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ANNEXES

PAKISTAN - BASIC HEALTH SERVICES

(Annexes not included in Project Paper)

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SUBJECT: BASIC HEALTH SERVICES LOAN - FY 77

SUMMARY: ASIA PROJECT ADVISORY COMMITTEE ON DECEMBER 2, 1975 APPROVED MISSION PROCEEDING WITH DEVELOPMENT OF PP FOR A PROPOSED LOAN OF DOLS 7.5 MILLION FOR FY 77. FUNDING FOR FY 79 PROPOSED LOAN WOULD DEPEND ON REVIEW OF PERFORMANCE UNDER PHASE ONE OF THE PROJECT AND AVAILABILITY OF FUNDS. IN ADDITION TO ISSUES CONTAINED IN PRP,

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REVIEW DISCLOSED FURTHER POINTS WHICH PP SHOULD ADDRESS.
END SUMMARY.

1. COORDINATING MECHANISM: PRP STATES NEED FOR WELL-DEFINED ORGANIZATIONAL STRUCTURE AT NATIONAL LEVEL TO COORDINATE POLICY AND ALLOCATE RESOURCES FOR A MAJOR HEALTH DEVELOPMENT PROGRAM UNDER NATIONAL MANDATE. AID/W WISHES UNDERSCORE IMPORTANCE OF THIS ASPECT AND NEED FOR SATISFACTORY SOLUTION TO BE DEVELOPED WITH GOP IN EARLY STAGES PROJECT DEVELOPMENT, AND THAT ARRANGEMENT BE ACCEPTABLE TO AND FACILITATE OTHER DONOR SUPPORT AND PARTICIPATION IN PROJECT. SUITABILITY OF SETTING UP SEMIAUTONOMOUS HEALTH DEVELOPMENT CORPORATION SIMILAR KOREAN PATTERN AS MENTIONED PRP SHOULD BE FURTHER INVESTI-

GATED. PP SHOULD CLEARLY DISCUSS WHAT CHANGES OR IMPROVEMENTS IN INSTITUTIONAL FRAMEWORK WILL BE TAKEN BY GOP (AND WHEN) TO INSURE POLICY AND RESOURCE COORDINATION.

2. FINANCING: BOTH PRP AND REVIEW DISCUSSION INDICATE MANY FINANCING AND RELATED PROBLEMS TO BE RESOLVED IN PREPARATION OF PP. THESE INCLUDE:

A. CAPABILITY AND EXTENT OF LOCAL FINANCING OF CAPITAL AND RECURRING COSTS.

B. MECHANISMS TO MOBILIZE LOCAL RESOURCES AT VILLAGE LEVEL TO SUPPORT RURAL HEALTH SERVICES.

C. AMOUNT OF FEES, IF ANY, TO BE CHARGED IMMEDIATE BENEFICIARIES OF PROJECT FOR SERVICES RENDERED.

D. CAPABILITY OF GOP AND PROVINCIAL GOVERNMENTS TO FINANCE RECURRING COSTS FOLLOWING EXHAUSTION OF AID LOAN FUNDS. RAPID EXPANSION OF MEDICAL COLLEGES MAY PRESENT SIGNIFICANT FINANCIAL BURDEN UNDERMINING CAPABILITY OF GOP FUNDING OF RECURRING COSTS THIS PROJECT.

E. THE SPECIFIC ELEMENTS OF THE PROJECT TO BE FINANCED BY THE AID LOAN.REQUIREMENTS OF AID FINANCING RECURRING

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COSTS SHOULD BE CAREFULLY EXAMINED AND GOP STRATEGY ESTABLISHED TO ABSORB THESE COSTS BY END THIS PROJECT.
F. PROPOSED METHOD OF DRAWING DOWN AID LOAN FUNDS. PREFERABLY SUCH DRAWDOWNS SHOULD BE IN TRANCHES ON COST REIMBURSEABLE BASIS.

3. CONVERSION TO LOCAL CURRENCY: GAIDANCE WILL BE FURNISHED MISSION LATER ON PROCEDURES FOR CONVERTING LOAN DOLLARS TO LOCAL CURRENCY.

4. INTEGRATION OF VARIOUS HEALTH DELIVERY SYSTEMS:
AID/W
AWARE OF PROBLEMS INVOLVED IN COMBINING VARIOUS VERTICAL HEALTH DELIVERY SYSTEMS BUT CONSIDERS SUCH INTEGRATION DESIRABLE IN LONG RUN. THIS MUST BE PRECEDED BY DEVELOPMENT OF RURAL HEALTH PROGRAM AS PROPOSED THIS PROJECT. PP SHOULD OUTLINE PROGRAM BY WHICH INTEGRATION OF THE VERTICAL HEALTH PROGRAMS CAN BE ACCOMPLISHED AND DEAL WITH QUESTIONS RAISED IN THE DAP HEALTH SECTOR STRATEGY CONCERNING INTEGRATION OF MALARIA WORKERS AND FAMILY PLANNING WORKERS.

5. RELATIONSHIP TO DAP: PRP MENTIONS GOP - WHO HEALTH SECTOR STUDY OF COUNTRY HEALTH PROGRAMMING BUT NOTHING

ABOUT NATIONAL NUTRITION SURVEY EXPECTED MID-1975 (PAGE 11 OF DAP HEALTH SECTOR STRATEGY). PP (AND SUBSEQUENT DAP SECTOR STUDIES) SHOULD REFLECT RESULTS OF THESE STUDIES AND PROVIDE REASONABLE EVIDENCE (IF THIS IS TRUE) THAT BASIC HEALTH UNIT APPROACH IS MOST EFFECTIVE METHOD OF DELIVERING INCREASED HEALTH BENEFITS TO RURAL POPULATION IN PAKISTAN.

LOGFRAME: SUGGEST MISSION AGAIN REVIEW LOGFRAME AND INCORPORATE LANGUAGE DESCRIBING GOAL, PURPOSE AND EOPS SIMILAR TO STATEMENTS ON PAGE 8 OF PRP.

7. REFERRALS: THE PRP DOES NOT INCLUDE SUFFICIENT INFORMATION ON REFERRALS OR HOW VILLAGE HEALTH WORKERS WILL HANDLE CASES BEYOND THEIR CAPABILITY. PRESUMABLY DUE TO COSTS AND LACK OF TRANSPORTATION SYSTEM, COMPLEX

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CASES IN SOME INSTANCES MAY NOT RECEIVE ADEQUATE TREATMENT. THIS ISSUE SHOULD BE ADDRESSED IN PP.

8. LOGISTICS: PRP NOTES IMPORTANCE OFADEQUATE LOGISTICAL SYSTEM FOR PROVIDING SUPPLIES TO VILLAGE MEDICAL PERSONNEL. AID/W CONSIDERS THIS ASPECT OF PROJECT CRUCIAL AND SHOULD BE SPECIFICALLY ADDRESSED IN PP.

9. BENEFICIARIES/ROLE OF WOMEN: WE NOTE PROJECT DEVELOPMENT SCHEDULE IN PRP PROVIDES FOR SOCIAL ANALYSIS AND IDENTIFICATION OF BENEFICIARIES. REGARD THIS AS CRITICAL TO ASSESSMENT OF WHETHER PROJECT WILL COMPLY WITH MANDATE THAT AID ASSISTANCE BENEFITS POOR MAJORITY. SPECIFICALLY SOCIAL ANALYSIS SHOULD IDENTIFY THAT SEGMENT OF POPULATION I.E., THAT PORTION OF POOR MAJORITY BENEFITING FROM PROJECT.

PROJECT TO SOME EXTENT WILL HAVE IMPACT ON TRADITIONAL MEDICAL PRACTITIONERS DRAWING FUNDS AWAY FROM THEM. DOES PROJECT MAKE USE OF THESE LOCAL PRACTITIONERS? HOW IS THIS POTENTIAL AREA OF CONFLICT TO BE MINIMIZED?

PP SHOULD DISCUSS ROLE OF BENEFICIARIES GENERALLY AND ALSO WOMEN SPECIFICALLY AS DECISION MAKERS IN DESIGNING AND IMPLEMENTING PROJECT, AS WELL AS AGENTS AND BENEFICIARIES OF PROJECT. AID/WWILL ATTEMPT TO FURNISH LATER EXAMPLES OF HOW THIS INPUT MIGHT BE EFFECTED; REFERENCE SHOULD BE MADE TO HANDBOOK THREE AND AID CIRCULAR A-687, DECEMBER 9, 1975 FOR GUIDANCE IN INITIATING MISSION STUDIES.

10. CONSULTANTS' SUPPORT: SYSTEM FOR PROVIDING ADEQUATE LOGISTICAL SUPPORT FOR CONTRACTOR PERSONNEL SHOULD BE DEVELOPED AND DESCRIBED IN PP.

11. OTHER DONORS AND THE GOP: THE PRP MAKES REFERENCE TO CLOSE DONOR COOPERATION IN SECTION VI AND DRAWS ON SEVERAL SOURCES IN "FEASIBILITIES ISSUES" IN ANNEX II. BUT HARD TO GET FEEL HOW CLOSELY ATTUNED THE VARIOUS DONORS ARE WITH THE DIFFERENT INTEREST GROUPS IN THE GOP AND PAKISTAN MEDICAL PROFESSION AND WHERE AREAS OF

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DETAILED PROJECT BACKGROUND

A. Background

The purpose of this section is two-fold: to offer a brief assessment of the health status of Pakistan's population and its current resources for meeting the nation's health needs and to call attention to the evolution of health policies and programs in Pakistan.

The present Pakistan health delivery system is characterized by wide regional variation in the quality and quantity of services in both urban and rural areas. Historically, the health system has served urban over rural needs; placed more emphasis on the training of doctors than auxiliary manpower; skimped on operating budgets for the public health sector; and neglected preventive and community health in favor of curative services.

The following brief statistical description of Pakistan's population and its health status as well as the present health delivery system is intended to provide project background. The data are drawn mainly from Planning Commission studies. For more statistical detail, see the data tables in Annex A.

1. Current Health Status

a. Population and Characteristics

Pakistan's most recent census, in 1972, indicated a population of 64.8 million. This population is predominantly rural and poor. There are roughly 43,000 villages containing perhaps 75% of the country's people. Population projections based upon linear extrapolation of the data suggest that the current (1976) population size is 72.5 million (of which approximately 54 million live in rural areas) and the population in 1980 will be roughly 81.5 million (of which approximately 61 million will live in rural areas).

The age distribution of the current population is such that 44.9 percent of the total population is under the age of 15, 41.6 percent is between the ages of 15 and 44, and only 13.5 percent is over the age of 44. In all cohorts, there are more males than females.

b. Health Status

The crude death rate is estimated to be 15.5 per thousand population at the present time. The infant mortality estimate is 115 per thousand live births which accounts for about fifteen percent of the crude death rate.

The present system for the collection of demographic information does not permit calculation of specific death rates for all diseases. However, a Planning Commission study of proportional deaths due to different diseases indicated that in rural areas two-thirds of all deaths are due to infective and parasitic diseases, exclusive of malaria which at present accounts for over ten percent of the rural total. Other major killers are tuberculosis, birth-injury, and complications of pregnancy. The life expectancy of males is consistenly higher than that of females through the age of 34.

Meager data on morbidity is available and is hospital-based and therefore biased by the selection of patients. Yet, in 1973, patient records of public hospitals and dispensaries were studied in terms of the overall incidence of disease. Gastro-intestinal and parasitic diseases, respiratory diseases, fevers, diseases of the skin and areolar tissue, and malaria account for roughly 72 percent of reported illness.

