

Community participation eludes Pakistan's maternal, newborn and child health programme

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المساهمة المجتمعية تتفقت من برنامج صحة الأمهات والولدان في باكستان تسليم أخت، زوهيب خان، ساميار عوف

الخلاصة: تدرس هذه الورقة مدى شمولية أسلوب الرعاية الصحية الأولية في برنامج صحة الأمهات والولدان والأطفال في باكستان والذي انطلق عام 1997. وتتضمن طريقة الدراسة استعراض وثائق الدلائل الإرشادية في البرنامج، وإجراء مقابلات معمقة مع المديرين والمشاورين، وإجراء مناقشات في مجموعات من المجتمع المحلي ومن مقدمي الخدمات. ويطبّق برنامج صحة الأمهات والولدان والأطفال في باكستان نموذجاً أولياً مختاراً، ويؤدي مديرو البرنامج ومستشاروه قلقهم حول جودة التدريب والتدخل السياسي والتنفيذ غير المستكمل؛ كما أن مقدمي الخدمة لم يعملوا بعضهم مع بعض كما هو متوقع. واشتكت القابلات المجتمعيات من ما لدى المجتمع المحلي من تصورات نحوهن. ولم يكن أعضاء المجتمع المحلي على علم بتنفيذ البرنامج في المناطق التي يعيشون فيها. ويحتاج برنامج الصحة الأولية في باكستان للمراجعة وللتنقيح وفق الطريقة التي يفكر بها الناس حالياً حول مدى إسهام المجتمع والتعاون بين القطاعات من أجل تسريع وتيرة التقدم صوب بلوغ المرميين 4 و5 من المرامي الإنمائية للألفية.

ABSTRACT This study looked at the comprehensiveness of the primary health care approach being applied in Pakistan's National Maternal, Newborn and Child Health (MNCH) Programme launched in 2005. The methods included a review of the programme's guideline documents, in-depth interviews with managers/advisors and focus group discussions with community groups and service providers. The MNCH Programme is applying a selective primary care model. Programme advisors and managers were concerned about the quality of training, political interference and incomplete implementation. Service providers were not working together as envisioned. Community midwives complained about the community's perceptions of them. Community members were unaware of MNCH Programme implementation in their areas. Pakistan's primary health care programme needs to be reviewed and revised according current thinking on community participation and inter-sectoral collaboration to accelerate progress towards achievement of Millennium Development Goals 4 and 5.

La participation communautaire absente du programme de santé de la mère, du nouveau-né et de l'enfant au Pakistan

RÉSUMÉ La présente étude a examiné le caractère exhaustif de l'approche des soins de santé primaires actuellement appliquée au sein du programme national de santé de la mère, du nouveau-né et de l'enfant qui a été lancé en 1997 au Pakistan. La méthode employée comprenait un examen des lignes directrices, des entretiens approfondis avec des administrateurs et conseillers ainsi que l'organisation de groupes de discussions avec les groupes communautaires et les prestataires de services. Le programme de santé de la mère, du nouveau-né et de l'enfant applique un modèle de soins primaires sélectifs. Les conseillers et administrateurs du programme étaient inquiets au sujet de la qualité de la formation, de l'ingérence politique et de la mise en œuvre incomplète du programme. Les prestataires de services ne travaillaient pas ensemble, comme il avait été initialement prévu. Les sages-femmes communautaires se sont plaintes de la perception de la communauté vis-à-vis de leur profession. Les membres de la communauté n'avaient pas connaissance de la mise en œuvre du programme de santé de la mère, du nouveau-né et de l'enfant dans leur région. Le programme de soins de santé primaires du Pakistan doit être examiné et révisé conformément à la pensée actuelle en matière de participation communautaire et de collaboration intersectorielle afin d'accélérer les progrès en vue de la réalisation des objectifs du Millénaire pour le développement 4 et 5.

