Respiratory Disease : 1 = 10%
- Epileptic Fit : 1 = 10%
- Upper GI Bleed : 1 = 10%
- Pulmonary Embolism : 1 = 10%
- Malignancy : 1 = 10%

AVOIDABLE FACTORS : *(n=75)*

- Home Confinement : 41 = 54.6%
  Care Provider : - Dais : 26 = 34.6%
  - Doctors : 27 = 36%
- Failure in seeking Medical Care : 12 = 16%
- No Referral : 20 = 26.6%
  - By Dai : 15 = 75%
  - By Doctors : 4 = 20%
  - By Nurse : 1 = 5%
- Late Referrals : 6 = 8%
- Inappropriate Treatment at Tertiary Care Hospital : 6 = 8%
- Late Intervention : 6 = 8%
- Lack of Facility
  - for emergency treatment : 2 = 2.6%
  - for Blood Transfusion : 4 = 5.3%
- Unsafe Induced Abortion : 2 = 2.6%
- Early discharge from hospital : 4 = 5.3%
- Outdoor Management : 2 = 2.6%
- Emergency Surgery : 3 = 4%

REFERRAL LEVEL HOSPITAL SURVEY :

DIRECT CAUSES :

- Haemorrhage : 20.80%
- Haemorrhage/Sepsis : 6.25%
- Sepsis : 20.80%
- Hypertensive Disorders : 18.75%
- Indirect : 18.75%
- Accidental : 2.08%
- Obstructed Labour : 8.33%
- Anaesthesia : 4.16%

INDIRECT CAUSES *(n=9)* :

- Cardiac disease : 4 = 44.44%
- TB : 1 = 11.11%
- Hepatic Failure : 3 = 33.3%
- Pulmonary Embolism : 1 = 11.11%

AVOIDABLE FACTORS :

- Non Referral : 4 = 8.33%
- No Antenatal Care : 8 = 16.66%
- Late presentation/Referral : 17 = 35.14%
- High Risk handling by Dai : 10 = 20.83%
- Unsafe Abortion : 2 = 4.166%
- Lack of BT : 8 = 16.66%
- Lack of Equipment : 11 = 22.9%
- Lack of ICU : 1 = 2.083%
- Cost of Treatment : 4 = 8.33%
- Substandard Care in tertiary hospital : 12 = 25%
    - Lack of consultant involvement : 4 = 8.3%
    - Delay in management: 2 = 4.16%
    - Poor Post-op care :
    - Lack of transport/ Long distance : 6 = 12.55%
- Poor Nutritional status : 3 = 6.25%
- Male doctor in referral Hospital : 1 = 2.08%
- Non-acceptance by referral hospital : 2 = 4.16%
- Lack of training at PHCC : 2 = 4.16%

SUGGESTIONS/RECOMMENDATIONS :

- **SENSITIZATION :**
  - of community for regular antenatal care specially in the second half of pregnancy
  - of doctors at primary health care centre for early referral
  - of referral hospital staff for acceptance & early treatment

- **TRAINING :**
  - Refresher training of TBAs
  - Refresher training of PHCC doctors
  - Standard training of doctors at referral level hospitals
  - Refresher courses for specialists

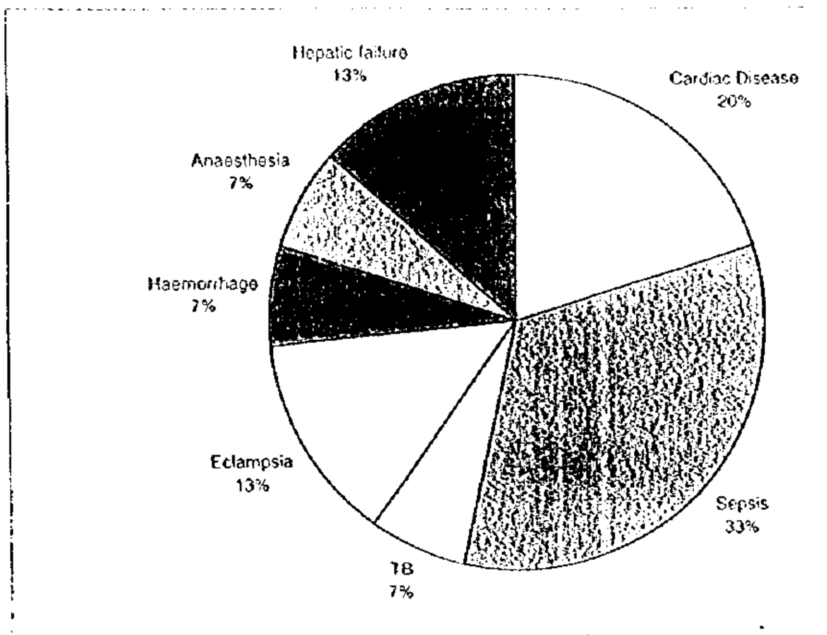
- **FACILITIES :**
  - Establishment of functioning PHCC
  - Efficient intensive care units
  - Updating of Blood Banks
  - Radiology
  - Pathology
  - Availability of free medicine

