PAKISTAN PRIMARY HEALTH CARE:
State Delivery System and Foreign Assistance

April 1992

Pakistan Office
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パキスタンのプライマリー・ヘルスケア
（政府の施策と外国援助）

はじめに

日本の社会セクター援助については、１９９０年１２月の経済協力総合調査において、特に教育とプライマリー・ヘルスケアに重点を置く旨強調され、両国政府間で合意に至っています。　又、１９８９年１２月に発足された当事業団によるパキスタン国別援助研究会の最終報告（１９９１年２月）でも最重点援助分野を社会セクターにすることが再確認されてきました。

これらの援助方針をもとに当事業団は１９９１年１１月に、社会セクターの具体的優良案件形成を目的とし、特に基礎医療・初等教育分野に絞り込んだプロジェクト形成調査を実施し、現在実現に向けての検討が進められています。

一方、パ政府は計画省次官を委員長とし関係各省次官からなる社会セクター行動計画（ＳＡＰ；SOCIAL ACTION PROGRAMME ）委員会を設置し、計画省下の２８のセクター別委員会と各州政府ＳＡＰ委員会と連係をとりつつ、８次５ケ年計画（１９９３－９７）策定を進めてきています。　他方、特に同セクターへの援助の重要性は全援助機関が強く認識しており、長期的展望に立って各機関がそれぞれの特徴と有利性を活かし発揮できるようドナー間の調整が望まれています。　当該国への第１援助国として当事業団、とりわけ在外事務所主導の優良案件発掘・形成として当パキスタン事務所に一層求められるのは、他援助機関と協議し役割分担を調整した上で総合的な援助を機能させることです。

これらを踏まえ、質の高い援助実施にはパキスタン国政府はもとより、他援助機関との情報交換・調整による連けいプロジェクトを中心に優良案件を形成することが基本となることから、同セクターにおける受益国政府の政策及び事業に加え、他援助機関の援助経験を含む基本情報の整理がまず必要であると考えます。

本報告書はパキスタン事務所が事業団内外の関係者の協力を得て、在外専門調整員制度を活用し基礎医療分野（プライマリー・ヘルスケア）の基本情報についてとりまとめたものであり、別冊の初等教育分野報告書とともに、内外の援助関係者に広く有効利用されることが望まれます。

１９９２年４月

国際協力事業団
パキスタン事務所
所長　御手洗　章弘

PAKISTAN PRIMARY HEALTH CARE

FOREWORD

With regard to the Japanese assistance for the social sector in Pakistan, the Japanese Economic Cooperation High Power Mission, in December 1990, suggested that special emphasis on a priority basis be laid on the Primary Education and Primary Health Care, and both the Governments of Japan and Pakistan mutually agreed on this approach. Furthermore, the Japan International Cooperation Agency (JICA) established a Country Study Group of Pakistan at its Headquarters and the Group reconfirmed the importance of social sector assistance to Pakistan in its final study report in February 1991.

Based on the above policy, JICA conducted a Project Formulation Survey in November 1991 in the fields of Primary Health Care and Primary Education for the purpose of promoting the formulation of aid projects. Since then, the necessary formalities and procedures have been initiated in both the countries in order to realize the project ideas which were observed and discussed during the survey.

On the other hand, the Government of Pakistan established a committee of Social Action Programme (SAP) headed by the Secretary, Ministry of Planning and Development and including Secretaries of all the related Ministries. Twenty-eight sub-committees of SAP in Federal Ministries were also formed, which coordinated their activities with the provincial SAP committees and proceeded ahead with the preparation of the 8th 5-year National Plan. Additionally, since all the donors have recognized the significance of their assistance for the social sector, a better coordination among them is desirable for providing effective and concrete programmes in which each donor could extend its characteristic facilities towards foreign aid.

I fully appreciate that exchange of views and ideas with the Government of Pakistan and the coordination with other donors are indispensable for implementing quality assistance. Therefore, as a part of this effort, JICA Pakistan Office has compiled this report on "Pakistan Primary Health Care, State Delivery System and Foreign Assistance" as the basic information required for the action programmes. I hope it would be of great advantage to all concerned as well as to the people of Pakistan.

April 1992

Mr. Akihiro MITARAI
Representative of JICA
Pakistan Office

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I

An Overview of Primary Health Care in Pakistan

Most developments in Pakistan's health sector have been biased towards curative care, urban areas and educating doctors. Health cover to the rural areas, the training of paramedical staff, preventive care and community health have remained inadequate.

A. The State Service Delivery Structure

The armed forces and autonomous bodies such as the railways manage their own health facilities. A few health facilities of the Social Security Commission for workers are the responsibility of respective provincial Labour Departments. The Federal Government runs hospitals and health facilities for the capital territory, the Northern Areas and the Federally Administered Tribal Areas. The Federal Government also directly administers centers of excellence for post-graduate teaching and medical research. These centers function as apex referral centers on the national level. However, the delivery of state health care services to the general population is managed by provincial departments of health.

1. The Provincial Health Department

The Health Department of each province is headed by a Secretary who is supported by an elaborate secretariat staff including additional secretaries, deputy secretaries, under-secretaries and section officers for various functions.

Two main operational divisions report separately to the Secretary Health.

The first is a group of provincial medical colleges and affiliated teaching hospitals, directly under the control of the Secretary Health. These are normally located in the main cities of the province.

The second is what is known as the "attached department", reporting to the secretary through its head, the Director Health Services. The attached or line-department forms an integral part of the provincial administrative structure. Its organization extends downwards to all levels of territorial administrative units - the division, the district and the Tehsil or sub-division. The designations given below may differ in the individual provinces. However, the general structure is the same. Figure 1.

2. The Directorate of Health Services

The Director Health Services of the province is assisted by Deputy Directors who are a part of the Directorate staff; normally one each for Communicable Diseases Control (CDC), Basic Health Services (BHS), and Planning and Evaluation (P&E). In addition there are a host of Assistant Directors taking care of technical specialities, accounts, personnel, logistics, statistics etc., including an Assistant Director responsible for Medical Stores and Drug Control.

3. The Division

At the Divisional level, within the regions, the department is headed by Deputy Directors Health Services (DDHS). They report to the Director at the provincial capital. The District Headquarter Hospitals, one in each district of the region, are directly under the control of the DDHS.