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Introduction

Primary health care (PHC), as envisioned at the Alma-Ata international conference, explicitly outlined a comprehensive strategy that emphasized health promotion and disease prevention, community participation, self-reliance and intersectoral collaboration [1]. Experts at the time, however, considered comprehensive PHC as idealistic and too expensive for developing countries, and favoured a disease-focused, selective approach to PHC [2]. This is the approach applied in Pakistan's health policies and strategies. There is evidence now that the selective approach has failed to deliver, and there have been calls for revisiting the comprehensive PHC approach [3]. The World Health Organization's (WHO) *World Health Report 1998* underscored the role of PHC in addressing growing health inequities and emphasized community participation, a multisectoral approach and appropriate technology as the 3 prerequisites for the success of the PHC system [4]. The *World Health Report 2008* advised countries to adopt comprehensive PHC and make their health systems people-centred and participatory [5].

It is now widely accepted that community participation is necessary for achieving health service sustainability [6–8], as a means to cost-effectively achieving project objectives and as an empowerment tool enabling communities to take control of their own development [7]. Assessing the role of community participation in achieving health improvements is an ongoing challenge, largely due to the multiplicity of definitions [9]. Indicators of successful participation include interest in participation, communication and information transfer, responsiveness, motivation, accountability, sustainability, control over resources and experience of participation [10].

Pakistan has implemented a succession of programmes to improve the health indicators of its population and has recently accelerated its efforts to achieve Millennium Development Goals (MDGs) 4 and 5 to reduce child mortality and improve maternal health [11]. The results are modest and the country is not likely to achieve MDGs 4 and 5 by 2015. Furthermore, there is little quality data from within the country to identify the factors impeding the performance of maternal and child health programmes. The study reported here was undertaken with the aim of determining the level of community participation achieved in the Government of Pakistan's National Maternal, Newborn and Child Health (MNCH) Programme launched in 2005 [12,13]. This Programme aimed to accelerate progress towards achievement of MDGs 4 and 5 by achieving functional integration of all the ongoing maternal and child health programmes with the overarching goal of improving accessibility to quality MNCH services. A key strategy of the Programme was the introduction of a new cadre of community health workers called community midwives (CMWs). Our study aimed to assess the effectiveness of the Programme's implementation strategies in introducing this new and unfamiliar cadre to the community and in promoting their acceptance and utilization by the community.

Methods

Study design and setting

The study was undertaken in the Mardan district of Khyber Pakhtunkhwa province. Data were collected from July to August 2011 through in-depth interviews and focus group discussions (FGDs). The research team included a qualitative research consultant (female), 2 lecturers in public health (female)

and an assistant director of research and development (male) at Khyber Medical University. The consultant trained and supervised the research team.

Data sources

Data sources included MNCH Programme guideline documents; advisors, managers and service providers; women who had delivered babies during a defined 6-month period and mothers-in-law of the women; and members of the community whose opinions and practices influenced other community members (community opinion-makers). Service providers included the new CMWs, as well as lady health workers (LHWs) and lady health visitors (LHVs). Community opinion-makers included politicians, landowners, government officials, schoolteachers, religious teachers, journalists and women entrepreneurs.

Data collection

Table 1 outlines the objectives, methods and sample selected for the study. FGDs were undertaken with the following groups: LHWs; LHVs; female opinion-makers; male opinion-makers; and poor mothers and mothers-in-law (defined according to monthly income of < Rs 5000, quality of house, ownership of house, known to be poor by local field assistants). A total of 14 FGDs were undertaken with 94 participants. One team member moderated the discussion and one made handwritten notes. A total of 15 in-depth interviews with policy-makers and managers were completed; 13 were face-to-face and 2 were telephone interviews. Three interviews were done with CMWs with whom a planned FGD could not be arranged owing to their absence from their assigned areas.