- **HEALTH EDUCATION :**
  - To improve sanitary conditions

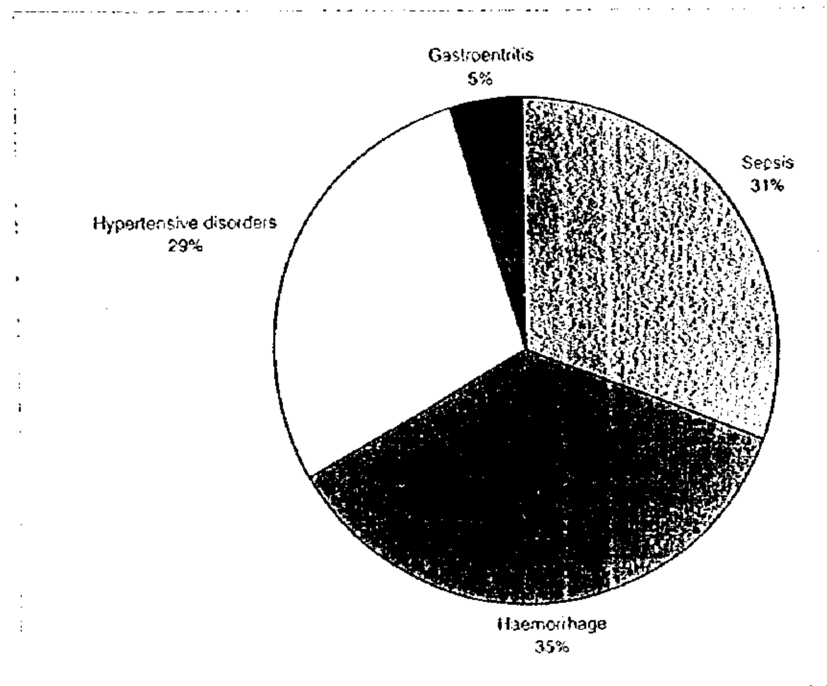
- Privacy of patients or minimum exposure of the patient during delivery *(Patients don't like to be exposed)*

- To develop sense of human rights in the community

COMPARISON BETWEEN MAJOR CAUSES OF MORTALITY & MORBIDITY AT PIMS



Causes of Mortality at PIMS



Causes of Severy Morbidity at PIMS

ACTIVITY PLAN

(Project Design Matrix)

OVERALL GOAL :

To reduce "Maternal Mortality" by promoting "Safe motherhood" in target areas

PROJECT PURPOSE :

Human resource development for maternal health care in target areas

TARGET AREA :

- ICT (Islamabad Capital territory)
- Nowshera (North West Frontier Province)
- Attock (Punjab)

BENEFICIARIES :

- **Direct** : Health care providers
- **Indirect (Final)** : Pregnant women in the rural areas

INSTITUTIONS INVOLVED :

- Maternal and Child Health Center, PIMS
- DHOs (ICT, Attock, Nowshera)
- BHUs, RHCs (ICT, Attock, Nowshera)
- Referral facility e.g., THQs, DHQs and Teaching Hospitals

OUTPUT :

1) Information on Maternal Health

1-1 : Referral level hospital survey
1-2 : Health facility survey
1-3 : Maternal and under five children mortality household survey
1-4 : Qualitative community survey
1-5 : Data collection from HMIS (Health Management Information System)