2. Current Resources

The existing system reflects a pattern not unusual for developing countries. All types of facilities and manpower are scarce and are heavily skewed toward urban areas despite the preponderantly rural nature of the population. Current estimates are that modern health services extend to only fifteeen percent of the total population and to perhaps as little as five percent of the rural population. Although public sector expenditures for

health have risen four-fold during the past five years, they still account for less than one percent of GNP and less than three percent of total expenditures in the public sector.

a. Manpower

While data is collected on available health manpower in the country, it is of questionable accuracy and dated. There are a number of factors which affect the actual availability of medical manpower including: out-migration, retirement and deaths, and the frequently short actual career span of female medical personnel. A 1974 estimate of available health personnel is as follows:

Category	Number	Per Capita Ratio (Urban)[1]	Per Capita Ratio (Rural)[1]
Doctors	10,000	1 : 2,467	1 : 21,600
Nurses	3,000	1 : 7,708	1 : 90,000
Auxiliaries[2]	9,000	1 : 8,222	1 : 8,000
Traditional Practitioners[3]	40,000	1 : 1,850	1 : 1,800

[1] There are no current data on the geographical distribution of health personnel between urban and rural areas. In determining these ratios, it has been assumed that 75% of all doctors, 80% of all nurses, 25% of all auxiliaries and traditional practitioners work in cities and towns.

[2] The 9,000 figures accounts for lady health visitors and dispensers who are considered primary health workers, although they are not adequately trained for the tasks they are performing. To this figure, the Government frequently adds another 5,000 auxiliaries which include midwives, physiotherapists, pharmacists and medical technologists who do not serve as primary health workers.

[3] 4,000 of these are Tibia College trained hakims who work in urban areas. For a fuller discussion of traditional practitioners and their roles see the Social and Technical Analyses.

b. Physical Resources

A current estimate of Pakistan's primary health facilities appears as follows:

Category*	Number	Population/Facility
Dispensaries	3,430	
MCH Centers	750	
RHCs	160	
RHC Subcenters	400	
TOTAL	5,288	13,710
Hospital Beds	38,840	1,867

* MCH Center = Maternal and Child Health Centers
RHCs = Rural Health Centers

An examination of the location of institutions by type reveals considerable inequities when compared with the geographical distribution of the population. Less than twenty-five per cent of all hospitals are in rural areas, and less than twenty per cent of all hospital beds are rural. Even if allowance is made for the fact that many hospitals and health institutions located in urban sites serve people from the rural areas as well, it is evident that the scale on which health services are available for the population of the rural areas is comparatively much poorer.

c. Financial Resources

The most recent estimates of health expenditures are for 1974-75. In that year, the total development expenditure by federal and provincial governments was 300 million rupees (roughly 30 million dollars). Roughly 60 percent of the allocations were at the provincial level. In total, development expenditures represented 0.3 percent of GDP for that fiscal year.

During the same year, total non-development expenditures on health totalled 280 million rupees (slightly more than 28 million dollars). Roughly 75 percent of non-development allocations were made at the provincial level. In total, non-development expenditures represented 0.28 percent of 1974-75 GDP. Combined development and non-development expenditures totalled roughly 580 million rupees and represented a per capita expenditure of slightly more than 8 rupees (80 cents) per person. Estimated recurrent expenditures on rural health services are less than 70 million rupees (or 7 million dollars).

Public expenditures have tended to be made for Western-style health services, such as a recent heavy investment in medical school expansion. For a fuller discussion of Pakistan's public health-related expenditures, see the Financial Analysis.

Current statistics suggest that Pakistanis today rely far more on the private sector than the public sector for health care. The Planning Commission's estimates of annual expenditures for medical treatment in the private sector vary. Taking an average of these estimates, it may be assumed that such expenditures total roughly 1.1 billion rupees per year (for hospital beds, doctors in private practice, traditional healers, and drugs and medicines). This is about twice the amount spent in the public sector, and raises per capita public and private expenditures to about 1.8 percent of GDP.

The foregoing brief discussion of Pakistan's health status suggests that patterns of morbidity and mortality do not differ significantly from those of other developing countries. A cursory look at its health delivery system indicates the minimal coverage afforded by present manpower and facilities throughout the country. The Western-styled health system, public and private, probably does not reach more than fifteen percent of the total population, and five percent of Pakistan's rural population. There is considerable evidence that the facilities that do exist to serve rural peoples are frequently understaffed, often poorly supplied and managed, and, in some cases, badly located. These characteristics of the present delivery system as well as others may explain why it is also under-utilized.

3. History of Rural Health Policies and Programs

a. Policy

In 1946, the Health Survey and Development Committee, chaired by Sir Joseph Bhore, surveyed health conditions in British India and recommended the directions for future health policy. The central recommendation of the Bhore Report was that both preventive and curative health services be provided to the urban and rural population through heavy reliance on a combination of professional and auxiliary medical personnel. Since Independence, there has been a steady evolution of thought in the subcontinent about how to structure health services in such a way that the mid-level health worker supplements scarce professionally-trained medical manpower. An examination of historical policy statements leads to several major conclusions:

1) In the Subcontinent there is a demonstrable tradition of thought during the last thirty years concerning the responsibility of the government to extend adequate health services to rural as well as urban populations.

2) As policy has evolved it has consistently assumed the impossibility of achieving adequate coverage solely through professional medical personnel with Western-style training and traditional medical facilities.

3) There has been a steady refinement of thought concerning the training and deployment of auxiliary medical personnel and the construction of a hierarchy of treatment facilities which assure the provision of preventive as well as curative services.

b. Programmatic Efforts

Despite many stops and starts, there has also been a history in Pakistan of programmatic efforts to implement this policy. Representative programs of three types deserve brief

mention: those programs begun before partition and still functioning those programs begun during the 1950s and 1960s and then abandoned; and a number of current relatively small-scale auxiliary training efforts.

Three training programs -- for Lady Health Visitors (LHVs), dispensers, and sanitary inspectors -- have long histories in the subcontinent. The LHV, trained since the 1920s, ranks below the doctor and the nurse. After more than two years of training in maternal and child health and brief training in diseases of women and children common to rural areas, she works predominantly in rural health centers, family planning programs, and maternal and child health centers. There are currently only about 1,000 LHVs (or one per 72,500 population) working in Pakistan despite a fifty year training effort. Dispensers, on the other hand, receive on-the-job training in hospitals and clinics. They function as auxiliaries, although they are trained as assistant pharmacists. Current estimates are that roughly 8,000 dispensers are available within the country. The sanitary inspector receives 18 months of specialized training in basic hygiene and sanitation, and he serves predominantly in rural areas in the field of preventive public health. The Government estimates that fewer than 1,500 sanitary inspectors are presently working in Pakistan.

During the 1950s and 1960s, several ambitious programs were initiated for the purpose of significantly expanding Pakistan's cadre of trained auxiliary medical manpower. A number of these, including one to train Assistant Medical Officers and one to train Health Technicians, were abandoned after a few years because many of the individuals trained subsequently went on to medical school or emigrated to urban areas because of poor rural health management. In the mid-and late-1960s, a major effort was undertaken to build Rural Health Centers and to staff them with Rural Health Inspectors. Although the building program proceeded more slowly than planned, there are now approximately 137 RHCs and 369 subcenters, the majority of which are in the provinces of Punjab and Sind. Centers have continued to be built in the 1970s, although the training program for the inspectors was abandoned several years after its inception, and the training institutions became medical schools.

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A number of smaller-scale efforts to train medical auxiliaries have been undertaken in the 1970s, none with a national focus. In 1973-74 a program with the aim of training more than 700 male and 700 female Health Guards to serve in the Northern Areas of Pakistan was begun. During the same year, as part of the Integrated Rural Development Program, a scheme to train Pesh Imams (village Muslim functionaries) as "barefoot doctors" was initiated at Daud Zai Markaz in the North West Frontier Province. In 1975, the Punjab Province inaugurated a training program for Medical Assistants attached to existing district hospitals.[4] All three programs have been plagued with problems with the recruitment, training, deployment, and retention of auxiliary personnel. In no case is either the quality or quantity of care provided sufficient to meet the health needs of the target populations.

c. Lessons from the Past

Although the preceding discussion of programs is cursory, it is illustrative of Pakistan's thirty year history of experimentation with health programs for training auxiliary medical personnel. Pakistan's program experience is based on an underlying policy commitment which has evolved consistently since partition. But, it is clear that there have been a number of implementation failures. In general terms, this can be explained by a lack of sustained financial and political support despite a consistent evolution of policy among thinkers in the health field. More specifically, it seems clear that past program efforts have faltered because of a failure to satisfactorily resolve some or all of the following issues:

1) Recruitment: How can male and female workers be recruited and retained in sufficient numbers, and with the needed commitment to service in rural areas, and with sufficient prior skills such as basic literacy?

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[4] For the most of the year in which the program operated, the trainees in the Punjab were on strike, protesting the quality of the training they received and demanding that the program be upgraded into one that would confer medical degrees. There were no graduates of the program before it was abandoned in April 1976.

2) Training: How does one locate training facilities in such a way that they are not urban-based (thereby exposing recruits to the temptations of urban migration) but are sufficiently large that they offer the trainee a full range of medical experience: and, how long must the training period be and what sort of curriculum and mix between didactic and on-the-job training are needed to assure that required skills are learned?

3) Deployment: Where should treatment facilities be located to assure maximum utilization by the rural population; and, what mix of auxiliary and professional personnel should be deployed to these facilities to assure that a full range of both curative and preventive health services is offered?

4) Management: What are the minimal requirements for adequate support of personnel, for management of personnel, facilities, and the supply system; and, what management techniques are required to assure continuing attention to preventive as well as the more popular curative services?

4. Future Directions

Against this background, the Government is attempting to develop an effective health policy for the near future. A number of recent Government publications suggest the direction of current thinking.

The People's Health Scheme was released in draft form in 1972. Building upon the policies and programs of the past decade, the Scheme included a network of health units to be completed in the first four years. The Scheme also urged absorption of all currently trained professionals and para-medicals. To overcome the shortage of health manpower, the Scheme proposed the expansion of existing medical colleges and a decentralized program for training para-medical staff at district and tehsil hospitals.

In March 1975, the Government completed, with assistance and support from WHC, a Country Health Programming exercise.[5] The proposals of the programme document are designed around four components of a Basic Health System: physical infrastructure, manpower training, logistic and drug support, and a management and information system. The programme document describes a network of Rural Health Centers and Basic Health Units. The central manpower proposal is for the training of auxiliaries. The programme contains detailed suggestions for the numbers and types of auxiliaries needed to man the network of rural health facilities.

Current discussion of rural health needs in Pakistan has centered around the development of a Fifth-Five-Year Development Plan (1976-81).[6] The Working Papers for the Development Perspective (1975-80)[7] and recent discussions with Government officials as well as drafts of the Fifth Five-Year Plan have focussed upon implementation of the notions incorporated in the People's Health Scheme and the Country Health Programme. The basic objective of the Development Perspective (1975-80) is to extend the coverage of health facilities both in terms of distance and cost as rapidly as feasible, to the maximum number of people. The following are some precise objectives for the period:

(i) To achieve balance between rural and urban areas in the provision of basic health cover and to extend such cover from the existing 15 percent of the total population to about 50 percent of the population.

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[5] Country Health Programme: Information Document. (Government of Pakistan, Ministry of Health and Social Welfare, December 1974).

[6] As of this date, the Fifth-Five-Year Plan is still in the form of published Working Papers. Originally intended for the period 1975-80, it is now contemplated for 1976-81.

[7] Working Papers for the Development Perspective, (1975-1980). (Government of Pakistan, Planning Commission)

(ii) To produce the following trained health personnel: doctors: 9,000; dentists: 500; nurses: 5,000; pharmacists: 1,000; and paramedics and auxiliaries: 27,000.[8]

To achieve rapid and extensive coverage in rural areas, proposed strategies aim at providing:

(1) A basic health unit (BHU) for every 10,000 persons in densely populated areas and 5,000 in sparsely populated areas.

