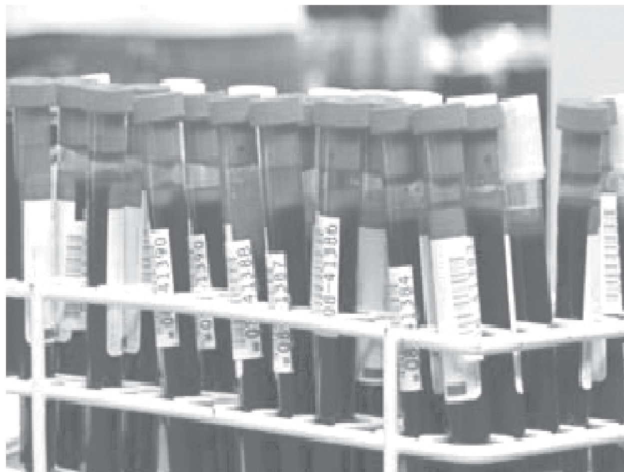
march 2007
vol. 1 issue 2
SAAHMI
saahmi@jhsph.edu

BLOOD SAFETY: A Rising Priority in Pakistan

by AYESHA RASHEED, MBBS



Blood is an exceedingly important resource – every second, someone in the world needs blood to survival. An estimated 80 million units of blood are collected worldwide. However, developing nations, despite comprising a great majority of the world's population, house only 38 percent of the total blood supply. The World Health Organization (WHO) estimates that up to 150,000 pregnancy-related deaths can be avoided through safe blood transfusions. Yet, the roughly 80 percent of the global population with access to only 20 percent of the global supply of 'safe blood' is also the 80 percent at highest risk for pregnancy-related deaths.

'Safe blood' is more than blood that is screened for diseases. It is blood that 'does no harm' and is of the right concentration; is free of infections or contamination due to alcohol, drugs or other chemical substances; is used within the specified time period and stored in the right container, correctly labeled, and properly sealed.

The provision of a safe, efficacious and adequate blood supply at the national level is primarily the responsibility of the government or national health authority of every country. In this respect, blood transfusion services (BTS) must be established in accordance with national blood policy and guided by an appropriate legislative framework. The responsibilities of national health authorities for BTS involve establishing and maintaining a national quality system, developing guidelines and maintaining standards, staff training, establishing a data/ information management system and a system for the monitoring and evaluation of all the blood transfusion activities within the country.

In Pakistan, these responsibilities have not been adequately addressed. The blood transfusion sector in Pakistan is not properly organized and services vary by facility. Recent estimates by the national blood transfusion authority show that approximately 1.3-1.5 million units of blood are transfused annually in Pakistan. About 60 percent of these transfusions are carried out in the private sector, with the public sector accounting for the rest. Until 1996-97 professional/paid donors fulfilled at least 20 percent of the total demand for blood in the country while the majority of donors were family or replacement donors, and voluntary donors accounted for a minor 2-3 percent of all. On average about 40 percent of donated blood undergoes the complete battery of required screening tests, including screening for HIV, Hepatitis B and Hepatitis C.

Currently blood transfusion services are hugely fragmented and lack an appropriate system for standardization of blood and blood components and their rational clinical use. In Pakistan at the provincial level, Punjab is the only province which has some degree of organization in BTS with the existence of basic infrastructure managed by the Institute of Blood Transfusion services. Other provinces primarily have individually-managed blood banks with varying levels of competency.

The National Blood Transfusion Ordinance was enacted in 2002 after the development of the National Policy Document (1999); however, this was applicable only for the capital territories, while other provinces have separate laws related to BTS applicable at the provincial level. A National Blood Transfusion Committee was notified under the ordinance but its functioning is hampered by an inadequate budget and lack of complete commitment by authority members. Blood Transfusion Authorities (BTAs) have been notified in each province and the Sindh BTA has initiated registration and licensing of both public and private sector blood banks. At the national level the NBTC assists the BTAs by providing policy guidelines and technical support.

The AIDS control program has supported screening of blood and blood products for HIV and Hepatitis B since 1995 with some additional support of consumables and basic equipment to all functional public sector facilities through respective provincial BT programs. This has recently been enhanced to include support for Hepatitis C screening.

