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TRANSFORMATION STRATEGY PROPOSAL

FOR PHC/MARDAN

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TRANSFORMATION STRATEGY PROPOSAL FOR PHC / MARDAN

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INTRODUCTION

1. The Primary Health Care (PHC) and sanitation projects initiated by the Austrian Relief Committee (ARC) in 1980 have been the best organised and most successful of all ARC undertakings in Pakistan. As ARC begins to wind up its work in Pakistan after fourteen years of commendable humanitarian efforts on behalf of Afghan refugees, the question of the future of PHC needs to be addressed. The present Paper, requested by ADC/Vienna, attempts to present a comprehensive picture of the present situation and the future of PHC. In particular, it examines various options for transformation of PHC, enumerates the pros and cons of each option and provides indications for actions that need to be undertaken for ensuring a viable and sustainable future for a new Pakistani entity.

SECTION 1: WHAT IS

CHAPTER I: Present structure of PHC

A. Functions

2. PHC is an integrated health care system consisting of five components:
(i) diagnostic/curative activities such as lab tests, provision of drugs, dressings, injections, minor surgery, physio-therapy, dental care and referral to hospital,
(ii) preventive activities including immunisation, TB control, malaria control, control of respiratory and diarrhoeal diseases and environmental sanitation;
(iii) health promotive activities such as ante-natal care, supervised deliveries and post natal care, under-two clinics, child-spacing, home visits, school health as well as more general health education;
(iv) nutrition rehabilitation;

(v) training programmes for volunteer assistants i.e. community health workers (CHWs), traditional birth attendants (TBAs), malaria supervisors as well as in-house training of medical staff.

3. The integrated health care system of PHC is confined to somatic treatment only. What exists of psychosomatic disease is treated medically. Despite the fact that the target population, individuals and groups of refugees, can be assumed to suffer from traumas and consequently to have a relatively high rate of mental disorders common among any refugee population, mental care is not, and has not been hitherto a part of PHC.

B. Structure: administrative/financial/operational

4. PHC employs 85 staff members. Ten are Pakistani, most of them doctors placed at the top levels of the programme. Since the beginning, a policy of using multi-skilled personnel for non-professional functions, and promote them after a certain period of performance observation, has been applied. As a result, about 75 per cent of the staff have worked themselves up through the system from volunteer positions. Consequently, they know how the system works from bottom up. A probation policy is also applied to employment of professional staff. The probation period is three months.

5. Staff members are all remunerated with a cash salary. Yearly increments are granted to satisfactory job performers. The level of salary for all medical staff corresponds to the those of the NGO community in Peshawar for locally recruited staff which is way above comparable Pakistani levels. The rule seems to be two to three times higher than the salaries would have been, had PHC deployed a local-personnel-local-salary policy.

6. Buildings are well-constructed and well-maintained. Equipment and supplies seem adequate, if not plentiful, in terms of quantity and quality. Only Western medicine is used with the result that certain drugs sporadically run out of stock. Traditional medicine has not been experimented with at all, not even in periods of shortage of Western supplies. The implicit assumptions behind this reflect non-local standards. European value premises seem to be governing the programmes.

7. Since 1982, medical staff members have attended curative and preventive courses held by UNHCR, four to five times a year. Reportedly, PHC has been commended by UNHCR for a consistent

policy of keeping professional staff upto date on new developments within the field of medicine.

8. Monthly workshops and seminars are held for CHWs and TBAs by the doctors, where the status and policies of the programme are discussed alongwith specific problems relating to their work. Once a year, an in-depth refresher course of one to two weeks is organised on topics identified by the CHWs and TBAs, and according to their need of further instruction in topical medical issues. In 1994, the topic on the agenda is preventive measures for AIDS.

9. The PHC work week runs from Saturday through Wednesday, one day staggered in relation to the normal work week in Pakistan, and only three work days in common with agencies in Austria. Work hours fall between 8 a.m. and 2 p.m. hours which, given the time difference between Pakistan and Western Europe, leaves only 1-2 hours for direct telephone communication with Vienna.

10. The Basic Health Units (BHUs), located in the three refugee camps in which PHC operates, Baghicha, Gandaf and Kagan, serve men and women patients on alternating two days a week, children four days a week. One day a week is for home visits by the doctors and other medical personnel.

11. Seven Lady Health Visitors (LHVs), 250 CHWs and TBAs, all trained by the in-house training department, provide a network of out-reach services to all households of the camps. Beyond BHU hours, CHWs and TBAs make referrals directly to the hospital in Mardan.

