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THE PAKISTAN BASIC HEALTH SERVICES PROJECT: A CRITIQUE

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## Table of Contents

Introduction . . . . .	1
Project Objectives and Description . . . . .	1
Summary of Project Inputs and Outputs . . . . .	5
Project Implementation Difficulties . . . . .	6
Project Planning Deficiencies . . . . .	13
Assessment of Project Impact . . . . .	17
Major Lessons Learned . . . . .	23
Conclusions . . . . .	29
Bibliography . . . . .	32

## Introduction

Was the Pakistan Basic Health Services Project a success or failure? What criteria were applied by the different parties involved in judging project success or failure? Were such criteria reasonable and appropriate? What major lessons were learned from the project?

## Project Objectives and Description

The purpose of the Pakistan Basic Health Services Project was to improve and expand basic health services coverage for rural populations through the development of "Integrated Rural Health Service Complexes."<sup>1</sup> The project provided for training of health care providers and support personnel, construction and equipping of rural facilities, and development of management support infrastructure over an eight year period, divided into two phases: Phase I, an initial three years (1978-81), and Phase II for five years (1981-86). Joint USAID and WHO support was given for Phase I, which has now been completed. Phase II continuation, which was to be dependent upon successful completion and evaluation of Phase I, is now considered unlikely because USAID funding for Pakistan projects was discontinued due to Pakistan's nuclear energy development policies. There remains considerable doubt that such funding will be reinstated in the future.<sup>2</sup>

In order to place Phase I in perspective, the overall eight-year strategy is briefly described. The concept of an Integrated Rural Health

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<sup>1</sup>"Basic Health Services Project Paper," (Islamabad, Pakistan: United States Agency for International Development, May 1976), p. 18.

<sup>2</sup>Interviews with USAID officials, Washington, D.C., September 1980, reconfirmed by discussions with them in January 1981.

Complex (IRHC) was to be implemented, and provide the critical functional unit for delivery of services. Composed of one Rural Health Center (RHC) and 5-10 Basic Health Units (BHUs), the IRHC would serve a population of 50,000 to 100,000 in a geographical area of 150 to 250 square miles.<sup>3</sup>

The RHC was to be the focal point for management of the basic health services. It was to be staffed with one male and one female doctor, two supervisory mid-level health workers, and two mid-level health workers delivering care. It also was to be the home base for four mid-level workers deployed on a rotation to the BHUs. Each RHC would be linked to the District Health Officer through a supervisory relationship. Proposed activities of the RHC were: to provide primary health care, to serve as referral center for its affiliated BHUs, to plan and manage preventive/promotive programs including family planning, to provide supervision for all workers, to collect data, and to serve as a drug and equipment warehouse.<sup>4</sup>

The BHU was to be the most peripheral facility of the system. It was to serve 5,000 to 10,000 people and cover an area of 15 to 25 square miles. Each BHU was to be staffed with a minimum of two mid-level workers and their support personnel. Each BHU and mid-level worker was to be linked to the RHC by supervisory mid-level personnel and by doctors. Proposed activities of the BHU staff were: to provide primary health care, to serve as a referral point for community health workers (CHWs) in villages, to plan and supervise activities of CHWs, and to supply CHWs with drugs and equipment.<sup>5</sup>

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<sup>3</sup>"Basic Health Services Project Paper," p. 19.

<sup>4</sup>Ibid., p. 20.

<sup>5</sup>Ibid., p. 21.

The CHW was to deliver a limited range of preventive and curative care at the village level, thereby forming the first tier of the four tiered integrated rural health care system. The CHW was to be supervised regularly by mid-level health workers. A significant proportion of CHW time was to be given to family planning, nutrition surveillance, and immunization programs. They were also expected to translate their health knowledge into language understood by the villagers, thereby helping to bridge the social and knowledge gap between the health system and the village.<sup>6</sup>

To train the new personnel required, training materials were to be developed, tutors trained and a series of training schools for mid-level health workers established. MEDEX prototype training materials/modules were to be adapted to the specific health problems of rural Pakistan, translated into Urdu and, if required, into major dialects. The curricula for both the mid-level worker and the CHW were to produce trained workers capable of performing at specified standard levels for all tasks and duties, as defined by the Government. A program to train adequate numbers of capable training officers and tutors to staff the training schools was to be initiated concurrently with development of training materials.<sup>7</sup>

Mid-level health worker training capability was to consist of twelve training units by the end of the first project year. A second group of 12 training units was to be opened after 18 months and a third group was to be made operational by the 30th month of the project, so that by the middle of the third project year there would be a total of 36 training units in operation. The period of training was to be eighteen months.

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<sup>6</sup>Ibid., pp. 22-23.

<sup>7</sup>Ibid., pp. 27-30.

Class size was to be 25, and new classes were to start at six month intervals so that output per training unit would be 50 mid-level workers per year. By the end of the second project year there were to be 270 mid-level health workers trained and working in the service delivery system, and by the end of the third project year, 800 workers were to have been trained and working.<sup>8</sup>

Community health workers were to be selected for training by their villages, with the advice of RHC and BHU personnel. Training of CHWs was to be carried out primarily by the mid-level health workers using the newly developed training materials. Initial training was to provide simple preventive/promotive skills and treatment capability for a few common illnesses. Additional training in more complex tasks was to vary. Because training of CHWs was largely dependent upon trained mid-level workers functioning in the IRHCs, CHWs would not be in the system in large numbers before the beginning of the third project year. However, in an effort to gain some early experience with the CHW concept, and to learn more about various aspects of their mobilization and utilization, such as selection criteria and payment mechanisms, a limited number of CHWs were to be trained and evaluated in selected IRHCs during the first and second project years. By the end of the third project year, at least 1,350 CHWs were to be trained and working.<sup>9</sup>

The project also was to strengthen the infrastructure support for the expanded rural health system by establishing, within the Federal Ministry of Health and the Provincial Departments of Health, special offices (cells) to provide: coordination for expansion of basic health

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<sup>8</sup>Ibid., pp. 46-47.