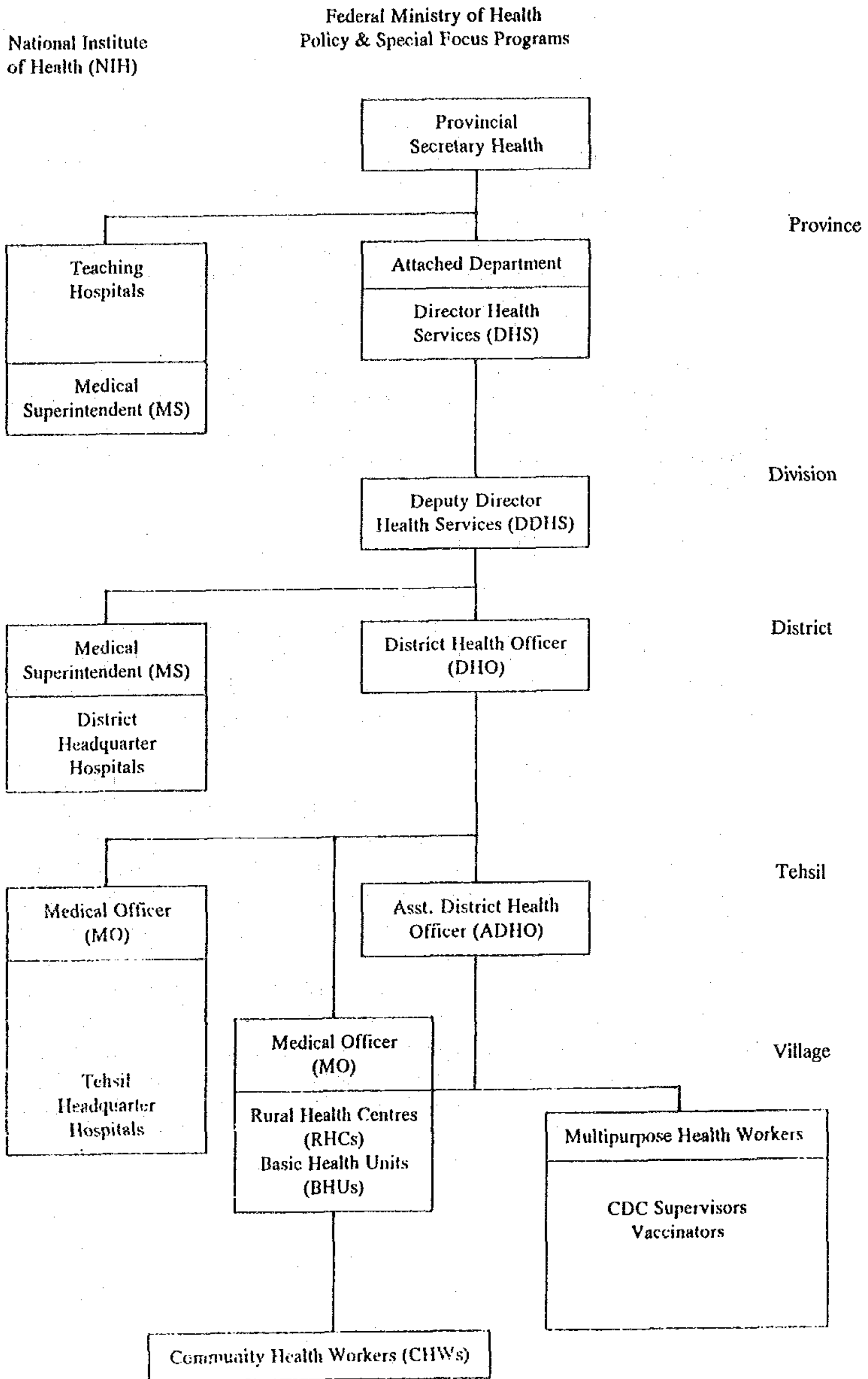
4. The District

A District Health Officer (DHO) is in charge of the department at each district in the division. However, the DHO has no jurisdiction over the District Headquarter Hospital which has clinical facilities and doctors for major specialities and is located in the main town of the district. The District Headquarter Hospital is headed by a Medical Superintendent (MS). Both the DHO and MS report independently to the DDHS at the divisional level.

The DHO has an Administrative Officer (AO), a Communicable Disease Control (CDC) Officer, an Assistant Entomologist and a Sanitary Inspector on his staff at the district headquarter. These assist the DHO to perform the entire range of functions of the Health Department at the district level. These include administering Tehsil Headquarter Hospitals, one in each Tehsil; Rural Health Centers and Basic Health Units (BHUs) spread all over the district on the village level; and a large out reach field staff.

Figure I

PRIMARY HEALTH CARE STATE DELIVERY STRUCTURE



5. The Tehsil

Each tehsil in the district has a government hospital located at the Tehsil Headquarter. The Tehsil headquarter Hospitals are headed by a Medical Officer (MO) and have a provision for basic specialities. All other functions of the department within the Tehsil are under the charge of an Assistant District Health Officer (ADHO) who exercises delegated authority on behalf of the DHO. Both the MO Tehsil Headquarter Hospital and the ADHO report independently to the DHO.

The ADHO supervises the curative and preventive operations of the health department in the field. On the curative side these include Rural Health Centers (RHCs) and Basic Health Units (BHUs). However, the doctors or Medical Officers at these facilities report directly to the DHO at the district headquarter.

6. The Rural Health Facilities

The RHCs and BHUs are physical health facilities that form the core of the primary health care delivery system. The RHCs have an operation theater, a small in-patient facility, X-ray equipment and other basic diagnostic facilities. Some also have ambulance cars. The BHUs are simple symptom management facilities, with a limited inventory of basic drugs.

These facilities were originally part of a three-tiered Integrated Rural Health Complex (IRHC) approach that was adopted by the Government of Pakistan in its Fifth Five-Year Plan 1977-82. An IRHC comprised of one RHC and 4 to 5 satellite BHUs. The IRHC was meant to serve a population of 50,000 to 100,000. Under this approach the BHUs were to be staffed with para-medical staff only, called Medical Technicians (MTs). The MTs were to refer cases beyond their competence to the RHCs which are meant to have two attending doctors, a male and a female. However, due to the number of unemployed doctors in the country the government has also posted one doctor each in the BHUs. In some cases beds and diagnostic facilities have also been added. This amongst other factors has disrupted the original IRHC approach and has practically resulted in two different sized parallel health facilities at the field level.

The Community Health Worker (CHW) was an important feature of the original three tiered approach. This third tier was trained by the MTs at the BHUs to deliver a limited range of preventive and curative care at the village level. The CHWs were to refer problems beyond their competence to the next tier in the system - the BHU. Some CHWs were trained but have not been integrated into the system due to, amongst other factors, a lack of supervision and the overall failure of the IRHC three-tier concept. In addition there are a large number of trained Traditional Birth Attendants (TBAs) that have not been integrated.

7. The Preventive Field Force

On the preventive side at the field level, the Health Department has a large Communicable Disease Control field force. This includes supervisors, sanitary inspectors and vaccinators who functions under the control of the ADHO at the Tehsil level.

As multi-purpose health workers, this staff operates in defined territories with an out-reach approach for immunization, malaria control, health education, or any other mass health prevention campaigns and special focus programs.

8. The Status of State Primary Health Care Facilities

In terms of competence and extent of services, Pakistan has a five level state health delivery establishment that resembles a pyramid.

Level 5: Teaching Hospitals With all Specialities

Level 4: District Headquarter Hospital with Major Specialities

Level 3: Tehsil Headquarter Hospitals with Basic Specialities

Level 2: Rural Health Centers (RHCs) and Basic Health Units

Level 1: Community Health Workers (CHWs), Traditional Birth Attendants and the Health Department's Communicable Disease Control (CDC)/ "Multi purpose" Staff

Levels 1 & 2 constitute "primary health care". Level 3 comprises "secondary health care". And Levels 4 & 5 form "tertiary health care".

The state health delivery establishment cannot be termed a system: primarily because it is not integrated through a systematic referral system. An upward and downward referral system is present in concept but does not function for numerous reasons.

CHWs at the village level barely exist. The public or end-users of the state health facilities have a horizontal perspective, and rightly so. They cannot be expected to perceive a referral system which does not exist. They may attempt the nearest functioning facility; whether it is a RHC or BHU, the private clinic of a qualified doctor, or the part-time "quackery" of a para-medic of the Health Department. However, the tendency is to rush to the major hospitals in the cities, mostly with an acute condition.

The limited drug inventory in the basic health facilities and a perpetual shortage of their supply has also contributed to the public by-passing these facilities.

The location where these facilities have been constructed has not always been ideal for accessibility. Even special focus programs of the government such as the Expanded Program of Immunization (EPI), directed at rapid coverage, could not rely on these under-utilized fixed facilities and had to use expensive mobile outreach approaches to access their target populations.

In summary the state health service delivery does have a "curative health system", even though it might cater for only a segment of the population. However, it does not as yet have an institutionalized and integrated "primary health care system". What it does have in primary health care is at best an establishment which is bureaucratically administered.

Significant factors for this state of affairs are:

a) the pre-service professional education and training of doctors;

b) the incentives and rewards in the curative branch;

c) the career and service conditions in the government;

d) and the general political-administrative and socio-cultural context of Pakistani society.

However, under the leadership of the Federal Government and the assistance of international and bilateral donors, the provincial governments have initiated a process of change.

First, in removing an imbalance between the curative and preventive, in favour of the latter.

Second, in instituting a primary health care "system" within the state delivery establishment.

Special Focus Programs are a potential vehicle for this process.

B. The Special Focus Programs of the Federal Government:

The Federal Government establishes the policies, priorities and national targets in the health sector, while the provinces implement them.