The following MNCH Programme policy and strategy documents were examined:

Table 1 Objectives, methods and sample selected for the study to assess the effectiveness of the implementation of Pakistan's Maternal, Newborn and Child Health (MNCH) Programme

Objectives	Data type	Sample
<ul style="list-style-type: none"> Determine the role assigned to the community in the CMW Programme policy, planning and implementation strategies 	<ul style="list-style-type: none"> Secondary data: document search and analysis 	<ul style="list-style-type: none"> Guiding documents identified in Research and Advocacy Fund document <i>Maternal and newborn health—the policy context in Pakistan</i> [13]
<ul style="list-style-type: none"> Assess the perceptions of Programme policy-makers and managers towards the role of the community in the Programme Record managers' views and suggestions for establishing the role of the community in the Programme Evaluate the criteria used for candidates' selection for training as related to sociocultural norms and practices Determine community representation in the structures established for implementation of the CMW programme—selection methods, supervision and monitoring Determine the role assigned to the community in conflict resolution and accountability of CMWs Identify the different mechanisms in place for pay and incentives to CMWs 	<ul style="list-style-type: none"> Qualitative data: in-depth interviews with health and MNCH Programme managers and health and population professionals associated with MNCH Programme 	<ul style="list-style-type: none"> Available health and MNCH Programme managers. Other professionals associated with MNCH Programme were identified by Programme managers Planned to interview 18 people; interviewed 15 (national MNCH Programme managers became unavailable owing to devolution; provincial MNCH Programme managers were unavailable owing to an official inquiry)
<ul style="list-style-type: none"> Get feedback from CMWs regarding community's attitudes, acceptability and utilization of their services Record CMWs' views and suggestions on community participation 	<ul style="list-style-type: none"> Qualitative: FGD with a group of 10–12 CMWs (not done) 	<ul style="list-style-type: none"> No group was selected owing to absence of CMWs in the study union councils
<ul style="list-style-type: none"> Determine the status of CMWs in the community Record community's perspectives on its role in the CMW programme Document community suggestions about institutionalization of the CMW programme 	<ul style="list-style-type: none"> Qualitative: FGD with community groups, LHWs and LHV.s. 	<ul style="list-style-type: none"> 14 FGD done: 4 with women opinion-makers; 4 with male opinion-makers; 2 with poor mothers and mothers-in-law; 2 with non-poor mothers and mothers-in-law; 1 with LHWs; 1 with LHV.s
<ul style="list-style-type: none"> Compare the level of satisfaction of mothers with the care provided by CMWs and other MCH providers Get feedback from relevant stakeholders in the community on the quality and cost of care provided by the CMWs and other service providers 	<ul style="list-style-type: none"> Quantitative: women who had deliveries after CMWs were deployed. FGD with mothers and mothers-in-law. 	<ul style="list-style-type: none"> All women who delivered in the period 01/10–31/03/11 were identified and selected for interviews. Total 757 women

CMWs = community midwives; LHWs = lady health workers; LHV.s = lady health visitors; MCH = maternal and child health; FGD = focus group discussions.

National Health Policy 2001; Population Policy 2002; Ten-Year Perspective Development Plan 2001–2011; National MNCH Communication Strategy Framework; and MNCH Programme Planning Commission 1 (PC-1) document. After devolution of health to the provinces in 2012 and integration of the national MNCH Programme into the provincial health sector these

documents are no longer available online, although a mid-term evaluation of the Programme has been published [13].

Data analysis

The conceptual framework given in Table 2 was developed to guide data analysis as regards levels of community participation. The framework

for document analysis included a statement about the perceived need for community participation, conceptualization and definition of community participation, the level of participation aimed to be achieved and the objective to be achieved through participation. Data from other sources were analysed for opinions and perceptions of the MNCH

Table 2 Conceptual framework of levels of community participation in health programmes

Level of participation	Process	Outcome
Ownership (the ideal) ↑	Community takes full responsibility as owner and implementer. Government becomes facilitator	Full community empowerment for decision-making/self-reliance
Partnership/ contribution ↑	Community recognized as a partner. Community contributes to costs and infrastructure	High level of empowerment. Community involved in decision-making
Involvement ↑	Community recognized as facilitator involved in selection, monitoring, security and accountability	Community empowered to a limited extent
Awareness ↑	Community recognized as a utilizer of services only	Community becomes "aware utilizer" of services
Passive utilization ↑	No recognition of community role. Community is passive utilizer of services	No community empowerment

Programme and the role of the community in PHC programmes.