<sup>9</sup>Ibid.

services, development and management of training programs, and strengthening of support systems. The cells were also to oversee the utilization of technical advisors, development of special training in primary health care planning and management, and the development of specialized technical support functions, including: operational planning and evaluation, logistics and supply management, personnel management (including supervision), information management, communications management, budget formulation and financial management, and development of operations reference manuals for health care management.<sup>10</sup>

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<sup>10</sup> Ibid., pp. 30-38.

FIGURE 1: SUMMARY OF PHASE I PROJECT INPUTS AND OUTPUTS  
PAKISTAN BASIC HEALTH SERVICES PROJECT

Outputs	Planned <sup>11</sup>	Revised <sup>12</sup>	Actual <sup>13</sup>
1. MLHW Training Units Established	36	---	20
2. Trained MLHW Tutors	103	---	70
3. Trained MLHW's	800	80	270
4. Trained CHW's	1,350	---	123
5. Trained Executive Managers, District Health Officers and ADHO's	72	---	0
6. Trained Personnel, Drug and Supply, Financial Managers	195	---	0
7. Trained Information System Supervisors	60	---	0
8. BHU's and RHC's Constructed	365	---	600+
9. Operational Research Studies	3	---	6
10. Operational Manuals Developed	5	---	3
11. Minutes of Radio Time	945	---	0
12. Pamphlets Produced	100,000	---	0
13. Posters Produced	40,000	---	0
14. IRHC's in Operation	12 then 36	12 then 36	0
15. % of IRHC's where 90% of curative and preventive care activities are above standard	80%	---	0%
16. % of IRHC's with 90% of standard drugs and equipment on hand	80%	---	0%
17. % of IRHC's with more than one supervisory visits/worker/month	80%	---	0%
1. USAID - Loan Funds (In millions of \$)	\$13.5	\$11.5 then 7	Now 4.5 maybe \$7
- Grant Funds (In millions of \$)	1.5	---	1.5
- Long-Term Technical Advisors (Person Years)	12	14	14
2. WHO - Grant Funds (In millions of \$)	\$.48	---	?
- Long-Term Technical Advisors (Person Years)	6	---	3
3. UNICEF	---	---	?
4. Government of Pakistan	9.8	---	\$17.4
Total (In millions of \$)	\$25.3	---	\$25+

<sup>11</sup>Ibid., pp. 41-47.

<sup>12</sup>James Martin, et al, Pakistan Basic Health Services Project No. 391-0415, Terminal Evaluation, (Islamabad: U.S. Agency for International Development, March 1981.), p. 27.

<sup>13</sup>Ibid., pp. 9-17. Also exit interviews of long-term advisors upon Project completion, February to March 1981.

Responsibility for project implementation rested primarily with provincial departments of health and included: starting and operating training units for mid-level workers; training CHWs on a trial, and then on a permanent basis; coordinating with, and advising, the federal cell on the setting of skill standards for mid-level workers; providing continuing education for mid-level and CHW graduates; construction of RHC and BHU facilities in networks to form IRHCs; sending employees to federal cell for management training; and assisting in data gathering and analysis.

Planned, revised and actual project inputs and outputs are summarized in Figure 1.

#### Project Implementation Difficulties

Political, institutional and technical factors adversely influenced implementation of the project. Shortly after project implementation began, the political leadership of Pakistan abruptly changed. The senior national government official, who had served as the primary advocate for the project, was no longer available to provide the leadership and mandate needed to sustain a national development effort of the scope and magnitude of the project. Under new political leadership, provincial governments, which had the primary role in, and responsibility for cost of, project implementation, assumed greater independence from the national government. An effective mechanism (other than informal persuasion) to sustain provincial government interest and involvement did not then exist. Even the incentive of foreign aid funds was missing, as these funds were not seen by officials at the provincial level.<sup>14</sup>

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<sup>14</sup>Interviews of Pakistan Federal and Provincial officials, and long-term American advisors, Islamabad: November 1978.

Moreover, national level officials were prone to avoid what was seen as risk-taking ventures in an environment of political instability and change. There was a clear retreat by national level officials in imposing project requirements upon provincial governments, particularly the controversial aspects of the project: mobilization, training and deployment of CHWs in villages which had been de-organized by the previous political regime; and conducting analytical studies of what many officials believed were corrupt and malfunctioning management support systems.<sup>15</sup> Moreover, many of the health officials previously involved in conceptualizing and designing the project had been replaced by officials not previously involved, who lacked understanding of the project.<sup>16</sup> Consequently, there did not exist, at the beginning of project implementation, the degree of support, cooperation and commitment needed to effectively launch a new development effort of this magnitude. As time passed, and as the new political regime consolidated itself and achieved stability of power, greater receptivity for the project developed and project implementation moved ahead, albeit unevenly among project components and among the provinces. The Northwest Frontier Province rapidly established a formal commitment and allocation of resources, and it has since demonstrated the greatest commitment and progress in moving to achieve project objectives.<sup>17</sup> Conversely, the provinces of Sind and Punjab have yet to establish an adequate formal commitment to restructure their rural health delivery systems, and have tended to treat the project with great disinterest and low priority.<sup>18</sup>

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<sup>15</sup>Ibid.

<sup>16</sup>Ibid.

<sup>17</sup>Michael J. Porter, "Basic Health Services Final Report," (Islamabad, Pakistan: University of Hawaii Technical Advisory Team, February 1981), p. 25.

<sup>18</sup>Ibid., p. 35 and p. 49.