(2) A Rural Health Center to be created for every 5-10 Basic Health Units which provides more space, staff, equipment and ten hospital beds.[9]

Relation to AID and Other Donor Efforts in Pakistan

While the description of the proposed project which follows is consistent with current health policy as well as past thought in Pakistan, it is also consistent with the U.S. Congress mandate to address development assistance to the rural poor majority. Furthermore, it is in keeping with the 1974 AID Mission Health Sector Analysis, prepared as part of the Development Assistance Plan (DAP). One of the core problems identified was the question of health manpower shortages. In addition, one of the potential roles identified for AID and other donors in the DAP was support of:

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[8]Ibid., pp. 303 - 304. The figure for paramedics and auxiliaries includes family planning workers, malaria workers, etc. Primary health care targets at 50% coverage are around 6,400 mid-level workers.

[9]Ibid., p. 305.

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> a health program which centered on addressing the most basic needs of the rural poor and gave a major place to preventive health through well-trained medical auxiliaries. Conversations with WHO, UNICEF and other potential donors indicate a shared conviction that a system of medical auxiliaries will not only mean better health care at lower cost for more people but offers the additional advantage of creating additional productive employment in a society where thousands of well-educated persons are without jobs...![10]

Finally, Pakistan's current policy commitment to the extension of basic health services through the training of auxiliary personnel and the proposed project are consistent with current World Health Organization (WHO) policy:

> As early as 1951, at a time when many developing countries were concentrating their efforts on specialized mass campaigns for the eradication of diseases, the Director-General of WHO stated in his annual report that these efforts would have only temporary results if they were not followed by the establishment of permanent health services in rural areas to deal with the day-to-day work in the control and prevention of disease and the promotion of health ... This trend in the Organization's policy has grown stronger in the successive general programmes of work ... [In 1973] the Health Assembly reiterated its "strong conviction that each Member State should develop a health service that is both accessible and acceptable to the total population, suited to its needs and to the socio-economic conditions of the country, and at the level of health technology considered necessary to meet the problems of that country at a given time".[11]

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[10] USAID, Development Assistance Plan, Health Sector. Islamabad: USAID, December 1974, p. 13.

[11] V. Djukanovic and E. P. Mach, eds., Alternative Approaches to Meeting Basic Health Needs in Developing Countries, a joint UNICEF/WHO study. Geneva: World Health Organization, 1975, pp. 108 - 110.

DETAILED SOCIAL ANALYSIS

The social soundness analysis is intended to justify a proposed project from the perspective of its feasibility and its impact on social development. There are three distinct but related aspects to the analysis which follows: 1) a discussion of the socio-cultural feasibility of the project; 2) consideration of the potential for diffusion of the proposed innovation; and, 3) discussion of the social impact or distribution of benefits and burdens among different groups of the population. In something of a departure from the PP outline, the last section also explores the interface between the proposed project and other sectors.

1. Socio-Cultural Feasibility

In addressing the question of socio-cultural feasibility, we view the culture from the perspective of its people as program participators (both as users of the system and as workers in it). In so doing, a heavy emphasis is placed upon the role of women for a number of reasons. First, in order to have a maximum impact on the health status of the population one must emphasize care for women and children under the age of five. Second, tradition and culture place special constraints upon the behavior of women which are discussed at great length later. Finally, it is consistent with AID's Congressional mandate that special attention be given to the role of women in the development process.

The discussion of socio-cultural feasibility which follows is divided into four major sections: an overview of the existing social landscape; development of participator profiles and a discussion of their anticipated perceptions of project benefits; consideration of the necessary contextualism of the proposed project; and, consideration of the cultural baggage or demands carried by the innovation.

a. Existing Social Landscape

Pakistan contains a wide variety of ethnic groups, incorporating not only the indigenous populations of the Indus watershed, but also refugees coming from India after partition in 1947. Each of the four major regions of the country is dominated by an ethnic group distinguished by a separate language: Panjabis in the Panjab, Pathans in the Frontier, Sindhis in Sind and Baluchis in Baluchistan. In addition there are groups who do not form a majority anywhere, such

as Jatts and Lassis in Sind, and Brahuis in Sind and Baluchistan. The people of the mountainous northern areas (which have been historically isolated both from the plains and from each other) belong to a number of diverse ethnic groups, often with distinct customs of their own. Approximately 97% of the population of the country as a whole are Muslim, a factor which tends somewhat to mitigate the ethnic differentiation.

Tribe, caste and language are important factors in social classification. The Pathans and Baluchis are organized on a basis of tribe and lineage. In the Panjab and Sind, however, caste is more important as a distinguishing feature. The main classification in the Panjab is between agricultural castes and occupational or service castes. Sind is more diverse than the other provinces; the Sindhis themselves are divided into a great number of geographical, tribal, caste and occupational groups; there are large groups of Baluchis and Brahuis; and approximately one sixth of the people are refugees from India.

Urdu, which has been designated as the national language of Pakistan, is the mother tongue of only 8% of the people. Approximately 60% speak Panjabi as a mother tongue, 13% speak Sindhi, and a little over 8% speak Pushtu. A variety of languages - Baluchi, Brahui, Pushtu and Sindhi -- is spoken in Baluchistan; and an even greater variety of Dardic languages is spoken in the northern areas. All of these languages are subdivided into regional dialects. Except for Sindhi, none of them is commonly used as a written language. Urdu, which is the medium of instruction in the schools, is used instead, and is also widely spoken and understood as a second language. Literacy rates are low, however -- around 20% -- and in rural areas, women are less likely than men to speak a second language.

Three fourths of the population lives in rural villages. Agriculture, including animal husbandry, is the major source of livelihood; the estimated 1975 income per household of $90 reflects the fact that these people are poor and only partially integrated into a cash economy.

Police and revenue functions are carried out on a circle rather than village level and intra-village affairs are managed on an informal basis and along considerations of kinship, caste and social class.

The significant organizational units involved in village-level activities are (1) the family, (2) the biraderi, or lineage; and (3) the zat (quom), or caste. The system as a whole is hierarchical, with authority vested in older people generally, and especially in men and wealthy farmers. Women are expected to defer to the authority of their male relatives; and among families which can afford it, they observe purdah, or seclusion within the home. Even among poorer groups, women associate mainly with other women and are supposed to avoid social contact with men who are not relatives.

Decision-making and economic cooperation are primarily functions of the lineage. Within a village different lineages perform separate economic functions; village politics may be viewed as a process of alliance and faction formation among lineages. A village council, known as the panchayat or jirgah, exists, and consists of the heads of lineages; but its power is limited and is mainly confined to dispute settlement.

Zats are named, ranked social groups composed of lineages; they function in the organization of marriage and marking of social status; membership is determined by birth. Some zats, mainly those of artisans, are occupational groups, though most are not. As zats are distributed on a regional basis, they constitute a source of intervillage social, economic and political linkages.

Zat classifications overlap with, and are sometimes parallel to, distinctions in socio-economic class, such as those between landlord/tenant, small farmer/merchant, or landholder/artisan. For members of the lower classes, access to resources is in varying degrees mediated through upper-class, educated, politically and economically powerful landlords.

Many specialized occupations found in villages such as Maulvi, barber, tailor, shopkeeper are associated with specific zats. Pertinent to this discussion are those specialists providing such medical care as is available in most villages: midwives and barbers.

b. Perception of Project Benefits by Participators

Participators in this case are both the users of the proposed health services and the workers within the proposed delivery system. In order to gain some understanding of the way in which beneficiaries may be expected to perceive the system, it is necessary to understand their health problems, their concepts of disease causation and cure, and their current mode of relieving pain and suffering. For example, what is their concept of illness? To what degree do they believe they can have an effect upon their health? Where do they now go for health services? What is their attitude toward government - provided services, toward indigenous practitioners?

A data-based discussion of the health status of the rural population appears in Part II, A. Project Background. In order to gain some further insights into the role of women in particular as providers and beneficiaries of health care in rural areas, a small-scale anthropological inquiry was conducted in four districts of the Punjab and North West Frontier Provinces. It was addressed primarily to two issues: What are the perceived health problems of rural women and how can they be best met? and, In view of the need for female paramedical staff to attend rural women and children, how can women be recruited into training programs and motivated to serve in rural posts once they are trained? (As noted in the introduction to the Social Analysis, we feel there is ample justification for emphasizing the concerns of women).

1) Health Needs and Treatment Seeking Behavior of Rural Pakistani Women

In the course of an anthropological inquiry in early 1976, Pakistani women attending various rural dispensaries were asked a series of questions related to the medical problems for which they sought help. Common were gynecologic complaints and problems related to pregnancy. Other complaints related to malaria, anemia, diarrhea, upper respiratory infections, scabies and typhoid. A high percentage of the women attending the clinics stated that they were "fit", an opinion confirmed by the attending physician, which suggests that there is a social motivation for clinic visits. Quite possibly, seeking medical treatment is one of the few socially acceptable justifications rural women have for leaving the seclusion of their homes.

The women were also asked about other places they go for health care. From their answers it became apparent that these women consult a whole range of medical specialists, both allopathic and indigenous. A taxonomy of these specialists, as provided by the women themselves, follows:

a) Male Doctors: The women consider that male doctors are located in hospitals or larger dispensaries, and are generally better trained than most lady doctors. They may be consulted for "general" (non-gynecological) illnesses, generally of a fairly serious nature; or on behalf of one's children.

b) Lady Doctors, Nurses and Lady Health Visitors. A lady doctor with an MBBS is the preferred medical specialist for all women insofar as their own needs are concerned. In practice, lady doctors are so scarce in rural areas that consulting them generally involves a trip to the city. All of the women interviewed in the dispensaries were consulting lady health visitors or trained nurse-dais; and most of these women said they preferred to consult a trained rather than untrained dai for pregnancy and delivery of one's child.

c) Dais. The dai is a universal feature of women's lives in Pakistani villages. She not only delivers babies but treats minor gynecological ailments, performs abortions, and provides a variety of personal services to both the newborn and its mother (such as feeding the baby, massaging the mother, and preparing herbal remedies for both). A dai develops a close personal relationship with the families she serves and is an integral part of a Pakistani woman's most important "rite of passage". Most dais have received only informal training from other dais, though some acquire sufficient expertise to be referred to as "lady hakims". Their fees are modest and most rural women consider them competent to handle normal deliveries.

d) Hakims. Hakims practice the Greco-Arabic medical system, which is well established in the Muslim world and preceeded the germ theory of medicine. They are supposed to be licensed to practice by the All Pakistani Unani Medical Board, but the actual training and skill (and probably also the official status) of hakims varies, especially at the village level. Hakims generally charge only for medicines (which are prominently displayed in the front of the shop); they are supposed to be "religious" men and to adhere to high standards of self-sacrificing service to others. In practice, the skill of hakims appears to be assessed by their potential clients on the basis of what they perceive as the hakims' cure rate.