Results

The data analysis was explored in 4 themes: guideline documents; MNCH Programme advisors' and managers' perspectives; service providers' perspectives; and opinion-makers' perspectives.

Theme 1: Commitment to and conceptualization of the PHC approach & community participation in MNCH Programme guideline documents

The MNCH Programme guideline documents showed a disconnect between vision, goals and strategies. The *National Health Policy 2001* takes the Health for

All goal as its vision and PHC and gender equity as major areas of focus. The policy fails to define either of these concepts and its 10 target areas are focussed on technical strengthening of health services at the primary and secondary levels. No explicit mention of community participation is made (Table 3). Dissemination of information, development of interpersonal skills of community-based workers and participation of civil society organizations are mentioned as strategies for creating mass awareness on "public health matters". There is no mention of any collaboration of the MNCH programme, developed and implemented by the Ministry of Health, with the functionally related Population Welfare Ministry, which had overlapping responsibilities towards reproductive health and population control.

Analysis of the document *Population Policy 2002* showed that the policy is "designed to achieve social and economic revival by curbing rapid population growth and thereby reducing its adverse consequences for development". Important strategies include integration of reproductive health services with family planning. Community participation is limited to awareness creation.

The *MNCH Policy and Strategic Framework* document lists "lack of community involvement in planning, implementation and accountability" and "emphasis on biological determinants and not on cultural and social aspects" as key governance issues but the recommended strategies fail to address these concerns. Community participation is limited to awareness creation.

Table 3 Commitment to and conceptualization of community participation in Pakistan's National Maternal, Newborn and Child Health (MNCH) Programme guideline documents

Document	Felt need for participation	Concept and definition	Level of participation envisioned	Objective to be achieved through participation
National Health Policy 2001	Nil	Nil	Awareness creation	Behaviour change and enhanced utilization of services
Population Policy 2002	Nil	Nil	Awareness creation	Increased contraceptive use
MNCH Policy and Strategic Framework 2005	Stated	Nil	Awareness creation	Utilization of services
National MNCH Communication Strategy	Stated	Nil	Awareness creation and community involvement	Utilization of services and behaviour change
National MNCH Programme PC-1	Stated	Nil	Awareness creation and community involvement	Utilization of services and behaviour change

PC-1 = Planning Commission 1.

Table 4 Implementation of Pakistan's National Maternal, Newborn and Child Health (MNCH) Programme Planning Commission 1 (PC-1) strategies: selection of community midwives (CMWs) and coordination with lady health workers (LHWs)

PC-1 strategies	Implementation status
Selection of CMWs	
CMWs shall be selected from rural areas	<ul style="list-style-type: none"> • Candidates are selected from urban areas based on: <ul style="list-style-type: none"> • False documents • Political influence • Interest in monetary benefits by politically selected candidates
Female, preferably married, will be selected	<ul style="list-style-type: none"> • There are few suitable candidates • "There is no sincere effort" • Politically selected candidates are unmarried • Unmarried women leave assigned location after marriage
Overall impression of the selection process	<ul style="list-style-type: none"> • Selection criteria are not followed • There is political interference • Stipend of Rs 3500 of trainee CMWs is the reason for political interference • "If the provincial managers are politically appointed, how can it be expected that they will not to be influenced politically in the selection of CMWs?"
Coordination between CMWs and LHWs	
LHWs will introduce the CMWs to the community and refer cases to them	<ul style="list-style-type: none"> • LHWs did not know the CMWs working in their assigned areas • CMWs reported lack of cooperation from LHWs
LHWs and CMWs will develop referral and transport networks in collaboration	<ul style="list-style-type: none"> • Professional jealousy reported between LHWs and CMWs • LHWs wanted to become CMWs • LHWs attended deliveries
LHWs and CMWs will hold planning workshops supported by experts from MNCH Programme to mobilize the community for establishing referral and transport linkages	<ul style="list-style-type: none"> • These workshops were not held: <ul style="list-style-type: none"> • Money was not released • District-level MNCH Programme managers did not have capacity to lead this community-oriented process

PC-1 = Planning Commission 1.