A general lack of knowledge and understanding about the project among many health officials and workers throughout Pakistan, at all levels of the system, has been a continuing problem. This includes misunderstanding about specific project objectives and strategies, as well as widespread ignorance about primary health care concepts, principles and methods. Conceptual barriers continue to exist, including opposition to the utilization of mid-level health workers to provide curative care, and a general belief that CHWs cannot be trained and maintained to work in villages. These beliefs are still held by many despite the fact that the concepts have long been tried and proven successful in various places within Pakistan.<sup>19</sup> Other than formal visits by Pakistan officials and foreign technical advisors to selected locations in Pakistan, particularly provincial capitals, and workshops that were held for limited numbers of health officials, no educational program was mounted to overcome the widespread knowledge gap. Even some district health officers and RHC medical officers directly involved in the project, by the end of the third project year, had not yet achieved an adequate understanding of the project and its objectives.<sup>20</sup> At the project's end, the most recent Secretary of Health was quoted as having said, "Mid-level health workers are a temporary measure, the Basic Health Unit (BHU) will eventually be staffed, at least part-time, by M.D.s"<sup>21</sup>

For these and other reasons, a general lack of commitment to the project seems to have continued to exist at all levels of the national

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<sup>19</sup>Ibid., p. 93.

<sup>20</sup>Noted by author when attending the National Workshop on Management for Primary Health Care held in Islamabad, September 1980. Confirmed by exit interviews of long-term advisors, Honolulu, February to March 1981.

<sup>21</sup>Informal notes of meeting with Secretary of Health, prepared by USAID External Evaluation Team Member, Fred Simmons, January 1981, p. 3.

system, except in the Northwest Frontier Province and scattered locations in other provinces. The lack of commitment was reflected by: continuing reluctance to ask for and/or to allocate essential resources, including failure to assign adequate numbers of staff to the offices (cells) responsible for implementation; and the assignment of disinterested and unmotivated personnel to project implementation responsibilities, often without relieving them of their regular duties. This resulted in too few counterpart officials, and counterpart officials who had neither time nor interest to work with foreign technical advisors. Lack of commitment is seen in the reluctance to sanction and fund permanent positions for mid-level health workers, their tutors and program training officers (a problem which was only partially overcome by the end of the project) and the assignment of officials with inadequate rank and authority to direct project implementation activities. Even the national director of the program had rank and stature below that of provincial officials, and therefore limited influence, in an institutional environment where hierarchical status is all important.

Lack of commitment was also reflected by a continuing reference to the project as an American, not a Pakistan, project, although this problem was disappearing as the project ended.<sup>22</sup> Unwillingness of key health officials to exercise leadership responsibilities by actively promoting the project among subordinates inhibited development.

Project implementation was also hampered by weak administration of national and provincial governments. The federal health ministry and provincial health departments encountered difficulties with central planning, personnel and finance agencies in obtaining necessary approvals

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<sup>22</sup>Porter, "Basic Health Services Final Report," p. 11.

for project implementation actions. This was often due to inadequate preparation of planning documents, including justifications, to support action requests for resources, personnel classifications, etc.<sup>23</sup> The complexities of planning the many different implementation requirements, including adjustments in ongoing operational activities, was beyond existing administrative capability, and despite recommendations of advisors, there was little or no attempt to strengthen such capability in order that it be adequate for the task. The continuing transfer of administrative staff, often after short tours of duty, also undermined continuity of project implementation. In the Northwest Frontier Province turn-over of staff was not a problem and project implementation proceeded with much greater success.<sup>24</sup>

During implementation, USAID partially withdrew its financial support for the project and significantly reduced required project outputs. (See Figure 1). This served to lessen donor pressure for implementation. The USAID contribution was reduced from 13.5 million dollars to 8.5, and the number of Integrated Rural Health Complexes (IRHCs) to be established was reduced from 36 to 6. Moreover, USAID imposed a new policy in the summer of 1979, requiring 50% of those trained under the project be women, an unrealistic requirement given the cultural and institutional characteristics of Pakistan.<sup>25</sup> These actions did not enhance an already

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<sup>23</sup>Observed by author when visiting Pakistan. Confirmed by exit interviews of long-term advisors, Honolulu: February to March 1981.

<sup>24</sup>John R. Watson, "Quarterly Report: Pakistan Basic Health Services Project" (Islamabad: University of Hawaii Technical Assistance Team, January to April 1978), p. 4. Also Porter, "Basic Health Services Final Report," p. 38-39.

<sup>25</sup>Summary Notes prepared by USAID External Evaluation Team Member, James P. Carter, of Interview Notes prepared by Melvin Thorne, January 1981, pp. 3-4.

antagonistic relationship between Pakistan health officials and USAID, developed during previous years over other USAID funded projects. The adversary relationship between Pakistan health officials and USAID detracted greatly from project implementation efforts and made the provision of technical assistance difficult at times. The emergency evacuation of American technical advisors, when the American Embassy and other American facilities were burned in November 1979, was objected to by Pakistan health officials and this further eroded relationships.<sup>26</sup> While some advisors were able to establish fairly close personal relationships with Pakistan officials, professional working relationships remained, for the most part, somewhat constrained. American advisors were tolerated but not seen as an integral part of the program, although having to perform much of the implementation work themselves due to the absence of functioning counterparts. This may have been cause for the occasional accusation that they were working in isolation.<sup>27</sup> Travel restrictions imposed on advisors, and a tendency to avoid involving them in key planning activities, were symptoms of this problem. The ability of advisors to influence Project implementation decisions and actions was, consequently, less than ideal. Pakistan official's attitude towards advisors was, at least partially, reflected in their non-responsiveness to recommendations of advisors and in decisions that were contrary to such recommendations. Examples of such areas of disagreement or disregard include: the need for counterparts; the need to translate training materials into Urdu; the need for formal orientation programs to educate health officials and workers on the project, including the reinstatement of a

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<sup>26</sup>Ibid., p. 4.