The government is now interested in launching a national quality improvement initiative which is to be implemented in a phased manner. The project is being supported by GTZ (Deutsche Gessellschaft fur Technische Zusammenarbeit, a German funding agency) and is expected to revamp the organization of blood services through a mechanism independent of the AIDS Control Program. However, real development and sustainability of blood transfusion services in Pakistan still remains an issue.

Civil Society Participation in Health Sector Reforms

by SYED ABBAS, MBBS

It is well acknowledged that the Indian population is undergoing a major epidemiologic transition. Because of the recent economic boom India is experiencing disparities on a scale never experienced before. Health policy planners in India have their work cut out to make sure the performance of the health care sector is able to match the expectations of the nation.

Many researchers have suggested a formal mechanism of civil society partnerships as a way to fulfill oversight functions as well as to sensitize the government to the needs of the society. Such partnerships have the potential for helping the government execute many priority interventions in a more effective fashion than would have been possible otherwise.

The State Health Resource Center (SHRC) has evolved as a collaborative effort of the government, academicians, funding agencies and civil society representatives in the newly formed state of Chhattisgarh in India. Among other initiatives, the center was instrumental in helping the state government mobilize a 60,000 strong network of health worker-cum-activists at the grassroots level.

Some of the achievements of the Resource Center in its short span of functioning have involved forming a network of Mitanin (the female health activists), as well as recruiting, training and effectively mobilizing community health workers to act as independent pressure groups on the political leadership and to increase the focus on health led development in the community. Their achievements on the policy front have been to develop, among other policy documents, a health manpower plan, an integrated health and population policy for the state, the state drug policy, drug formulary, essential drug list as well as standard treatment guidelines.

On similar lines to the SHRC, the Government of India launched the National Rural Health Mission (NRHM) in 2005 to carry out necessary architectural correction in the basic health care delivery system in the country. While the NRHM aimed for wide spread restructuring, its chief agents of change lay in the rural accredited social health activist (ASHA) who was to be recruited from the community and trained similarly to the *Mitanin* of Chhattisgarh. Similar to the resource centers formed in Chhattisgarh, State Health Resource Centers have been formed in multiple states to act as agents of change from within the Health Ministry in many states.

Two years after the NRHM was launched and five years after the Health reforms began in Chhattisgarh, it is an opportune time to take stock of the situation as well as to explore the viability of the concept of engaging the civil society directly in the policymaking process.

COUNTRY IN FOCUS:

NEPAL

A Primary Health Care Experiment in Nepal

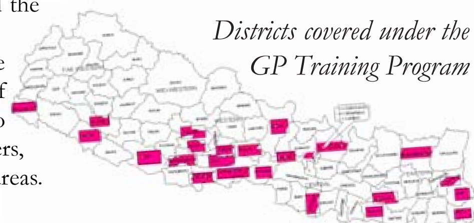
by KRISHNA RAI, MBBS, MD

While for-profit hospitals provide the bulk of curative services in urban Nepal, its rural areas are covered by government public health centers. Health services are organized through district health offices, health posts and sub-health posts across the country. The government services in Nepal, as in most of South Asia, suffer from inefficient supplies, lack of resources including human resources, inconsistent policies, and lack of career opportunities to the health care providers. In many parts of the country, access to service is affected by natural barriers like mountains, lack of a good road network and other means of communication.

While current strategies are focused upon adding more material and manpower resources, the Health Ministry is facing difficulty in retaining physicians in remote districts owing to poor infrastructure and inadequate incentives for the physicians working at the district level. Since the patients can not afford to go to distant facilities, a single physician has to provide multiple services at the district level ranging from routine consultation to dealing with life-threatening conditions.

A strategy for primary health coverage

Following the Alma-Ata declaration in 1978, the government wanted to ensure essential health and primary health care to all citizens. In 1980, the Institute of Medicine of Tribhuvan University in collaboration with the Calgary University of Canada developed a curriculum for a post-graduate training program in general practice. The curriculum focused on providing emergency obstetric and surgical skills in addition to comprehensive medical services training including family planning and surgery. The main purpose was to train physicians with multiple technical skills keeping in mind the needs of the remote districts.