C. Achievements

12. In the period 1980-1984, when PHC programmes focused on curative measures, the foundation of the present highly somatic, medical application, but also extremely effective treatment, was laid. The most important component of the curative treatment, vaccination campaigns for women of child-bearing ages (15-45 years of age) and children, was introduced in 1982.

13. By 1985, after five years of operation, the living conditions of the refugees had been considerably improved and were, already then, better than those of the host population. Under-five mortality rate had fallen from 225/1000 (at the time, one of the highest in the world) to 101/1000 and infant mortality from 156/1000 to 81/1000.

14. Seven years later, by 1992, preventive measures and health education had also had their impact. The two rates had then decreased to 28/1000

and 19/1000 respectively (see, ANNEX I: Infant and Under-five Mortality). The expected average lifetime of the refugees (both sexes combined) had increased from 40 years (in 1980) to more than 63 years. About 90 per cent of the population were covered by the health care system, and regularly attended to by health staff. Everybody had access to safe water supplies for human consumption, and about 99 per cent to sanitation measures. Some 85 per cent of pregnant women were under prenatal care. Practically every birth was attended by health personnel, and the rate of low birth weight babies fell to four per cent (see ANNEX II: Deliveries in 1992/1993).

15. Also, in the period 1988-1993, malnutrition among the under-five, another key health indicator, was brought down significantly through intensive feeding programmes. The well-nourished group grew from 31 to 82 per cent; the percentage of those with 3rd degree malnutrition reduced from four to one (see ANNEX III: Nutrition Status of Children).

16. Through this positive evolution, PHC's target population surpassed not only the level of the surrounding Pakistani population in every respect, but also the world level to some extent. In 1991, (the year for which data is available for all three settings), the infant mortality rate reached 101 per thousand live births in Pakistan and under-five mortality rate 158, while those of the world fell to 64 and 93 respectively against the PHC population to 20 and 27. Life expectancy at birth was 57 years on the average in Pakistan, 64 years in the world against about 62 among the refugees.

17. Seen in a long-term perspective, the achievements of PHC are even more notable. From 1960 to 1991, infant mortality declined by 38 per cent (from 163 to 101) in Pakistan, by 50 per cent at the world level (128 to 64) against 91 per cent in the PHC population. If one were to base comparison on statistics issued by the UN on health conditions of member states, no country has ever achieved a decline of the infant mortality rate during the three decades from 1960 to 1991 similar to that of the PHC target population.

18. Regarding other health indicators (not available at the world level), Pakistan reportedly has 85 per cent coverage of access to health services, 50 per cent to safe water supplies, and merely 22 per cent to sanitation. The coverage of prenatal care for pregnant women reaches 70 per cent, as does also that for births attended by health personnel. Low birth weight rate is 30 per cent, while malnutrition among the under-five reaches 40 per cent (first, second and third degree of malnutrition combined). Clearly, Pakistan is far behind the PHC population; in relative terms, a few generations in fact.

19. Evidently, the achievements of PHC speak for themselves. They reflect a concerted and systematic effort which, in the course of about fourteen years, brought a population which, to a great extent, had been among those with least access to good health, upto a level prevailing in far more technologically advanced societies. Credit goes to ARC/PHC for these impressive results with the Afghan refugees in Pakistan. But the question is whether Pakistanis can be happy as well? Inevitably, the achievements mentioned above have made the PHC covered area an island of positive discrimination in the Pakistani landscape. The health conditions of the refugees were developed far beyond those of the surrounding Pakistani population and, as a result, placed refugees in a blatantly advantageous position.

20. Although the PHC in Kagan refugee camp treats significant numbers of local people as well, local patients generally are not aware of the work procedures of the BHU and, consequently, are treated last, despite the fact that many of them travel to the BHU from long distances. Thus, within Mardan District, the refugees are much better off in terms of health care as compared to the Pakistanis, potentially a cause for friction and antagonism between the two populations. In addressing this problem, various options for action exist. Each one of them have disadvantages and/or advantages. The following chapter deals with these issues.

The achievements of PHC programme are summed up in the **twenty-two annexes** attached to this Report. The statistics provided in them speak for themselves.

SECTION 2: WHAT CAN BE

Chapter II: Options for Action

A. Gradual phasing out

21. The easiest but certainly not the best option would be to phase out the activities of PHC alongwith other projects of ARC. This would involve gradual ending of staff contracts over a period of time and disposal of property and equipment etc. In this scenario, three possibilities exist:
(a) PHC will disappear;
(b) PHC will be handed over to the Pakistani government Health authorities; and
(c) PHC will be taken over by another, most probably, foreign-based NGO in Peshawar.