<sup>27</sup>Ibid., p. 2.

medical officer orientation program which had ended in 1962; the need for infrastructure strengthening; the need for short-term specialist technical advisors; selection criteria for students, tutors and program training officers; the need for longer and more substantial clinical training experiences for students; and a wide variety of other recommendations that were simply not favorably acted upon.<sup>28</sup>

The World Health Organization also did not fully live up to its commitment to provide support to the project. Of the two technical advisors to be provided by WHO at the inception of the project, one arrived one year after the project began, and the second arrived two and a half years late. It was clear from the beginning that WHO advisors had their own agenda and priorities, and did not view themselves as a part of the technical assistance team of the project. They were not particularly motivated to support the objectives of what was seen as an American project, nor did they have the requisite skills to be of much assistance to Pakistan officials.<sup>29</sup> The very late arrival of the second WHO advisor, who was to serve as the key management advisor on infrastructure development, seriously delayed implementation activities in this area and ultimately required that the University of Hawaii amend its contract to employ a management advisor for the project.<sup>30</sup> The great delay, however, resulted in very little project impact in this area.

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<sup>28</sup>John R. Watson, "Quarterly Report: Pakistan Basic Health Services Project" (Islamabad: University of Hawaii Technical Assistance Team, August to October 1977), pp. 2-3. Also John R. Watson, "Brief for Presentation to Secretary of Health," (Islamabad, May 1978). Also John R. Watson, "Report for Semi-Annual Review Meeting," September 1979. Also Porter, "Basic Health Services Final Report," p. 45.

<sup>29</sup>Assessment initially made by author, November 1978, later confirmed by Porter, "Basic Health Services Final Report," pp. 81-82.

<sup>30</sup>Watson, "Quarterly Report" (November 1978 to January 1979), p. 4.

In reviewing the quality of American technical assistance, including the technology and related prototype materials adapted for use in Pakistan, it is now clear that there were also some short-comings. The prototype training modules and related training materials, including audio-visual materials, were at an evolutionary stage of development. They were too oriented towards curative medicine, not yet having achieved an appropriate curriculum balance between curative and community/preventive health practice. The curriculum did not include health service management, a subject now judged essential. The prototype modules were written at a language level now considered to be too difficult, which was not adequately adjusted during the adaptation process. There was also a need for more substantial training of tutors and preceptors, given the level of their instructional skills when entering the program.<sup>31</sup>

In reviewing the overall training process, it is now clear that quality control was seriously lacking due to the shortage of functioning counterparts and because American advisors were "spread too thin". Unwillingness of the host-country to allow replacement of the American curriculum advisor, who terminated after the 2nd project year, aggravated this problem.<sup>32</sup> Failure of Pakistan officials to carry out essential aspects of the training program (e.g., preceptorships and evaluation of clinical skills), and inconsistencies in managing the training program (e.g., starting new training units while closing others), also contributed to the quality control problems.<sup>33</sup>

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<sup>31</sup>Porter, "Basic Health Services Final Report," pp. 43-45. Also exit interviews of long-term advisors, February to March 1981.

<sup>32</sup>Ibid.

<sup>33</sup>Ibid.

The above description of difficulties clearly portray a most unsympathetic environment in which to implement a project of such complexity and magnitude.

### Project Planning Deficiencies

Many of the difficulties encountered during the project's implementation can be directly attributed to deficiencies in project planning and design. There may have been a comprehensive national primary health care development strategy in the minds of the Director General of Health and of officials of the central planning agency. Such a strategy could have provided a coherent framework and context within which the project was to fit. However, no such strategy apparently existed in the minds of other key health officials, particularly at the provincial level. Certainly no strategy had been formally established.<sup>34</sup> With the subsequent change in political leadership, whatever grand strategy did exist was lost. There is substantial evidence, however, that the Americans and Pakistan officials involved in project design, considered the project itself as the grand strategy.<sup>35</sup> Consequently, clear definition of the context within which the project would have to be implemented was neglected. The actual context, in many respects, turned out to be incompatible with the project.<sup>36</sup> Thus, it would appear that the Pakistan officials and their American advisors were caught up in an over-centralized planning effort, based on assumptions that the subsequent political leadership would not, or

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<sup>34</sup> Interviews with Pakistan Federal and Provincial officials, and American long-term advisors, Islamabad and Lahore: November 1978.

<sup>35</sup> "Basic Health Services Project Paper," p. 18.

<sup>36</sup> Watson, "Quarterly Report", (January to April 1978), p. 4. Also Porter, "Quarterly Report," (November to January 1981), p. 6.

could not, keep. This, perhaps, also explains the lack of close collaboration with provincial level officials (health, planning, finance, personnel, etc.) in the project planning effort, and also helps to explain the subsequent breakdown in project cooperation between the national and provincial governments during project implementation. Thus in planning the project, national officials and their American advisors did not have access to the kinds of information needed to accurately design a project which was intended to impact primarily upon the periphery of the health system. Failure to collaborate with those who had such information precluded taking proper advantage of Pakistan's long experience in attempting to develop rural health services. Understanding of the many problems to be encountered and of lessons learned from a wide variety of intervention strategies and methods previously attempted was therefore lacking, despite some discussion of the subject in the Project Paper.<sup>37</sup> If such collaboration had occurred, many of the project design deficiencies might have been at least partially avoided.

There were other critical omissions in the project design that experienced USAID officials and American advisors would normally be expected to guard against. These include: incomplete identification and analysis of recurrent cost obligations that the project would generate for the host country; inconsistency between project implementation resource requirements and the resources agreed to be provided by the various donors and by the host country; lack of detailed specification of implementation costs that the host country was obligating itself to provide when agreeing to the project, (e.g., costs of experimental CHW pilot projects, travel and accommodation costs for Pakistan officials attending workshops,

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<sup>37</sup>,"Basic Health Services Project Paper," p. 11.

student and tutor stipends and housing, printing of training materials, training equipment and supplies, and vehicles for IRHC's, to name a few).<sup>38</sup> Such funding omissions surfaced during the project implementation stage, resulting in various requests to UNDP, UNICEF, WHO, and USAID for assistance.<sup>39</sup> Such remedial activity contributed to implementation delays and resulted in essential project components going unfunded and, therefore, not implemented or inadequately implemented.<sup>40</sup> Certainly, the shortage of staff for provincial offices (cells), training centers, district offices, etc., can be at least partly attributable to failure to fully identify resource needs during the project design stage.