2) Establishment of MCH Center

2-1 : Building and equipment (Grant in aid)
2-2 : Establishment of managing plan and implementation (staff, budget)
2-3 : Establishment of training plan and implementation
2-4 : Establishment of monitoring and evaluation of administration, training and medical services
2-5 : Propaganda on MCH center
2-6 : Coordination and Cooperation among concerned authorities and other provinces (MOH, Punjab, NWFP, ICT)

3) Establishment of Referral Model in ICT

3-1 : To improve awareness of community
3-2 : Early detection of high risk at home
3-3 : Improve transportation
3-4 : Training of health staff in BHUs and RHCs
3-5 : Appropriate response by referral hospitals
3-6 : Coordination among concerned authorities

STRATEGY :

1) To establish and implement refresh training programs for health care providers

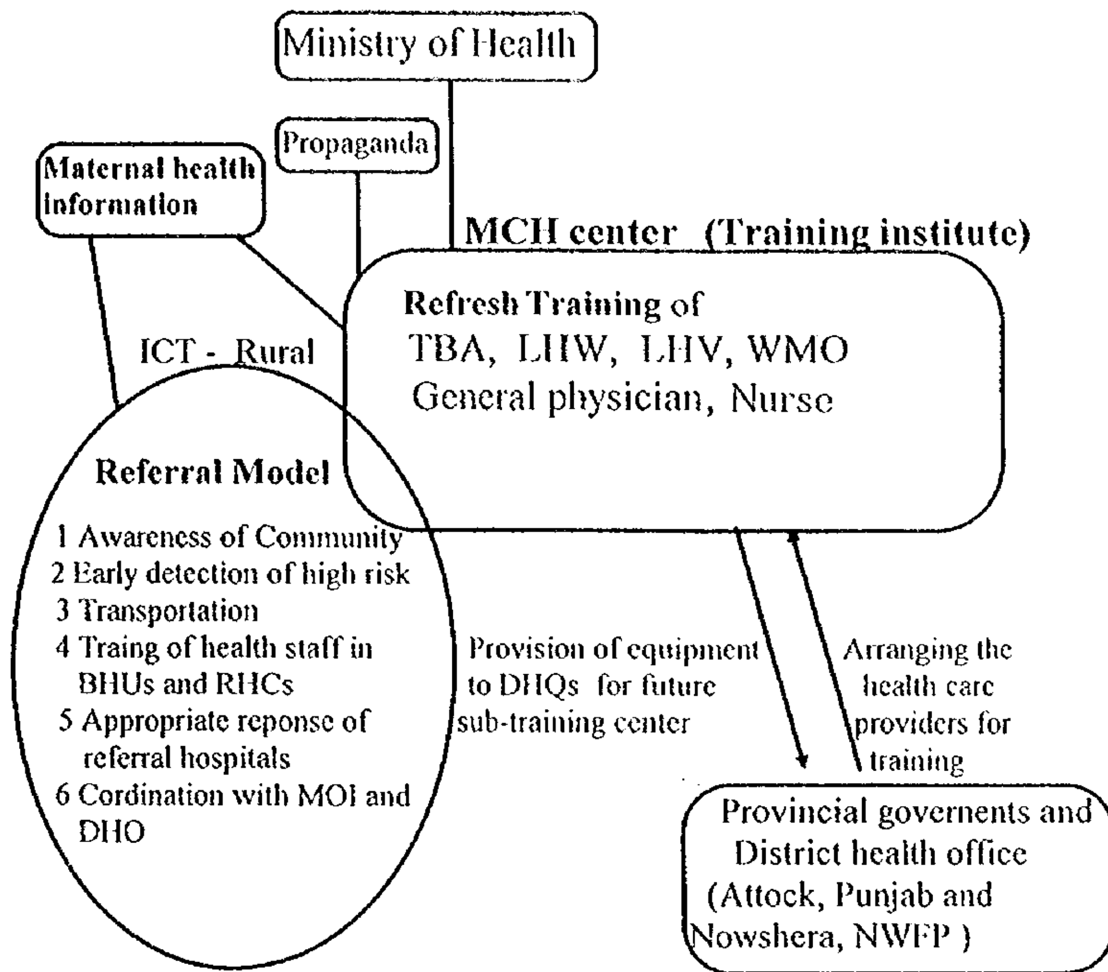
2) To assess health care providers' performance and effect on mothers in referral model (ICT) and its feedback to training program