22. If (a) above is pursued, some funds (derived from the disposal) will be available to ADC. Buildings will be used for other purposes by the authorities of Pakistan or by the people in the areas. The health conditions of the former target population will deteriorate rapidly: in the first instance, to the level of the Pakistani population; subsequently below this level as the group in absolute poverty conditions is much larger among the refugees than within the local population (70 percent among the Afghan refugees as compared to about 30 per cent among Pakistanis). Consequently, the long-term development effect of PHC will decline considerably. All efforts hitherto made by ARC/PHC will be wasted.

23. If (b) is pursued , PHC is likely to suffer from instability for one to two years or more. Professionals will look for jobs within the foreign-based NGO sector. A high turnover of qualified staff is likely to ensue. Financial inputs will undoubtedly decrease significantly and, most probably, flow in irregularly. The maintenance of buildings, assets and equipment will suffer. The health conditions of the target population will decline, at least to the local level. A certain amount of decay will result. A good part of the achievements of PHC will be lost.

24. If (c) is pursued, achievements may be maintained for a further period of time. But as no foreign-based NGO can run health care systems on an open-ended basis in a developing country, it would only be a temporary arrangement for everybody concerned. Ultimately, scenario

(a) or (b) mentioned above would emerge. Buying time cannot be, and has never proved, a sustainable solution.

B. Extension into Afghanistan

25. A second option is to extend the PHC programme into Afghanistan in order to help meet the needs of the people living in appalling conditions in their country of origin. Obviously, the thought has considerable humanitarian value, but the experience of ARC with BHUs in Afghanistan has not been altogether positive. The activities in Loghar and Ghazni have suffered from unfavourable local conditions and internal management problems of ARC's overall programme within Afghanistan. The BHU in Jalalabad can play a useful role at this point in time due to the continuing conflict and the growing number of internally displaced persons. But this partial role, dictated by circumstances, cannot serve alone as the basis for planning the whole BHU programme.

26. Extension of PHC into Afghanistan will require:
(i) in-depth knowledge of the local conditions prevailing at project site(s);
(ii) availability of qualified and committed staff at all levels and of reliable local volunteers;
(iii) uncomplicated lines of communication between PHC Mardan and PHC Afghanistan;
(iv) satisfactory possibilities to monitor regularly the activities.
At present, none of these conditions can be easily met.

27. To obtain in-depth knowledge, extensive health surveys need to be conducted. That in itself is a major difficulty as long as the war continues to ravage the countryside and the population. The present human settlement patterns are not stable enough to yield reliable data. When the health conditions cannot be properly researched, only partial health care systems can be introduced.

28. Furthermore, there is a considerable shortage of qualified health personnel inside Afghanistan. Basically, they need to be educated and trained first. Available health personnel is already employed by the NGO sector operating out of Peshawar and Quetta.

29. The public communication system in Afghanistan is in total disarray. Telecommunications and power supply function sporadically at best, and only in urban areas. Transport to project sites takes days due to bad road conditions and in winter becomes even more difficult due to heavy rains and snowfall. Getting the necessary medical supplies to project sites can be extremely cumbersome.

The Chosen Option is (b).

C. Transformation into an indigenous NGO

30. Under this option, two possibilities exist: reincarnation into
(a) an Afghan NGO which serves inside Afghanistan and among the refugees, or
(b) a Pakistani NGO for local Afghans and Pakistanis.

31. As for (a), an Afghan NGO would need to be registered both with the Afghan authorities in the capital or the province and/or district in which it works as well as with the Pakistani authorities. A liaison office in Peshawar would serve a useful purpose in ensuring regular supply lines, and close contact with the donor community.

32. The model could have distinct advantages. It could employ the 75 or so Afghan staff members of PHC, some of them in higher positions, keep those among the Pakistani staff who volunteer to remain with the agency at appropriate positions, train volunteers among CHWs and TBAs for other jobs and, in time, regain full staff level. Self-management, a prerequisite for development, would be obtained. Most important, however, it would stimulate active participation of the Afghans in their own future in a peaceful way.

33. But such an entity would face much the same difficulties with programmes inside Afghanistan as mentioned under B above. Little would be achieved within a time span of two to three years, unless health programmes are launched as mobile health clinics operating in emergency camps (the very same form in which PHC was initiated in 1980).

34. Funds will undoubtedly decline, because the funding appeal of Afghan NGOs is negatively marked by the complex political situation prevailing among Afghan leaders, and their alliances within the Afghan NGO community. Given this complexity, there is a serious risk of politicization of such an entity with inevitable negative repercussions..

35. Also such an entity may be resented by the local Pakistani authorities. It may thus be handicapped to work among the PHC target population, in which case the health conditions of these people will decline, as described above, and the development effect of PHC would vanish in time.