It is interesting to observe that USAID officials and American advisors involved in the design effort were willing to accommodate Pakistan's over-centralized planning system, but were unwilling to accommodate other Pakistan realities, such as the long lead-time required to implement major institutional changes proposed by the project. In retrospect, there was a great insensitivity and naivete about the speed with which institutional change can be made to occur in Pakistan. The usually unrealistic time-frame requirements imposed by USAID perspectives and policy no doubt contributed significantly to this problem. USAID's continuing reliance upon project planning methods more designed for physical system development

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<sup>38</sup>Ibid., pp. 60-70. Also Watson, "Quarterly Report," (February to April 1978), p. 3. Also exit interviews of long-term advisors, February to March 1981.

<sup>39</sup>Ibid.

<sup>40</sup>Porter, "Quarterly Report," (May to July 1980), p. 4. Also Michael J. Porter, "Report on the UNICEF Programme to Assist the Rural Health Services of NWFP," (Islamabad: Unicef, February 1981), pp. 29-30.

planning than social system planning also contributes greatly to this problem, i.e., designating overly specific outcomes rather than designing specific processes to achieve desired outcomes.<sup>41</sup>

Finally, the technical assistance plan was not well conceived. It was believed that a direct contract between the Pakistan Government and the American technical assistance institution would more responsively serve the needs of the host country. Also, that the host country would benefit by having to exercise direct accountability over the technical assistance, including expenditure of funds for such technical assistance. This approach had not been previously tried in Pakistan. Although based on theoretically sound principles, this approach did not prove successful in actual practice. Given the vested interests of USAID as the donor of funds, a three party contract was created, notwithstanding declarations to the contrary contained in the contract. The process of later obtaining approvals for needed contract amendments during project implementation, and for reaching mutual agreement among three parties, was laborious and frustrating for all. This detracted from the technical program development work upon which Pakistan health officials and American advisors were supposed to be concentrating. Distractions included the need for Pakistan health officials to approve payments for technical assistance costs based on American requirements, which were ten or more times the cost level with which they were familiar, a very disturbing problem for them. Consequently, significant delays in obtaining approvals were encountered. In some cases approvals could not be obtained.<sup>42</sup> The

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<sup>41</sup>Ernest E. Petrich, "Management Systems Development Strategy, Annex L, MEDCAM Project Paper," (Yaounde: USAID, May 1980).

<sup>42</sup>Ernest E. Petrich, "Field Work Report," (Honolulu: Pakistan Basic Health Services Project, HMDS, School of Medicine, University of Hawaii, March 1981), pp. 3-4.

unavailability of standardized and pre-tested legal provisions for AID funded direct host-country contracts was a further problem. Unanticipated difficulties were encountered with contract provisions, including residual financial liabilities vested in the contractor, that were not discovered until after the contract became legally binding.<sup>43</sup>

The technical assistance plan also called for close collaboration with WHO representatives in providing technical assistance for essential components of the project. Experience has since demonstrated that this commendable expectation was unrealistic. WHO representatives were not particularly motivated to further the objectives of what was seen as an American project. In addition to great delays in assigning WHO technical advisory personnel, the personnel who were assigned proved to be less than adequately qualified and were unprepared to work in a close team relationship with Pakistan officials and American advisors.<sup>44</sup>

#### Assessment of Project Impact

It is helpful to first review project impact as perceived by the different parties involved and to assess the criteria they have, or seem to have, applied in evaluating project impact.

Pakistan officials have tended to remain somewhat non-committal. When pressed on the subject, they have indicated that the project did not represent any new program shift from what they had been attempting to achieve over the past 20 years in developing rural health services.<sup>45</sup>

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<sup>43</sup>Ibid., p. 4.

<sup>44</sup>Porter, "Basic Health Services Final Report," pp. 80-81.

<sup>45</sup>Interviews of Pakistan officials, Islamabad: September 1980. Also interview notes prepared by USAID External Evaluation Team, January 1981, p. 1.

The continuing construction of rural health center and basic health unit facilities proceeded as usual. They acknowledge the improvements in training which were achieved through the project, i.e., standardized curriculum, decentralized training, the use of improved training methods, and improvement in curriculum content.<sup>46</sup> Some criticize curriculum content for what is considered to be too heavy emphasis on curative medicine, and some remain skeptical about the feasibility of CHWs. Most officials, however, agree that the project was instrumental in promoting a growing understanding and awareness of the need for, and the difficulties involved in, providing basic health services coverage to rural areas. They also acknowledge the growing commitment to use of non-physician health workers in rural areas.<sup>47</sup> In the context of Pakistan's long history, a three-year project does not assume the degree of importance that a westerner's perspective might suggest. The time horizon of Pakistani officials prompted them to ignore unrealistic project output targets and to see the favorable changes that did occur as measures of success in moving the country along what they see as a very long road towards improved basic health services. Their view of the project as artificially contrived and as basically an American project changed somewhat over time, to the extent that by the 3rd project year many began thinking of it as a Pakistan project.<sup>48</sup> Nevertheless, it was all the more reason for them to be pleased with whatever favorable impact the project may have had. Pakistan finance officials were, no doubt, pleased with the receipt of hard currency to alleviate foreign balance of payment problems. A

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<sup>46</sup>Ibid., p. 2.

<sup>47</sup>Martin, Terminal Evaluation, p. 2.

<sup>48</sup>Porter, "Basic Health Services Final Report," p. 11.

variety of overseas trips for Pakistan officials, including some paid for by the project and others indirectly attributable to the project that were paid for by international agencies such as WHO, gave these officials special benefits, recognition and status not otherwise available. The project was instrumental in enhancing their leadership role and prestige. The criteria they have applied, and the judgements they have made, appear to be reasonable from their perspective.

