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9. ABSTRACT

The American Public Health Association, under a contract with the Agency for International Development, has designed a program in public health improvement which is called the Development and Evaluation of Integrated Delivery Systems (DEIDS). The activity is designed to assist countries to demonstrate how to establish health delivery systems within seven years. Such projects include, but are not limited to, Maternal and Child Health and Family Planning and Nutrition. The projects are to cover large populations in predominantly rural areas. They are to utilize in-country resources for the service component, although external assistance organized by DEIDS is available for planning, evaluation, training, and limited amounts of essential equipment. It is expected that successful health delivery systems can be subsequently replicated in the country or in the region.

- These are phases through which DEIDS projects proceed:
- a) Phase I -- reconnaissance within a specific country or region, to gather information about disease patterns, health services as currently organized, local resources, cultural aspects, community involvement, the potential for integration of various parts of public health, opportunities for innovation, current and potential staffing, training, supervision, emphasis upon preventive services, outreach, cost, and evaluation
  - b) Phase II -- Detailed planning. This phase begins if the survey in Phase I recommends it, and involves experts from the host country as well as experts assigned by DEIDS.
  - c) Phase III -- Pilot Project Operations, which continue for as long as eight years.

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DEIDS Reconnaissance Visit

August 30-31, 1972

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Report on DEIDS Reconnaissance Visit to

PAKISTAN

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## INTRODUCTION

The "reconnaissance" visit to Pakistan was the first time a DEIDS team was fielded by APHA. Therefore, we were learning about procedure as well as about the country. Undoubtedly there are some gaps in our information as a result of not seeing all the pertinent people and of not asking all the pertinent questions. We wish to thank officials and staff of the Pakistan and Punjab Governments and other Pakistanis who answered our questions with candor, as well as all in USAID and the UN agencies who contributed ideas and information. The list of persons contacted and our itinerary are found in Attachment A.

Until additional reconnaissance visits are completed, definitive recommendations cannot be made. However, we have come to some tentative conclusions, which were expressed in our debriefing sessions and which are stated and supported in this report.

## I. General

### A. Political Situation

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In general it can be said that Pakistan, in its short history of 25 years, has had more than its share of political upheaval and instability. This turmoil has resulted in long and extended periods of martial law, with very limited opportunity for the people to participate in their own government.

The original intent of the founders of the country was to provide a homeland for the Muslims of the subcontinent. It was to be a religious state with a predominantly Muslim population to carry on the traditions and beliefs of the Muslim religion. However, from the very beginning a conflict developed between traditional Muslim philosophy and the desire for rapid economic development. The conservative Muslim attitudes were generally held by the villagers, the mullahs, the illiterate, the poor, the elderly, the hakims, etc., while the new or development attitudes were held and fostered by the military leadership, the young intellectuals, the newcomers, the moderate Muslims, and westerners.

The basic political policy which was evolved in Pakistan's first few years of life depended on a very

sophisticated, planned economic growth, copied from the western cultures, managed by the center government, and administered through a rather rigid, authoritarian, bureaucratic administrative structure with very little involvement of the people in the planning or administrative process. The planning process was a very complicated and sophisticated process not understood by the common man. What the common man observed was that a "few" were getting what appeared to be all of the breaks and financial gravy while the "many" were encouraged to tighten their belts. The common man was aware also of the influx of new ideas, values, patterns of dress, etc., which appeared to be inconsistent with basic Muslim values, and this gave fodder to the village mullah and others who felt the country was moving in the wrong direction.

From time to time things seemed better for the common man. He seemed to reap the harvest of stability which required rigid controls. Then came the two disastrous wars, the loss of East Pakistan and the resulting national psychological shock.

Into the void came President Bhutto and the People's Party. It appears that the present Government is torn between continuing the present developmental model or moving rapidly toward a type of socialism.

## B. Economic Situation

The national budget for the current fiscal year (July 1972-June 1973) is 11,122 millions of rupees. This is nearly as high as for each of the previous three years, even though last year included heavy military expenditure and revenue has been cut by roughly 40% by the separation of Bangladesh. External aid also is being reduced. One can only conclude that the budget is overoptimistic regarding revenue.

## C. Administrative Structure

The administrative machinery and organizational model operating in Pakistan today is in a state of flux. No one interviewed could draw a clear picture of how decisions are being made or how the government is relating to all of its parts. There appear to be two opposing forces at work within the governmental machinery. One is pulling for a strong central system like that which has been in use for the past fifteen or so years and the other is pressuring for new decentralization, putting the power and authority for most activities back in the hands of elected provincial governors and assemblies. A new force has been introduced, the People's Party, and no one is certain how this will relate to the others.

#### D. Policies and Laws

1. Family planning is accepted by the Government as an essential part of their development program. The Family Planning Program is managed by a Board which is autonomous. The Fourth Five Year Plan (which has now been discarded) called for integration of the Family Planning Program at the periphery. The People's Health Scheme also calls for integration of all health programs. However, the Family Planning Board and its concern for its special cadres of personnel, may be one source of opposition to the Scheme.

2. The laws and regulations regarding medical practice include registration acts regularizing the practice of graduates from recognized medical schools and colleges and hakims, who pass through the three schools now operating, or who were registered under the "grandfather" clause. In addition to these two groups, there are numerous persons in private practice who have had little or no training. Although this is illegal, no enforcement is expected in the near future. Under the sponsorship of the Department of Health, several types of trained auxiliaries also practice, in theory under the

supervision of a registered physician. Thus, the use of trained auxiliaries, with adequate supervision, is accepted as a necessity, and will be greatly expanded under the People's Health Scheme (Attachment B)

## II. Health Administration, Responsibilities and Activities

### A. Official

1. The Federal or Central Government's Health Ministry is headed by the Minister, who is a politically appointed non-medical person. His administrative chief is the Secretary, a civil servant, also non-medical. The technical input is supplied by the Director General of Health Services and his staff.

Although health is considered a Provincial subject, much guidance and financial support is provided from the Center. For instance, the People's Health Scheme (Attachment B) was developed by the Center, with thorough consultation with the Provincial officers.

Funding for the established health services in a Province comes from what is called the "current account." As such it is made up principally of Provincial funds, part of which are granted from the Center. If an incremental program, such as family planning is and such as implementation of the People's Health Scheme would have to be, it is called "developmental." In this case, a small portion ( $\pm 25\%$ ) comes from Provincial funds,  $\pm 25\%$  may come from the Center in a general allocation to the Province for all developmental projects, and  $\pm 50\%$  will come from the Center,

designated for the particular developmental project.