The Federal Ministry of Health, through its operational arm - the Office of the Director General Health (DGH) - is responsible to coordinate and monitor the implementation of national health programs. The country wide functions of the DGH include:

a) drug regulation and quality control;

b) regulating the standard of professional education;

c) undertaking measures for containing communicable disease; and,

d) managing external relations in health.

Over the years the Federal Government has combined the latter two resistibilities to develop a primary health care program for the country. It has drawn upon international experience to combat and control communicable diseases and deliver basic rural health services through foreign technical assistance and resources. It adapts individual technology packages, clinical case management and outreach techniques to control high rates of morbidity and mortality in target populations in the short run. It also develops long term strategies for prevention in the future.

These centrally managed primary health care programs have included services such as:

a) immunization, malaria, tuberculosis, acute respiratory infection and diarrheal disease control; and,

b) providing rural primary health care infrastructure, management and professional and auxiliary staff training.

The Federal Government normally appoints a National Co-ordinator and Manager for each program. It also deputes an Assistant Director General in the Directorate- General to liaise with the provincial government and facilitate implementation of individual programs. International agencies and foreign donors either help initiate such programs or contribute technical assistance, equipment and other resources to on-going programs. The National Institute of Health (NIH) in Islamabad provides facilities for vaccine concentrate dilution and packing, and technology development for clinical case management for the use in these programmes.

The central programs are implemented vertically, through the provincial health departments. The accelerated or short -term thrust is normally spearheaded and delivered by the out reach CDC or multi-purpose health workers of the provincial health departments, in addition to their regular work. They are rapidly trained in the technical aspects of the delivery. The long-term or preventive aspects or programs that require clinical case management, are gradually delivered through fixed facilities, which also serve as training units.

Some of the accelerated programs such as the Expanded Program of Immunization (EPI) have been successful. Their success has been recognized internationally. However their integration within the primary health establishment is still a distant goal.

C. Donor Input and Experience

Foreign assistance to Pakistan's health sector till the late 1970's has mostly been provided to activities other than Primary Health Care (PHC). However, attention towards PHC has increased in the last decade. The resources and inputs provided by the donors to Pakistan's PHC activities have typically included:

a) support for construction of rural health facilities

b) support for vertical crash programs in immunization, malaria, acute respiratory infection and diarrheal control

c) support for planning, management, and supervision at the provincial and federal level

d) establishing training institutes and facilities

e) training of paramedical staff, traditional birth attendants and community health workers

f) in-service training for doctors

g) supply of syringes and needles, diagnostic and cold chain equipment and transport

h) supply of vaccines and quality control technical support

i) supply of insecticide and spraying equipment

j) supply of food commodities: milk, cooking oil and wheat

k) supply of oral rehydration salts and iodinated salts and oil.

l) equipment and technical support for disease surveillance and management information systems

m) technical and material support for health education, interpersonal communication skills of health personnel and mass media programs

The uniform experience of all donors in the primary health care sector has been that targets are over optimistically designed. These need to be more realistic keeping in view the constraints of government financial mechanisms, administrative approval procedures, service conditions and motivational levels of the field staff. Weak donor coordination has often resulted in contradictory efforts. Coordination needs to be improved for policy dialogue, analytic and project work. Some of the clear lessons, findings and recommendations from past experience have been:

a) political commitment at the federal and provincial levels is important for the success of programs

b) programs have not always responded to local needs and have not paid sufficient attention to community involvement

c) there is need for coordinated planning between the provincial Departments of Health, Finance and Planning

d) recurrent budgets are inadequate

e) annual development budget restrictions placed by the IMF have a negative effect on the absorption of foreign loans and grants in the health sector

f) there is a severe need to strengthen the referral system and the management of all levels of the basic health services

g) centralized management of health delivery in the provinces needs decentralization, for operational purposes, to the divisional and district levels

h) drug procurement and supply procedures need modification to improve availability in peripheral facilities.

i) patience and persistence is required to establish new cadres of paramedical workers such as the MTs or CHWs

j) female paramedical staff are crucial to encouraging increased female participation in maternal and child health services including family planning

D. Stated Government Policy for Primary Health Care

The states policy goals and targets are reflected in Five- Year development plans and the national health policies of successive governments.

The Planning and Development Division (P&D) in the Federal Ministry of Finance, Planning and Economic Affairs has responsibility for formulating the five-year development plans for the health sector. These targets are developed through close collaboration between the Federal Ministry of Health and the Provincial Departments of Planning and Development and of Health.

The Federal Cabinet of each government, especially the Health Minister is responsible for articulating the health policy. Development activity in Pakistan is currently approaching the fourth year of the Seventh Five-Year Plan (1988-93). The present government is yet to finalize its policy on health. The last policy issued was that of the previous government in 1990.

Both the Seventh Five-Year Plan and the National Health Policy 1990 adopts primary health care as the means to meet the basic health needs of Pakistan. The Sixth Plan had already prioritized improving the quality of existing rural health services rather than increasing their numbers. The present plan has continued with this stress and includes:

a) emphasis on preventive programs like immunization, training of birth attendants, control of diarrheal diseases and malaria etc.

b) outreach services by health auxiliaries

c) community involvement in health through boards, committees etc

d) providing care to vulnerable groups

e) integrating maternal health and child spacing into primary health.

f) establishing a national school health service

g) removing imbalances in health manpower

h) incentives to the private sector to establish health facilities

i) enhancing the managerial capacity of the health system.

Latest Trends

The Social Action Program (SAP) initiated by the World Bank is the most contemporary policy development instrument in the social sector. SAP represents a convergence of the concerns of the Government of Pakistan and the donors to rethink their strategy towards the social sector. SAP addresses most of the issues discussed above. In addition it makes a recommendation to the provinces to initiate their own policies and priorities in the social sector. The Government of the NWFP has already taken a lead and organized a high level seminar to initiate a concrete plan in the middle of October. The Federal Government followed with a seminar at the end of October. The other provinces are expected to follow suit.

A. Inventory of Ongoing, Major Past and Future Projects

Donor	Project	Region(s)	Agency(a)	Start	End	Cost (million $)	Summary on page
1. UNICEF	Expanded Program on Immunization.	National	Ministry of Health Provincial Health Deptts.	1992	1996	14.455	19
2. UNICEF	Control of Diarrheal Diseases Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	2.5	20
3. UNICEF	Acute Respiratory Infections (ARI) Control Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	2.5	21
4. UNICEF	Primary Health Care (PHC) Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	5.09	22
5. UNICEF	Health Education Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	1.45	23
6. UNICEF	Health Sector Support.	National	Ministry of Health Provincial Health Deptts. Unicef.	1992	1996	4.455	24
7. UNICEF	Advocacy & Social Mobilization for Safe Motherhood.	National	Ministry of Health Provincial Health Deptts.	1992	1996	0.370	25
8. UNICEF	Traditional Birth Attendant (TBA) Training Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	4.04	26
9. UNICEF	Strengthening Mother & Child (MCH) Services.	National	Ministry of Health Provincial Health Deptts.	1992	1996	2.23	27

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Donor	Project	Region(s)	Agency(a)	Start	End	Cost (million $)	Summary on page
10. UNICEF	Family Planning & Child Spacing.	National	Ministry of Health. Ministry of Population. NGOs.	1992	1996	2.55	28
11. UNICEF	Nutrition Support Program.	National	Ministry of Health. Planning Div. Provincial Health Deptts. Municipal Corporations. NGOs.	1992	1996	1.79	29
12. UNICEF	Breast-feeding & Infant-feeding Program.	National	Provincial Health Deptts.	1992	1996	0.31	30
13. UNICEF	Iodine Deficiency Disorders (IDD) Control Program.	NWFP. Northern Areas. AJK.	Ministry of Health, Health Deptt. (NWFP, NA, AJK)	1992	1996	1.88	31
14. UNICEF	Prevention of Vitamin A Deficiency Program.	National	Ministry of Health Provincial Health Deptts.	1992	1996	0.905	32
15. CIDA	Training of Traditional Birth Attendants (TBAs).	National	Population Welfare Division.	1983	1989	3.881	33
16. CIDA	Communication and Motivation Project.	National	Ministry of Health Provincial Health Deptts.	1984	1992	3.268	34
17. CIDA	Rabies Human Diploid Cell (HDC) Vaccine.	Islamabad	Ministry of Health.	1986	1992	4.634	35
18. CIDA	Immunization (Polio) III.	Islamabad	Ministry of Health.	1987	1992	4.920	36