Unani pharmacists, called pansaris, also exist. They compound the Unani remedies, and may, though not necessarily, be in the process of acquiring the training to become hakims themselves. As is the case with pharmacists elsewhere, they are sometimes asked for advice by the ill.

e) Homeopathic Physicians. Homeopaths also provide some care to rural women, although almost all are urban based. They prescribe medicines in very small doses because of their belief that high dosages exacerbate the disease.

f) Other Indigenous Medical Specialists. Certain medical services in villages are performed by barbers (nais) and wrestlers (pahelwans). The nai does minor surgery and cupping, and keeps leeches. He operates on abscesses or visible cancers, such as cancer of the breast. Nais also make ointments for wounds and ulcers of the skin. Pahelwans set broken bones; their technology is limited however by the lack of suitable materials.

g. Religious Specialists Providing Medical Care. The religious specialist most frequently consulted for medical care is the pir, or saint. He gives amulets, or taaveez, for a variety of purposes ranging from headaches to winning at kabaddi (a popular outdoor game). Women consult him with regard to scabies, infertility, hysteria, muscle or joint pains, headaches, stomach aches, and common children's ailments. A pir can also give dum (reciting certain verses of the Quran and blowing them on the painful part of the body or on food). The ability to give dum is inherited. Both taaveez and dum can be used for malevalent as well as beneficial purposes. Other religious specialists consulted, though less frequently, include sayyids (descendants of the prophet), sanyasis (wandering medicants possessing a knowledge of herbal medicines), and mandrois, or specialists in manders (recited verses which are supposed to possess the property of neutralizing insect and snake poisons). Women also visit shrines, or ziarats, which are reputed to be useful for certain ailments.

Among considerations which determine the selection of health providers are the following:

1) In circumstances where a person has a choice, the decision to patronize a given practitioner appears to be based on an assessment of the individual's skill, his experience and his

attitude toward the patient. Both doctors and hakims are evaluated on the basis of their cure rate, the quality of the medicines they provide, and by the degree to which they demonstrate concern for and care of the patient.

2) The patient is cost conscious and expects to receive something tangible (generally medicine) for his money. A commonly mentioned shortcoming of allopathic dispensaries and hospitals was the failure to provide medicines.

3) Accessibility of the service is an important factor in its utilization, especially where women are concerned. Women in general are less mobile than men; their domestic duties make it more difficult for them to leave their homes, and when they do travel, purdah regulations require that they be accompanied by some relative (so that the travel expense and inconvenience of two people must be borne).

2) Minimum Participator and Worker Profiles

Drawn largely from the anthropological inquiry and from the brief cultural description presented earlier, participator profiles were developed. The attributes of workers which are mentioned are based on the following two program assumptions:

- That community health workers who will function at the village level will be selected with assistance from the community in which they serve. Preference will be given to older women who have demonstrated leadership in some capacity, and who express a desire to provide medical care to the women in their village. Among this group, literate candidates will be preferred over illiterate candidates. If older women cannot be recruited to fill these positions, younger women (preferably literate) may be recruited. If the village so desires, existing indigenous practioners may be recruited and trained.

- That mid-level workers will be recruited from rural areas and posted so far as possible in the vicinity of their home area. They will be required to be matriculates unless it is necessary to lower standards for women in order to recruit them in sufficient numbers. Initially people with no prior health experience will be recruited in order not to decrease total coverage by recruiting present health workers. In time, present allopathic

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practioners such as dispensers, sanitary inspectors, and lady health visitors will be re-trained as mid-level health workers. Given these program assumptions, the attribute profile of health workers is likely to look something like the following:

Community health worker: a large proportion of these would be people in their thirties and forties, since very young individuals have not had time to establish confidence in their skills. Their educational attainments are likely to be minimal among the women. Nevertheless, their position among their fellow villagers will probably be quite firm; most likely they will belong to service castes with whom the villagers have longstanding relationships of economic exchange and mutual obligation. They will, consequently, come from the poorer sections of the population.

Mid-level worker: Since Matriculation (Grade 10) is the minimum qualification, the majority of these would probably be young people who have just finished their secondary education (late teens and early twenties). They would be of rural origin. Since the chief motivation for entering this field appears to be an economic one, they would probably not come from the wealthiest families. On the other hand, they would not come from the poorest families either, since these do not possess the resources to educate their children through secondary school, or compete effectively in getting their children admitted to training programs for which considerable number of applicants exist. Lastly, the matriculation requirement may have to be eased in the case of women, if it is not possible to recruit female matrics in sufficient numbers.

The Beneficiaries of these health workers will be residents of the village. As a whole, they will tend to fall into two groups: (1) women, girls, and small children, and (2) men and boys over ten years of age. The former group would seek medical care from female medical personnel and the latter from male medical personnel. The women would tend to outnumber the men, sometimes by as much as two to one.

3) Participator Perception of Project Benefits

It is assumed that participator perceptions will shift over the life of the project. It has been noted above that villagers now seek medical services from those in whom they have the most confidence and with whom they feel the most comfortable. As the mid-level health workers and community health workers establish themselves and their reputations, utilization levels will presumably increase.

Furthermore, as it becomes known throughout the villages that the community health workers have good backup through the referral system and physician supervision, they should develop a reputation for providing "better" service.

Assuming the continued existence of parallel allopathic and indigenous systems, it should be assumed that villagers will continue to use both systems. This may be especially true in the case of emotional disorders where the "personalistic" services of the hakim are especially valued. However, it is anticipated that the improvements in the availability of trained medical manpower, in the supplies of drugs and medicines, and in the location of rural facilities will increasingly draw villagers to the allopathic system. In summary, motivation to seek health services is clearly already present in rural areas of Pakistan; what remains is for the proposed system to generate increased utilization by "proving itself".

c. Cultural Obstacles

The purpose of this section is to explore the degree to which use of the proposed services will result in social disruption. Will the proposed health delivery system disrupt the existing social organization of rural life in Pakistan? Will the proposed roles of rural men and women as beneficiaries and providers of health care require changes in their social attitudes, customs or beliefs? In short, what are the culture-specific obstacles to project implementation?

The project, as proposed, will not in any sense threaten the social organization of rural Pakistani village life. Nonetheless, there are some potential cultural obstacles to successful project implementation which have been given serious attention in designing the project. One is the issue of the interface between existing medical practioners and the community health workers and mid-level health workers to be trained and deployed. A Government of Pakistan Commission is currently considering the future of the indigenous system. It appears likely that a policy permitting the parallel existence of two medical systems -- one that is essentially Western (allopathic) and one that is indigenous (the Unani system) will result. It would be the implication of that policy that every rural community would have resources of both types available to its population.

Use by the people of the indigenous practitioners is traditional and therefore easy. The newly introduced allopathic system will have to prove itself. Although a communications strategy has been designed to facilitate this (see following section), there may be some initial resistance. Studies of rural medical practices suggest that attitudes toward allopathic medical personnel among rural people are not always positive. Because they are urban based and use alien symbols such as the white coat and the stethoscope, they are frequently perceived as foreign. Also, unlike hakims, they do not profess a strong religious orientation and their services have not been as personalistic. However, paramedical personnel of rural origin are expected to be less subject to this prejudice than would fully trained doctors of urban origin. Also, because the community health workers will be chosen with the consent of the communities in which they will serve, they will be familiar to their clients and will have a longstanding personal relationship with the community. By virtue of this familiarity, the community health workers should in turn facilitate use of the services of the mid-level health workers to whom their "patients" will be referred.

The other major potential cultural obstacle to project implementation is to be found in the purdah system. While considerable attention has been given in the preceding section to the health status of rural women and to their treatment seeking behavior, little mention has been made of the way in which working conditions for women need to be structured to facilitate their performance as providers of health services.

Because of the complex cultural constraints on female employment and travel, careful attention will be given to posting female mid-level health workers close to their homes and husbands' work. Whenever it is not possible to post women within an easy distance of their homes, attention will be given to creating a "safe" work and travel environment by establishing secure quarters for married as well as non-married female workers.

d. Communications Strategy

Finally, in order to maximize project success in overcoming cultural barriers to implementation, communications with the target population (mostly rural women) is considered a critical facet of this project. The community health worker (CHW), a villager (usually female) and trained within 10 miles of home, will be the change agent

who can best convey messages to her neighbors. She will receive training from the mid-level worker in preventive and simple curative care which she can explain in the context of the village idiom. She is the boundary spanner between the Government health system and the village social system for communicating health messages.

To support the CHW, the National Basic Health Services Cell has a Communications and Health Education Division. This support group, after conducting basic studies on communications with rural villagers, will develop selective communications strategies supporting the jobs of the CHW and mid-level worker. These will include short filmed talks to villagers by national and provincial leaders and by key religious figures. These will be on basic health subjects. Radio spots and longer programs on health as well as pictorial pamphlets and posters will be distributed to support the preventive work of the CHW.

To repeat, however, the key to good communications in this project is the use of villagers themselves as change agents who concentrate first on medically high-risk village groups (where they can be expected to have the most dramatic results) in order to maximize their impact.

2. Spread Effects: The Diffusion of Innovation

This program is a national one with diffusion expected to proceed in parallel with implementation of the IRHCs. Supported by a communications campaign with some health education focused nationally and some selectively directed at implementation areas, the workers should be able to encourage adoption of new health practices which do not entail radical life style changes.

Diffusion effects of this project should extend throughout the Islamic world. Since it is the largest program of its kind outside of the Communist bloc, it will generate (and already has) considerable international interest.

a. Leadership/Authority

Within the village, the recruitment of CHWs will be aided by village leaders. This, plus community awareness of the jobs of the CHW through the communications strategy, will intentionally maximize the acceptability of the worker. Thus the CHW strategy builds

on the strengths of village leadership/authority structures.

b. Patterns of Mobility

The project realizes the limited physical mobility of the secluded village woman and attempts to support her with home visits by female CHWs who live within the same village. The mid-level workers themselves will not be very far away from project beneficiaries, especially in densely populated areas of the country.

The social structure of rural Pakistan limits social mobility as well as physical mobility. The social gap between villagers and urban-born, upper class doctors is great. By training villagers as CHWs and rural-based people as mid-level workers, this social gap will be narrowed, with the expected result that the diffusion process is greatly increased.

c. Maximum Information and Resource Distances

As noted in the Background Section, there have been a number of past attempts to implement programs for training auxiliary medical manpower. Many have failed because they did not receive sustained financial and political support. Another reason for failure, however, is that there have been serious technical gaps in knowledge about how to achieve lower morbidity and mortality in rural areas. The proposed use of "risk analysis" to focus on vulnerable subgroups within the village population allows limited resources to be used at maximal efficiency. This will shorten the time needed to increase system utilization, because the rural population is expected to change behavior patterns when the pay-off is obvious and risk is minimal. By going into the home to find the high-risk child, seeing him day after day, and bringing him into a normal medical risk category program credibility will be established and that will shorten the change process. As children die less frequently, parental acceptance of "new ways" will become easier and the receptivity of the village to innovation will be increased.

3. Social Consequences and Benefit Incidences

Any project may be expected to affect different groups of the population in different ways and to differing degrees. Some groups may be better off and some worse off as a result of project implementation. In order to determine differing effects, social impact must be projected.

Current work on refining the methodologies of social impact assessment[1/] is an outgrowth of a longstanding interest in the implications of policy and program for the social structure of society. Concentrated work in this area by social scientists, however, is nascent. Nonetheless, social impact assessment has become an accepted part of the planning process; and interest in refining our capacity for measuring the relatedness of social phenomena is a result of its potential predictive utility.

a. Social Benefits and Burdens

This section of the social analysis addresses the question of social impact measurement. In the absence of reliable indicators of predictive value, however, this analysis approaches the issue of social consequences in a tentative fashion. Therefore, quantitative measures are found only in a few sections.

