

Corrections needed to Pakistani programme details

I read the paper by Bhutta et al.¹ published in the *Bulletin* with great interest and I congratulate the authors.

Maternal and child health is a significant problem in developing countries. Factors such as poverty; cultural factors which restrict women's autonomy, promote early marriage or support harmful traditional practices; nutritional deficiencies; reproductive factors like young age of mothers at first birth; distance to health services; and inadequate health-care behaviour or use of services are all associated with poor maternal and infant outcome.² In 1994, the Ministry of Health in Pakistan launched a community health worker programme known as the National Programme for Family Planning and Primary Health Care to improve maternal and child health in low-income Pakistani communities.³ The programme regularly recruits women and trains them to provide family planning and primary health care services in their own communities. These women known as lady health workers (LHWs) are the frontline of primary health care in many low-income communities of Pakistan. One LHW is responsible for approximately 1000 residents, or 150 homes, and she visits 5 to 7 houses per day. The scope of work and responsibility of LHWs

includes health education regarding antenatal care, vaccination and support to community mobilization, provision of contraceptives and basic curative care. Although LHWs receive no training in delivering babies, they need to liaise closely with community and health facility staff to improve maternal and newborn care. In this context, Bhutta et al. have developed an intervention package for LHWs, *dais* (traditional birth attendants) and local community members to improve maternal and newborn care. Findings of the pilot study recently published in the *Bulletin* are very encouraging as the rates of home delivery, still birth and neonatal mortality were significantly reduced in the intervention area.

Moreover, a higher number of LHWs were present at the time of delivery in the intervention area compared to the control area.¹

However, a couple of statements quoted in this paper depict a lack of in-depth knowledge about the programme. The authors mention that the official stipend for LHWs is 1800 Pakistani rupees per month plus local travel costs,¹ which is contrary to the actual situation. At present, the official stipend for an LHW is 2990 Pakistani rupee per month with no local travel costs.³ Moreover, the authors mention that the standard LHW training takes 18 months, including 3 months of lectures,¹ which is also not true. In reality, the LHW training takes 15 months, including 3 months of classroom training and 12 months of field training.³ Therefore, I suggest that the necessary corrections should be made to the original paper. ■

Competing interests: None declared.

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References

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