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Donor	Project	Region(s)	Agency(a)	Start	End	Cost (million $)	Summary on page
19. USAID	Basic Health Services Project.	National	Ministry of Health Provincial Health Deptts.	1977	1982	9.0	37
20. USAID	Primary Health Care.	National	Ministry of Health Provincial Health Deptts.	1982	1990	30.0	38
21. USAID	Child Survival Program.	National	Ministry of Health Provincial Health Deptts.	1988	1993	17.0	39
22. USAID	Malaria Control II	National	Ministry of Health Provincial Health Deptts.	1982	1992	61.0	40
23. World Bank	I. Family Health Project.	NWFP Sindh	Health Deptts. NWFP & Sindh	1992	1998	31.88	41
24. World Bank	II Family Health Care	Balochistan Punjab	Health Deptts. Balochistan & Punjab	1992	1999	81.0	
25. Save the Children Fund	The Family Health Project (World Bank-I)	NWFP	Health Deptt. NWFP	1992	1999	1.0	42
26. FINADA	Upgrading & Standardization of Diagnostic Services.	National	Ministry of Health . Provincial Health Deptts.	1988	1991	18.320	43
27. Asian Development Bank	I. Health & Population Project	Punjab	Health Deptt. Punjab	1982	1986	15.0	
28. Asian Development Bank	II. Health Project.	Islamabad Sindh	Ministry of Health, Population Welfare Div., Department of Health, Sindh.	1985	1989	16.0	44

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Donor	Project	Region(s)	Agency(a)	Start	End	Cost (million $)	Summary on page
29. Asian Development Bank	III. Health Project	Islamabad NWFP Balochistan	Ministry of Health, Deptts. of Health, NWFP & Balochistan	1987	1992	30.4	45
30. Asian Development Bank	IV. Health & Population Program	National	Ministry of Health, Provincial Health Deptts.	1993	1999	22.89	
31. FAO (WFP)	Supplementary Feeding Program in Primary Health Care	National	Provincial Health Deptts.	1991	1993	3.0	46
32. JICA	Medical Equipment for Primary Health Care	Punjab	Health Deptt. Punjab	1989	1990	5.67	47
33. WHO	Primary Health Care Training of Voluntary Health Workers Pilot	Islamabad	Ministry of Health	1991	1992	0.10	

B. Foreign Assisted Primary Health Care Project Summaries

1. Title: Expanded Program on Immunization (EPI).	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health, Health Departments of all Provinces.
5. Cost: $ 14.455 million (including $ 5.3 million still sought thru supplementary funds)	*6. Period:* 1992-1996
7. Goal: Reduce morbidity and mortality resulting from the 6 EPI target diseases.	*8. Purpose:* To maintain high coverage, strengthen the surveillance for EPI diseases, initiate aggressive outbreak control measures and achieve self-sufficiency in EPI implementation.
9. Project Components:	*10.Expected Outputs:*
a) Training & Supervision.	a) Enhanced program efficiency and improvement sterilization techniques.
b) Vaccine Production and Supply.	b) Annual production of 4 million doses of measles vaccine and reconstitution of 8 million doses of oral poliomyelitis vaccine (OPV)
c) Cold Chain.	c) A comprehensive inventory system instituted to continuously monitor the cold chain for maintenance and repair.
d) Syringes/Needles.	d) Utilization of reusable syringes/needles at fixed immunization sites.
e) Information, Education and Communication.	e) Improved face-to-face communication strategies and mass media messages based on program priorities.
11. Beneficiaries: 90 percent children under one year of age. 90 percent females of child-bearing age.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues: Provincial Governments do not provide sufficient budgets for recurrent costs of EPI. Program reliance on mobile teams must reduce and an active demand for services at fixed immunization sites created.	

1. Title: Control of Diarrheal Diseases Program.	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces.
5. Cost: $ 2.5 million	*6. Period:* 1992-1996
7. Goal: Reduction of deaths due to diarrhoea in children under 5 years.	*8. Purpose:* To reach health care workers at the community level and train them in correct case management (CCM) and preventive measures.
9. Project Components:	*10.Expected Outputs:*
a) Training.	*a) Systematic training for para-medical workers.* Orientation in preventive measures and correct case management at the household level. Private practitioners and pharmacists trained in CCM.
b) ORS Production/Supply.	b) One million additional ORS packets available annually for treatment of diarrhoea and training.
c) Information, Education and Communication (IEC).	c) Widely available information on preventive measures through inter-personal and mass media channels.
d) Strengthening MCH Services.	d) Established Oral Rehydration Therapy ORT centres/units in health facilities with staff trained in CCM.
e) Applied Research.	e) Information to make the IEC component more effective.
11. Beneficiaries:	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues:	

1. *Title:* **Acute Respiratory Infections (ARI) Control Program.**	2. *Region(s):* National
3. *Donor:* UNICEF	4. *Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. *Cost:* $ 2.5 million	6. *Period:* 1992-1996
7. *Goal:* Reduction of deaths in children under 5 years of age due to acute respiratory infection (ARI).	8. *Purpose:* To enhance standard treatment and increase access to standard case management.
9. *Project Components:* a) Training. b) Information, Education and Communication. c) Applied Research. d) Logistics and Supplies.	10. *Expected Outputs:* a) Trained health professionals in the government and private sector and better informed Community Health Workers in the Correct Case Management of ARI. b) Enhance the early detection of ARI and prompt health care seeking outside the home. c) Alternative approaches to program implementation and a knowledge base for appropriate messages and communication strategies. d) The availability of appropriate antimicrobials, adequate treatment of wheezing and safe cough and cold mixtures at every health facility.
11. *Beneficiaries:* Children under 5 years of age and health personnel.	
12. *Current Status:* This project is a carry over from the previous ongoing program 1988-1991.	
13. *Implementation Issues:*	

1. Title: Primary Health Care (PHC) Program.	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. Cost: $ 5.09 million (including $ 3.7 million still sought thru supplementary funds)	*6. Period:* 1992-96
7. Goal: Provision of basic health care to the population.	*8. Purpose:* Increase the utilization of the health care network by integrating vertical programs into a substantial PHC system at the village level.
9. Project Components: a) Community Health Workers Project. b) Primary Health Care Development.	*10.Expected Outputs:* a) Staff of Basic Health Units and Rural Health Centers oriented to train and support Community Health Workers on the basis of a defined curriculum. b) Support for integration of vertical programs into the health care infrastructure at all levels. Available assistance for community-based PHC projects to develop innovative approaches such as introduction of user charges.

11. Beneficiaries: Rural and unreached groups and health personnel.

12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.

13. Implementation Issues

1. Title: **Health Education Program**	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. Cost: $ 1.45 million	*6. Period:* 1992-1996
7. Goal: Increase awareness in the prevention of disease.	*8. Purpose:* Strengthening health education units at all levels and integrating health education components into health programs.
9. Project Components:	*10.Expected Outputs:*
a) Capacity Development.	a) Enhanced capacity of Health Education Cells at the federal, provincial and divisional levels to manage, coordinate and monitor health education activities; and support for NGO activities in Health education.
b) Training.	b) All curricula for preventive programs to include basic communication skills. Introduction of appropriate training of primary school teachers for health education. Availability of basic visual aids for communicating with parents on health.
c) Material Production.	c) Increased capacity of Health Education Cells to manage programs and develop materials.
d) Social Mobilization.	d) Partners mobilized to assist Health Departments to disseminate health education.
11. Beneficiaries: General public and health personnel.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues: Health education is an ad-hoc activity. GOP must make regular and mandatory budgetary allocations for this activity.	