Districts covered under the GP Training Program

So far 65 postgraduates in general practice have been trained and most of them are working in 22 remote districts (as shown in the map) servicing about 400,000 to 500,000 population at each center. It is to the credit of this program that, in spite of the limited facilities at their disposal, the graduates of this program have been able to conduct such operations as emergency laparotomy, resection/anastomosis, repair of perforated duodenal ulcers, appendectomy, caesarean section and other minor surgical and gynecological/obstetrical procedures in remote areas.

Lessons learnt

The Nepal government initiated the postgraduate general practice training program to ensure primary care to remote districts. However, this experimental academic program has not been successful in attracting many physicians. The primary cause is a lack of recognition on the part of government and a perception on the part of medical graduates that it is not a good career option. The problem has been compounded by the frequent changes in the government and the lack of an institutional memory among the policy makers. So far less than 100 such doctors have been trained and most of them are not satisfied with their current role which limits them to the district setting only. The dissatisfaction owes its origin to a large extent to a lack of future career development opportunities, lack of professional and governmental recognition, as well as the political instability that results in frequent policy changes. There has been no formal evaluation of the training program so far. Thus the future of the program is unknown as is the role of these doctors within the primary health care system in Nepal.

Future directions

Policy makers should ensure easy access to affordable and sustainable health services including essential emergency surgical/obstetric care to the whole population by mobilizing both private and public sectors and bringing them within regulatory laws. Such a policy of bridging the gap is the prime need of today to ensure access to essential health services with referral support of high tech-modern medical services to both rural and metropolitan population of any country. Physicians trained especially for the purpose of providing care to remote populations can play a major role in delivering primary care. However, they need to be supported adequately by the government through better career prospects, adequate promotions, recognition of their role within the health care delivery system, increased support in the form of better infrastructure and human resources and continuity of political will.

Nepal: Past and Present

600 B.C.

563 B.C. - Siddhartha Guatama, a prince of the Sakya clan, was born in the Lumbini area of Nepal. He woud later become the Buddha.

1800 A.D.

1812-1814 - Anglo-Nepalese War, culminating in a treaty that established Nepal's current boundaries

1950

1951 - End of Rana rule, with sovereignity of crow restored. Anti-Rana rebels in Nepalese Congress Party form government.

1953 - New Zealander Edmund Hillary and Nepal's Sherpa Tenzing Norgay become first climbers to reach the summit of Mt. Everest.

1955 - Nepal joins the United Nations.

1960

1960 - King Mahendra seizes control and suspends Parliament, Constitution and party politics after Nepali Congress Party wins elections with B.P. Koirala as premier

1989 - Trade and transit dispute with India leads to border blockade by Delhi and worsening economic situation.

1990

1991 - Nepali Congress Party wins 1st democratic elections. Girija Prasad Koirala becomes Prime Minister.

1994 - Koirala's govt defeated in no-confidence motion. New elections led to Communist govt in control.

1995

1995 - Communist govt dissolved. Radical leftist group, the Nepal communist Party begins insurrection in rural areas to abolish monarchy and establish People's Republic.

2000

2001 - (June) Crown Prince shoots King Birendra, other royals and himself. Prince Gyanendra crowned King of Nepal.
(July) - Maoist rebels step up violence. Sher Bahadur Deuba becomes PM after Koirala quits over the violence. Heads 11th govt in 11 years.
(Nov) - State of emergency declared. King Gyanendra orders army to crush Maoist rebels.

2002 - Intense clashes between miliary and rebels. Rebels declare 1-month ceasefire, rejected by the govt.

2004 - (April) Nepal joins World Trade Organization.
(June) - King Gyanendra reappoints Deuba as PM.
(Aug) - Maoist rebels blockade Kathmandu for a week.

2005

2005 - Maoist rebels and main opposition parties agree on plan to restore democracy.

2006 - (April) King agrees to reinstate Parliament after opposition protests. GP Koirala is appointed PM. Maoist rebels call 3-month ceasefire.
(May) - Parliament votes unanimously to curtail King's political powers. Nepal govt and Maoist rebels begin peace talks, the 1st in nearly 3 years.
(Sept) - Parliament strips the King of his command over army.
(Nov) - Nepal govt and Maoists sign peace accord, declaring formal end to 10-year rebel insurgency. Rebels are to join transitional govt and their weapons will be placed under U.N. supervision.

Info compiled from http://news.bbc.co.uk/2/hi/south_asia/country_profiles/1166516.stm