Because of these financial controls from the Center, the Provinces are generally not allowed to deviate much in implementation of agreed-upon plans.

2. At the Provincial level there is also a Minister, a Secretary, who at present in the Punjab happens to be a physician, and a Director of Health Services, who is always a physician. The Institute of Hygiene and Preventive Medicine and the medical colleges are administered from the Provincial level.

3. The Deputy Directors of Health Services (DDHS) are located at Divisional headquarters covering several districts and are responsible for the administration of all the hospitals and health center, except for medical college hospitals.

4. At the district level the Superintendent of the District hospital is responsible to the DDHS. The District Health Officer (DHO) is responsible to the DDHS for the administration of all other health department facilities and staff. The District Malaria Eradication Officer and the District Family Planning Executive and Information Officer are directly responsible to their respective Provincial headquarters.

5. Peripheral to the District\*, there are a number of Rural Health Centers (RHC), staffed by one or two doctors and paramedicals. Rural Health Centers often have several sub-centers, to be called Basic Health Units (BHU), staffed by resident auxiliaries and visited once or twice a week by the RHU doctors. The RHU and BHU are administered and supervised by the Department of Health through the DHO and the assistant district health officer.

There are approximately 800 MCH centers in Pakistan. Some of these are established in rural health centers and some operate separately in urban or semi-urban areas. They are usually headed by a lady health visitor, who is assisted by one or two midwives and peons. Clinics for mothers and children are conducted and some home visiting is done. Deliveries are occasionally supervised and a few indigenous midwives are often under training. These centers are supervised by the Inspectress of MCH, out of provincial headquarters. Most supplies and equipment come from UNICEF.

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\*The team divided into two groups, each using two days to visit each kind of peripheral facilities in separate districts.

There are also scattered "Civil" dispensaries under DHO control and "rural" dispensaries which are governed and paid for by the local town councils, but supervised by the DHO. Most of these have posts for a doctor and some of these posts are actually filled.

Union councils are the rural equivalent of the town councils, each covering about 10,000 people. They often employ an auxiliary or two as sanitary inspector, dispenser or midwife. This staff is supposed to receive technical supervision through the health department.

The administrative situation at the town council, union council, and village level is quite confused. The mechanism for constituting councils was abolished several months ago and the new system has not been established. The impending Constitution is expected to be followed by elections which will establish the membership of the equivalent of the councils. In the meantime, their responsibilities are being carried out by the paid secretaries. However, changes cannot be negotiated because there is no organization with which to negotiate and stimulation of people's participation and contribution is difficult because of the absence of an established mechanism.

## B. External Assistance

There are several UN agencies involved in assisting Pakistan with various health related programs. At present the USAID is the only active bilateral program. The participation is as follows:

1. WHO supports a number of unrelated projects in Pakistan, but has nothing in the way of a comprehensive health project. The programs with which WHO is assisting are: a) smallpox eradication, b) malaria eradication, c) tuberculosis control, d) the Nutrition Institute, e) teaching of sanitary engineering at the University of Lahore, f) leprosy control, g) community water supply and rural sanitation, h) the National Health Laboratories, i) occupational health, j) the Institute of Hygiene, k) freeze-dried BCG vaccine production, l) pharmaceutical quality control, m) training and research in family planning, and n) epidemiology and health statistics.

The representative of WHO was not in Pakistan at the time we visited but we were able to talk with his "Acting," a Dr. Barkat, who is their nutrition expert. He clearly stated that WHO would welcome a DEIDS Project and would give whatever assistance they could.

2. UNICEF has always been particularly interested in maternal and child health and would therefore assist in any way the DEIDS Project would need its help, according to Mr. Zablotsky, the Deputy Director. He said that UNICEF has about 1,000 outlets in the country, and that each of these centers serves about 100 clients each month.

UNICEF is particularly interested in paramedical training and realizes that Pakistan needs to increase the proportion of the paramedics a great deal before an efficient health delivery system can be developed. There are presently about six institutions that receive some sort of assistance from UNICEF in the training of women in various types of paramedical courses. One of these is the four-year nursing course and another is the 27-month lady health visitor's course. There are also courses for assistant nurses and lady family planning visitors which are shorter. UNICEF has offered to help establish other training centers, but so far the Government of Pakistan has not followed through with a request. They would be able to support any type of training which would improve the M.C.H. services for the women and children of Pakistan.

They would also be able to increase the amount of supplies, providing an active delivery system were established to get them to the mothers and children.

3. The UNFPA does not conduct programs but is supporting five UN organizations carrying out various aspects of family planning activities. As reported by Dr. Holliday, most of these programs are not functioning well. They are as follows:

a) The UN Population Division has contracted to give support to TREC, the Training Research and Evaluation Center, which is attached to the Family Planning Board. However, no progress has been made in this support.

b) The ILO -- International Labor Organization -- is making some progress in the education of workers on family planning.

c) UNESCO has undertaken to develop population education in the schools. It has supplied one consultant, but his efforts were not productive. (However, when we visited TRLC, which is not closely connected with the UNESCO project, we heard that they were in the process of reviewing all school textbooks in regard to their population education content.)

d) UNICEF obtains commodities and assists in payment of staff in the Sialkot and other pilot project districts. These payments have been stopped for several months because of some discrepancies in the accounting. Procurement of two million cycles of pills has been delayed because reports regarding the present use level and projections for the future have not been submitted by the Government. Forty jeeps and some other vehicles are being held in Karachi and will not be released until agreed upon conditions are met. These include the provision of proper repair facilities, adequate allowances for gas and oil, and formal training of the drivers.

e) WHO is assisting with the post partum family planning program and biological research in one of the institutions in Karachi. The research on biological aspects of family planning seems to be going well. The post partum program is at a standstill because the channels for the funds to pay for sterilizations are clogged and the fees do not get out to the surgeons.

4. USAID's chief interest in health has been in the area of family planning. It has supplied commodities, participant training and technicians. Recent AID contributions

for other aspects of health have been limited to the malaria eradication program, the Cardiovascular Institute, and the Pakistan Medical Research Center. Agreements regarding future support of these programs seem unlikely.