36. As for possibility (b), an indigenous Pakistani NGO would start off with a number of advantages. It could serve the population of both Pakistan and Afghanistan in a feasible way. It could cover local Afghans

and Pakistanis, i.e. the PHC target population and surrounding local communities on an equitable and non-discriminatory basis.

37. It could maintain the present health conditions of the PHC target group and improve the health of people in nearby areas towards this level. It could also promote better health inside Afghanistan by lending its training department to courses for barefoot health staff (barefoot doctors, LHVs, CHWs, TBAs, vaccinators and dental assistants) who would then go to work in their communities.

38. It need not lose the immense development effect attained by PHC. It would remove the present imbalances between the Afghan refugees in the three PHC camps and surrounding local population and thus could weed out seeds of possible hostility between the two groups. It could be a reincarnation of PHC in the shape of a people's health programme (which could be named: People's Health Committee (PHC) or, in urdu, Awami Sehat Commitee (ASC). *

39. A stable funding situation would be required for the first 3-5 years, until all programmes have got firm hold of the new population and developed a sustainable financial base. The new entity would not necessarily require more financial input than the amount allocated for PHC in 1993. The funding would have to come from external sources until Pakistani authorities can afford to take over the responsibility, or the local fund-raising and target population can carry the burden.

40. In view of the above, reincarnation into a Pakistani NGO serving local Afghans and Pakistani emerges as the most sensible option for ARC/ADC to pursue. The next chapter, therefore, is devoted to what such a reincarnation involves in terms of planning and programming.

SECTION 3: WHAT SHOULD BE

CHAPTER III: PHC as a model Pakistani NGO

A. Scope and scale of the reincarnation

(i) General

41. The present level of service should be maintained, a few more components added, and more emphasis placed on preventive measures and health education. Curative practices should be linked explicitly to these measures since there is no ultimate cure without prevention and health education. A slogan for the new entity (ASC) could be: "No cure without prevention; no prevention without health education".

42. The prime target groups would be women of child bearing age, young girls aged 14-16 and children of school age. These groups are the prime movers as far as people's health is concerned, because, to a very large extent, they serve as managers (and assistants) of the household diet, compound hygiene and sanitation in an Afghan and Pakistani setting.

43. It is, therefore, important to be sensitive to the possibilities for women and young girls which their culture offers for instruction in disease prevention and health education; and thus to make use of whatever appropriate networks the target groups function in, including groups of related women and young girls gathering within the compounds in the afternoon for social and work related purposes.

(ii) Specific

44. The present sessions of instruction held at the MCH clinics, malnutrition units and at local primary schools should be continued and intensified with more out-reach service than is hitherto given by LHVs, CHWs and TBAs. Training of a number of family health educators for on-the-spot instruction within the compounds would serve a very useful purpose.

45. As regards the new target, i.e. the Pakistani population, an information campaign should be launched in nearby communities to advise them about the new status of PHC, and a network of out-reach services (LHVs, CHWs and TBAs recruited within the target communities) should be trained and put into operation as a matter of first priority to ensure full coverage of all the target groups. Primary and

secondary schools should also be approached, students informed about the new entity and a series of health education lectures arranged with lecturers provided by ASC Health.

46. The extension into the Pakistani communities would naturally increase the workload of the doctors, but with the present rather short work week observed at PHC, the daily work schedule can be prolonged by two hours without exceeding the daily work hour norm for Pakistan.

(iii) Supplementary Components

47. With regard to the additional components for both target populations, mental health care and traditional medicine should be included in the existing field of medicine. The entire programme should be expanded with research and activities enhancing the quality of life for the people.

48. Mental care: Neither the Afghans nor the Pakistanis have access to mental care and counselling. Mental disease, or disorder, is usually taken care of within the extended family, and as such often dealt with inadequately.

49. An appropriate approach would involve a three-phased programme:
(i) a mental health survey among a representative sample of the target to identify the patterns of disease and disorder;
(ii) training of highly motivated barefoot, lay psychologists in mental care, recruited among experienced CHWs and TBAs, because they are already accepted by the people and their present duties touch on mental health as well; and
(iii) establishing firm work routines for the lay psychologists in order to ensure that regular care is provided.