3) To replicate this referral model in other target areas in Attock, Punjab and in Nowshera, NWFP

4) To recommend these refresh training programs to implement as a national program to MOH

PROJECT DESIGN MATRIX

NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATIONS	IMPORTANT ASSUMPTION
OVERALL GOAL To reduce "Maternal Mortality" by promoting "Safe motherhood" in target areas.	Maternal Mortality rate in ICT	LHW monthly report	
PROJECT OBJECTIVES Human resource development for maternal health care	KAP(Knowledge, attitude, Practice) of health care providers	* Evaluation (Pre-training, post-training, Follow-up)	Support from Ministry of Health
OUTPUT **1. Information on maternal health** 1-1 Referral level hospital survey 1-2 Health facility survey 1-3 Maternal and under five children mortality household survey 1-4 Qualitative community survey 1-5 Data collection from HMIS (Health Management Information System)	1-1 Completion rate of survey 1-2 Completion rate of survey 1-3 Completion rate of survey * MMR and IMR in each district 1-4 Completion rate of survey 1-5 Collected data	* Survey reports * Periodical project report * Report from District Health Office	Support from each province
2. Establishment of MCH center 2-1 Building and equipment (Grant in aid) 2-2 establishment of managing plan and implementation (staff, budget) 2-3 Establishment of Training plan and implementation 2-4 Establishment of monitoring and evaluation of administration, training, and medical services 2-5 Propaganda on MCH center 2-6 Coordination and Cooperation among concerned authorities and other provinces (MOH, Punjab, NWFP, ICT)	2-1 Completion rate of construction 2-2 Organization chart, staffing, budget, and operational plan 2-3 * Training plan * Number of training course * Number of trainees * Cost per cases and per trainee 2-4 * Number of evaluation 2-5 * Knowledge about MCH center 2-6 * Number of trainees from target areas in each province	* Report from construction team * Brochure of MCH project * Patients record * Training record * Personnel record * Accountant record * Evaluation report * Questionnaire	Allocation of budget for staffing and running cost from the Government of Pakistan
3. Establishment of referral model in ICT 3-1 To improve awareness of community 3-2 Early detection of high risk at home 3-3 Improve transportation 3-4 Training of health staff in BHUs and RHCs 3-5 Appropriate response by referral hospitals 3-6 Coordination among concerned authorities	3-1 * KABP of the community * Utilization of facilities 3-2 * Number of referrals 3-3 * Number of users 3-4 * Performance and practice 3-5 * Number of referrals * Patient's satisfaction 3-6 * Number of trainees	* Evaluation report * Health facilities record * Health facilities record * Usage record * Performance record * Facility record (MCH center) * Forms/questionnaire * Monthly meeting with DHO ICT	Support from each province Continuation of LHW program



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TRAINING PLAN

TRAINING COURSES AT MCH CENTRE :

1. REFRESHER TRAINING COURSES

A) Four Days Course for TBAs : *(Language : Urdu)*

- DAY-I : Haemorrhage
- DAY-II : Eclampsia
- DAY-III : Sepsis, Chronic Medical Disorders & Hygiene care of the new born
- DAY-IV : Maternal Health Education Birth Spacing

B) One Day Course for LHWs :

- Maternal Health Education
- Birth Spacing

C) Four Day for LHVs & Nurses :

- DAY-I : Haemorrhage
- DAY-II : Standard Intensive Obstetric Care
- DAY-III : Sepsis, Chronic Medical Disorders & Hygiene care of the new born
- DAY-IV : Maternal Health Education Birth Spacing

D) One Day Course for General Practitioners (GPs & WMOs) :

- Role of General Practitioners
- Guidance for Management of high risk
- When to Refer
- Alert & Action Symptoms

2. INTENSIVE COURSES

Two Day Courses for Specialists. Same subjects with emphasis on management.