1/ Among other publications, see:

1. Abt Associates, Identification and Assessment of Social Impacts. (Cambridge, Mass.: Abt Associates, 1971)
2. Bauer, R.A. "Detection and Anticipation of Impact: The Nature of the Task," in Bauer (ed.). Social Indicators. (Cambridge: M.I.T. Press, 1967)
3. Brecher, C., The Impact of Federal Antipoverty Policies. (New York: Praeger, 1973)
4. Duncan, O.D., "Social Forecasting: The State of the Art," The Public Interest, 17 (Fall), 88-118.
5. Merton, R.K., "The Unanticipated Consequences of Purposive Social Action," American Sociological Review, 1, 6 (Dec.), 894-904.
6. Spengler, J.J., "Is Social Science Ready," in L.A. Zurcher and C.M. Bonjean (eds.), Planned Social Intervention: An Interdisciplinary Anthology, (San Francisco: Chandler, 1970)
7. Wolf, C.P., "Social Impact Assessment: The State of the Art," in Wolf, ed., Social Impact Assessment. (Environmental Design Research Assoc., 1974)

In dealing with the issues of equity and benefit incidence, a number of criteria may be considered. Among them, the broadening or narrowing of access to resources and opportunities is certainly critical, because measurement of this criterion may serve as an indicator of the effect of the project on the distribution of the society's wealth and services. In the case of this program, the goal is to redress an existing imbalance in the availability of services. It has been shown in earlier sections of the PP that while Pakistan's population is predominantly rural only a small proportion of existing health personnel and facilities are located in rural areas. For this reason, the Government of Pakistan, in its Working Papers for the Development Perspective (1975-80), articulated the following precise objective:

> To achieve balance between rural and urban areas in the provision of basic health cover from the existing 15 percent to about 50 percent of the population.

Consistent with this Government objective, it is the objective of this program to achieve nearly fifty percent coverage of the population by the end of the eighth project year.

Employment generated is a second criterion which might be considered. While this is not an employment project per se, it does incorporate a substantial training component. Not only will it result in the employment of a number of persons, but it will also result in the development of a new sub or semi-professional class of workers in Pakistan: the mid-level health workers and the Community Health Workers. Projected new employment as a result of this program is as follows:

108 tutors will be employed by the end of year 3; about 8,000 RHAS and 32,800 CHWs, mostly female, will be trained and in place by the end of year 8; and, approximately thirty professionals will be employed in the National Basic Health Services Cell.

The degree to which the project might result in rural displacement, migration, and urbanization is not quantifiable. It may be hypothesized, however, that by increasing the availability of health manpower and facilities in rural areas, the project will not encourage, and may in fact discourage, urban migration.

A fourth possible criterion for measurement of the benefit incidence of the proposed project is the degree to which changes in power and participation might be expected to result. Status in terms of power and participation is relative and not readily quantifiable. It may be suggested, however, that, by increasing the level of rural health coverage, the rural population will participate to a higher degree in the society's benefits. It cannot be argued, however, that this project will have any direct effect upon the capacity of the rural population to influence public policy.

In the preceding paragraphs, it has been argued that the proposed project is anticipated to have a positive effect on the benefit incidence of the rural population. The corollary -- that it could adversely affect other segments of the population -- cannot be ignored. By redressing a current imbalance, the project will serve to offset the present superior access to health services of the urban population. Urbanites will therefore be negatively affected to the degree that resources allocated to improving the health of the rural segment of the population will not be available for urban programs.* Viewed more positively, it should be argued that the proposed project will equalize benefit incidences rather than have a negative impact on the non-rural population.

A related issue to that of social impact assessment (or the measurement of benefit incidence) is the inter-relatedness of various aspects of the social development process. The linkages between health and other sectoral concerns is complex and only recently becoming well documented.

*In fact, various revenue-generating proposals are currently under discussion in the Government which would defray part of the projected costs of health programs. One of these would involve charging for drugs, X-rays and other services provided at urban and rural public health facilities. If enacted, this would impose a new burden on the urban population, although one shared by the rural population.

b. Inter-Sector Impact

Myrdal makes the point that health is an integral part of the development process and thus must be considered in the context of its complex interrelationships. Health, he suggests, has an impact on many aspects of individual functioning such as nutrition, fertility, occupation, income and education, among others, and these in turn affect health.[2]

The value of investment in health from an economic standpoint will be addressed in the Economic Analysis. The relationship of health to other sectoral concerns is explored here. The central question to be addressed is: What will be the impact of the investment in the proposed project upon population growth or education or nutrition, to mention a few.

1) Population Impact

The Basic Health Services project will have both direct and indirect demographic consequences in both the short term and the long term. These consequences will be felt both in terms of fertility and in terms of mortality.

The project anticipates direct consequences for both fertility and mortality in the short run through its plan to include the provision of family planning services among the other health services which are provided, and through its explicit goal of reducing the rate of infant and child mortality.

While the efforts to decrease the mortality rate, especially among children 0-4, will have a short-run effect of slightly elevated population growth, the longer-term effect should be a significant decline in the fertility rate. Recent research both in Pakistan and elsewhere in the Third World suggests that parents who experience significant changes in the probability of child survival alter their fertility behavior accordingly, although this shift usually occurs several years after

[2] Gunnar Myrdal, Asian Drama: An Inquiry into the Poverty of Nations. (New York: Twentieth Century Fund, 1968)

the objective situation has changed.[3] Nonetheless, to the extent that the project achieves its goal of substantially reducing infant and child mortality, it is reasonable to predict that a significant lowering of the birth rate will result before the end of the century. How quickly this fertility decline will occur is a function of both the speed at which the mortality decline occurs and the pace at which parental perception change. The latter can be significantly affected by a widespread publicity campaign which calls people's attention to the fact that they no longer need eight or ten pregnancies to guarantee the survival of three children.

The provision of family planning services will help to offset the short-run impact of declining infant and child mortality. In addition, the plan to give emphasis to the health of women, especially women of reproductive age, will be especially conducive to the acceptance of family planning services. It has been effectively demonstrated in a number of experimental settings that the simultaneous delivery of health and family planning services significantly increases the rate

[3] The most recent and most comprehensive examination of the relationship between infant mortality and fertility in Pakistan is the doctoral dissertation of Abdul Razzaque Rukanuddin, "The Effects of Sex Preference and Infant and Child Mortality on Fertility Behavior of Couples in Pakistan," School of Hygiene and Public Health, The Johns Hopkins University (Baltimore: 1975), unpublished. Evidence in support of the basic conclusion that declines in infant and child mortality are associated with declining fertility can also be found in T. Paul Schultz and Julie DaVanzo, Analysis of Demographic Change in East Pakistan: A Study of Retrospective Survey Data. The Rand Corporation: Santa Monica, Ca., 1970; and in T. Paul Schultz, "Economic Factors Affecting Population Growth: A Preliminary Survey of Economic Analyses of Fertility." University of Minnesota: Minneapolis, Minn. 1972.

of acceptance of contraception.[4/] While it is not envisioned that the Basic Health Services project will completely supplant the Continuous Motivations System through which family planning services are currently offered, the plan does call for a gradual integration of health and family planning services as the rural health infrastructure is developed. To the extent that rural health services are expanded over the next eight years, the simultaneous provision of family planning services should result in an important increase in the number of continuous users of contraception over the present estimated four to five percent (two percent at parity 2) in the rural areas of Pakistan, with a consequent decline in the birth rate.

In sum, the aggregate short-term effect of this project should be to slightly increase the rate of population growth. The aggregate long-term effect should be a substantial decline in the rate of population growth.[5/]

Indirect Impact:

While the Basic Health Services project will have stronger direct implications for population than most other AID projects in Pakistan, it will have several important indirect consequences as well -- all of them antinatalist. Most important among these will be the creation of jobs for women. It is anticipated that by the end of the eighth year, there will be between 30,000 and 35,000 women working in the basic health services program in the rural areas. Of these, around 28,000 will be basic health workers assigned to individual villages. These women will be between 25 and 40 years old (the prime child-bearing years), functionally literate, and earning incomes of sufficient size to make an important contribution to the total family income. While the employment of this number of women will not have

4/ The most recent evidence comes from the Danfa Experiment in Ghana, carried out jointly by the Schools of Public Health of the University of Ghana (Legon) and the University of Southern California, Los Angeles; and the Narangwhal project in India carried but by the Government of India and the School of Hygiene and Public Health, Johns Hopkins University.

5/ This conclusion corresponds with that of William P. McGreevey and David N. Holmes, "The Population Impact of the 'Development Perspective'," Interdisciplinary Communications Program, the Smithsonian Institution: Washington, D.C., 1975 (a report prepared for the USAID Mission to Pakistan).

a major demographic impact by itself, the symbolic significance of women holding positions of employment throughout the rural areas of Pakistan can not be dismissed lightly. As a basic resource of the community, they should by example and by action prove to be an important source of information and inspiration to other women to control their fertility. It is highly likely that the women employed in the program will have lower than average fertility[6/] and that they will be committed to communicating the advantages of the small family norm to their clients, many of whom will for the first time have continuing and direct contact with a confidential source of information and supplies for family planning. Beyond the fact that this project will serve as a source of employment for rural women, then, the fact that these women should prove to be effective promoters of family planning will represent an important indirect population consequence of the project.

A final indirect consequence, and perhaps a tenuous one, is the possibility that the project, by introducing comprehensive modern preventive health services for the first time in rural Pakistan, will contribute to the breaking down of taboos associated with contraception. By putting family planning firmly within the context of preventive health care, the project may result in greatly changed perceptions of family planning in the rural areas. Whereas many rural dwellers may presently see family planning as a single-purpose program directed at their reproductive behavior -- an unwarranted governmental intrusion on their privacy -- these perceptions may change rapidly when family planning services are offered as part of a package of preventive health care. This may be especially true as women come to realize the risk to their health and the health of their children that continual child-bearing represents.

6/ There is a considerable and growing literature on the relationship between female employment and fertility. The best recent study on this relationship in Pakistan is Nasra M. Shah, "Female Labour Force Participation and Fertility Desire in Pakistan: An Empirical Investigation," Pakistan Development Review, XIV, 2(Summer 1975), pp. 185-206. While Shah does not examine the relationship between female employment and fertility directly, her findings, based on data from the 1968-69 National Impact Survey, do suggest a strong relationship between female employment and the desire for additional children. More generally, literature reviewed in William P. McGreevey, Nancy Birdsall, et al. The Policy Relevance of Recent Social Research on Fertility (Interdisciplinary Communications Program, The Smithsonian Institution: Washington, D. C. 1974) shows a clear and direct relationship between female employment outside the home and low fertility.

2) Nutrition Impact

The relationship between nutritional status and health is fairly well documented.[7/] It is evident from these studies and others that poor nutrition increases susceptibility to infection. Furthermore, where malnutrition is prevalent, improved health programs and services alone may not be sufficient to achieve significant decreases in morbidity and mortality:

> The synergistic interaction of nutrition and infection has been noted. The policy implication is that where malnutrition and poor sanitation prevail, curative medical care may have relatively little community impact... A program of relatively expensive preventive medicine and medical care in one /Guatamalan/ village had no effect on the frequency of illness among children (though there were fewer deaths), while less expensive supplemental feedings of the pre-school population in a second village, without any other intervention, gave an appreciable but limited improvement in disease incidence.[8/]

7/ Among other studies, see:

1. Scrimshaw, Nevin S., Carl E. Taylor, and John E. Gordon, Interactions of Nutrition and Infection. Geneva: World Health Organization Monograph Series No. 57, 1968)
2. Winick, M. and P. Russo, "Malnutrition and Cellular Growth in the Brain, "Proceedings of the Eighth International Congress on Nutrition. (Prague, August 28 - September 5, 1969)
3. Wyon, John and John Gordon, The Khanna Study. (Cambridge: Harvard University Press, 1971)
4. Young, Vernon R, and Nevin S. Scrimshaw, "The Physiology of Starvation, "Scientific American, Vol. 225, No. 4, October 1971, pp. 14-21.

8/ Oftedal, Olay T. and F. James Levinson, "Health, Nutrition and Income Distribution, " a paper prepared for the Princeton/ Brookings Income Distribution Project. (Cambridge, MIT, August 1974) p. 14.