To what extent did the rural people of Pakistan benefit from the project? Unfortunately, not much. Facility construction created some temporary jobs. The large number of rural health facilities constructed remains mainly unstaffed, and they are already deteriorating. The lack of a maintenance system suggests that facility deterioration will continue. Although 270 MLHWs completed their training, only 207 qualified for and took certifying examinations, and only 138 passed, for an attrition rate of 49%.<sup>49</sup> By project end, however, none had been employed in sanctioned posts to function as intended. Many had returned to their previous jobs, albeit with improved skills and capability.<sup>50</sup> A few villages, where CHW pilot projects were carried out, presumably continue to benefit from the trained CHWs who hopefully are continuing to serve as unpaid volunteers. Unfortunately, no institutional infrastructure to support CHWs had been developed, and with the wide spread skepticism about the CHW concept, it is not expected that the CHW program component will be sustained. One can argue that 3 years is too short a time to expect direct benefits for the rural target population, particularly in a project of this magnitude and complexity. A baseline survey was designed and conducted to assess

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<sup>49</sup>Exit interviews of long-term advisors, Honolulu: February to March 1981.

<sup>50</sup>Ibid. Also Porter, "Basic Health Services Final Report," p. 60.

health status and utilization prior to project impact.<sup>51</sup> The baseline study was completed at the very end of the 3rd project year, which suggests that project impact benefiting the rural target population was not expected prior to that date. The conclusion must be reached, therefore, that little if any early benefit was expected to accrue to the target population. Even if the project had been better designed and had experienced less difficulties during the implementation stage, it seems doubtful that any real benefits could have been felt by the rural population over such a short time period.

The USAID perspective is quite interesting. USAID officials are required by Congress and agency policy, to apply quantitative criteria in measuring project impact. This approach is intended to insure "objective" evaluation of project success or failure.<sup>52</sup> On the basis of quantifiable measures, benchmarks to determine project progress are set. These provide "conditions precedent" to be met by the host government before transfers of AID funds occur. Such "conditions precedent" are sequentially scheduled during the project, and are expected to be fully met by the time of project completion. A key USAID criteria of project success is in completing the full transfer of project funds to the host government. For political and technical reasons, USAID found it expedient to periodically revise downward the quantifiable indicators of project progress, in order to satisfy fund transfer objectives.<sup>53</sup> Measured in these terms, project "success" can be guaranteed. USAID officials have readily

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<sup>51</sup>Robert Mack, et al, "Baseline Health Survey" (Islamabad: Basic Health Service Cell, February 1981).

<sup>52</sup>Handbook 3 - Project Assistance, (Washington D.C.: Agency for International Development, Department of State, June 1979).

<sup>53</sup>Porter, "Basic Health Services Final Report," pp. 87-88. Also Martin, Terminal Evaluation, p. 27.

acknowledged the adjustments that have occurred, and attribute the need for revision to the cut-off of American aid to Pakistan, and to project implementation difficulties over which they had no control. Diplomatically, they evaluate project outcome as successful, and relative to other USAID projects in Pakistan, this could well be a fair assessment.<sup>54</sup> Given all of the project implementation problems, and having had primary responsibility for project design, USAID officials are inclined to consider the project a "remarkable" success.<sup>55</sup> The "external" project evaluation conducted by the USAID Mission health officer previously responsible for the project, was quite positive and confirms the USAID Mission conclusions about the project.<sup>56</sup>

University of Hawaii long-term advisors acknowledge the multiple obstacles encountered during project implementation and the major flaws in project design, including unrealistic schedules. As agents for change, their criteria for project success appears to be the extent to which improvements introduced by them remain in place after they depart.<sup>57</sup> Evidence regarding this will not be available until later, and a favorable result will depend greatly upon whether or not the Government of Pakistan permanently institutionalizes the gains that were made. It appears unlikely that recommendations formulated, but not yet implemented by end of the project will be implemented. This includes operational research studies of management support systems and other matters related

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<sup>54</sup>Interviews of long-term advisors and USAID officials, Islamabad: November and September 1980.

<sup>55</sup>Ibid. Also exit interviews of long-term advisors, Honolulu: February to March, 1981.

<sup>56</sup>James W. Martin, et al, "Basic Health Services Project No. 391-0415, Terminal Evaluation, (Islamabad: U.S. Agency for International Development, March, 1981).

<sup>57</sup>Exit interviews of long-term advisors, Honolulu: February to March 1981.

to infrastructure strengthening.<sup>58</sup> Consequently, conclusions reached by long-term advisors as to project success or failure will probably vary according to individual contributions and to what happens to those contributions in the future. Such criteria, and the need for future judgements to be made regarding them appear reasonable.

The Health Manpower Development Staff of Honolulu believe that the project was helpful in field testing MEDEX technology, including prototype training materials, which is being developed for world-wide use in assisting developing countries to strengthen their primary health care.<sup>59</sup> The project provided evaluation feedback about the difficulties of conducting operational research studies of management support systems. This feedback is being utilized to develop prototype systems technology materials for use elsewhere. Project experience has also contributed to the further development of technical guidelines for designing, implementing and evaluating primary health care programs in developing countries, more fully discussed below under 'major lessons learned'. It is generally acknowledged that the three-year project was far too short to even begin to achieve a viable nation-wide primary health care program.<sup>60</sup> It is difficult for staff who were directly involved in the conceptualization, design and implementation of the project to objectively evaluate project outcome. Consequently, their attention seems to be focused more upon the

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<sup>58</sup>Ibid. Also John H. Eaton, et al, 'Management Systems Studies for Establishment and Operation of Integrated Rural Health Complexes,' (Islamabad: National Basic Health Services Cell, December 1980), and related correspondence of same date.

<sup>59</sup>Interviews and meetings with Health Manpower Development Staff, Honolulu: January to March 1981.

<sup>60</sup>Ibid. Also Porter, "Basic Health Services Final Report." Also informal notes of Fred Simmons, January 1981, pp. 1-3.

project's contributions to the effort of developing MEDEX technology materials, and to project benefits perceived by USAID and Pakistan officials.

### Major Lessons Learned

In the opinion of the author there are some very important lessons to be learned from the Pakistan experience. It remains to be seen whether these lessons will be learned and whether the mistakes will not be repeated in the future.