50. Traditional medicine: Introduction of traditional medicine (herbal medicine) would serve two main purposes:
(i) to reduce dependency on imported commodities, and hence avoid shortfalls in vital supplies; and
(ii) to revive the strong well-tested, medical traditions of South Asia. Traditional medicine may be less expensive, less complicated to get hold of and it may have less side effects. Hence, where local herbal medicine applies with satisfactory results, it should be made us of. The example of China with its bare-foot doctors and production in the back-yards of medicinal herbs required for common illnesses, could be emulated to the extent appropriate. "Traditional medicine" is taught in recognised medical schools in Pakistan. Qualified "hakeems" (not quacks) should eventually be co-opted. It is ironic that while the developed countries in the West are turning increasingly to homeopathy and natural curative methods as well as preventive strategies, the developing countries are

increasingly turning to Western medicine, forgetting the knowledge accumulated over centuries.

51. Research is an important support activity for all programmes, and vital for programme development, especially at times of rapid expansion. PHC has already served as experimental laboratory for malaria control research conducted by the foreign-based NGO, Médicins sans Frontières (MSF). The present group of doctors has had the opportunity of participating in the project for some time and seems well motivated for research.

52. In the first instance, ASC should concentrate on control of widespread diseases (preventive, educative and curative aspects) to which the population has little resistance, malaria for example among the Afghans and the main communicable diseases among the Pakistani infants and women, including appropriate immunisation and medication. In this respect, research into traditional, local medicine (available in abundant quantity within Afghanistan and Pakistan) could be a key issue, in particular so as long as the team of doctors is inadequately tuned to this kind of treatment.

53. Family planning is another area of great importance which has hitherto received inadequate attention. While child-spacing strategy of PHC has had commendable success, the issue of family planning as such has not been frontally addressed. Having the advantage of experienced staff which enjoys the confidence of the local population, PHC/ASC could do some pioneering work in the area in the field of family planning for which it could certainly have the support of the Pakistan Government and the UN Fund (UNFPA). Such an initiative could also attract considerable financial support from foreign sources.

54. Another field of expansion is the linkage between health issues to the concept of "quality of life". The key issue here is to allow the health programme to positively influence related aspects of people's livelihood, because for good health to stay with people, and to be effective in the long-term perspective, education, adequate food supply, and a sustainable level of income are prerequisites.

55. People perceive their livelihood within a holistic perspective of which health is just one component. For them to feel that their "quality of life" has improved, positive changes in education, food availability and level of income are necessary. It is, therefore important to introduce education and income-generation programmes wherever this fits into the current health programmes.

56. So far, PHC has been successful in motivating through its children's park programme at Gandaf: (i) girls for primary education and training for income-generating; and (ii) purdah-bound young girls and women for literacy and numeracy as well as more general education and income-generation programmes which do not go beyond the bounds of their culture. ASC would be ideally placed to follow up on these issues and should do so.

57. The groups can be targeted through the present network of outreach services. Education, training, agricultural and income-generation measures can be introduced to the households by the LHVs and CHWs first, followed up subsequently by a special household visitor, a Family Educator (FEs).

58. FEs would instruct the compounders in skills training and basic education combined. They should be recruited among the target population, and would obviously need to be trained for this specific task, preferably at the training department.

59. As a result, micro-enterprise could evolve at the compound level and, in the event of successful development, eventually become attached to a cottage industry placed within the BHU compound. The main advantage of placing education/training/income-generation services under the health service premises is to locate them within women's area of mobility.

60. Over the years, women have gradually gained permission to attend the BHUs whenever needed; a development which has been strongly supported by the persistent approach to female health of the PHC. Therefore, non-health services attached to the health premises are likely to be accepted relatively easily by the (male) population.

61. By expanding the services of the BHUs, the field of health would thus be lending its "good offices" to enhancement of the "quality of life" of the target population. ASC can hence lift the level of living of the target population in a culturally acceptable way which fits in with the holistic "quality of life" perspective of the people, and at the same time, truly live up to the connotation of its name: People's Health/Awami Sehat

B. Adjustment to national standards

62. For the new entity to be viable on a long-term basis and to have a sustainable base, it would be necessary for it to adjust itself to national standards. The dilemma facing it would be that the present PHC standard of health service is much higher. Obviously, one cannot recommend that the standards be lowered to the national level but some adjustments can

be envisaged. For example, the level of salaries should be reviewed, not so much to cut down the present income of everybody but rather to introduce cohesive, equitable and sustainable criteria for recruitment and remuneration. Similarly, to qualify for financial support from the Government, the UN agencies or other local sources, some technical adjustments might be called for. These are beyond the scope of the present Report but their study should be initiated at an early stage. The advantage for donors and mangers of an expatriate agency when the latter is transformed into a local entity is that the change presents a good occasion for a review of the whole system. It should not be missed to ensure the sustainability of the entity in the long run.