However, treating health as the independent variable, the determination of the effect of changes in health status upon nutritional status is more complicated. One major effect is clear: that the absence of certain diseases, especially gastrointestinal infestations, results in more efficient utilization by the body of food, thereby decreasing nutrient loss and nutrient requirements. "Thus even where adequate food is available one may not be able to utilize it sufficiently due to disease." 9/

Other effects on nutrition of the proposed project should also be noted. The proposed weighing program to be undertaken by CHWs will identify underweight (and under-nourished) children. The Government's recently announced Preschool Protection Programme will include the provision of government-supplied foods to each family which has been identified as having severly malnourished children. 10/ Furthermore, the preventive work of the CHWs will include health education stressing the importance of not weaning children too early as well as food-preparation techniques which maximize nutritional values of foodstuffs.

3) Education Impact

The interrelationship between education and health has also been fairly well documented. It is customary to focus on the implications of improved education for health status. For example, it is frequently argued that improved educational attainment will lead to improved personal hygiene, nutrition, health practices, and so on, assuming that the education provided has a health component.

Fewer attempts have been made to measure the impact of improved health status on educational attainment. It may be suggested, however, that when educational services are available to the individual, his state of health will affect the efficiency with which he can use such services if at all. Further, the capacity of potential members of the work force to utilize their skills fully may also be dependent on their state of health.

The preceding discussion of the interdependence of health and other sectoral concerns has highlighted the major areas in which health may be considered the independent variable which affects other social development factors. Its effect on income, consumption and other related concerns is discussed in Economic Analysis which precedes the Social Analysis.

9/ Ibid., p. 10

10/ Naseer Ahmad Sheikh, Director General Health, Plan Outlines: The Preschool Protection Programme (PPP) of Pakistan. (Muzaffarabad, Azad Kashmir, April 28, 1976).

TABLES ON CURRENT HEALTH STATUS AND RESOURCES

Table A-1 : Expectation of Life by Age and Sex

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Table A-3 : Health Personnel * 1974

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Table A-5 : Development Expenditure on Health (Federal) 1970-71 - 1975-76

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ANNEX A. TABLES ON CURRENT HEALTH STATUS AND RESOURCES

(All tables are from Health and Health Related Statistics, a December 1975 publication of the Planning Commission of the Government of Pakistan or from the draft of the Government's Fifth Five -Year Plan.)

Table A-1
EXPECTATION OF LIFE BY AGE AND SEX

	1962-1965		1968 and 1971 (Based on PGS two-years average)	
	Male	Female	Male	Female
Under 1	47.49	45.06	52.9	51.8
1-4	54.40	51.37	59.3	56.9
5-9	55.51	54.43	58.5	56.7
10-14	51.48	50.53	54.4	52.8
15-19	47.07	46.18	49.8	48.6
20-24	42.71	42.08	45.2	44.4
25-29	38.38	38.03	40.6	40.1
30-34	34.05	33.96	36.0	35.7
35-39	29.75	29.97	31.4	31.4
40-44	25.50	25.93	26.8	27.0
45-49	21.31	21.79	22.2	22.6
50-54	20.35	17.58	17.7	18.1
55-59	13.07	13.32	13.3	13.7
60-64	8.97	8.95	9.0	9.3
65 and over	4.70	4.68	4.8	4.8

SOURCE: Health and Health Related Statistics, Table 22, page 21.

Table A.2

MAIN CAUSES OF DEATH

S.No.	Name of Disease	Pakistan	Urban Areas	Rural Areas
	All causes	100.00	100.00	100.00
1	Tuberculosis of all forms	5.55	2.86	6.09
2	Bacillary Dysentery and amoebiasis	2.51	2.88	2.44
3	Malaria	10.44	7.86	10.96
4	Diabetes Mellitus	1.14	0.75	1.22
5	Diseases of hear and circulatory system	1.79	3.92	1.35
6	Tumours	0.34	0.00	0.41
7	Peptic ulcer, appendicitis, intestinal obstruction and hernia	1.20	1.09	1.22
8	Complications of pregnancy and child birth	1.13	1.39	1.08
9	Congential anomalies, birth-injury, difficult labor and causes of perinatal mortality	7.36	5.64	7.71
10	Infective and parasitic diseases	53.84	67.64	63.07
11	Accidents, poisoning and violance	1.88	1.05	3.03
12	Unknown causes	2.85	4.91	2.44

SOURCE: Statistical Division, Population Growth Survey - 1971, Karachi, 1974.

Table A.3

HEALTH PERSONNEL * 1974

S.No.	Category	Number	Per Facility for Population of
1	Doctors	10,000	7,000
2	Dental Surgeons	700	100,000
3	Nurses	3,000	23,300
4	Health Visitors	1,000	70,000
5	Midwives	2,700	25,900
6	Physiotherapists	150	466,700
7	Pharmacists	500	140,000
8	Dental Hygienists	NIL	
9	Medical Technologists	100	700,000
10	Dispensers	8,000	8,750
11	Sanitary Inspectors	1,450	48,300

* These are estimates of the number of persons available within country.

SOURCE: Health and Health Related Statistics, Table 64, page 77.

Table A.4

HEALTH INSTALLATION BY URBAN AND RURAL AREAS

Facility	Pakistan	Urban		Rural	
	No.	No.	%	No.	%
Hospitals	548	413	75.36	135	24.64
Dispensaries	3,086	989	32.05	2097	67.95
Maternity child health centres	715	399	55.80	316	44.20
Rural health centres	137	1	0.73	136	99.27
Sub-centres of rural health centres	369	-	Nil	369	100.00
Tuberculosis clinics	92	87	94.57	5	5.43
Total installations	4,947	1,889	38.19	3058	61.81
Hospital Beds	38,033	30,533	80.33	7480	19.67

SOURCE: Health and Health Related Statistics, Table 58, page 71.

Table A.5
DEVELOPMENT EXPENDITURE ON HEALTH (FEDERAL)
1970-71 - 1975-76

(Millions Rupees)

S. No.	Name of Sub-sector	1970-71 Actual	1971-72 Actual	1972-73 Actual	1973-74 Revised Estimate	1974-75 Revised Estimate	1975-76 Allocation
1.	Malaria Eradication Programme	0.610	0.520	0.480	0.500	80.500	239.100
2.	Tuberculosis control	0.108	0.068	0.059	0.050	-	-
3.	Rural Health program	-	-	-	1.952	2.949	2.000
4.	Hospitals	4.271	1.183	4.129	3.908	12.836	16.438
5.	Medical Education and Training	-	-	5.500	10.380	10.000	17.000
6.	Research	-	-	-	0.800	2.487	3.400
7.	Miscellaneous	-	-	-	-	2.231	46.738
8.	FATA	-	-	-	5.155	16.368	16.800
9.	Azad Kashmir	0.465	0.425	1.002	3.000	4.532	10.500
10.	Northern Areas	0.309	0.364	0.756	3.000	2.479	4.000
	Total:	5.763	2.560	11.926	28.745	134.382	355.976

SOURCE: Health and Health Related Statistics Table 61(a), page 72.

Table A.6
NON-DEVELOPMENT EXPENDITURE FEDERAL GOVERNMENT

(Rupees)

Item	1970-71 Actual	1971-72 Actual	1972-73 Actual	1973-74 Actual	1974-75 Revised Estimate	1975-76 Budget* Estimate
Health Establishment	4,502,907	5,312,710	5,663,313	5,315,614	7,161,500	5,437,300
Hospitals and Dispensaries	5,410,943	7,486,360	12,532,598	8,669,238	9,851,100	12,862,600
Grant for Health Purposes	1,667,166	1,633,800	1,078,638	1,642,022	5,814,300	7,107,200
College and Schools	12,227,519	9,132,132	12,235,986	13,385,855	20,[illegible]62,900	21,188,00
Expenses on epidemic diseases	1,153,854	1,175,906	617,881	1,235,222	1,665,500	2,036,000
Laboratories	3,041,241	229,127	2,774,317	4,040,400	5,885,900	5,725,500
Expenses connected with relief supplied from AID	127,429	186,639	488,072	804,673	947,600	1,067,200
Lumpsum provision for drugs and medicines	-	-	-	24,687,065	20,000,000	20,000,000
Miscellaneous	-	4,514,196	336,604	161,170	2,775,200	4,653,600
Total:	28,131,059	29,670,870	35,727,409	59,941,259	74,364,000	80,077,400

Excludes Northern Areas, Azad Kashmir and FATA

SOURCE: Health and Health Related Statistics, Table 62(a), page 74.

Table A.7

ESTIMATED ANNUAL EXPENDITURE ON TREATMENT IN PRIVATE SECTOR

(Million Rs.)

(i)	Hospital beds	120.00
(ii)	Doctors in private practice	96.00
(iii)	Traditional healers	480.00
(iv)	Drugs and medicines	400.00
	Total:	1,096.00

SOURCE: Planning Commission Estimates.

OTHER DONOR ASSISTANCE

There are clear indications that other donors are moving toward increased support of Pakistan's efforts to improve rural basic health services. This increased level of interest coincides with the development of this project and should contribute substantially to the liklihood of success. Planned expenditures by these donors over the next several years appear to be supportive, and consistent with, the development of a basic rural health system. A brief description of on-going and projected donor activities follows.

A. Health

World Health Organization (WHO)

The WHO is firmly committed to the development of an improved rural basic health system in Pakistan and is planning to provide two long-term advisors to this project. Both local and non-resident WHO experts contributed to the design of the project, and as detailed in the Project Paper, an important WHO role is envisioned during project implementation.

The WHO anticipates expenditures in support of Pakistan's health services of approximately $1 million annually over the next three years. These funds will support local efforts in auxiliary training, rural health coverage, malaria control, TB, smallpox eradication, drug quality, production of biologicals, and an expanded immunization program. In addition, WHO will support medical education fellowships abroad, and development of improved health statistics, information feedback, and other management system improvements.

World Food Program (WFP)

Efforts are currently underway to utilize some of the food available through the WFP to provide nutritional rehabilitation to malnourished children who are identified (using growth charts) through the existing, and planned health delivery system. Related to this, the WFP in supporting a project in the Division of Nutrition within the National Health Laboratories to study the impact of a supplemental feeding program on health status. In addition, a proposal to support the Malaria Control Program, by providing food to workers and their families, is under active consideration by the Ministry of Health. The current annual level of expenditure in Pakistan is about $77 million.

Canadian International Development Agency (CIDA)

In November 1975, the Government of Canada and the Government of the Punjab reached tentative agreement regarding two projects in support of improved basic health services. One project would train and orient medical students toward careers in preventive and community health, while the other would train health auxiliaries to be used in the new basic health services scheme. CIDA was prepared to provide $3.3 million, including technical assistance, in support of these projects. The Canadian Embassy has indicated that they are unclear on where the proposed agreement stands; they have been advised that the projects will have to await a Government of Pakistan decision regarding the total approach adopted for strengthening rural health services.

Iran

Pakistan's Federal Ministry of Health, WHO, and the Government of Iran completed a project agreement in January 1976 to support an expanded immunization program in the Northwest Frontier Province. The Government of Iran will fund commodity support, including vaccine, refrigerators, and transport, and WHO will provide all of the required technical assistance. Implementation is scheduled to begin during the second half of CY 76.

UNICEF

UNICEF will continue to assist the expanded immunization program in Pakistan by providing vehicles, equipment and vaccines, and by supporting local production of vaccines. They will also continue to support programs to upgrade the skills of health and nutrition workers through workshops and refresher training.

World Bank

Involvement in the health sector by the World Bank has been limited to a project in a slum area of Karachi. To the best of our knowledge, no other assistance in this sector is currently under consideration.

B. Population Planning

Several donors provide support to the Government's Expanded Population Planning Scheme, an important effort to provide family planning services to the rural population. In view of the emphasis being given to family planning in the proposed Basic Health Services Project, a short description of these activities follows.