- DAY-I : Haemorrhage, Eclampsia
- DAY-II : Sepsis, Chronic Medical Disorders & Hygiene care of the new born Maternal Health Education Birth Spacing

3. SYMPOSIA :

a) **One Day Symposium on Specific Subject of Gynae/Obs**

- Labour Ward Management
- High Risk Pregnancy Management
- maternal Health Education
- Maternal Mortality & the Role of Gynaecologist in reducing its rate

b) **One Day Symposium (Neonatal)**

- Resuscitation of new born
- Neonatal Care of Obstetrics

4. COURSES ON TEACHING METHODOLOGY

Courses for Master Trainers (Doctors & Nurses) :

- Teaching Methods and Materials
- Curriculum

ANNUAL TRAINING PROGRAMME :

No. of Courses	I (3m)	II (3m)	III (3m)	IV (3m)
TBA	4 Days	4 Days	4 Days	4 Days
LHW	1 Days x 3	1 Days x 3	1 Days x 3	1 Days x 3
LHVs & Nurses	4 Days	4 Days	4 Days	4 Days
GPs & WMOs	1 Days x 3	1 Days x 3	1 Days x 3	1 Days x 3
Specialist Intensive	4 Days	4 Days	4 Days	
Symposia	1 Days	1 Days	1 Days	1 Days

INTENSIVE TRAINING COURSES FOR SPECIALISTS :

WHO SHOULD ATTEND ?

1. Specialists
2. Post Graduates for FCPS, MCPS
3. General Practitioners

- *Depending upon the number and the needs of the participants individualised group courses to be arranged*

INTENSIVE TRAINING COURSES FOR SPECIALISTS :

DAY - I :

- Role of Specialists
- Experience from Asian countries
  - Bangladesh
  - India
  - Sri Lanka
- Mortality Studies
- Morbidity
- Severe morbidity - Nearmiss
- How can we decrease mortality related to haemorrhage
- Measures to decrease primary PPH
- Update on active management of 3rd stage
- Blood transfusion & Blood products
- DIC
- Referral

DAY - II :

- Sepsis
  - Aseptic technique
  - Method of Sterilization
  - Role of immunization
  - Recognition of chronic medical disorders
  - Sensitisation to treatment of prolonged fever & its common causes
  - Investigation
  - Management of Sepsis
- Eclampsia
  - Causes of Pregnancy induced hypertension
  - Current concepts in
    - Aetiology
    - Management
- Update on contraception
- Resuscitation of new born
- Nearmiss concept
  - Role of medical personnel at each level

COMMUNITY CARE PROVIDERS :

TBAs (Traditional Birth Attendants) :

- Community Female Care Takers
- Home Deliveries

LHWs (Lady Health Workers) :

- Local medical care takers from the community
- 3 months training course

LHVs (Lady Health Visitors) :

- Trained (2 years)
- One year midwifery & One year general health

GPs (General Practitioners) :

- Private Setup in the community

WMOs (Women Medical Officers) :

- Private & Rural Health Centres (RHCs)

REFRESHER COURSE FOR LHV's AND TBA's

2 Day Focus Training Programme

(GUIDELINES FOR HOME DELIVERIES)

DAY-I :

Haemorrhage :

PPH :

- Risk factors for retained placenta on history
- Understanding of physiology
  - Normal mechanism of separation of placenta
- Role of Drugs :
  - Ergometrin
  - Syntocinon
- Management of 3rd stage of labour
  - How long to wait for separation of placenta?
  - When to transfer/ask for help ?
  - Alert symptoms
  - Action symptoms
- Secondary PPH & Referral

APH :

- Assessment of the general condition of mothers
- Amount of bleeding
- Diagnosis of the cause on history and examination
- Importance of avoiding vaginal examination
- Action & Referral

Abortion :

- Knowledge of types
- Risk of induced abortion
  - Infection
  - Haemorrhage
- When to refer ?

DAY - II :

Eclampsia :

- High risk identification
- Symptoms
- Emergency management during convulsion
- General management
  - Maintenance of respiration
  - Nursing care and positioning
  - Drugs avoided
- Referral
- Complications and their significance
- Role of magnesium sulphate

DAY - III :

SEPSIS :

- Aseptic technique during delivery (cord clamping and hand washing)
- Complications of sepsis
- Symptoms
  - Fever
  - DIC
- Timely Referral
- Chronic Medical disorders
- Hygiene
- Care of New born

DAY - IV :

- Maternal Health Education
- Birth Spacing

TRAINING COURSES AT MCH CENTRE :

MATERNAL HEALTH EDUCATION :

Antenatal Care :