C. Cooperation with similar and related NGOs

63. Co-operation with other NGOs is a must for various reasons. ASC should gain as much experience as possible within its field(s) of operation. It should develop a network of contacts on which to draw when new lines of action are to be pursued. And it should have potential partners to combine forces with in case ASC, as a model Pakistani NGO, is requested to multiply its efforts elsewhere in Pakistan.

64. In relation to the donor community, co-operation among similar or related NGOs is also an advantage. Comprehensive, or more complex programmes can be negotiated, and a more stable funding situation obtained.

65. Co-operation can take many shapes, from ad hoc collaboration through systematic adjustment of programmes to fit the needs of other agencies, to actual merging of agencies into a consortium of NGOs operating within the field of health and related issues. At present, the former would have immediate positive impact and consolidate the work of ASC during the period of change and expansion.

66. For instance, ad hoc co-operation with Médicins sans Frontières, other research-oriented NGOs or university departments, in and outside Pakistan, on research identified by ASC would assist the agency in building up its own research capacity without draining the agency of senior manpower needed for other activities as well.

67. As regards collaboration through adjustment of programmes, the training department could, with little extra effort, adjust to the needs of Afghan and foreign-based NGOs for barefoot health personnel in Pakistan and Afghanistan, preferably on funding provided by the collaborating partners. It would also strengthen the training capacity of ASC, and ensure an even level of competence among trainees.

D. Cooperation with Pakistani authorities

68. Expatriate NGOs in the developing countries function, by and large, in "splendid isolation". They are (or are perceived by the local population to be) small islands which do not really belong to the country. They maintain standards that are usually higher than the local standards, pay their employees more, often follow alien practices and introduce foreign values that the locals sometimes resent. When the financial support from abroad dries up, such NGOs usually wither away or gradually degenerate. The pattern is common and often a major handicap to economic development efforts in the Third World. PHC does not entirely belong to this category: it has, in relative terms, remained closer to field realities and local populations. However, when changing its status from a foreign NGO to a local one, it will also have to "trim the edges" and get closer not only to national standards but also to national authorities.

69. Cooperation with Pakistani authorities will need to be developed or strengthened at three levels: i) local ii) provincial and iii) national. At the local level, PHC/ASC needs to get closer not only to the local Pakistani population, as noted earlier, but also to the district authorities, i.e. the health authorities and the local medical community; the administrative authorities of the Civil Service etc.

70. At the provincial level, closer contacts are essential since under the present system in Pakistan, the provincial ministry of Health and the Health Department are the most relevant decision-making bodies for PHC/ASC. Hitherto, it is the Ministry of the Interior and the departments dealing with refugee matters and foreign entities that have been the main interlocutors of NGOs like PHC. When the latter becomes a national NGO, the interlocutors will change.

71. At the national level, the role played by PHC until now and its transformation into a "model" Pakistani agency in the field of health care and community development, need to be recognised. It would be appropriate to raise considerably the present level of government contacts of PHC. Pakistan's Minister of Health and/or his senior colleagues must be brought into the transformation process. Some appropriate occasion(s) should be identified for such contacts to be developed.

SECTION 4: HOW ?

IV. Evolution from PHC to Community Development

72. Before commenting on the evolution of PHC, it is important to emphasise that the technical formalities of transformation into an indigenous entity can, in large measure, condition its future development. The first task is to draw up the "Statutes" or constitution of the new NGO.*The objectives and the scope of its activities need to be carefully thought out. Flexibility, potential for growth and eventual expansion of its functions and activities should be built into the statutes, even if during the initial stage, these might appear to be ambitious or unrealistic. Likewise, the choice of individuals who would be its Board members/Governors can be of decisive importance. It should not consist only of professionals linked to the medical activities of the NGOs but a broader range of persons who can either be useful in national and international fund raising or bring prestige and professional clout to the entity. *

73. In terms of its functions and role, the evolution of PHC/ASC should be a gradual, phased process consisting of three stages:
i) maintenance of present services and standards without feeling the impact of the foreseen major change from a foreign to a national NGO
ii) gradual addition of services and activities as suggested in Section 3 above. These should be absorbed as a part of natural growth process rather than as a dramatic change
iii) functional expansion into a holistic community development centre with a comprehensive, inter-sectoral approach encompassing all facets of the quality of life in its area of activity. *

74. The first two stages are essentially attitudinal in that the senior management would need to have the mind-set*for continuation (business as usual) and then gradual expansion on the basis of financial and institutional support. As for the more challenging (and ambitious) third stage, it should be noted that the "Community Development Centre" (CDC) concept was first discussed for the settings of Afghanistan and Pakistan in 1989 at a conference organised by UNICEF and UNIFEM in New York, but strangely enough not yet implemented in either country.