1. A USAID-funded PHC development project alone, no matter how large and comprehensive, cannot and should not serve as a nation's grand strategy for strengthening PHC, but must instead be designed within the context of such a grand strategy. PHC development is simply too broad and complex to be incorporated within one donor project. This suggests the need for donor assistance to developing countries to help each develop its grand PHC strategy, a lengthy and time-consuming process which could be, itself, a special project.

2. The design of USAID-funded PHC development projects cannot and should not be done by a static "blueprint" approach to planning. PHC is a software, not a hardware, system. As such, PHC requires an "action planning" approach to development. The Project Paper should consist of the detailed design of specific action planning processes to achieve desired general outcomes, rather than design of what the final specific outcomes should be. It is no wonder that host-country health officials have looked upon USAID, and USAID contractors, as neo-imperialists intent upon solving other peoples' problems, rather than upon helping other people solve their own problems. It is the author's view that this approach

has been paternalistic and dependency-creating, and does not result in building self-confidence and self-sufficiency among host-country officials. Much of the relationship stress between Pakistan and USAID officials resulted from an unwillingness on the part of Pakistan officials to accept the usual USAID approach. For this, the Pakistani's should be commended.

3. The relatively short time allotted to design a USAID project inhibits adequate collaboration with host-country officials, particularly with key officials at lower echelons of the health system. Involvement of these officials is essential to achieve full understanding, based on prior actual experiences, of system development needs and obstacles. Their involvement in the design process is also critically important to help ensure their subsequent support during the project implementation phase. USAID officials and American advisors tend to relate to, and reinforce, what is usually an over-centralized planning process. Until a more appropriate hierarchical PHC planning system is developed, special attention should be given during the project design phase to correcting the mis-information and distorted perspectives that flow from an over-centralized planning system.

4. Inadequate lead-time for project design also contributed to a superficial assessment of resources required to effectively implement a project, and to under-estimating recurrent cost obligations which the project will generate. The tendency to avoid meticulous detailing of project and recurrent program costs leads to inadequate support of critical components during project implementation and ultimately to project breakdown, if other donors are not available on short notice to rescue the project, such as UNICEF and others did in Pakistan. True government commitment to the project is not obtained when commitment is based upon

incomplete or false information, particularly about the amount of government resources that will be required during and after the donor-supported phases.

5. The failure to involve in project design those key government officials who later have authority to approve allocations of government resources for the project is a continuing problem with USAID projects everywhere.<sup>61</sup> Central finance, planning and development officials at national and provincial levels are expected to give favorable responses to resource requests on a post-facto basis, and they seldom will. This is particularly true for health ministries and health departments because they have an established reputation for deficient planning and general mis-management of resources, and for steadfastly resisting the utilization of modern management practices, including the use of professional planning and management specialists.

6. The desire to demonstrate tangible project outputs early in the implementation phase, at least partly prompted by the nature of short-term projects, results in premature production of trained health workers before the necessary infrastructure for their support is in place. It is easier to set up new activities, such as training centers, than to change long established bureaucratic structures. In Pakistan (and every other MEDEX country project to date), trainees have been graduated before their new roles and rank have been sanctioned, and before supervision, transportation, communications and information systems are in place. This initial focus on launching training of MLHWs and CHWs tends to downplay and give lower priority to meeting infrastructure needs, a

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<sup>61</sup>Noted by author in reviewing Evaluation Reports of AID Projects conducted in Africa, Asia, Middle East and South American, Washington, D.C.: USAID, September 1980.

development task much more difficult to accomplish and requiring a much longer period to achieve. Greater realism is required in planning project activities to accommodate a sequential program development, which supports and reinforces gains, rather than undermining them.

7. The lack of a hierarchical planning and evaluation system for PHC, if not corrected during the project implementation phase, results in a piecemeal approach to implementation and operations planning, characterized by intermittent "stop and go" planning efforts lacking the continuity and collaboration needed to develop a self-sufficient PHC delivery system. The Pakistan project, in design and implementation, seriously omitted this essential component, and consequently by the end of the 3rd project year, little had been done to establish permanent on-going planning and evaluation capability.

8. Probably because of prior conditioning from specialized program development efforts sponsored by foreign donors, host country officials are inclined to inaccurately conceptualize primary health care as another vertical program. This partly occurred in Pakistan, and tended to reinforce the traditional fragmented approach to delivery of services. The use of multi-purpose MLHWs and CHWs to deliver a full-range of single purpose services requires consolidation and integration of specialized vertical programs to serve the periphery. This has implication for vertical and horizontal reorganization of central, provincial and district level roles and structures if appropriate supervisory and managerial support is to be developed for peripheral PHC workers. Although steps were taken during project implementation to integrate the Malaria Control program and the Expanded Program for Immunization into the Basic Health Services Program, organizational realignment was not adequately considered during the project design stage. The establishment of new specialized basic

health services offices (cells) at national and provincial levels served to reinforce a vertical program concept for PHC and therefore inhibited the consolidation and integration of other PHC programs/fragments.

9. Effective PHC strengthening involves, directly or indirectly, all health care providers in a country, including local governments, and consumers of services as well. They can either be cooperative or obstructive. Experience indicates major attention needs to be given to educating very large numbers of people about the PHC development strategy, and their roles and responsibilities in assisting with its planning, implementation and maintenance. This requires a major government commitment and a large amount of resources.

10. Although management deficiencies represent the single greatest obstacle to sustaining rural PHC systems, the importance of improving management (both support systems and managerial practice) is not well understood or appreciated by many LDC health officials. Their apathy or even cynicism towards management takes much effort and time to overcome before the mandates and resources necessary to proceed are given. It is interesting that when tangible results of management analysis studies are seen, and when concrete improvement actions appear feasible and begin to be taken, apathy turns to very positive support, sometimes to "evangelism". A conversion takes place. The development of tangible prototype management systems analysis and management training modules and materials for country specific adaptation and use, which were not available in Pakistan, is expected to greatly assist in overcoming this problem.