### C. Voluntary Organizations

The major voluntary organizations which are making some contribution to the health of Pakistanis are as follows:

1. The Hamdard Foundation is a combination of a voluntary organization and a profit-making drug firm. It ties together many of the hakims, who are the practitioners of the Unani system of medicine, the most prevalent indigenous health care system in Pakistan. We were not able to visit headquarters in Karachi, but we were able to visit a subcenter in Lahore. In talking with the hakims in Lahore, visiting several of them in the rural areas and in talking with the Pakistan Medical Association and others involved in the delivery of health services, we concluded that this system should not be ignored, but that it would be unwise to base a DEIDS Project on it. Details are given in Section III, C, 3.

2. The Family Planning Association of Pakistan works mainly in the urban areas and would not be of much assistance in developing a program for rural areas.

3. The Red Cross and St. John's Ambulance Corps are also rather limited in their distribution. We did not visit their offices, but if a detailed plan were to be developed for one of the districts of Pakistan, it would be necessary to see if any of their chapters are working in that district and to make use of their assistance whenever possible.

4. Medical Mission groups, Catholic and Protestant, are not active in rural areas, although they run several first-class hospitals in the cities. The Protestant Mission Hospital in Lahore attempted to develop a rural program near the city, but has been requested to stop this activity. Some of the elements of their plan need further study to determine applicability to the possible DEIDS Project.

#### D. Man and Woman Power

As in many developing countries, the ratio of auxiliaries to doctors is too low for efficient service. Pakistan has concentrated on the development of medical colleges and will soon be graduating an adequate number

of doctors. However, schools and training centers for auxiliaries are far too few to provide staff required by the People's Health Scheme (Attachment B), or a staffing pattern we might suggest for DEIDS, or for any other scheme which aims at widespread coverage. The facts given below concentrate on the situation in the Punjab, although part of the description pertains to the country as a whole.

1. Medical Doctors. There are approximately 14,000 doctors in Pakistan, but only about 1,500 of these are in Government service. The rest of them are in private practice and most of those in Government service are also allowed private practice. The base pay for doctors is low, with the expectation that most of them will supplement their income, perhaps even triple or quadruple it, through private practice. There is some medical unemployment in Pakistan as the Government budget is not able to absorb all those who would need work. There has been some loss of medical personnel through two channels of brain drain: to the United Kingdom and the United States, where Pakistanis fill many positions in the hospital services of those countries, and to a systematic recruitment

by Libya, Iraq, and other Arab countries for positions in their health services, which pay a great deal more than Pakistan is able to pay.

The medical colleges are growing in number and each college is required to take additional students each year. Therefore, they are now graduating about 1,200 doctors a year in Pakistan and expect that it will soon rise to 1,500. This supply of new doctors would be adequate to staff their growing health services under the People's Health Scheme, although they are not sure about the budget for all of these personnel. Furthermore, the budget must be further increased to cover special allowances in order to get the doctors to live as far out as the plan requires.

2. Public Health Personnel. Another training resource of Pakistan is the Institute of Hygiene and Preventive Medicine, which is located in Lahore and run by the Provincial Government. Dr. Awan, the Dean, is expecting to be allowed to go to Iraq as Professor of Preventive Medicine. Several of the other professors' positions have not been filled, because of the difficulty in meeting the requirements of the University and of the Pakistan Medical Council. Furthermore, some of the positions which are filled are occupied by people who are near retirement. For all these reasons the future strength of the Institute is unpredictable.

Presently the Institute is offering courses for medical graduates which result in the Diploma in Public Health (20 a year), the Diploma in Maternal and Child Health (20 a year), and refresher and orientation courses for doctors assigned to public health and rural work. It also gives courses resulting in a certificate for sanitary inspectors and rural health inspectors.

There is governmental pressure to increase training capacity in all of the above courses. Paradoxically, the number of stipends is limited and in the past few years intake has been under capacity because of shortage of candidates at all levels. Facilities would allow increased admissions, but this would only be feasible when the Institute is fully staffed.

The Institute is expecting to be heavily involved in the training of auxiliaries when the People's Health Scheme is implemented. They are already in the process of developing job descriptions for the new categories of health workers and in preparing training programs to match.

We were interested to hear that the Institute has a field training area in which they are conducting a

small-scale field study on the integration of MCH and FP. They have assigned one lady health visitor for every 5,000 people and arrange to have a doctor visit each center three times a week. They report that there has been a reduction in the birth and mortality rates in this study area.

3. Lady health visitors and midwives. Schools for women auxiliaries are few in Pakistan. We reviewed the situation in the Punjab only.

a) Lady health visitors. The only school for training these women is in Lahore, where staff and facilities seem to be adequate. The candidates must have passed high school before entering and are given one year of public health nursing and one year of midwifery. The school accepts 70 students a year. The Government is suggesting that the number be increased to 100, but this would overcrowd the facilities. There are plans for the establishment of a similar school at Multan, where the facilities are adequate, but staff has not been recruited to make this new school possible.

One of the paradoxes of the situation in regard to lady health visitors is that many who have been trained are not employed. Positions have not been sanctioned and budget is not available. In asking about the class which

graduated in April of 1971, we were told that only 50% were currently working. On the other hand, the staffing requirement for lady health visitors under the People's Health Scheme is so enormous that this school and the proposed school in Multan would not be able to provide enough of them within 25 years.

b) Indigenous midwives (Dais). These women receive a one-year course during which they stay at the institution, although they are taken to some of the nearby homes for supervised training in deliveries. The Government supplies the stipend for dais who undergo this training. Currently this school is allowed stipends for only six women and there is an adequate caseload of home deliveries for training this many. Reportedly there are plenty of candidates who would attend if more stipends were available and additional home deliveries were available for training.

4. Assistant Nurse/Midwife. We were not able to visit any of these schools, but understand that several of the district hospitals have responsibility for this training. Generally, these women will have had an 8th grade education plus approximately two years in general

nursing and midwifery. The People's Health Scheme calls for several thousands of assistant nurse/midwives.

E. Budget

The departments of Health at the Central and Provincial levels have been subjected to stringent economies. Salaries continue to be paid, but vacant and new positions are not being filled. Budget for medical supplies remains static and things like travel expenses are being pared to the bone. Actual figures regarding current and past budget and the relationship of DOH expenditures to the national budget were not obtained due to the delicate situation in the country.