- Self check-up(Anemia, Oedema)
- Advice for daily life (Exercise for shape-up)
- Precaution during pregnancy (Personal hygiene, smoking, intake of medicine with out consultation
- Nutrition
- Regular antenatal check-up (From any health unit)
- Vaccination (T.T.)
- Birth spacing

Postnatal Care :

- Maternal Care
- Self observation by mother(perennial care, any offensive discharge, contraction of uterus)
- Nutrition
- Care of new born(Resuscitation for Nurses, LHV, TBA only)
  - Breast feeding and care of breast
  - Care of umbilical card
- Immunization
- Birth Spacing

④ カウンターパートとの協議議事録

MEETING WITH THE COUNTERPARTS OF MCH PROJECT

Date : December 17, 1997
Time : 10.00 a.m.
Venue : Conference Room of Executive Director's Office,
Pakistan Institute of Medical Sciences, Islamabad

A Meeting was held in the Conference Room of Executive Director's Office at PIMS to introduce and explain the activity of the counterparts of MCH Project. The Agenda of the Meeting was as follows ;

AGENDA

1.	Introduction of Pakistani Counterparts/ Participants and their Role in MCH Project	Dr. Asif Mahmood Deputy Executive Director, PIMS
2.	Introduction of Japanese Counterparts/ Participants	Dr. Tamotsu Nakasa Chief Advisor MCH Project
3.	Introductory Address	Prof. Mahmood Ahmed Executive Director/Project Director PIMS
4.	Discussion : ■ Management of MCH Centre ■ Budget of MCH Centre ■ Staffing of MCH Centre	
5.	Closing Remarks	Prof. Mahmood Ahmed Executive Director/Project Director, PIMS

PARTICIPANTS

PAKISTANI SIDE :

- Prof. Mahmood Ahmed
  (Executive Director/Project Director, PIMS)
- Dr. Asif Mahmood
  (Deputy Executive Director, PIMS)
- Prof. K. A. Abbas
  (Professor of Paediatrics, Children's Hospital, PIMS)
- Prof. Ghazala Mahmud
  (Consultant Surgeon & Head, Department of Gynae/Obs, PIMS)
- Dr. S. Batool Mazhar
  (Associate Surgeon, Department of Gynae/Obs, PIMS)
- Dr. Gul N. Rehman
  (Registrar, Children's Hospital, PIMS)
- Ms. Mumtaz Begum
  (Nursing Superintendent, Children's Hospital, PIMS)
- Ms. Athar Sayed
  (Social Scientist, MCH Project Office, JICA)
- Mr. Zaheer Adnan
  (Social Welfare Officer, Children's Hospital, PIMS)
- Dr. Shamsa Zafar
  (Registrar, Department of Gynae/Obs, PIMS)
- Dr. Sofia N. Sheikh
  (Research Physician, MCH Project Office, JICA)
- Ms. Nasreen Bajwa
  (Nutritionist, PIMS)
- Ms. Nilofer Ghani
  (Staff Nurse, Children's Hospital, PIMS)
- Ms. Nasim Sohail
  (Head Nurse, Department of Gynae/Obs, PIMS)
- Ms. Anis Fatima
  (Charge Nurse, Department of Gynae/Obs, PIMS)
- Ms. Fazilat un Nisa
  (Lecturer, College of Nursing, PIMS)

JAPANESE SIDE :

- Dr. Takefumi FUKAHARA
  (Leader of JICA Advisory Team)
- Dr. Katsuhiro YOSHITAKE
  (Member of JICA Advisory Team)
- Ms. Yoko KONISHI
  (Member of JICA Advisory Team)
- Ms. Yukari ONO
  (Member of JICA Advisory Team)
- Dr. Tamotsu Nakasa
  (Chief Advisor, MCH Project)
- Mr. Akira Naruse
  (Project Coordinator, MCH Project)
- Ms. Mari Chitose
  (Nutrition Expert, MCH Project)
- Dr. Shuzo Kanagawa
  (Paediatrician, Short Term Expert, MCH Project)

MINUTES IN BRIEF

INTRODUCTORY COMMENTS BY EXECUTIVE DIRECTOR

Welcoming the Japanese Mission E.D introduced himself briefly and then the Deputy Director Dr. Asif Mahmood introduced the Pakistani Counter Parts to the Japanese Mission.