11. If American advisors are not provided with host country counterparts of suitable quantity and quality, the advisors quickly become "doers" rather than true advisors and trainers. A "dependency

syndrome" rather than a "self-sufficiency syndrome", results. This undermines development objectives and creates more harm than good. If a host-country does not keep its commitment to provide appropriate counterparts, then development projects should be simply ended, or temporarily discontinued, until it does. Such a policy should be clearly defined, and mutually agreed to, prior to project implementation.

12. Political instability in the developing world is an endemic problem. There is a tendency to proceed post-haste, with project implementation, despite the loss of project mandate which often occurs when a host government changes hands. Overly rigid concern with project implementation deadlines tends to obscure the need, and the time required, for obtaining a new mandate. To struggle on with project implementation activities when lacking an appropriate mandate only serves to create frustration and stress among the different parties involved, and seems, in retrospect, quite unwise and unproductive for everyone.

13. When a PHC development project is seen as a true host-country project, rather than as an American project in the host-country, there is reason to believe that closer collaboration may be possible with other donors. An overly paternalistic USAID attitude and heavy presence of USAID project monitoring (including USAID project evaluation rather than multi-donor joint program evaluation) serve to inhibit effective multi-donor collaboration. This has adverse impact upon PHC development, because USAID is usually unwilling to finance all of the many start-up costs of a national PHC strengthening effort for which donor funds are needed. Such effort usually requires, and involves, many other donors.

14. Unrealistic time expectations and schedules, based on American standards and USAID short-term project perspectives, are not applicable to PHC development in Pakistan (and most other developing countries).

Strengthening and developing PHC is far too complex and difficult to achieve through one short-term project. If appropriate collaboration is to occur, if health institutions are to be reshaped, if the gains made in training workers are to be protected by a reinforcing infrastructure, and if self-sufficiency rather than dependency is to be created, either much longer USAID projects, or a series of projects, are necessary.

Many other lessons were learned in Pakistan. In the revision, application and adaptation of MEDEX technology, discussed throughout this paper, what was learned there has resulted in significant revisions and improvements. We can mention some very difficult problems which remain to be tested and solved: In the training of MLHWs, how can countries best integrate classroom and field skills development experiences during the module phase of instruction? How can they mobilize logistical support for the community phase of MLHW training? How can they best evaluate the skill levels of MLHWs, particularly in community preventive health and managerial roles? How can they best select and prepare tutors and preceptors of MLHWs? How can they best mobilize and finance CHWs? How can they best maintain adequate skills levels in MLHWs and CHWs through performance evaluation and continuing education? How can they best orient/train supervisors of MLHWs and first-line doctors to support peripheral workers? How can they keep MLHWs from shifting to greater role modeling of doctors (i.e., from becoming facility-bound curative practitioners rather than actively involved and participating in community focused preventive/promotive interventions)? There is much to learn.

### Conclusions

Applying quantitative criteria, i.e., planned project outputs, the author concludes that the project failed to achieve its intended outputs. However, those knowledgeable about the project generally agree that planned

project outputs were quite unrealistic and that consequently the quantitative output criteria by which success and failure were to be measured are not considered to be relevant.

Applying qualitative criteria, one can arrive at a whole range of conclusions. Some of these are more capable of assessment than others, but all are subjective, reflecting the particular values and priorities of the official or organization offering the judgement.

USAID would like to believe, and prove, that the project was successful. Its external evaluation confirms this. Pakistan officials seem to be, publicly at least, reasonably satisfied with the project's outcome, and want a continuation of donor support. The people of rural Pakistan have little to see and feel, and even less upon which to judge. Too many project planning, design and implementation deficiencies, and too short a project time period, resulted in no real consumer impact. Nevertheless, viewed in Pakistan terms, some progress was made in moving towards their long-term objective of basic health services coverage for the rural population.

Some very valuable experience was gained by Pakistan officials, USAID Mission officials, and contractor advisors, in the complexities of designing and attempting to implement an improved basic health services delivery system. One must ask, however, if the cost (over \$25 million) was worth it? Much of what was learned already existed in the form of organized knowledge. USAID and the contractor simply repeated many of the mistakes in development planning and implementation that had been learned in the 1960's, if not before.<sup>62</sup> One must ask if this is due to a lack of

<sup>62</sup>Milton J. Esman, "System Approach to Technical Cooperation: The Role of Development Administration," Public Administration Review, (September/October 1969). Also see Bibliography on Planned Social Change, 3 vols. (Madison: Center for Comparative Analysis, University of Wisconsin, 1965). Also John R. Irish, Economic Development, (New York: Praeger Special Studies in International Economics and Development, 1968).

"institutional memory" within USAID: the failure to pass on knowledge and experiences to its members, or to change its institutional practices to reflect lessons learned. As for the American advisors who were involved in project design (primarily health professionals with limited development management expertise), perhaps there was an assumption that such expertise was resident in (or available to) and being applied by the USAID Mission, a false assumption. As for American advisors later involved in project implementation, their hands were tied and their impact constrained, by adverse political, institutional, project design and technical circumstances. It is remarkable that they accomplished what they did. But one must still ask, whether the project and its cost were adequately justified in terms of the impact achieved; the author's conclusion is that they were not. Many of the critically essential program components of a rural delivery system remain missing, without much expectation at this point in time that they will be developed soon enough to protect the project gains that were achieved. The only possible exception to this conclusion, is the Northwest Frontier Province, where UNICEF may come to the rescue again, in a very substantial way.<sup>63</sup> In the other 3 provinces, representing about 82% of Pakistan's population, including the 2 larger provinces which are still uncommitted to the Project's basic concepts, further donor support and technical assistance appear unlikely at this time. Therefore, it is expected that project's gains will not remain in place long enough to serve as base for further development. Over \$25 million of project investment should have purchased much greater lasting benefits for Pakistan.

<sup>63</sup>Michael J. Porter, 'Report on the UNICEF Programme to Assist the Rural Health Services of the NWFP,' (Islamabad: UNICEF, February 1981).

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