### III. DEIDS -- Special Considerations and Criteria

#### A. Official Invitations

1. There is no question about the interest of the AID mission in having a DEIDS Project started in that country. The Mission Director told us of a letter that he had written to the Assistant Administrator for Asia urging that experimentation of this type be carried out on a much greater scale than is envisioned under DEIDS. Therefore, the support which we received from the Director and his staff was strong and our appointments and discussions were all carried on in the light of this encouragement.

2. There has not been an official request in writing from the Government of Pakistan. However, there is good evidence that Pakistan would look favorably on a DEIDS Project. Our first meeting with government officials included the Minister of Health, who gave us 10 or 15 minutes of his time and spoke favorably about DEIDS. We later had an extensive discussion with the Director General of Health Services (DGHS) and several of his staff. The Secretary of Health for the province of Punjab as well as the Director of Health Services for that province were included. The reaction from the Central Government officials seemed to be highly in favor of a DEIDS type

program and they understood that DEIDS would supply mainly technical assistance. Several times the DGHS repeated the fact that the project should be developed on a budget which would be suitable for the country.

It was evident the decision had been made previously that, if a DEIDS Project were to be established in Pakistan, it would be in the province of Punjab. During the meeting we asked if it might be possible for other provinces to be considered, but there was reluctance on the part of all the officials to take this under consideration. Stated reasons were that the resources in the Punjab were such that it would make success of a DEIDS Project more likely and that the population in other provinces was so dispersed that obtaining an area for the demonstration project would be relatively difficult.

The actual feelings of the officials from the province of Punjab were difficult to elicit. When they were in the meeting with the DGHS they said little, although they contributed factual material. When we visited them in Lahore, we found that they had done admirably at setting up appointments, but the schedule left little time with them for discussion of DEIDS and for eliciting their opinions about it.

Those of us who went to Multan had the experience, which the others should not have missed, of meeting a retired medical officer by the name of Dr. M.J. Bhutta. He traced the history of the development of health plans in Punjab from 1921 to the present. In 1957 he had been the author of a comprehensive health plan for the Punjab, which had a 15-year implementation schedule. Unfortunately, by the time its implementation was agreed upon, other programs had absorbed all available funds. Dr. Bhutta was frank in stating that he felt that the 1957 plan had been the victim of pressures from Washington and Geneva. In other words, the emphasis and finances devoted to the malaria program beginning in 1959 and the FP program beginning in 1961 siphoned off funds which would have been more wisely spent in implementing that plan to develop the rural health infrastructure.

It was evident that Dr. Bhutta, and possibly others in the Punjab, felt technical assistance is not the primary need in the Punjab. They have a suitable plan, the People's Health Scheme being an adaptation of the 1957 model, and what they really need now are the funds for implementation.

## B: AID/W and WHO Opinions

Inasmuch as the DEIDS reconnaissance team was requested to go to Pakistan, it is evident that AID/W considers Pakistan as a real possibility for a DEIDS Project.

In our discussions with the Acting Representative for WHO in Pakistan, we were assured that that organization would assist a DEIDS Project in any way that it could.

## C. Previous Health Innovations

1. The history of large-scale pilot projects in Pakistan seems to be limited to those of the special health programs, such as malaria eradication, smallpox eradication, and family planning. The eradication programs are based upon international recommendations with some adaptations to the special conditions obtaining in Pakistan. Although seemingly successful at first, they are foundering on the rocks of bureaucracy and financial cutbacks.

The family planning program has been under an administration completely separate from the health department since 1965. When the program was new, had a strong administrator, received full support from the military Government and did not lack for national funds and foreign

aid, it seemed to be an example of successful innovation.\* Within that program provision was made for an unusual amount of evaluation and research, which actually resulted in modification of program policies. This also resulted in a districtwide pilot project, which in itself is a worthwhile example of innovation in Pakistan.

In Siālkot District a completely different staffing pattern was instituted. Enough staff were provided for continuous training and supervision of the field staff. The peripheral workers are assigned in teams, a man and a woman, each team responsible for a population of about 10,000 people. They visit each house every ten weeks, and continuously record the number of family members and their use of contraceptives.

This pattern has been called the continuous motivation system for family planning and gives us some leads as to the ways in which a DEIDS program might be structured in Pakistan.

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\*The FP Program now seems to have lost its impetus and the need for administrative change was obvious.

The systematic home visiting should be retained but might be modified by adding other functions and concurrently reducing either the frequency of visits or the number of households covered. With emphasis on maternal and child health and family planning, it may not be necessary to have as many men workers as women workers. The system of continuous training and checking of records could well be adapted for a DEIDS Project.

This Sialkot pattern, which was to be implemented into a large number of districts by this time, has been put into operation in only two others, Lyallpur and Lahore districts. Recruitment and the registration of all families have been completed, but motivational effort and follow-up has just begun. Funds were not available to implement this system in two other districts, which were to have been included this year.

The original plan for Sialkot is an outstanding example of successful innovation. However, it must be remembered that it was planned and implemented under the strong leadership of the Family Planning Board at the height of its power. It may be difficult for the regular health department to arrange for the extra provisions and unusual administrative procedures which contributed to the Sialkot success.

2. Auxiliaries. The utilization of paramedicals and auxiliaries has long been accepted by the Government of Pakistan and is sanctioned by the Pakistan Medical Association. However, there are still some differences of opinion regarding the categories which are needed, their job functions, training, and supervision. As of 1970, the categories and numbers employed were approximately as follows:

526 lady health visitors

2,397 health technicians (curative)

220 sanitary inspectors

1,855 trained midwives (non-nurses)

500 lady family planning visitors (IUD inserters)

600 family planning officers

Anticipated requirements of these and other categories of staff are compared with present supply in Attachment B.

3. Indigenous health systems. Our unanimous opinion was that a DEIDS Project could not rely entirely upon the Unani practitioners, nor upon equal partnership of the Unani and Allopathic systems. The reasons behind this were that the Unani system has an entirely different concept of physiology, pathology and therapeutics, and

has not carried out systematic research as we know it, that there seems to have been very little change taking place in the system over the past few centuries, and that the Pakistan Medical Association has taken a very strong stand against the inclusion of hakims as equals in the medical service. However, this does not rule out the possibility that some functions under the Government establishment might be carried out by hakims or the retraining of hakims as paramedicals within the Allopathic system.