The *MNCH Programme Planning Commission 1* document involves the community in the verification process of applicants and selection for CMW training. The document also prescribes the holding 5-day planning workshops at district level to mobilize the community for establishing referral and transport linkages.

Theme 2: MNCH Programme advisors' and managers' perspectives on the adequacy of the MNCH Programme strategy and implementation mechanisms and on community participation

All the MNCH Programme advisors and managers were satisfied with the role given to the community in the MNCH Programme documents and strategies. The 2 district level managers expressed concerns about

political interference, quality of training and issues related to the integration of MNCH services at the district level. They also revealed the issue of non-payment of salaries to deployed CMWs and delays in the release of funds for programme implementation.

Theme 3: Service providers' perspectives regarding MNCH Programme and community participation in the Programme

Service providers were concerned about the selection process for CMWs and the integration of MNCH at the district level (Table 4). The selection process was reported to be in violation of criteria detailed in the *MNCH Programme PC-1* document. LHWs expressed ignorance about the presence of CMWs, and

CMWs reported lack of cooperation from LHWs.

Theme 4: Community awareness about MNCH Programme and views on their role in PHC programmes

Most opinion-makers expressed ignorance about the implementation of MNCH Programme in their areas. One participant, who knew a CMW, reported that she was working with an NGO and not in her assigned area. A women participant had a good opinion of a CMW she knew and according to her, "CMWs deal kindly with all sorts of patients whether rich or poor, and their behaviour is good with everyone". Not much knowledge or perspective emerged as regards the community's role in health programmes. The participants mostly expressed their needs

and expectations. These included accessibility, affordability, compassion from services providers and respect for patients' privacy.

Discussion

This study found many issues in Pakistan's MNCH Programme that are likely to impede the achievement of the programme's objective of achieving MDGs 4 and 5. The Programme is focussing on increasing the number of skilled birth attendants, availability of technology and management improvement. Community participation is limited to awareness creation. Even this selective PHC approach is not being implemented effectively. Integration of MNCH services has not happened. A situation of competing interests has developed among LHWs, LHV's and CMWs. The Programme premise that these service providers will work in coordination has proved erroneous because they have overlapping skills and roles. This issue was identified in a study in Karachi which advised that clearly defined roles should guide the work of community-based workers [14].

The issue of payment of salaries to CMWs is emerging as a threat to the sustainability of the programme. Who should be paying community health workers such as the CMWs is an unresolved issue. Community health workers are usually volunteers selected by the community and accountable to the community. If the government pays them, their accountability to the

community cannot be assured. However evidence from other south Asian countries shows that if they are not paid a regular salary they are likely to stop working [15]. Our study verifies this concern. There is a need for resolving this dilemma through consultations and testing of models for community health workers remuneration.

The reported political interference in the MNCH Programme is another unresolved governance health-care issue especially in developing countries [16]. Although the problem is widely known and criticized, there is little research on the issue. The reported influence on the selection of MNCH Programme managers and CMWs by politicians is likely to negatively affect their acceptance by the community and their accountability to the community. This in turn is likely to compromise the effectiveness of the MNCH programme. Our findings regarding the management issues of the MNCH Programme are mirrored in the Oxford Group 2009 review of Pakistan's National Programme for Family Planning and Primary Health Care [17]. The review found incomplete implementation of the directions and key activities of the strategic plan and PC-1 of the Programme owing to absence of strategic review mechanisms and high management turnover.

Conclusions

From this study it can be concluded that Pakistan's MNCH Programme is performing sub-optimally. The Programme is rooted in the selective PHC

approach, with a focus on technologies and service provision. Pakistan's health policy-makers, planners and managers need to familiarize themselves with the current thinking on PHC, promoting the 3 essential approaches: community participation, intersectoral collaboration and evidence-based decision-making. The current PHC programmes need to be reviewed and revised accordingly to accelerate progress towards the achievement of the MDGs.

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