1. Title: **Health Sector Support**	*2. Region(s):* National.
3. Donor: UNICEF	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments UNICEF
5. Cost: $ 4.455 million	*6. Period:* 1992-1996
7. Goal: Strengthening the Public Health Sector infrastructure.	*8. Purpose:* Strengthening GOP capacity to plan, manage, coordinate and utilize health services research.
9. Project Components:	*10.Expected Outputs:*
a) Health Information System (HIS).	a) Technical continuity to maintain HIS developed by USAID after its adoption on the national level.
b) Management Training.	b) Availability of management training programs for senior and mid-level health professionals with appropriate curricula and on-the-job training.
c) Field Epidemiology Training.	c) A national training program in applied epidemiology.
d) Operational Research.	d) Well designed studies and national training courses in research methodology. Studies considering future directions in public health programming.
e) Program Support.	e) Continuity in country program management and technical assistance for the coordination of all national Unicef Child Health initiatives.

11. Beneficiaries: Policy-makers, senior and mid-level managers of the health sector.

12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.

13. Implementation Issues:

1. *Title:* **Advocacy & Social Mobilization for Safe Motherhood**	2. *Region(s):* National.
3. *Donor:* **UNICEF**	4. *Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. *Cost:* $ 0.370 million	6. *Period:* 1992-1996
7. *Goal:* To strengthen a broad based constituency of politicians, journalists,etc. for safe motherhood goals.	8. *Purpose:* Support institutions advocating Safe Motherhood.
9. *Project Components:* a) Dissemination of Information. b) Human Resources Development. c) Applied Research.	10.*Expected Outputs:* a) Workshops, seminars and conferences on Safe Motherhood and Women's development and publication of their proceedings. b) Trained staff of government agencies and NGOs involved in safe motherhood initiatives. c) Sociological and anthropological research data on antenatal care and family planning practices.
11. *Beneficiaries:* Women of child bearing age.	
12. *Current Status:* This project is a carry over from the previous ongoing program 1988-1991.	
13. *Implementation Issues:*	

1. Title: **Traditional Birth Attendant (TBA) Training Program**	*2. Region(s):* National.
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. Cost: $ 4.04 million in supplementary funds.	*6. Period:* 1992-1996
7. Goal: Reduction of maternal and neonatal mortality rates.	*8. Purpose:* Improve the skills of TBAs and strengthen their role to improve attitudes towards maternal and child care.
9. Project Components:	*10.Expected Outputs:*
a) Training new TBAs.	a) 30,000 new TBAs countrywide Orientation for 3,000 trainers and strengthening of mobile teams and curricula.
b) Refresher Training.	b) Centre-based refresher training will be instituted through a standardized protocol. 24,000 TBAs will receive refresher training annually.
c) Strengthening Referral Mechanisms.	c) Supportive supervision for TBAs and tested mechanisms to establish linkage between TBAs and the health system.
d) Development of Monitoring and Evaluation Systems.	d) A monitoring system to evaluate activity levels of TBSs and health status indices for newborns and mothers.
e) Project Management Support.	e) Effective project implementation through relevant training of project staff.

11. Beneficiaries: Women of child bearing age and TBAs.

12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.

13. Implementation Issues:

1. Title: Strengthening Mother and Child (MCH) Services	*2. Region(s):* National.
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. Cost: $ 2.23 million	*6. Period:* 1992-1996
7. Goal: Reducing Maternal Mortality.	*8. Purpose:* To improve the technical skills of MCH health workers and the operational capacity of MCH facilities.
9. Project Components:	*10.Expected Outputs:*
a) Comprehensive Maternal Care at MCH Centers.	a) MCHs will be strengthened to determine referral to higher levels, provide counseling for family planning and maintain programs for antenatal, delivery and postnatal care including immunization.
b) Upgrading First-level Referral Units.	b) The operational capacity of Tehsil & District hospitals will be increased in terms of staff competence for MHC.
c) Advocacy for Curricula Revision.	c) Critical revisions in the curriculum of health functionaries for MCH.
d) Improvement of Reporting/ Feedback Systems.	d) MHC information system will be revised to yield meaningful data for planning and program analysis. It will also be linked to the larger Health Information System being restructured by USAID.
e) Community-based Projects for Safe Motherhood.	e) Developed sustainable community-based approaches with particular focus on the transportation of referral cases.
11. Beneficiaries: Women of child bearing age and MCH workers.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues:	

1. Title: **Family Planning & Child Spacing**	*2. Region(s):* National.
3. Donor: UNICEF	*4. Implementing Agency(s):* Ministry of Health Ministry of Population NGOs
5. Cost: $ 2.55 million (including 0.46 million still sought thru supplementary funds)	*6. Period:* 1992-1996
7. Goal: To reduce the population growth rate.	*8. Purpose:* To expand family planning coverage through the Health Department.
9. Project Components: a) Information, Education and Communication. b) Family Planning Inputs into Health Programs. c) Human Resources Development. d) Research and Evaluation.	*10.Expected Outputs:* a) An effective communications strategy for population control based on sound audience research. b) Incorporation of contraceptive services as an integral part of health department and facilities. c) The creation of a network of family counselling trainers from training institutes and maternity hospitals. d) Availability of creative approaches to implementing community-based family planning services.
11. Beneficiaries: Families in general.	
12. Current Status: This is a new project being incorporated for the first time in the program.	
13. Implementation Issues:	

1. Title: **Nutrition Support Program**	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Ministry of Health-Planning Division. Provincial Health Departments. Municipal Corporations. NGOs.
5. Cost: $ 1.79 million	*6. Period:* 1992-1996
7. Goal: Reduction of malnutrition in children.	*8. Purpose:* To strengthen malnutrition prevention activities of relevant health staff.
9. Project Components:	*10.Expected Outputs:*
a) Training.	a) Uniform nutrition training materials. Enhanced training capabilities of the Departments of Health, Planning and Women's Development.
b) Provision of Supplies and Equipment.	b) Nutritional activity and surveillance sites will be equipped and have adequate supplies.
c) Advocacy/IEC.	c) Community representatives and relevant officials oriented in current nutrition concepts.
d) Applied Research.	d) Availability of innovative approaches to the implementation of community-based nutrition programs.
e) General Support.	e) National and provincial nutrition activities supported on a limited basis.
11. Beneficiaries: Children under 5 years of age.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues:	

1. Title: **Breast Feeding and Infant Feeding Program**	*2. Region(s):* National.
3. Donor: UNICEF	*4. Implementing Agency(s):* Provincial Health Departments.
5. Cost: $ 0.31 million	*6. Period:* 1992-1996
7. Goal: Preserve healthy breast feeding practices.	*8. Purpose:* To develop a national constituency promoting enlightened breast feeding and infant feeding practices.
9. Project Components: a) Improving Service Delivery Practices. b) Lactation Management Clinics (LMC). c) Information, Education and Communication.	*10.Expected Outputs:* a) Health personnel and administrators oriented to a national hospital/ health facility breast feeding policy. b) Establishment of equipped LMCs for use as training facilities. c) Discouragement in the use of substitutes for breast milk.

11. Beneficiaries: Children under 3 years of age.

12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.