The question of utilizing indigenous health systems as a basis for the DEIDS Project was carefully considered in Pakistan because one of the concepts which has appeared repeatedly in the DEID's literature is that the design could include any or all of the health systems which were actively used in any particular country. The possibility of basing a DEIDS Project in Pakistan on the Unani system of practitioners was explicitly mentioned in some of the USAID reports. Therefore, the major concerns of our team were to find out as much as we could about the system and to get reactions to the possibility of using practitioners of this system as the basis for a DEIDS Project.

The Unani system is very prevalent in Pakistan, there being somewhere between 30,000 and 35,000 practitioners of this system. The Unani system is derived from the ancient Greek medical system of Hippocrates, having passed through some evolution in Arabia and again in Pakistan. It is an empirical type of medicine, with most of the medications being herbal.\* Practitioners of this system are called hakims and they are supposed to be registered by a Government board. Many have received almost no training, others have had several years of apprenticeship at the side of an experienced hakim, and in recent years, three schools have been turning out quite a number of hakims on a regular and systematic basis. These schools require high school graduation for entrance and have a curriculum which runs for four years.

It is the general consensus that much of the rural population of Pakistan has faith in this system of medicine. The people understand the physiology and the dietary prescriptions, as well as the types of medication which are given. It is said that this type of treatment

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\*Some practitioners utilize powerful western medicines without understanding their actions and dangers.

is much less expensive than the Allopathic type, partly because the practitioners are used to a lower standard of living and partly because the drugs themselves are less expensive. We had the opportunity of examining some of the medications and their price tags and it did not seem there would be much difference in cost. It is further said that hakims are nearer to the people and are more willing to live in rural areas. However, there are large numbers of hakims, especially the famous ones, practicing in the cities, and it was alleged that recent graduates of their schools are not willing to live in rural areas any more than are the physicians being trained in the medical colleges.

During the course of our stay in Pakistan, we talked with many people about the possibility of combining them with Allopathic practitioners who are the backbone of the "establishment." We talked with foreigners, with famous hakims, with village hakims, with the Pakistan Medical Association, and with members of the Pakistan medical service. We visited the premises of a hakim training school and two Unani drug factories in Lahore.

One major difficulty is that the practitioners of the Unani system in the school and factory where we

were taken for observation came out flatly against family planning. This attitude would make their cooperation impossible in an integrated system of family planning and maternal and child health. Probably all of the practitioners do not support this stand, but theoretically it is the position which the orthodox practitioners would take.

Another major difficulty is that there are very few people who understand both the Allopathic and the Unani systems of medicine. One or two of these are in Pakistan, and we had expected to call upon one of them when we went to Karachi on our way out of the country. However, we did not do so, because by that time it seemed evident that a DEIDS Project could not put any great degree of emphasis on the Unani system and continue to work with the established Governmental medical system.

#### D. Readiness of Ministry of Health for DEIDS

Our judgment is that the Central Ministry of Health and the Punjab Ministry of Health are ready to cooperate on a DEIDS Project. However, the changes suggested in Section IV (Recommendation) need to be given consideration and clarification.

## E. Involvement of other Government Departments and Agencies

Implementation of a DEIDS Project in Pakistan would be most propitious if there could be pooling of the resources of the Department of Health, the Malaria Eradication Program, and the Family Planning Program. The total resources of these programs should allow the development of an adequate and integrated health delivery system for maternal and child health, family planning, nutrition, and vector borne diseases. Adding the resources of the Department of Public Health Engineering would also allow the Project to move towards the prevention of water and food borne diseases.

The possibility of integrating these programs was discussed with their respective administrators (except in the case of the Department of Public Health Engineering), but no actual commitments were made.

## F. Institutional Bases

1. In Pakistan, there seems to be no real alternative to using the Department of Health as the institutional base for the implementation of a DEIDS Project.

2. The Institute of Hygiene in Lahore could be useful in two aspects of the project, those of training and evaluation. However, in our discussions with the Principal and his staff it was evident that their strength is not as great as it should be. It would be helpful to the success of a DEIDS Project in the Province of Punjab if this Institute were to be strengthened.

#### G. Budgetary Support

At this stage no actual commitments regarding budget support were elicited. In the first place, negotiations were not at the right stage. Secondly, the budget requirements would not necessarily be higher than the amount already being spent on the several health projects. Thirdly, the economic situation of the country is uncertain.

One suggestion was made by the USAID Director regarding the possibility of using PL 480 rupees to give a DEIDS Project a head start. If the supposition can be made that the health budget will increase at 7% (real increase) each year, would it not be feasible to add several annual increments at the start? This possibility should be thoroughly considered if DEIDS proceeds to the design phase.

#### H. Current or Imminent DEIDS-like Projects

No other international nor bilateral agency is contemplating assistance for a DEIDS-like project in Pakistan. The People's Health Scheme might be considered such a project, because it is comprehensive and hopes to make acceptable services available to a large percentage of the population, but it is not designed to be a pilot or a demonstration project. The plan is to go ahead with implementation so that the whole country is covered within five years. However, finances have prevented the beginning of this implementation and we could not determine when or how much money will become available.

#### IV. Recommendation

That active consideration of a DEIDS Project in Pakistan be continued pending:

1. Reconnaissance visits to other countries so that comparisons as to suitability can be made; and
2. Additional information regarding the final form of the People's Health Scheme and the rate of its phasing, funding, and implementation.

In the meantime, there are a few conceptual and administrative changes which would strengthen the case for recommending a DEIDS Project for Pakistan. USAID/ Islamabad may be able to move Government to favorably consider:

1. Allowing exploration of the possibility of the demonstration area being in a less developed area than in the Punjab.
2. Allowing flexibility in staffing pattern, job assignments, and training plans within the Project area which would take cognizance

of those being proposed for the People's Health Scheme but not correspond exactly.

3. Planning for ways in which the the techniques and procedures found to be suitable in the Project area will be utilized in the rest of the districts.
4. Continuing the Project for about eight years with provision for continuity in leadership and key positions.
5. Pooling budget and equipment of the Department of Health, the Family Planning Program, and the Malaria Eradication Program within the demonstration area.
6. Allowing the Project, under the direction of the District Health Officer, discretion on the selection, re-assignment, re-training, and transfer of the staffs of those programs within the Project area.
7. Permitting flexibility in the use of budget which would empower the District Health Officer to exchange personnel categories, purchase supplies directly in emergencies and when they can be obtained at a rate lower than through the Government supply system, and to transfer funds between line items of the budget.