Dr. T. Nakasa Chief Advisor JICA MCH Project introduced the Japanese Mission and the Japanese mission and the Japanese staff to the participants of the Meeting Dr. Nakasa requested the chief of the Japanese mission to explain the objectives of the visits.

DR. TAKEFUMI FUKUHARA

Explaining the objectives of the Japanese Advisory Mission, Dr. Takefumi FUKUHAR the leader of the mission said that he is very glad for being here. This was his first visit to Pakistan. Japan and Pakistan have a long history of co-operation. MCH is a very important project and the purpose of MCH project is to secure safe delivery and training of personnel in MCH activities. Other characteristic of this project is technical co-operation is integrated with the grant aid co-operation.

The purpose of the mission's visit is to discuss the important issues pertaining to budget and staffing, as the MCH building phase I is going to be completed in April 1998.

He further explained that as the head of International Medical Co-operation he has to look after budget and to know the actual situation of the project and to exchange views with the Pakistan Counterparts.

ADDRESS BY EXECUTIVE DIRECTOR

Executive Director/Project Director Dr. Mahmood Ahmed, welcomed the guests and describe observations of his own visit to Japan in Comparison with Pakistan. While explaining the statistical situation of Health related to staff in Japan with Pakistan. The statistics given by E.D. are as follows:

JAPAN	PAKISTAN
- 200,000 Doctors working in Japan	- 7,000 Doctors working in Pakistan
- 400,000 excellently trained Nurses in Japan	- 30,000 Nurses working in Pakistan officially while actually there are only 10,000 nurses working in Pakistan.
- 24,000 highly trained technician in Japan	- 4,000 technicians working in Pakistan

While address ED/PD emphasis the role of MCH as a training facility for Doctors, Nurses, Midwifes as well as providing health care to the women. E.D. emphasised that it is our duty to provide good medical care to the women.

While discussing the maintenance and other matters, which he has discussed with Ministry of Planning and development, the maintenance cost per year will be around Rs. 60 million. As in the new health policy the hospitals will be given more autonomy then we will be able to generate Rs. 30 million year, that is after 4 years of commissioning of the MCH. As MCH is a place where every body come happily and cheerfully and that is why they are ready to pay. Our Government is happy to start the MCH from next year.

He further informed the participants that they have problem of trained Nurses and other medical personal. We will start with the training immediately.

QUESTIONS BY JAPANESE MISSION

The Japanese Advisory Mission inquired that what is an existing training system in Pakistan and who can you develop a training system all over the country. In response to the questions, the method to develop a role model for training in MCH Centre was discussed CMH Centre will be made a seat of training a Master trainers from all the provinces of Pakistan and for that purpose the medical personal from all the others area will be called for training which is return, when they go back to the periphery they will train the medical staff or try to set up the small model of MCH in their respective areas. The MCH training centre will be a model of training institute.

The mission asked whether present counter parts who work for the project and carried out surveys will be assigned in MCH Centre. The ED/PD answered that initially every one will be assigned in the MCH Centre.

TRAINING FACILITIES

The second phase of the building, which is our outpatient department (OPD) when commissioned will be OPD at ground level and training Institute at 1st floor, which will have a huge auditorium (for 150 persons) and five class rooms for 60 persons each.

In the first phase, at the end of each unit there is a room which can accommodate about 30 persons for lectures, this will help facilitate on the spot training of the personal. 70% of the training will be practical and 30% will be lecture.

ADMISSION SYSTEM

This requires a full time training co-ordinator to co-ordinate the:

- Application system
- Selection system
- Schedules

MONITORING SYSTEM

Logistically it is not feasible to call all the people from the province, therefore the Master Trainers will be called for training. A system is to be developed to monitor and get the feed back from the field.

AUDIO-VISUAL AIDS

In the training centre development of audio visual educational materials is very important and the proper display of Education materials in the waiting areas to educate the women visiting MCH Centre.

TRAINING DIVISION AND STAFF

In the organisational chart training division is made the part of administration. But it is not training is a separate set up from the administration and clinical. At present the staff is inadequate and more staff and specialists are required. If one specialist is busy with the clinical side/wards, the other can go for the training's.

The mission requested to develop detail organization and staffing of the training division based on the training plan including audit system. IEC and statistic section and specialist for training uneducated people such as TBA's.