13. Implementation Issues:

1. Title: **Iodine Deficiency Disorders (IDD) Control Program**	*2. Region(s):* NWFP Northern Areas, AJK.
3. Donor: UNICEF	*4. Implementing Agency(s):* Ministry of Health Health Department (NWFP, NA & AJK)
5. Cost: $ 1.88 million	*6. Period:* 1992-1996
7. Goal: Protection of 6.8 million people from IDD by June 1993.	*8. Purpose:* To create an awareness and demand for iodine intake.
9. Project Components:	*10.Expected Outputs:*
a) Iodized Oil Project.	a) Trained school teachers and health staff in the distribution of iodized oil.
b) Iodinated Salt Project.	b) Private sector involvement in the production and distribution of iodinated salt.
c) Information, Education and Communication.	c) A comprehensive approach to sensitizing those affected of the consequences of IDD and preventive measures. A demand for iodinated salt.
d) Advocacy.	d) Informed government and other decision makers of the seriousness of IDD, and necessity of using iodinated salt as the long term solution.
e) Training and Research.	e) Tested alternative approaches to the delivery of project services and improved surveillance methods.
11. Beneficiaries: People living in affected areas.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues:	

1. Title: Prevention of Vitamin A Deficiency Program	*2. Region(s):* National
3. Donor: UNICEF	*4. Implementing Agency(s):* Federal Ministry of Health Health Departments of all Provinces
5. Cost: $ 0.905 million	*6. Period:* 1992-1996
7. Goal: Reduce the incidence of Vitamin A deficiency in the country.	*8. Purpose:* To assist the government to develop national guidelines on the use of supplementary Vitamin A.
9. Project Components: a) Advocacy. b) Supply/Distribution.	*10.Expected Outputs:* a) Increased awareness in health professionals and policy makers regarding the role of Vitamin A in disease resistance and general good health. b) Availability of Vitamin A to take care of high risk cases in paediatric hospitals and urban slums.
11. Beneficiaries: Children 0-3 years of age. Children 0.3 years of age.	
12. Current Status: This project is a carry over from the previous ongoing program 1988-1991.	
13. Implementation Issues:	

1. Title: **Training of Traditional Birth Attendants (TBAs) I**	*2. Region(s):* National.
3. Donor: CIDA	*4. Implementing Agency(s):* Population Welfare Division.
5. Cost: $ 3.881 million	*6. Period:* 1983-1989
7. Goal: To reduce maternal and neonatal mortality.	*8. Purpose:* To improve the antenatal delivery and postnatal skills of TBAs.
9. Project Components: a) Training. b) Expansion. c) Mobile Teams.	*10.Expected Outputs:* a) Trained practicing and non-practicing TBAs. b) The establishment of new Family Welfare Centers. c) Trained TBAs in remote rural areas and a short duration training approach.
11. Beneficiaries: Women of child bearing age.	
12. Current Status: Complete.	
13. Implementation Issues:	

1. Title: Communication and Motivation Project	*2. Region(s):* National.
3. Donor: CIDA	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments
5. Cost: $ 3.268 million	*6. Period:* 1984-92
7. Goal: To support EPI & CDD Programs at the national level through communication and motivation activities.	*8. Purpose:* To establish capability at the National Institute of Health (NIH) to conduct communications research and training and to train health personnel in interpersonal communication.

9. Project Components:	*10.Expected Outputs:*
a) Institutional Strengthening.	a) A fully equipped and competently staffed Communication and Motivation Unit at NIH.
b) Training Module.	b) 300 trainers from the provinces trained to extend the project's Communication and Motivation Training Program to more than 10,000 vaccinators. Training handbooks and guide in Urdu and regional languages. Training material adapted to train other Primary Health Care Workers.
c) Health Education/Material.	c) A Desk Top publishing network will be operative at the NIH Communication and Motivation Unit.Regular publication of bilingual newsletter.
d) Communication Research.	d) Authentic information available on listening, viewing and reading patterns of women.
e) Coordination.	e) Secretariat support to the Federal Communications Advisory Group for the planning and coordination of health communication activities in the federal government and donor agencies.

11. Beneficiaries: End users of Health Services and health personnel.

12. Current Status: Operational.

13. Implementation Issues: It took 4 years to get a government counterpart in place.

1. Title: **Rabies Human Diploid Cell (HDC) Vaccine**	*2. Region(s):* Islamabad.
3. Donor: CIDA	*4. Implementing Agency(s):* Ministry of Health (NIH) National Health Institute.
5. Cost: $ 4.634 million	*6. Period:* 1986-92
7. Goal: Treatment of rabies victims.	*8. Purpose:* Assist NIH to mobilize resources to produce 300,000 doses of rabies HDC annually.
9. Project Components: a) Equipment. b) Training. c) Quality Control.	*10. Expected Outputs:* a) Necessary equipment to manufacture rabies HDC. b) Trained staff to manufacture rabies HDC. c) Technology transfer for quality control of manufacture.
11. Beneficiaries: 60,000 rabies victims yearly.	
12. Current Status: Operational.	
13. Implementation Issues: HDC production interrupted due to lack of funds to repair a leaky roof.	

1. Title: **Immunization (Polio) III**	*2. Region(s):* Islamabad.
3. Donor: **CIDA**	*4. Implementing Agency(s):* Ministry of Health. National Institute of Health.
5. Cost: $ 4.920 million.	*6. Period:* 1987-92
7. Goal: To reduce infant mortality and morbidity	*8. Purpose:* To provide Polio vaccine.
9. Project Components: a) Production and Shipment. b) Quality Control. c) Management of Technology Transfer.	*10.Expected Outputs:* a) Oral Poliomyelitis Vaccine (OPV) concentrate produced and shipped along with necessary production components such as vials seals, etc. b) Equipment and technical assistance to perform quality control OPV doses. c) An evaluation of both the supply and dilution of OPV and an assessment of Pakistan's capability to manufacture its own OPV.
11. Beneficiaries: 90 percent children under one year of age.	
12. Current Status: Operational.	
13. Implementation Issues: The project's original expected completion date was extended by 2 years. OPV production unit interrupted due to lack of replacement of equipment parts.	

1. Title: **Basic Health Services Project**	*2. Region(s):* National
3. Donor: USAID	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments.
5. Cost: $ 9 million	*6. Period:* 1977-1982
7. Goal: To provide modern medical care to 50% of Pakistan's rural population.	*8. Purpose:* To strengthen the 3-tiered Integrated Rural Health Complexes (IRCH) approach to rural health.
9. Project Components: a) System Management. b) Medical Technician (MT) and Community Health Worker (CHW) Training. c) Construction of Basic Health Units (BHU) and Rural Health Centers (RHC) and Staffing.	*10.Expected Outputs:* a) 36 Managers trained. 6 Operations Manual produced. Basic Services Cell established at Federal level. b) 27 MT schools established. Curricula developed. 45 Tutors, 124 MTs and 55 CHWs trained. c) 6 RHCs constructed and fully staffed. 24 BHUs constructed and fully staffed.

11. Beneficiaries: Pakistan's rural population and para medical staff of the Provincial Health Departments.

12. Current Status: Completed.

13. Implementation Issues: The provincial governments did not sanction counterpart management staff. Big turnover of key personnel. The project was delayed due to the sudden cut-off of US assistance to Pakistan in 1979. Planned outputs were too optimistic to be met.

1. Title: **Primary Health Care**	*2. Region(s):* National
3. Donor: **USAID**	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments.
5. Cost: $ 30 million	*6. Period:* 1982-1990
7. Goal: Improve the health status of the rural population.	*8. Purpose:* Improve the quality and expand the coverage of Primary Health Care Services in the rural areas.
9. Project Components:	*10.Expected Outputs:*
a) Program Management.	a) Provincial operating plans, management systems and procedures, and operating manuals for BHUs developed and put to use.
b) Medical Technician and Community Health Worker Training.	b) 13 Medical Technician Training Schools constructed with male and female hostels. Revised curriculum and training materials for MT and CHWs trained.
c) Program Operation.	c) Performance of MTs and CHWs who will have uniforms, medical kits and low cost transport.
d) Research and Evaluation.	d) Baseline data on the prevalence and associated mortality of selected diseases.
e) Accelerated Expanded Program of Immunization.	e) Equipment for the production of DPT vaccine and simple cold storage equipment will be in operation and integrated into the Primary Health Care System.

11. Beneficiaries: Approx. 3,250,000 rural people (including about 500,000 children); MTs and CHWs who will be trained.

12. Current Status: Completed.

13. Implementation Issues: Changes in GOP policy required modifying objectives. The federal and provincial steering committees met infrequently. Provincial recurrent budgets were extremely tight, affecting the utilization of RHCs and BHUs. Short term training was under-utilized.