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August 20 All team members arrived in Islamabad on the same plane, rested most of the day and participated in the team meeting from 5 to 10 p.m.

August 21 was spent in discussion with the AID Mission Director, the Public Health Physician, the Nutrition Advisor, and others at AID.

August 22, 23 were spent in Central Government offices, at WHO, UNICEF, and UNFPA.

August 24, 25, 26 were spent at Punjab Provincial Headquarters in Lahore seeing Department of Health officials, members of the Hakims' organization, the Public Health Association, the Family Planning Board, the Malaria Eradication Program, the Lady Health Visitors Training School, and the Institute of Hygiene and Public Health, and the Training, Research and Evaluation Center for Family Planning.

August 28, 29 the team divided, two going to Muzaffargarh District, and two going to Campbellpur District to visit institutions and health services at all levels.

August 30, 31 were spent in debriefing at Islamabad.

PEOPLE'S HEALTH SCHEME

Planning for rural health services in Pakistan dates back to 1920. At that time, when the country was under the rule of Britain, there was an attempt to provide a curative clinic for approximately every 30,000 people, and this was very nearly accomplished, at least in the Punjab. Now that the population has ballooned, most of the facilities which originally served 30,000 will cover approximately 50,000. The other major plan was drawn up by the Bhorc Committee in 1946. Independence and shortages of staff and funds prevented its implementation. In 1957 Dr. M. J. Bhutta drew up an adaptation of the latter for the Province of Punjab, but because of shortage of funds little has been done toward its implementation. Now comes a new plan, constructed on the same basic pattern.

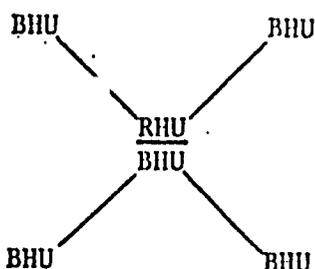
The People's Health Scheme was described in a radio address by the Minister of Health toward the end of March 1972. The chief feature of this scheme which is of interest to DEIDS is the administrative structure for the rural health services of Pakistan. Essentially, the plan calls for 3,364 basic health units (BHU), one for approximately every 10,000 people, supervised by 709 rural health centers (RHC), that is, one for every 50,000 people. Several of these RHCs would be under the

supervision of one of 154 tehsil health center, and several tehsils would be under the supervision of the district health officer (DHO). Staffing pattern and estimated costs are diagrammed in Figure 1 and manpower requirements by category are listed in Table I.

Figure 1

PEOPLE'S HEALTH SCHEME -- SUMMARY

4000 Basic Health Units, One for Each Union Council (about 10,000 people)



Cost of Building and Equipment per BHU: Rs 1,72,200  Recurring: 54,400 x 3,364 BHUs
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<u>Staff</u>	
Doctor	1
Hakim	1
LHV	1
Midwife	1
Health Tech.	2
Sanitarian	1
FP Staff	2
Other staff	2

BHU  
RHC  
Tehsil Health Center (60 beds)

Construction & Equipment Rs 21,75,000  Recurring: Rs 9,54,000 x 154 THCs
--

<u>Staff</u>	
Specialists	5
Doctors	10
Dentist	1
Nurses	12
Midwives	15
Sanitary Insp.	4
LHV	3
Radiologists	2
Pharmacist	1
Dispensers	3
Technicians	16
Administrators	8
Other staff	60

One Rural Health Center (10 beds)  
(Town Center) for every 5th Union  
Council (about 50,000 people)

Cost of Building and Equipment for each RHC: Rs 4,98,300  Recurring: 1,53,800 x 709 RHCs
--

Doctors	2
Hakims	2
LHV	2
FP Officer	1
Midwives	4
Sanitary Insp.	2
Technicians	3
Dispenser	1
Other staff	10

District Hospital (250 beds)

Construction & Equipment Rs 65,92,000  Recurring: Rs 33,18,600 x 44 DHS
---

<u>Staff</u>	
Specialists	15
Doctors	30
Dentists	4
Nurses	50
LHV	6
Midwives	6
Physiotherapist	1
Radiologists	6
Pharmacists	4
Technicians	39
Dispensers	6
Admin. staff	21
Other staff	156

T: e I

PEOPLE'S HEALTH SCHEME

PAKISTAN

MANPOWER REQUIREMENTS

CATEGORY	REQUIREMENTS						AVAILABLE					ADDITIONAL REQUIRED
	BHU (3364)	RHC (709)	THC (154)	D.Hqr. (44)	Nat'l Insts. (7)	Total	BHU (1511)	RHC (93)	THC (83)	D.Hqr. (44)	Total	
Doctors	3364	1418	1070	967	89	6908	832	181	159	206	1438	5470
Dentists	-	-	127	149	-	276	-	-	-	35	35	241
Clinical Specialists	-	-	635	607	68	1310	-	-	-	257	257	1053
Public Health Specialists	-	-	362	245	-	607	-	-	-	51	51	556
Lady Health Visitors	3364	1418	435	237	-	5454	104	88	-	144	336	5118
Nurses	-	-	1524	1858	173	3355	-	-	-	372	372	3183
Pharmacists	-	-	127	149	-	276	-	-	-	-	-	276
Sanitary Staff	3364	1418	562	736	-	6080	-	-	-	-	220	5860
Technicians/Dispensers	6328	2836	2521	1396	331	13412	1511	176	332	378	2397	11015
Radiographers	-	-	254	228	29	511	-	-	-	44	44	467
Midwife/Nurse Aid	3364	2836	2013	3145	-	11358	1475	154	-	226	1855	9503

The Minister enunciated several other principles of the People's Health Scheme, which are of concern to a DEIDS Project. These are as follows:

1. That all health services would be integrated into one program.
2. That the chief emphasis would be on preventive and promotive health services, although curative facilities would be provided as widely as possible.
3. Special emoluments would be available for staff working in the rural areas, so as to attract doctors, lady health visitors, and other staff.