UNFPA

A five year agreement between the Government of Pakistan and UNFPA provides up to $3.0 million per year through July 1980. About one-third of this is being used to purchase condoms. The remainder, in addition to providing salary support for field workers and lady motivators, is being used to assist the Training, Research, and Evaluation Center, Regional Training Institutes, and the National Postpartum Program.

Norweigan Agency for International Development (NORAD)

In early CY 76, NORAD and the Government of Pakistan signed a $4.3 million project agreement to assist with the health and clinical component of the Population Planning Program. In brief, this project covers local support costs, including salaries, of the Family Welfare Clinics in the population program. These clinics, which are staffed by Family Welfare Visitors who have been trained for 15 months, presently number 800, and the government plans to increase this number to 1,300 over the next 2 years.

Others

Several other donors, including the United Kingdom, Australia, and the Federal Republic of Germany, are providing commodities in support of the Expanded Population Planning Scheme. The Government has accepted a German offer to fund construction of a condom factory which which is scheduled to begin production in the fall of 1978. Other donors in the population field including Ford Foundation, Asia Foundation, and other non-governmental organizations.

BASIC HEALTH SERVICES

CHECKLIST OF STATUTORY CRITERIA

BASIC AUTHORITY

1. FAA ¢ 103; ¢ 104; ¢ 105; ¢ 106. Is loan being made

a. for agriculture, rural development or nutrition;	No.
b. for population planning or health;	Yes, for health
c. for education, public administration, or human resources development;	No.
d. for the following activities:	No.
1. programs of technical cooperation and development;	
2. programs to help the recipient country alleviate energy problems;	
3. programs of research into, and evaluation of the progress of economic development or into the factors of development activities and development assistance;	
4. programs of reconstruction following natural or manmade disasters;	

The following abbreviations are used:

FAA - Foreign Assistance Act of 1961, as amended.
FAA, 1973 - Foreign Assistance Act of 1973.
App. - Foreign Assistance and Related Programs Appropriation Act, 1975.
MMA - Merchant Marine Act of 1936, as amended.

5. programs designed to help solve special development problems;

6. programs of urban development.

COUNTRY PERFORMANCE

Progress Towards Country Goals

2. FAA ¢ 201 (b) (5), (7) & (8); ¢ 208

A. Describe extent to which country is:

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

Food production is a major focus of Pakistan's development effort. Current food production targets will make the country self-sufficient in wheat by 1979. The Government has supported these targets by adopting a price support policy for wheat, allocating large amounts of domestic credit for farmers and implementing rural credit campaigns. It has removed restrictions on the domestic sales and distribution of fertilizer, continues to invest major amounts in farm mechanization, improved irrigation, domestic fertilizer production and fertilizer imports. Since 1972, domestic fertilizer sales have increased from 381,000 nutrient tons to an estimated 584 thousand tons in 1976 (up 53%). It is making significant efforts to adapt foreign technology (supported by a major April 30, 1974 A.I.D. loan agreement), build new fertilizer plants, better distribute high-yielding seed varieties and extend irrigated acreage. The project is not directly related to increasing food production. However it may be assumed that a healthier rural population will produce more.

(2) Creating a favorable climate for foreign and domestic private enterprise and investment.	Nationalization of domestically owned banks and a number of major industries in fulfillment of election pledges by the current government created uncertainties for investors that have retarded private investment in large-scale industries. A formula for the payment to investors has been publicly adopted, and clearer demarcation of the industrial role of private and public investors have improved the climate somewhat. The Government's leaders have publicly affirmed that a substantial degree of domestic and foreign private investment is essential to the country's economic development. Inducements to new private investment are offered, and there is active growing investment in medium and small scale industry. Lately, U.S. investors have evidenced perceptible interest in establishing or expanding prospects and the Government has already approved many of these: e.g. Rafhan Maize (ICP), Premier Tobacco, Fauji Agrico fertilizer plant.
(3) Increasing the public's role in the developmental process.	The present government describes itself as a "People's Government". During the summer of 1973 a new constitution establishing a parliamentary form of government was put into effect in Pakistan. At the lower level, the fledgling People's Works and Integrated Rural Development Programs contemplate more active participation in development at the village level.
(4) (a) Allocating available budgetary resources to development.	Development investment expenditure account for about 38% of the consolidated Government budget in FY 1976. They have increased from Rs10,838 million (35%) in FY 1975 to Rs13,500 million in FY 1976.

(b) Diverting such resources for unnecessary military expenditure (See also Item No. 21) and intervention in affairs of other free and independent nations.) (See also Item No. 11).	The budget for defense expenditures increased by only 12% in FY 1976, significantly less than the 25% increase in development expenditures. In FY 1975 Rs6,832 million was spent on defense expenditures, and revised estimates this year are Rs8,200 million. There has as yet been no significant increase following (a) India's detonation of a nuclear device, (b) the continuing strain in Afghan-Pakistan relations, or (c) the lifting of the U.S. embargo on sales of lethal defense items to Pakistan.
(5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.	The current government promulgated a quick succession of different land, labor, banking, education, health, and law reforms, which are making significant contributions to social, economic and political development as they are being implemented. The rule of law is publicly endorsed, though the laws have recently been amended making it easier for the government to move against certain elements of political opposition. The government has announced a new plan to strengthen democratic local government.
(6) Willing to contribute funds to the project or program.	The Basic Health Services project will be substantially financed by the Government and the participating agencies. This loan will provide 60% of the total resources required for Phase I of the project.

(7) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.	As the responses above suggest, the recipient government has committed itself to meeting the vital economic, political and social concerns of its people. Since coming to power, the self-help measures the government has taken include the rupee devaluation of May 1972 and import liberalization program, increases in tax revenues and other stabilization measures, steps to increase subsidies on farm inputs, and substantial flood relief recovery and rehabilitation efforts. It has lifted or relaxed internal restrictions on the transport and sale of wheat, and increased the government procurement price substantially, measures that will give significant increased incentive to agricultural production.
B. Are above factors taken into account in the furnishing of the subject assistance?	Yes.
FAA ¢ 116	
(a) Has the Secretary of State made a determination that the recipient country does not engage in a consistent pattern of gross violations of internationally recognized human rights?	
(b) If not, does this loan directly benefit the needy people of the recipient country?	Yes.

Treatment of U.S. Citizens and Firms

4. FAA ¢ 620 (c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government.	No.
5. FAA ¢ 620(e)(1). If assistance is to a government, has it (including govern ment agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	The March 1972 Life Insurance Nationalization affected an American Company, which negotiated a satisfactory settlement, and received compensation in 1973. In addition, the nationalization of schools potentially affects one American church organization which owns substantial property in Pakistan. The church organization is holding discussions with the government on the matter.
6. FAA ¢ 620(o); Fishermen's Protective Act. ¢ 5. If country has seized, or imposed any penalty or sanction against any U.S. fishing vessel on account of its fishing activities in international water.	Not Applicable.
a. has any deduction required by Fishermen's Protective Act been made?	Not Applicable.
b. has complete denial of assistance been considered by A.I.D. Administrator?	Not Applicable.

Relations with U.S. Government and Other Nations

7. FAA ¢ 620 (a). Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargoes to or from Cuba?	Pakistan does not furnish assistance to Cuba. However, during October 1973, 4,000 tons of barley were shipped to Cuba by a private exporter. There had never been any previous barley exports from Pakistan to Cuba. The GOP was unaware of the transaction because there was no procedure for licensing or controlling shipments of barley. Controls have now been instituted and the GOP has assured the U.S. that no further exports will be made.
8. FAA ¢ 620 (b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the International Communist Movement?	The Secretary of State has determined that Pakistan is not controlled by the International Communist Movement.
9. FAA ¢ 620 (d). If assistance is for any productive enterprise which will compete in the United States with United States enterprise, is there an agreement by the recipient country to prevent export to the United States of more than 20% of the enterprise's annual production during the life of the loan.	Not Applicable.
10. FAA ¢ 620 (f). Is recipient country a Communist country?	No.
11. FAA ¢ 620 (i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?	No.
12. FAA ¢ 620 (j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?	No.

13. FAA ¢ 620 (l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, in convertibility or confiscation, has the A.I.D. administration within the past year considered denying assistance to such government for this reason?	Pakistan has instituted the investment guaranty program for the specific risks of expropriation, inconvertibility and war risk.
14. FAA ¢ 620 (n). Does recipient country furnish goods to North Viet-Nam or permit ships or aircraft under its flag to carry cargoes to or from North Viet-Nam?	Not Applicable.
15. FAA ¢ 620 (q). Is the government of the recipient country in default on interest or principal of any A.I.D. loan to the country?	No.,
16. FAA ¢ 620 (t). Has the country severed diplomatic relations with the United States. If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	Diplomatic relations with the United States have never been severed.
17. FAA ¢ 620 (u). What is the payment status of the country's U.N. obligations? If the country is in arrears were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget?	Pakistan is not delinquent in any obligations to the United Nations.
18. FAA ¢ 481. Has the government of recipient country failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such coun try, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?	No.

19. FAA ¢ 659. If (a) military base is located in recipient country, and was constructed or is being maintained or operated with funds furnished by U.S., and (b) U.S. personnel carry out military operations from such base, has the President determined that the government of recipient country has authorized regular access to U.S. correspondents to such base?	Not Applicable
20. FAA ¢ 666. Does the government of recipient country object to the presence of any officer or employee of the U.S. who is present in this country for the purpose of carrying out economic development assistance on the basis of the race, religion, national origin, or sex of such officer or employee?	No.

Military Expenditures

21. FAA ¢ 620 (s). What percentage of country budget is for military expenditures? How much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems? (Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RC).	During fiscal year 1976, Pakistan's known defense expenditures are projected to be about Rs8,200 million, 23% of the consolidated government budget. Last year defense expenditures were Rs6,832 million, about the same percentage of the total budget. We have no precise estimate of foreign exchange resources utilized to acquire military hardware and other defense equipment, but believe these to be about $200 million annually largely to replace and maintain obsolescent equipment, much of it supplied by the U.S. as military aid during the 1950's and early 1960's. Pakistan has purchased sophisticated weapon systems from abroad, including Mirage jet fighters from France, armored personnel carriers from the U.S. and tanks and jet fighters (many on concessional terms) from the Peoples Republic of China.

Conditions of The Loan

General Soundness

22.	FAA ¢ 201 (d). Information and conclusion on reasonableness and legality (under laws of country and the United States) of lending and relending terms of the loan.	The funds will be lent in compliance with the laws of the United States and of Pakistan. The lending terms, 40 years including 10 years grace period, 2% interest during the grace period and 3% thereafter are considered reasonable. The rate of interest is less than Pakistan's discount rate.
23.	FAA ¢ 201 (b) (2); ¢ 201 (e). Information and conclusion on activity's economic and technical soundness. If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds $100,000, has country submitted to A.I.D. an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?	A thorough analysis of the economic and technical soundness of the project is included in the PP. The program as proposed is considered technically economically sound. A joint USAID/GOP committee has developed. A loan application was received. (See Annex The loan agreement will include requirements for judicious use of the funds.
24.	FAA ¢ 201 (b) (2). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.	Pakistan's foreign exchange income is continuing to grow and its overall repayment capacity is also growing. This loan will directly contribute to this capacity by increasing the country's productive capacity. The repayment prospects for this loan are reasonable. (See Part III D of the Paper).