75. The concept is based on the convictions that:
(i) development problems have multiple, interrelated causes, requiring action in different sectors of society;
(ii) intersectoral action is a key element of primary health care, as indeed of all development work;

(iii) integration and co-ordination can greatly increase cost-effectiveness of programmes; and
(iv) intersectoral action also promotes a holistic approach to development at the community level.

76. The rationale behind CDC is that:
firstly, in order to respond to the priority needs of the communities and vulnerable groups, such as women and children, programmes should cover the spectrum of health and child care, agriculture and the care of animals, labour- and energy-saving technologies, income-generation and education;
secondly, for any of these programmes to be sustainable, it must have effective support structures. If programmes are to be community-based and integrated, so should be the support structures.

77. Because of its rural infrastructure, and social fabric of separate male and female domains, Pakistan has the unique occasion to construct appropriate, integrated and culturally acceptable rural development centres with health, educational, agricultural and economic services available in one place. In a traditional setting, however, buildings which allow for physical separation of the sexes are likely to be more culturally acceptable, and therefore effective and accessible to women.

78. CDCs should be centres for personnel, resources and training; they should in turn have adequate support through district or sub-district authorities, and as far as possible be physically contiguous, for greater co-ordination and cost-effectiveness. Such support facilities also need to be community-oriented and integrated. ASC, with its people-oriented, integrated community approach could be the agency to experiment with the CDC concept in the field, and to multiply the effort and the model, as appropriate and feasible.

V. Sustainability

79. The most important factor by far in the transformation of PHC would be the sustainability of the successor NGO. A well-defined strategy should be delineated at the outset for its eventual operational and financial self-sufficiency within a pre-determined time-frame.

80. The operational self-sufficiency of the proposed ASC would not be difficult to achieve since it would depend largely on the already available human resources. For the maintenance of the present modus operandi, the existing management possesses adequate experience and expertise. The process of eventual expansion should be gradual and allow for enough time of adjustment. On the basis of the past experience, it can be

said that in operational terms, PHC is already self-sufficient. In practical terms the transformation process should include the following steps:
i) Within 4 to 6 weeks after the transformation decision has been taken at Mardan/Vienna level, the statutes of the new entity should be finalised in consultation with the PHC staff and the Pakistani authorities. The experience of other agencies should be taken into account in this regard.
ii) During the same period, the head hunting process for the Board members/Governors should be completed
iii) The administrative and financial procedures of PHC should be reviewed for possible improvements/adjustments
iv) A monitoring mechanism should be devised for close watch during the first 6-12 months of the existence of the new NGO.
v) An operational appraisal/external evaluation should be carried out after the first year of operations

81. As regards the financial self-sufficiency, a funding strategy should be chalked out at the outset. In fact, without it the transformation decision cannot and should not be taken. A pre-determined period (ranging from three to five years) should be decided upon. ARC/ADC/BKA would be required to be the financial guarantors of the new agency. However, it would be appropriate if from the very first year of its operations, the new NGO has a consortium of donors. To the extent possible, dependence on a single donor should be avoided.* It should be a common effort of consortium members with shared responsibility. Already, at its inception, a strategy for funding from local sources should be agreed upon. In practical terms, the following steps may be considered:
i) A realistic yearly budget should be established (with an increase corresponding to expansion stages) for a period of three to five years
ii) The budget should be based on a revised salary scale which should reflect, to the extent possible, the local salary levels for comparable skill, qualifications and experience. The working hours should be adjusted to national standards. In principle, this exercise should result in a reduction of the present budget.
iii) A pledging meeting of potential donors should be organised as soon as the drafts of the new statutes, staff rules and financial regulations have been internally finalised.
iv) A strategy for the financial participation of the local community,* district and provincial authorities and possibly the central government as well as of UN agencies concerned and funding NGOs should be delineated.

patient contribution introduced 1/1/95.