Other major features of the People's Health Scheme have caused a great deal of discussion and controversy. These sections had to do with control of the pharmaceutical industry, with the physician's right to dispense, and with the use of hakims. Because of the strong objections raised by several interest groups, its implementation has been postponed pending modification. There is no way to tell how much longer it will take to resolve the differences of opinion. Then, implementation must wait on the allocation of sufficient funds.

It is interesting to note that a great many organizations have compiled their own versions of the People's Health Scheme. For instance, the Pakistan Medical Association has published a small booklet which gives their idea of what the set-up should

be. The Provincial Government of Punjab has also made some adaptations and is trying to get these accepted. The Punjab Government has also embarked upon the task of trying to frame job descriptions for the various types of workers so that when implementation time comes they will be able to go ahead with the training of these groups.

Our team has studied many of these suggestions, and although we hesitate to make specific recommendations after such a short visit and after such rapid perusal of the plans, it seems obvious that the possibility of implementation of any of the prepared plans is beyond the financial\*and manpower capacities of the Government of Pakistan. Some of the ways in which the People's Health Scheme might be made less expensive and, possibly at the same time, more efficient are as follows:

1. At the level of the basic health unit, no attempt should be made to provide a doctor, but auxiliaries, under supervision, should be relied upon for curative and preventive health services. The number of doctors provided at the tehsil health centers and the district hospitals could be reduced.
2. More emphasis needs to be placed upon prenatal care and systematic home visiting than seems to be provided for under this scheme. Perhaps less emphasis could be placed upon the supervision of deliveries. The reason

\*Currently there are large numbers of doctors and lady health visitors who cannot be employed by the Government because of budget limitations.

for suggesting that less emphasis be placed upon delivery is that few rural women take advantage of these services where they are currently available and that much of the infant and maternal mortality and morbidity could be prevented by systematic prenatal and infant visits. This change in function, if adopted, would allow the work to be carried on by a partially trained lady health visitor, rather than one whose training requires 24-27 months.

3. All of the Health Department facilities which we saw at a variety of levels were not being fully utilized. This may have been a seasonal matter, but the design of most of the buildings provided much space for which we could never see any use. Therefore, it seems that the People's Health Scheme should very carefully reconsider the space requirements for minimal services in the immediate future, possibly considering an add-on type of building which could expand as additional space is required. The amount and types of equipment at the various levels should also be carefully considered, depending upon the availability of personnel to utilize it, and especially, to maintain it.
4. Although the Pakistan Government is engaged in the development of a number of medical schools which are

capable of providing more than enough doctors, it has not devoted adequate resources to the development of training institutions and programs for paramedical personnel.\* The capacities of these institutions are limited by space, by finances, and by staff shortages. One of the ways in which to conserve training capacity is to reduce the number of functions for which the various personnel are to be trained, thereby reducing the length of training time required. Later on, short courses could be added which would bring all personnel up to a level which is desired. In addition to short-term training for new employees, much attention must be devoted to the retraining of existing staff of the various special programs so that they can be integrated effectively into the general health services. All of these training efforts require a retraining of the trainers, additional facilities for the training centers, and the development of rural practice fields in which trainees can actually get supervised practical experience. The People's Health Scheme needs to include provisions for the above.

5. In the detailed version of the People's Health Scheme a great deal of attention is devoted to people's participation. However, in discussing the Plan with

\*In our opinion, some of the resources scheduled for medical colleges could be used more effectively in training lower level staff.

the administrators, very little mention was made of this aspect. There are many ways in which the public can participate in the People's Health Scheme, thereby reducing the cash cost to the nation. One of these might be for some of the larger landowners to donate the land on which the centers are to be constructed. Another might be to organize for people's contributions in cash, labor or materials for construction. Another might be in the development of some sort of volunteer group to help in the running of the center, especially in the clerical functions. Perhaps some contribution toward the cost of medicine and services might be judiciously built into the system, although we realize that this may be contrary to the socialist doctrine of the present government.

## DEIDS PAKISTAN RECONNAISSANCE ATTACHMENT C

### Addendum to "I General"

#### A. Political situation

In general it can be said that Pakistan, in its short history of 25 years, has had more than its share of political upheaval and instability. This turmoil has resulted in long and extended periods of martial law, with very limited opportunity for the people to participate in their own government.

The original intent of the founders of the country was to provide a homeland for the Muslims of the subcontinent. It was to be a religious state with a predominantly Muslim population to carry on the traditions and beliefs of the Muslim religion. However, from the very beginning a conflict developed between traditional Muslim philosophy and the desire for rapid economic development. The conservative Muslim attitudes were generally held by the villagers, the mullahs, the illiterate, the poor, the elderly, the hakims, etc., while the new or development attitudes were held and fostered by the military leadership, the young intellectuals, the newcomers, the moderate Muslim, and westerners.

The basic political policy which was evolved in Pakistan's first few years of life depended on a very sophisticated, planned economic growth, copied from the western cultures, managed by the center government, and administered through a rather rigid, authoritarian, bureaucratic administrative structure with very little involvement of the people in the planning or administrative

process. The planning process has a very complicated and sophisticated process not understood by the common man. What the common man observed was that a "few" were getting what appeared to be all of the breaks and financial gravy while the "many" were encouraged to tighten their belts. The common man was aware also of the influx of new ideas, values, patterns of dress, etc. which appeared to be inconsistent with basic Muslim values and this gave fodder to the village mullah and others who felt the country was moving in the wrong direction.

From time to time things seemed better for the common man. He seemed to reap the harvest of stability which required rigid controls. Then came the two disastrous wars, the loss of East Pakistan and the resulting national psychological shock. Into the void came President Bhutto and the Peoples Party. The frustrations of the previous years welled over the rumors of corruption and favoritism became excuses for action, reaction, and over-reaction.

The Peoples Party is now in with a strong majority and is making the following demands:

1. A move toward the original concept of Pakistan as a Muslim state with Muslim ideals.
2. Education for everyone in the basic Islamic Tradition.
3. Lower prices, more consumer goods, benefits for the poor.
4. Major land reforms.
5. Pakistan for Pakistanis.

6. An end to corruption and privileges for the few.
7. Nationalization of industry to provide jobs for Pakistanis and to keep the benefits and profits at home.
8. A greater involvement of the common people in their government and therefore in their own destiny.

