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Primary Health Care in Punjab: Learning from Bangladesh

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Introduction

The Punjab Growth Strategy 2018 emphasizes that improving the health status of citizens requires focus on primary and preventive healthcare. The key program embedded in the Medium Term Development Framework for achieving this includes upgrading of Basic Health Units (BHUs) and ensuring around the clock operation of selected BHUs by 2018.

In the past few decades, community involvement in healthcare provision has become increasingly prominent. Policy design informed by community needs has improved health coverage and effectiveness of public healthcare [1]. In Pakistan, the establishment of BHUs and introduction of Lady Health Workers (LHWs) [2] are the first steps towards enhancing community involvement in healthcare. However, there are many challenges.

Currently the BHUs are struggling to become an efficient means for delivering healthcare services. They are facing multiple issues ranging from low quality of medical staff to inadequate stock of medicines. Moreover, the community served by each BHU remains generally unaware of the facilities and vaccinations being provided by the unit and that often leads to underutilization of its services[3].

Learning from Bangladesh

Bangladesh has made significant progress in developing an effective rural healthcare delivery system. Dr. Zafrullah Chowdhary, a renowned health expert, helped set up the Gonoshasthaya Kendra (GK), a multi-faceted community and development program encompassing agricultural cooperatives, community schools, primary health care centers and hospitals and women's vocational training centers. In fact, the experience of GK was used as a key concept to frame the Alma Ata Declaration of the World Health Organization[4].

The Government of Punjab (GoPb), keen to learn from Dr. Chowdhary's initiative in Bangladesh, invited him to visit Punjab. He and a team from GK setup a model BHU in the Nankana district, by tailoring the Bangladesh experience to local conditions. It was agreed that based on the Nankana experience, a manual would be developed to replicate the model in the rest of Punjab.

[1] Community Involvement in Health Development: Challenging Health Services – World Health Organization, 1991

[2] Lady Health Workers are residents of the community in which they work and are trained to provide essential primary health services in the community and fulfill the unmet health needs in rural and urban slum areas.

[3] Punjab Health Sector Plan 2015

[4] http://international.uiowa.edu/files/international.uiowa.edu/files/file_uploads/CVZafrullahChowdhury.pdf

Findings of the Nankana Experience

The important findings regarding the current operation of BHUs are:

- The number of pregnant women in each area served by the LHWs was high.
- The LHWs had limited skills to provide care to pregnant women. This is a critical issue since, in order to reduce infant and maternal mortality, it is important to provide basic antenatal, delivery and family planning services along with health and nutritional education.
- The family planning workers such as Family Welfare Workers (FWW) and Family Welfare Assistants (FWA) were too few to have effective contact with prospective family planning clients for every union council.
- The family planning workers worked independently without adequate coordination with LHWs.
- Female education was very low in the communities being served by the BHU.

Based on these findings, the Bangladesh team initiated health camps and training sessions to improve the operationalization of the BHUs.

Health Camps to Improve Attendance

The Bangladesh team setup health camps within the communities where LHWs were posted. These health camps were setup at local LHW's houses, health houses, community houses or at public schools. The LHWs informed the community members about the health camps with the result that on an average 150 to 250 patients attended these camps every day. Several patients were referred to BHUs for further treatment, investigations and follow up.

These camps demonstrate the impact of awareness campaigns on improving utilization of BHUs. Following the introduction of these camps, the number of patients attending BHUs had doubled if not more.

Training Sessions

Training sessions geared towards capacity building were also conducted for all LHWs and Community Midwives (CMWs)[5]. They were in the form of field site trainings organized within the communities, focused primarily on pregnant mothers. The overall aim of these trainings was to address an important aspect of the supply side constraint in delivering health services in Pakistan, which is lack of skilled health staff in BHUs.

On each day, 4 to 7 LHWs were trained. The trainings focused on how to do a correct and complete checkup on pregnant women, and on how to deliver. The trainings also stressed on the need for hygiene and proper sanitation of hands before performing any procedure or checkup. Family planning methods and how mothers could be motived to use

[5] The Maternal Newborn and Child Health program introduced a new cadre of skilled birth attendants called "Community Midwives" (CMW). These are rural women from the same community as their clients, who are trained in antenatal, intra- partum, postnatal and newborn care.

these methods for spacing after delivery were also emphasized upon. Furthermore, the FWAs and FWWs were present during these sessions to ensure coordination with LHWs. To sustain the process of trainings in other regions, health technicians and the Lady Health Supervisors (LHS[6]) were trained as master trainers.

Recommendations from the Bangladesh Team

In the context of the team's observations and experience at Nankana, following actions are recommended to help improve the performance of the BHUs.

a) The LHWs must be further trained to equip them with necessary skills, essential for providing care to pregnant mothers in the community.
b) LHWs and FWAs must work in a concerted manner towards increasing the performance of family planning initiatives. The activities and mandates of both LHWs and FWAs need to be coordinated.
c) The capacity of the BHU should be upgraded to enable it to deliver improved diagnosis and consultation services.

Conclusion

Dr. Zafrullah Chowdhury's approach towards conducting these trainings was based on his experience in Bangladesh. His training methodology and focus on community involvement, if replicated successfully in the rest of the province, can potentially help reduce infant and child mortality in Punjab. Furthermore, the unavailability of diagnostic and other medical facilities in BHUs and the lack of skills to utilize them should be addressed, before a policy to operate BHUs around the clock is deemed feasible.

[6] Lady Health supervisors are recruited to provide supervisory support and ensure quality performance by the LHWs.