

Obstetric Services in Pakistan: Where are we and what is the way forward?

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Pakistan is one of the six countries which together contribute to 50% of global maternal deaths. In Pakistan, the maternal mortality ratio was 276 per 100,000 live births in 2006-7 with annual estimate of 16,500 maternal deaths occurring nationally.¹ Worldwide, maternal death occurs during childbirth in 11-17% of cases while 50-71% cases occur in the post partum period and majority of these are avoidable. The largest proportion of such deaths are caused by obstetric hemorrhage, followed by eclampsia, sepsis, complications of unsafe abortion and indirect causes including malaria, cardiac and liver diseases. Illiteracy, multiparity, extremes of age and gender discrimination aggravate this situation.

In September 2000, all 191 UN member states committed to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women in the United Nations Millennium Declaration. The eight Millennium Development Goals (MDGs) are derived from this Declaration.² The MDG 5, related to improving maternal health, aims to reduce maternal mortality ratio by two thirds by the year 2015. For Pakistan, the target is reduction of MMR to 140 maternal deaths per 100,000 live births. The indicators for monitoring MDG 5 include antenatal care coverage, proportion of deliveries attended by skilled health personnel, total fertility rate and contraceptive prevalence rate.

In Pakistan, female literacy, particularly among rural women, is among the lowest in the world with 65% being illiterate. The vast majority of women in Pakistan have no access to modern health services particularly during pregnancy and childbirth while family planning clinics are accessible to only 10

percent of the population. The quality of available services at Basic Health Units (BHU's) and Rural Health Centers (RHC's) remains unreliable. Moreover, the standards of services vary between facilities.³ The recent 18th amendment and devolution of subject of health to provinces has added to the conundrum.⁴

To increase women's access to health care, the Lady Health Workers (LHW) program was introduced in the mid-1990s. The home visits of these female fieldworkers have resulted in increased uptake of family planning and immunization, yet little change has been observed in antenatal visits or hospital deliveries. A minimum of four antenatal care visits are recommended to ensure that pregnant women receive the interventions they need to prevent and manage complications. The proportion of women receiving the recommended number of visits remains low.

In the provision of health care services, the private sector provides almost 80 percent of the outpatient services.⁵ Three quarter of households consult the private sector while only one quarter goes to the public sector. The total public sector budgetary expenditure in 2005-06 on health, 70% was spent on general hospitals and clinics, 18% on health facilities and prevention measures, and only 0.5 percent on mother and child health care facilities.⁶

The slow reduction in maternal mortality as presently noted in Pakistan is attributed to three main factors; namely the lack of skilled birth attendant, unsafe abortion and a low contraceptive prevalence rate. In a study of 105 Home Birth Attendants (HBA) done in Thatta, Sind, only 3% HBA's were literate and uterotonics to prevent and treat post partum hemorrhage (PPH) was unknown

or unavailable to them.⁷ Community midwives, a new cadre to ensure skilled birth attendance in the community, are currently being trained and deployed in all provinces.

About half of mothers received antenatal care during their last pregnancy while 70-80% of women in labor received no assistance from a skilled birth attendant during delivery. This trend was more so in the rural areas. Treating the conditions that result in the deaths of mothers, fetuses and many newborns e.g. obstructed labor, placental abruption, preeclampsia / eclampsia, intrapartum asphyxia usually requires high levels of diagnostic skills, and treatments typically available in hospitals. These interventions are collectively known as emergency obstetric and newborn care or EmONC. The 'three-delay' model explains the loss of maternal life related to transfer from community to facility with EmONC. The first delay is in the community, second delay is during transport while a third delay may occur at the facility before care is received.

In the Sind province, 12% of facilities opened for only 6 hours in a day while 24 hour cover was provided only by the district headquarters hospitals. Transport for referral was available at only 35% of facilities. Maternal mortality records were available in 55% while only 33% of public hospitals were equipped to offer obstetric care.⁸ Users consequently visited private hospitals for these services. Reports also indicate that in all provinces and Azad Jammu and Kashmir, many secondary and most primary referral facilities do not provide EmONC³ which is the key to saving maternal lives.

In addition to emergency and comprehensive care for delivery, post partum care, post abortion care as well preventive services like family planning, screening and treatment of STI need to be upgraded and ideally available under the same roof. In this regard, innovative programs in collaboration with various NGO's and multinational donors are in progress. These include the southern Punjab initiative of mobile phone linkage to delivery by the community health workers, post partum care project in Mandi Bahauddin of JHPIEGO. Unfortunately, most of these initiatives are donor driven and subsequently become unsustainable. According to

the Economic Survey of Pakistan (2005-06), the government spent only 0.75% of GDP on health sector.⁶ In this regard, a number of vertical and horizontal programs regarding health facilities are operative in Pakistan like the lady health worker (LHW) program, expanded program of immunization (EPI) etc.

Pakistan's health care system is inadequate comprising of an under-funded and inefficient public sector and an expensive and unregulated private sector. The overburden of public tertiary care facilities, limited number of beds, medicines, blood banks and disposables available in the public sector and lack of ICU Care for the serious maternal morbidities is again a serious matter that needs attention from the elected representatives, the civil servants, academicians, clinicians and public health experts. An emergency needs to be declared to achieve the targets of safe maternal, newborn and child health.

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