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Pakistan's National Action Plan for non-communicable diseases

A tripartite public-private partnership

Von Sania Nishtar

In Pakistan, a tripartite public-private partnership was developed among the Ministry of Health, the nongovernmental organization Heartfile and the World Health Organization. NGOs typically assume a contractual role. This was the first time an NGO participated in a national health program. The partnership developed a national integrated plan for health promotion and the prevention and control of noncommunicable diseases.

Most developing countries do not comprehensively address chronic diseases as part of their health agendas due to lack of resources, limited capacity within the health system and the threat that the institution of vertical programs pose in terms of weakening health systems and competing with other health issues. However an integrated partnership-based approach could obviate some of these issues.

Chronic non-communicable diseases are estimated to cause 35 million deaths worldwide annually; of these 80% occurr in the developing countries. (1) In Pakistan – with a population of 150 million2 – chronic diseases are among the top ten causes of mortality and morbidity and account for approximately 25% of the total deaths. (3,4) One in three adults suffers from high blood pressure; the prevalence of diabetes is reported at 10%, 54% men use tobacco in one form or the other whereas Karachi reports one of the highest incidences of breast cancer for any Asian population. (5,6,7,8)

However, as in most other developing countries, non-communicable diseases had not featured prominently on the country's health agenda until 2003 which is when the efforts of the NGO Heartfile led to the creation of a tripartite public-private partnership constituted by Ministry of Health, Government of Pakistan, Heartfile and the World Health Organization Pakistan office. (9) This led to the development of a public health plan of action – the National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan (NAP-NCD) – currently in its first phase of implementation. The impact of the Plan, in terms of changes in population outcomes can only be assessed over a period of time. However, in this article we share experiences about the process, the perceived merits and limitations; discuss

issues with its implementation, highlight the value that such partnership arrangements can bring in facilitating the missions and mandates of participating agencies and suggest options for generalizability.

A population-based approach

Developed in a three stage process, the National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan looked at non-communicable diseases in an expanded definition. Therefore in addition to conventional non-communicable diseases or diseases that are linked by common risk factors – cardiovascular disease, diabetes, cancer and chronic lung conditions – mental illnesses and injuries were also added to this framework. The first stage of the Plan's development involved planning within the individual streams of diseases; the second included priority setting whereas the third stage involved developing an integrated approach. (10) This was assisted by the Integrated Framework for Action – a tool which aims to identify areas for common action across the broad range of con-communicable diseases on the one hand and helps to set country targets at a process, output and outcome level on the other in addition to allowing an assessment of progress to be made in this direction. (11)

The Action Plan prioritizes a population-based approach to non-communicable diseases encompassing mass education, behavioural change communication, legislation, regulation, since these have the greatest potential to reduce non-communicable diseases risk and uphold the principles of equity given that the high risk approach may be inaccessible to the majority of the country's under-privileged population (12); 30% of Pakistan's population is below the poverty line of 1 US$ a day.

The first phase of implementation of the Action Plan focused on surveillance and behavioral change communication. The former included the setting up of an integrated population based surveillance system for NCD risk factors with models on population surveillance on injuries, mental health and stroke and program evaluation. (13) The latter focused on two approaches – an integrated behavioral change communication strategy through an electronic media intervention targeting 90% of the country's population on the one hand and incorporation of NCDs in the workplan of Lady Health Workers on the other. Lady Health Workers are Pakistan's field force of more than 70,000 grass roots level health care givers, who had, up then been involved with delivering reproductive health and communicable disease services, door to door in poor and under-privileged rural areas at the grass roots level covering 70% of Pakistan population. Heartfile had previously pilot tested this approach in one district by training 700 Lady Health Workers and introducing cardiovascular disease prevention as part of their work-plan. (14)

The second phase of implementation is envisaged to reorient health services to a more preventative orientation with a focus on training and capacity-building of health professionals, up-scaling of basic infrastructure and ensuring availability and access to certain drugs at all

levels of healthcare. Since healthcare delivery in Pakistan is characterized by a variety of roles played by different categories of healthcare providers, all will be drawn into the loop.