1. Title: **Child Survival Program**	*2. Region(s):* National
3. Donor: **USAID**	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments.
5. Cost: $ 17 million (Reduced from $ 62 million due to Pressler Amendment).	*6. Period:* 1988-1993
7. Goal: Decrease infant and child mortality.	*8. Purpose:* Expand and institutionalize the Child Survival Program in the PHC System.
9. Project Components:	*10.Expected Outputs:*
a) Program Management.	a) Improved case and clinical management skills and tools for ARI, CDD, Nutrition and EPI. Management decisions to improve utilization of PHC facilities.
b) National Health Information System.	b) A sound decision making by Program Managers and policy makers. Computerized country-wide information system on all health components available.
c) In-service Training.	c) Coordinated and integrated training in EPI, CDD, ARI, etc.
d) Health Education and Communication.	d) A comprehensive communication stratergy will be available. Mechanism to use Private Sector resources for health education will be available.
e) Research.	e) Operations Research results available to enable planning and establishing practical procedures for decentralization on a sound basis.
f) Drugs and Logistics.	f) Cold chain equipment, syringes and needles and computers available for integration in the PHC services.
11. Beneficiaries: Children of 0-5 years of age and health personnel.	
12. Current Status: Operational.	
13. Implementation Issues: Started late due to delay in PC-1 process. Pressler Amendment has led to a redefinition of the original goals.	

1. Title: Malaria Control II	*2. Region(s):* National
3. Donor: USAID	*4. Implementing Agency(s):* Ministry of Health Provincial Health Departments
5. Cost: $ 61 million (reduced from $ 66 m due to Pressler Amendment)	*6. Period:* 1982-1992
7. Goal: Reduce morbidity and mortality from malaria.	*8. Purpose:* To assist the government to contain or reduce the incidence or Malaria.
9. Project Components:	*10. Expected Outputs:*
a) Program Management.	a) Expanded capacity of federal, provincial and municipal health services to control Malaria.
b) Training.	b) Senior and mid-level health personnel trained in Malaria control. Surveillance, appropriate drug treatment and analysis. Enhanced capacity and capability of the National Malaria Training Centre.
c) Basic and Operational Research.	c) Data on use and effectiveness of various insecticides under field conditions. Innovative approaches for obtaining public cooperation for the program. Knowledge about biological control of vector species.
d) Commodity Support.	d) Availability of insecticide and spraying equipment for residual house- spraying on which the Pakistan Malaria control program is totally dependent.
11. Beneficiaries: Targeted population in moderate and highly endemic areas.	
12. Current Status: Last year of implementation.	
13. Implementation Issues: The program is not sustainable due to high costs. There is more dependence on spraying and less case identification. Research element was not established.	

1. Title: **I. Family Health Project**	*2. Region(s):* NWFP Sindh
3. Donor: World Bank	*4. Implementing Agency(s):* Health Department NWFP Health Department Sindh
5. Cost: $ 31.880 million	*6. Period:* 1992-1999
7. Goal: To improve the health status of the population within the project provinces.	*8. Purpose:* To build institutional capacity to increase the effectiveness of the existing health care network.
9. Project Components:	*10.Expected Outputs:*
a) Strengthening Health Services.	a) An enhanced package of maternal health services including family planning. Communicable disease control activities, integrated and expanded mainly in rural areas. Selected BHUs and MCH Centers upgraded with equipment. Enhanced emergency handling capacity. Strengthened diagnostic capacity in rural facilities. A strengthened referral system.
b) Staff Development.	b) Improved capabilities and performance of primary health care staff and an increase in female para medical staff. A comprehensive regular inservice training program for health personnel. A new nursing college in Sindh established; and 3 existing para-medical schools rehabilitated in the NWFP.
c) Management and Organizational Development.	c) Provincial and district management units established. Systematic management training introduced.
11. Beneficiaries: The population of NWFP and Sindh.	
12. Current Status: Approved.	
13. Implementation Issues:	

1. Title: Family Health Project (World Bank-I)	*2. Region(s):* NWFP
3. Donor: Save the Children Fund	*4. Implementing Agency(s):* Health Department, NWFP.
5. Cost: $ 1 million.	*6. Period:* 1992-1999
7. Goal: To improve the health status of the population in NWFP.	*8. Purpose:* To build the institutional capacity of the Health Department to improve services.
9. Project Components: Save the Children Fund will provide technical assistance for the Management Development Component of the World Bank Project in the NWFP only.	*10.Expected Outputs:*
11. Beneficiaries: Rural population of the NWFP & health personnel.	
12. Current Status: Approved	
13. Implementation Issues:	

1. Title: **Upgrading and Standardization of Diagnostic Services**	*2. Region(s):* National
3. Donor: FINADA	*4. Implementing Agency(s):* Ministry of Health Provincial Health Department
5. Cost: $ 18.320 million	*6. Period:* 1988-1991
7. Goal: Improved health services for rural people.	*8. Purpose:* Upgrade and improve clinical chemistry diagnostic services in the health departments.
9. Project Components: a) Equipment Supply. b) Maintenance Capacity Building. c) Training Program. d) Transfer of Technology.	*10.Expected Outputs:* a) Laboratories of 441 hospitals (including 261 tehsil hospitals) equipped with similar diagnostic equipment, accessories and supplies. b) 5 fully equipped service workshops operative one each in Islamabad and the provinces. c) Concerned personnel and end-users of the diagnostic equipment completely trained. d) Initiation of local production of reagents and required PVC consumables.
11. Beneficiaries: Users of health services.	
12. Current Status: Operational.	
13. Implementation Issues:	

<table>
<tr><td>1. Title: II. Health Project</td><td>2. Region(s): Islamabad
Sindh</td></tr>
<tr><td>3. Donor: Asian Development Bank</td><td>4. Implementing Agency(s): Ministry of Health.
Population Welfare Division.
Department of Health, Sindh.</td></tr>
<tr><td>5. Cost: $ 16.0 million</td><td>6. Period: 1985-1989</td></tr>
<tr><td>7. Goal: Improving the health status of the population.</td><td>8. Purpose: Improving the delivery of health and population welfare services.</td></tr>
<tr><td>9. Project Components:

a) Basic Health Units.

b) Maintenance and Repair of Medical Equipment.

c) Health Manpower Development.

d) Regional Training Institutes (RTIs).

e) Family Planning Services through Line Departments.

f) Innovative Activities.</td><td>10. Expected Outputs:

a) 55 BHUs constructed and equipped in Sindh.

b) Workshop and two mobile workshops to support it, constructed and operational in Sindh.

c) Developed curricula, teaching aids, books and transport available to five provincial nursing schools.

d) Four RTIs for family planning workers constructed and equipped.

e) Trained personnel, supplies and equipment available for introducing family planning services in about 190 health outlets of Department of Health, Local Government and labor in Sindh.

f) Small-scale population projects through NGOs.</td></tr>
<tr><td colspan="2">11. Beneficiaries: Rural population and health personnel.</td></tr>
<tr><td colspan="2">12. Current Status:</td></tr>
<tr><td colspan="2">13. Implementation Issues:</td></tr>
</table>

1. Title: **III. Health Project**	*2. Region(s):* Islamabad NWFP Baluchistan
3. Donor: **Asian Development Bank**	*4. Implementing Agency(s):* Ministry of Health Health Department, NWFP & Baluchistan
5. Cost: $ 30.4 million	*6. Period:* 1987-1992
7. Goal: To assist the governments of Baluchistan & NWFP in improving the health of the population	*8. Purpose:* To improve health care delivery and key support areas in the two provinces and address the need for improved planning at the national level
9. Project Components:	*10.Expected Outputs:*
a) Referral Facilities	a) The civil works and equipment of Rural Health Centers and some Basic Health Units up-graded and accommodation for staff constructed and furnished.
b) Health Manpower	b) Up-graded civil works and equipment for nursing schools and their staff and trainee accommodations. Availability of teaching aids and and materials. An assessment for in-service training needs available.
c) Equipment Repair & Maintenance	c) Workshops established at four locations in each province.
d) Planning and Management of Health Services	d) A planning unit established within the Department of Health in Baluchistan; and the existing one in NWFP strengthened. Improved Supervision and management of rural health factualities.
11. Beneficiaries: Rural population of NWFP & Baluchistan and the health personnel of these provinces.	
12. Current Status:	
13. Implementation Issues:	