25.	FAA ¢ 201 (b) (1). Information and conclusion on availability of financing from other free-world sources including private sources within the United States.	Many donors, both bilateral and multilateral, are contributing or plan to contribute to facets of this rural health effort. A full discussion is included in Annex D. A.I.D. is not now aware of any U.S. private sector interest in investing or otherwise contributing to this project activity.
26.	FAA ¢ 611 (a) (1). Prior to signing of loan will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the United States of the assistance?	Yes. Se Part III A of the Project Paper.
27.	FAA ¢ 611 (a) (2). If further legislative action is required within recipient country, what is the basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of loan?	No such legislative action is required.
28.	FAA ¢ 611 (e). If the loan is for Capital Assistance, and all U.S. assistance to project now exceeds $ 1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?	Yes. See Annex F

Loan's Relationship to Achievement of Country and Regional Goals

29.	FAA $ 207; ¢ 113. Extent to which assistance reflects appropriate emphasis on: (a) encouraging development of democratic, economic, political, and social institutions; (b) self-help in meeting the country's food needs; (c) improving availability of trained manpower in the country; (d) programs designed to meet the country's health needs; (e) other important areas of economic, political and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (f) integrating women into the recipient country's national economy.	This loan will make a direct contribution to Pakistan's self-help efforts to improve the health status of its rural population. Increase the number of persons trained in health management and medicine. Public Administration improvements in the health sector are a major objective of this project. Also women are expected to participat fully in this project both as health care provider and as recipients of the new services.
30.	FAA ¢ 209. Is project susceptible of execution as part of regional project? If so why is project not so executed.	No
31.	FAA ¢ 201 (b) (4). Information and conclusion on activity's relationship to, and consistency with, other development activities, and its contribution to realisable long-range objectives.	This project is directly in line with Pakistan's development plans. The project is directly supportive of Pakistan's development activities in the areas of population, nutrition. (See Part III D of the Project Paper)
32.	FAA ¢ 201 (b) (9). Information and conclusion on whether or not the activity to be financed will contribute to the achievement of self-sustaining growth.	A healthier population will contribute greatly to the achievement of self sustaining growth.

33.	FAA ¢ 209. Information and conclusion whether assistance will encourage regional development programs.	Not Applicable.
34.	FAA ¢ 111. Discuss the extent to which the loan will strengthen the participation of urben and rural poor in their country's development, and will assist in the development of cooperatives which will enable and encourage greater numbers of poor people to help themselves toward a better life.	This loan will result in improved health for Pakistan rural population, which will have a direct impact on the qualitative improvement of the lives of people, and their chances for participation in development. Development of cooperatives is not a part of this project.
35.	FAA ¢ 201 (f). If this is a project loan, describe how such project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development.	This project will promote Pakistan's economic development by helping to improve the rural health status. The project will also provide improved training opportunities for villagers and support staff personnel.
6.	FAA ¢ 281 (a). Describe extent to which the loan will contribute to the objective of assuring maximum participation in the task of economic development on the part of the people of the country, through the encouragement of democratic, private and local governmental institutions.	The project which the team will assist in financing will reach all segments of the rural population.
37.	FAA ¢ 281 (b). Describe extent to which program recognizes the particular needs, desires and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The loan recognizes the needs of the rural population and the desire for improved health. The project will organize Pakistan's medical resources and institutionalize the rural health delivery system, including training of preventive medicine techniques to the general population.

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38.	FAA ¢ 201 (b) (3). In what ways does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities?	See Item 35 above.
39.	FAA ¢ 601 (a). Information and conclusions whether loan will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	a) The loan will have no direct effect on international trade. b) The loan is not expected to decrease the scope for private initiative. c) The project will not discourage monopolistic practice, increase formal or informal cooperative activity. d) The project will not discourage monopolistic practices. e) The project will increase the efficiency of rural productive sector by improving the general health of the rural worker. f) There will be no impact upon labor unions.
40.	FAA ¢ 619. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate?	Not Applicable.

Loan's Effect on U.S. and A.I.D. Program

41.	FAA ¢ 201 (b) (6). Information and conclusion on possible effect of loan on U.S. economy, with special reference to areas of substantial labor surplus, extent to which U.S. commodities and assistance are furnished in a manner consistent with improving the U.S. balance of payment position.	The loan will be administered in accordance with existing U.S. Government regulations, using fixed amount reimbursement through a Special Letter of Credit to pay a share of the cost of the project assisted The SLC will be spent for the purchase of goods and services from the United States. Also the loan will finance a limited amount of U.S. advisory services.

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42.	FAA ¢ 202 (a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources.	Loan funds will not go to the private sector in Pakistan. There will be no imports directly financed by the project loan except 4 vehicles to be financed under the bilateral assistance contract.
43.	FAA ¢ 601 (b). Information and conclusion on how the loan will encourage U.S. private trade and investment abroad and how it will encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	This loan is not expected to directly foster U.S. private trade and investment abroad.
44.	FAA ¢ 601 (d). If a capital project, are engineering and professional services of U.S. firms and their affiliates used to the maximum extent consistent with the national interest?	Limited professional services will be financed under this loan. Such services will be of U.S. source.
45.	FAA ¢ 602. Information and conclusion whether U.S. small business will participate equitably in the furnishing of goods and services financed by the loan.	AID procurement rules will be followed.
46.	FAA ¢ 620 (h). Will the loan promote or assist the foreign aid projects or activities of the Communist-Bloc countries?	No
47.	FAA ¢ 621. If Technical Assistance is financed by the loan, information and conclusion whether such assistance will be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis. If the facilities of other Federal Agencies will be utilized, information and conclusion on whether they are particularly suitable, are not competitive with private enterprise, and can be made available without undue interference with domestic programs.	Technical assistance from U.S. sources will be financed by the loan and will be from private enterprise sources.

Loan's Compliance with Specific Requirements

48.	FAA ¢ 110 (a); ¢ 208 (e). In what manner has or will the recipient country provide assurances that it will provide at least 25% of the cost of the program, project, or activity with respect to which the Loan is to be made? or has a determination been made that the recipient country is relatively least developed and the requirement has been waived?	The loan agreement will specify that the host country will provide at least 25% of the cost of the entire activity.
49.	FAA ¢ 660. Will loan be used to finance police training or related program in recipient country?	No
50.	FAA ¢ 114. Will loan be used to pay for performance of abortions or to motivate or coerce persons to practice abortions?	No
51.	FAA ¢ 201 (b). Is the country among the 20 countries in which development loans funds may be used to make loans in this fiscal year?	Yes
52.	FAA ¢ 201 (d). Is interest rate of loan at least 2% per annum during grace period and at least 3% per annum thereafter?	Yes
53.	FAA ¢ 201 (f). If this is a project loan, what provisions have been made for appropriate participation by the recipient country's private enterprise?	The loan will not directly involve participation of the private sector. Procurement of local drugs, equipment and construction services may be from the private sector.
54.	FAA ¢ 604 (a). Will all commodity procurement financed under the loan be from the United States except as otherwise determined by the President?	Yes

55.	FAA ¢ 604 (b). What provision is made to prevent financing commodity procurement bulk at prices higher than adjusted U.S. market price?	Not Applicable.
56.	FAA ¢ 604 (d). If the cooperating country discriminates against U.S. marine insurance companies, will loan agreement require that marine insurance be placed in the United States on commodities financed by the loan?	Not Applicable.
57.	FAA ¢ 604 (e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?	Not Applicable.
58.	FAA ¢ 604 (f). If loan finances a commodity import program, will arrangements be made for supplier certification to A.I.D. and A.I.D. approval of commodity as eligible and suitable?	This is a project plan.
59.	FAA ¢ 608 (a). Information on measures to be taken to utilize U.S. Government excess personal property in lieu of the procurement of new items.	Not Applicable.
60.	FAA ¢ 611 (b); app ¢ 101. If loan finances water or water-related land resource construction project or program, is there a benefit-cost computation made, insofar as practicable, in accordance with the procedures set forth in the Memorandum of the President dated May 15, 1962?	Not Applicable.
61.	FAA ¢ 611 (c). If contracts for construction are to be financed what provision will be made that they be let on a competitive basis to maximum extent practicable?	To be covered in the loan agreement.

62.	FAA ¢ 612 (b); ¢ 636 (h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the United States are utilized to meet the cost of contractual and other services.	The host country will provide agreed amounts of the local currency expenses of the project.
63.	Section 30 and 31 of PL 93-189 (FAA of 1973) Will any part of the loan be used to finance directly or indirectly military or paramilitary operations by the U.S. or by foreign forces in or over Laos, Cambodia, North Vietnam, South Vietnam, or Thailand?	No
64.	Section 37 of PL 93-189 (FAA of 1973); App. ¢ 111. Will any part of this loan be used to aid or assist generally or in the reconstruction of North Vietnam?	No
65.	FAA ¢ 612 (d). Does the United States own excess foreign currency and, if so, what arrangements have been made for its release?	The U.S. owns excess Pakistani rupees that are programmed for use in a number of projects.
66.	FAA ¢ 620 (g). What provision is there against use of subject assistance to compensate owners for expropriated or nationalized property?	Loan proceeds disbursement procedures will be included in the loan agreement will prevent use of the funds for purposes other than intended.

67.	FAA ¢ 620 (k). If loan is for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States exceed $ 100 million?	Not Applicable.
68.	FAA ¢ 636 (i). Will any loan funds be used to finance purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States or any guaranty of such transaction?	No.
69.	App. ¢ 103. Will any loan funds be used to pay pensions, annuities, retirement pay, etc., for military personnel?	No.
70.	App. ¢ 105. If loan is for capital project, is there provision for A.I.D. approval of all contractors and contract terms?	Yes
71.	App. ¢ 107. Will any loan funds be used to pay UN assessments?	
72.	App. ¢ 108. Compliance with regulations on employment of U.S. and local personnel. (A.I.D. Regulation No. 7)	Not Applicable.
73.	App. ¢ 110. Will any of loan funds be used to carry out provisions of FAA ¢ 209 (d) or FAA ¢ 251 (h)?	No.
74.	App. ¢ 112. Will any of the funds appropriated or local currencies generated as a result of AID assistance be used for support of police or prison construction and administration in South Vietnam or for support of police training of Souch Vietnam?	No

75.	App. ¢ 113. Describe how the Committee on Appropriations of the Senat and House have been or will be notified concerning the activity, program, project, country, or other operation to be financed by the Loan.	The loan proposal has been included in the Congressional Presentation for FY 1977.
76.	App. ¢ 501. Will any loan funds be used for publicity or propaganda purposes within the United States not authorized by Congress?	No
77.	App. ¢ 504. Will any of the funds appropriated for this project be usedto furnish petroleum fuels produced in the continental United States to Southeast Asia for use by non-U.S. nationals?	No
78.	MMA ¢ 901 b; FAA ¢ 640 C. (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed with funds made available under this loan shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.	Not Applicable.
	(b) will grant be made to loan recipient to pay all or any portion of such differential as may exist between U.S. and foreign-flag vessel rates?	Not Applicable.
79.	FAA ¢ 901. Has the country denied its citizens the right or opportunity to emigrate?	No.
80.	FAA ¢ 115. Will country be furnished, in same fiscal year, either security supporting assistance, Indochina Postwar Reconstruction, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?	No

81.	FAA ¢ 653 (b). Is this assistance within the country or international organization allocation for the fiscal year reported to Congress (or not more than $1 million over that figure plus 10%)?	Yes
82.	FAA ¢ 662. Will arrangements preclude use of funds for CIA activity.	Yes

ANNEX I

DRAFT PROJECT DESCRIPTION FOR LOAN AGREEMENT

The project is the three year first phase of an eight year program to develop a functioning system of Integrated Rural Health Center Complexes, to provide improved preventive and curative health care in rural areas. Each Integrated Rural Health Center Complex will be comprised of Rural Health Centers, staffed with trained physicians and other health workers; Basic Health Units, staffed with health workers trained to a middle-level degree of competency; and locally-posted Community Health Workers, operating individually under the supervision of senior health personnel.

To support the Integrated Health Complexes, the Project will finance the development and operation of required management and operations systems: training, personnel, planning, budgeting and accounting, communications, supply, and logistics.