It appears that the present Government is torn between continuing the present developmental model or moving rapidly toward a type of socialism. Both movements have strong support within the country. Following are some specifics which may help to shed light on the situation that now prevails:

1. The West Wing of Pakistan was previously a centralized administration, but it has been broken down into four Provinces: Sind, Baluchistan, Punjab, and Northwest Frontier Province. Each has its own governor and legislature.
2. The center Government at Islamabad is slowly working out its relationships with the new provinces and with the rest of the world.
3. 1200-1300 key officials were retired furloughed or placed under house arrest, many accused of corruption.
4. The 4th Five Year Plan has been shelved, but the center still has a planning unit working on a new plan.
5. Moderate land reform is being effected. However, its implementation appears to favor the status quo.
6. 23 industries have been nationalized with a promise of more to come.
7. On Sept. 1, 1972 all private colleges were nationalized.
8. There is martial law and press control with the movement of people tightly controlled. Numerous arrests are being made under martial law regulations.

9. The rupee was re-evaluated from 4.7 to 11 for the dollar to increase purchasing power, but there are no broad controls on prices as yet.
10. Provinces are all seeking more autonomy. Separatist movements are strong in Sind and NWFP, where there are strong desires to use their own provincial languages.
11. Punjab seems to be the favored province.
12. The conservative Muslim voice is heard throughout the land.
13. Center-province relationships are confused, waiting for the new constitution.
14. The President is on the move constantly, putting out fires, making more and bigger promises of nationalization.
15. Islands of resistance to the President are appearing.
16. There is a tremendous desire on the part of qualified talent to leave the country. The brain drain is likely to become a flood.
17. There is a continuous influx of Chinese and increased overtures are being made to the Chinese government.

Crisis leadership would best describe the situation at present in Pakistan. Public policy is being hammered out under stress, often during conditions of near riot, extemporaneously during public speeches by the President, and as a result it is developing in piecemeal fashion, keeping the administrative machinery in a state of emergency as it moves from crisis to crisis, meeting to meeting, thus taking valuable time away from proper planning. The President is holding the country together by promises, each a little more grand than the last, and with his own personal appeal and hoping to stabilize the situation until, with the efforts of the Peoples

Party, he is able to introduce a new constitution and some form of democratic process. However, there are indications that the political pressures are building at such a rate and the resources to meet them are so slim that he is having to resort to rigid controls and martial law, to keep on top of the situation.

The President is likely to have very rough sailing in the next few months. Many variables are at work which have not fallen into place as yet. It is likely to be some time before the country is stable enough to really move forward on such things as basic health plans.

#### B. Economic Situation

"Near Bankruptcy," "very critical," "approaching crisis" were the terms frequently heard to describe the present economic situation in the country.

The country is heavily in debt to the Western countries who have supported the development model of capital infusion. There is every indication that the present administration and the Peoples Party have abandoned this approach in favor of a more socialistic approach.

Two major meetings are to take place within the next four months in Pakistan which should shed more light on economic conditions. These are the meeting of the Consortium and the visit and evaluation by the World Bank team. The reports issued by these two groups and the agreements they make with

Pakistan will no doubt have a major impact on the direction in which the country will move politically and economically.

Some indicators of the present economic condition are these:

1. The 4th Five Year Plan has apparently been abandoned and a new one is being developed; in the meantime development appears to be at a standstill, which means it is actually losing ground.
2. The development debt is coming due and the unanswered question will the Western resources be willing to plow in more capital or will the country default to bankruptcy.
3. Loss of East Pakistan has caused the West Pakistani manufacturers a heavy loss in sales, estimates in some cases are as much as 40-50%
4. The high cost of rehabilitation of prisoners and displaced persons is an unexpected financial drain.
5. The lack of funds to support the family planning and malaria programs indicates the financial stress at this time.
6. Rumor to the effect that schools will not open (because funds are not available for teacher pay, etc.) is widespread.
7. The fact that the Pakistani MDs who were on tour with us were asked to use their own cars and burn their own petrol is another indication of the current lack of funds.
8. To preserve foreign exchange, there is an import ban on automobiles.
9. There are increased taxes on gasoline, cigarettes, income and customs.
10. There is great confusion between the center and the local governments as to who is responsible for what and who has budget for what.

11. The military is still getting between 50-60% of the national budget.
12. The spectre of inflation: Inventories of local goods at present seem to be adequate but labor unrest has cut into production and restrictions on imports have reduced consumer goods from foreign countries, so it would appear that in a short time there will be a scarcity of goods on the local market. This would result in forcing up prices, then stiff price controls, then an underground or black market. There are indications that smuggling is at its highest in the history of the country. The problem is not only of controls but of the machinery to make the controls work.

If additional funds are not made available, it would appear that rampant inflation is just over the horizon. Unrest over higher prices will continue to grow, placing greater political pressure upon the leadership. More industries will be nationalized and some may close their doors, as is happening in the drug industry at the present time.

The national budget for the current fiscal year (July 1972 - June 1973) is 11,122 millions of rupees. This is nearly as high as for the previous three years, even though last year included heavy military expenditure and revenue has been cut by roughly 40% by the separation of Bangladesh. External aid also is being reduced. One can only conclude that the budget is overoptimistic regarding revenue.

Resources are likely to be considerably below expectations (and this is a deficit budget too). If so, the Government will either have to cut expenditures or raise taxes. Cutting expenditures will be politically more dangerous than raising taxes. The military is the obvious target for cuts, but will probably remain sacrosanct. The huge expenditures on debt servicing will probably be a bookkeeping device and the

Government may resort to the printing presses in anticipation of much of the debt servicing being written off later by the consortium (at present the debt repayments are being credited in rupees at the State Bank of Pakistan; at some stage they should be repaid in foreign exchange). Cutting large federal subvention to provincial budgets would be very difficult at a time when demands for provincial autonomy are loud. One would expect cuts in the Central Government Development Budget. On the other hand one might expect a rise in taxation at all levels of Government.

Both ways the budget looks over-optimistic. Another very effective weapon in providing large budgets but small expenditures is of course the stranglehold of the Ministry of Finance. One might expect its criteria for the release of funds to become more stringent this year.

### C. Administrative Structure

The administrative machinery and organizational model operating in Pakistan today is in a state of flux. No one interviewed could draw a clear picture of how decisions are being made or how the government is relating to all of its parts. There appear to be two opposing forces at work within the governmental machinery. One is pulling for a strong central system like that which has been in use for the past fifteen or so years and the