1. Title: **Supplementary Feeding Program in Primary Health Care**	*2. Region(s):* National
3. Donor: FAO (WFP)	*4. Implementing Agency(s):* Provincial Health Ministry of Health Provincial Health Departments
5. Cost: $ 3.0 million	*6. Period:* 1991- 1993
7. Goal: To reduce infant & maternal mortality and combat malnutrition	*8. Purpose:* To provide an incentive to people to visit a government health facility.
9. Project Components: a) Food Commodity Supply	*10.Expected Outputs:* a) Wheat, dried skimmed milk and oil provided to underweight children and pregnant and lactating women.
11. Beneficiaries: Pre school children, pregnant and lactating women.	
12. Current Status: Operational.	
13. Implementation Issues:	

1. Title: Medical Equipment for Primary Health Care	*2. Region(s):* Punjab
3. Donor: JICA	*4. Implementing Agency(s):* Health Department, Punjab
5. Cost: $ 5.67 million (756 million Yen)	*6. Period:* 1989- 1990
7. Goal: To improve the health of the rural population.	*8. Purpose:* To strengthen primary health care delivery with necessary equipment
9. Project Components: a) Supply of Equipment	*10.Expected Outputs:* a) The following equipment made available to the primary health system: 203 Russicators 1847 Blood Pressure Apparatus 81 Centrifuges 1865 Diagnostic Sets 104 RHU Ambulance Cars 205 Mobile Shadowless Lights 1552 Microscopes 276 Standby Generators
11. Beneficiaries: The rural population of the province	
12. Current Status:	
13. Implementation Issues:	

III

A Bibliography Related to Primary Health Care

This select bibliography attempts to list relevant references that are available on primary health Care in Pakistan. It includes existing reviews, evaluations, reports and articles on the subject. Primary sources of information have been the Ministry of Health, Planning Commission, international agencies and National Institutes. Titles of published sources are underlined. The list cannot claim to be exhaustive. References available in the provinces were not considered. All the Legislative Acts that are administered by the Health Department have been included separately, at the head of the bibliography.

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Annexure 1: **Terms of Reference for Primary Health Care and Primary Education Sector Reviews**

I. Objective

JICA as part of its assistance to Pakistan is planning the design of project interventions in the primary health and primary education sectors. As a preliminary step, JICA is interested to gather background information that can help the actual project design process in both these sectors. The present terms of reference relate to this background information gathering exercise.

II. Scope of Work

Two separate studies shall be conducted, one on Primary Health Care and the other on Primary Education. The scope of work of both will include:.

1. A select bibliography

   This bibliography will comprise existing reviews, evaluations, reports, articles, public legal documents, acts and ordinances on the subject. Primary sources of information will be records and libraries of respective Ministries, the Planning Commission, donor and international agencies and national institutes.

2. An inventory of all on-going donor projects as well as the major ones of the past.

   The inventory will specify the various donors; the project titles; the region(s) of implementation; the implementing agency(s); cost of projects; starting year and ending years.

3. One-page format summary briefs for all projects on which documentation is accessible.

   The summaries shall include the project goal, purpose, components and inputs, specific output(s) at project closure, beneficiaries, current status and implementation bottle-necks; along with the project title, donor, implementing agency etc.

4. A descriptive overview of the state's service delivery structure in the subject sectors, including special focus programs and the government's stated policy.

5. A summary assessment and analysis of the input, experience and policy of the major donors in the subject sectors.

Annexure : II Statistics on Health Expenditure & Physical Facilities

Table 1

National Health Facilities as of June 1988

FACILITY	PUNJAB	SIND	NWFP	BALUCHISTAN	ICT	AJK	FATA	NA	TOTAL
1. Basic Health Units	1738	350	630	326	12	264	100	76	3496
2. Rural Health Centres	260	69	67	35	3	30	5	23	492
3 MCH Centres/Dispensaries/ Subcentres	2534	1734	973	376	..	47	183	203	6050
4. Hospital Beds	29244	17200	8838	3017	1320	2000	1200	800	63619
5. Doctors including dentists	14870	14200	3900	1200	750	500	500	80	36000
6. Nurses	4650	3500	1000	300	500	50	..	..	10000
7. Paramedics	29500	16400	8500	3000	2000	2000	2000	1600	65000
8. TBAS/Dias	25000	7500	7500	2500	...	1500	500	500	45000

Note:
1. The facilities of Federal Government (Health Division) are included in various geographical areas.
2. These figures include facilities of the private sector but do not include those of Defence

Source : Seventh Five Year Plan 1988-93

Table 2

Physical Facility & Manpower Achievements in Health by Plan Periods

Major Programmes	Unit	First Plan (1955-60	Second Plan (1960-65	Third Plan (1965-70	Non-Plan Period (1970-78	Fifth Plan (1978-83	Sixth Plan Achievements (1983-88)	Seventh Plan Target (1988-93)
PHYSICAL FACILITIES								
BHU	Nos	70	340	250	1,183	1,617	1,803	1,913
Urban health Centres	Nos							314
Rural health Centres	Nos		73	14	81	130	194	133
Hospital Beds	Nos	2,500	3,750	4,300	14,308	5,308	11,878	19,871
HEALTH MANPOWER								
Doctors	Nos	1,351	3,691	3,561	9,362	10,203	18,000	15,700
Dentists	Nos	-	-	-	-	-	700	800
Pharmacists	Nos	-	-	500	1,000	1,000	2,000	2,500
Nurses	Nos	275	800	1,681	4,311	4,246	4,980	10,000
Paramedics/Auxiliaries	Nos	3,800	4,520	4,653	9,756	13,576	22,770	88,850
TBAS	Nos	-	-	-	6,000	9,000	30,000	20,000

Source : Seventh Five Year Plan 1988-93

Table 3

Financial Outlays for Major Programmes by Plan Periods
(Rs. Million)

Major Programmes	First Plan (1955-60	Second Plan (1960-65	Third Plan (1965-70	Non-Plan Period (1970-78	Fifth Plan (1978-83	Sixth Plan Achieve-ments (1983-88)	Seventh Plan Target (1988-93)
Rural Health Programme	7	19	12	313	1,250	4,040	5,870
Preventive Programmes	13	82	159	952	704	1,600	1,014
Hospital Beds including Teaching Hospitals	28	55	58	552	1,256	4,000	3,178
Urban Health Centres	...	...	...	...	...	...	951
Health Manpower Development	22	28	40	418	1,167	1,250	2,645
Medical Research	4	10	12	18	79	Reflected in Science and Technology	
Miscellaneous Programmes	2	...	...	128	128	270	134
Traditional Medicine & Homoeopathy	...	....	...	...	...	45	188
Programmes for Disabled	...	...	...	...	...	...	170
TOTAL	68	174	281	2,381	4,584	11,255	14,160

Source : Seventh Five Year Plan 1988-93

Table 4

Total Expenditure on Health (at Current Cost Factor) 1972 - 1988
(Rs. Million)

YEAR	DEVELOPMENT EXPENDITURE	NON DEVELOPMENT	TOTAL	GNP	TOTAL
1972-73	95.55	171.90	267.45	61,877	0.43
1973-74	175.67	210.10	385.77	82,307	0.47
1974-75	363.00	278.00	641.00	104.704	0.61
1975-76	629.10	360.64	989.74	122,728	0.81
1976-77	540.00	439.20	979.20	141,462	0.69
1977-78	512.00	558.60	1070.60	172,064	0.62
1978-79	569.00	641.60	1210.60	192,571	0.63
1979-80	717.00	661.89	1378.89	228,886	0.60
1980-81	942.00	794.82	1736.82	270,288	0.64
1981-82	1037.00	993.10	2030.10	315,183	0.64
1982-83	1183.00	1207.00	2390.00	365,585	0.65
1982-84	1526.00	1564.90	3090.90	412,343	0.75
1984-85	1587.45	1785.12	3372.57	469,200	0.72
1985-86	1881.51	2393.81	4275.32	526,569	0.81
1986-87	2615.00	3270.00	5885.00	573.146	1.03
1987-88	3114.41	3600.00	6714.41	610.400	1.10

Source : Seventh Five Year Plan 1988-93

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