Merits

Within the public health system. By grouping non-communicable diseases and integrating actions, there is a shift from a vertical approach to diseases. By horizontally integrating actions with existing initiatives, it contributes to strengthening of the public health system whereas the integration of contemporary concepts such as the integrated models on surveillance and behavioral change communication will yield empirical evidence for emerging chronic disease programs in other low resource settings. The inbuilt evaluation mechanism of this model allows program assessment at a process and outcome level and an assessment of the level of contribution partners have made in achieving these objectives.

Engaging non-governmental organizations. In this model the NGO works in a nationally agreed framework. Non-governmental organizations and the civil society can contribute to achieving national goals; however this potential remains largely untapped. This model provides a mechanism for engaging non-governmental organization in the national decision making process and ensures their participation both in the formulation of health policy and implementation of national plans. The model will generate empirical evidence of relevance to the sustainability of non-governmental organizations in the developing countries, many of which are under funding constraints because of shifting donor focus on program aid as part of the Sector Wide Approach rather than project aid in which the civil society benefits directly. In this model, World Health Organization is gaining experience with a model where World Health Organization resources – which are otherwise, allocated for the public sector – support the private sector in a country model. The experience is also likely to yield evidence for other developing countries where tightly knit community structures and channels such as those created by primary health care and social welfare activities with out reach at the grass roots level can be conducive for advancing the chronic disease prevention agenda.

Limitations

Lack of procedural clarity. The initial stages of the program endured implementation challenges because of lack of procedural clarity in relation to public-private partnerships in the health sector within the country. Governments generally engage NGOs in a contractual mode. However as opposed to this approach, here was a case of a public-private engagement where the private sector partner lent impetus to the creation of the partnership, took active part in the decision making process and technically guided the design and implementation of the project. Such partnerships are known to create a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners; however, these also illustrate complex issues, as such arrangements bring together players with different interests and objectives, working within different governance structures. (15,16) The implementation of this project therefore underscored the need to establish principles and norms of such arrangements and policy, legislative and operational frameworks in order to obviate allied

ethical and procedural issues. It is envisaged that a firmer understanding of issues and clear articulation of polices will act as a bridge between the current mistrust between the public and the private sectors.

Bureaucracy as a bottleneck. Program implementation also gave insight into issues – widely perceived as implementation bottlenecks – which are generic to project implementation in a developing country bureaucracy. Key amongst these was onerous financial and administrative procedures and decision making delays. Lack of managerial authority, no accountability of the decision making process and lack of administrative efficiency in the public sector were observed to be important contributory factors to delays at the decision making and administrative levels – complicated by lack of performance-based incentives. These considerations highlight the need for strengthening institutional governance and accountability mechanisms.

Public sector: lack of capacity and motivation. In addition, it was observed that there was also a lack of capacity and/or motivation to deliver on stipulated targets within the public sector. Capacity issues at a human resource level were also complicated by low numbers for certain categories, migration of skilled workers, misdistribution of workforce, staff absenteeism, dual job holding, lack of motivation to perform and the proverbial brain drain – manifestations of the lack of economic opportunities and incentives often complicated by other factors. This warrants changes in the present arrangement of public and civil service operations, building performance-based incentives and creating a milieu to enhance performance.

Decentralisation issues. The implementation of this program also brought to the forefront, problems at the level of the federal-provincial interface particularly with reference to counterpart institutional arrangements, sharing of resources, issues with the ownership of federally led programs at the provincial level, the issue of provincial-district souring of relationships and the undue control that provinces exercise over fund-flows and personnel. These considerations warrant strategic and structural changes not only at the level of the public private interface but also broader governance and implementations arrangements in relation to public health programming in order to improve health outcomes.

An empirical basis for an integrated approach

Notwithstanding the before mentioned limitations, the National Action Plan for Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan serves as an empirical basis for an integrated approach to non-communicable diseases on one hand, and an experimental basis of health sector reform in the area of public-private collaboration on the other; most developing countries have limited approach with each. It also yields useful lessons for Ministries of Health, non-governmental organization and multilateral agencies for setting up non-communicable disease programs in the developing countries.

*Dr. Sania Nishtar; SI, FRCP, PhD, Founder and President of Heartfile, Islamabad, Pakistan. Contact: sania@heartfile.org, www.heartfile.org.

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Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Route de Ferney 150
CP 2100
CH-1211 Genève 2
Tél. +41 22 920 08 08
contact@medicusmundi.ch