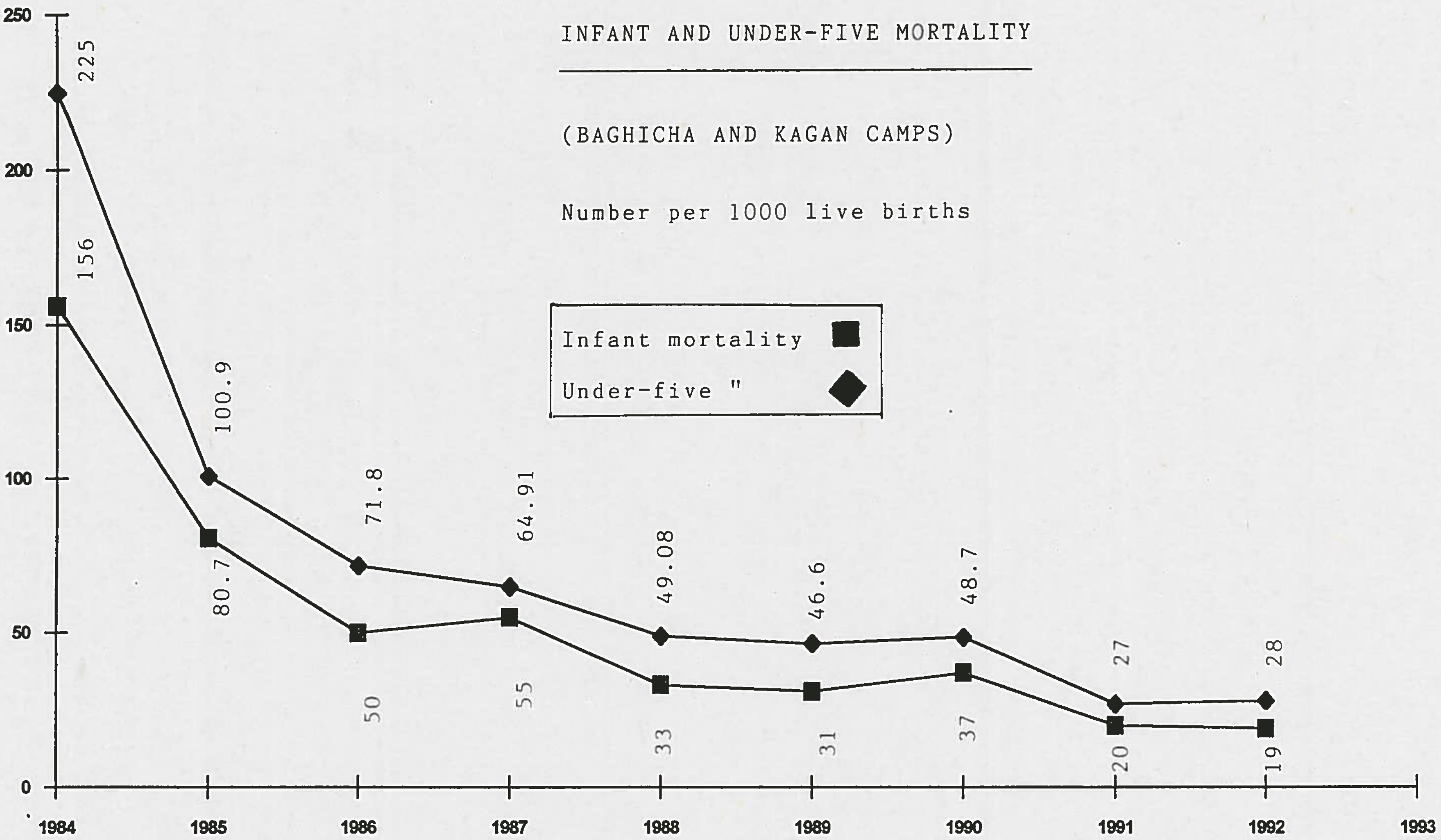
82. A pre-requisite for financial self-sufficiency is the fund-raising strategy that would be adopted by the new NGO. To the greatest possible extent, it should include the local/national sources. Funds from private sources are seldom tapped fully in Pakistan. The PHC area of activity and generally NWFP is full of rich and "newly rich" individuals who

may be willing to contribute towards health of the poor. This would be in line with the cultural and religious traditions of the society at large. The following possibilities might be explored:
i) seeking Zakat funds from the rich
ii) collecting funds outside the mosques as is commonly done in the Arab countries
iii) targeted appeal to selected well off individuals and business concerns
iv) voluntary contributions from the beneficiaries
v) fee for medical services, however symbolic
vi) funding from UN agencies such as UNHCR, UNFPA, WHO and UNDP for specific projects.

83. The result of the first five of the above possibilities may or may not be very encouraging at the beginning but they could certainly achieve the following:
a) increase community awareness of the activities of the NGO
b) produce a sense of participation
c) generate goodwill towards the NGO

84. Even though the dependence of the new NGO on the foreign sources might be considerable at the beginning, it is essential that this is gradually reduced to zero over a maximum period of five years. The reduction rate, say 15-20 per cent per year, should be agreed at the beginning and a thorough review of success/failure rate should be undertaken on yearly basis. The budget of the NGO, the scale of its activities and the pace of expansion should be adjusted in accordance with the findings of the yearly review of fund-raising activities.

ANNEXES



I

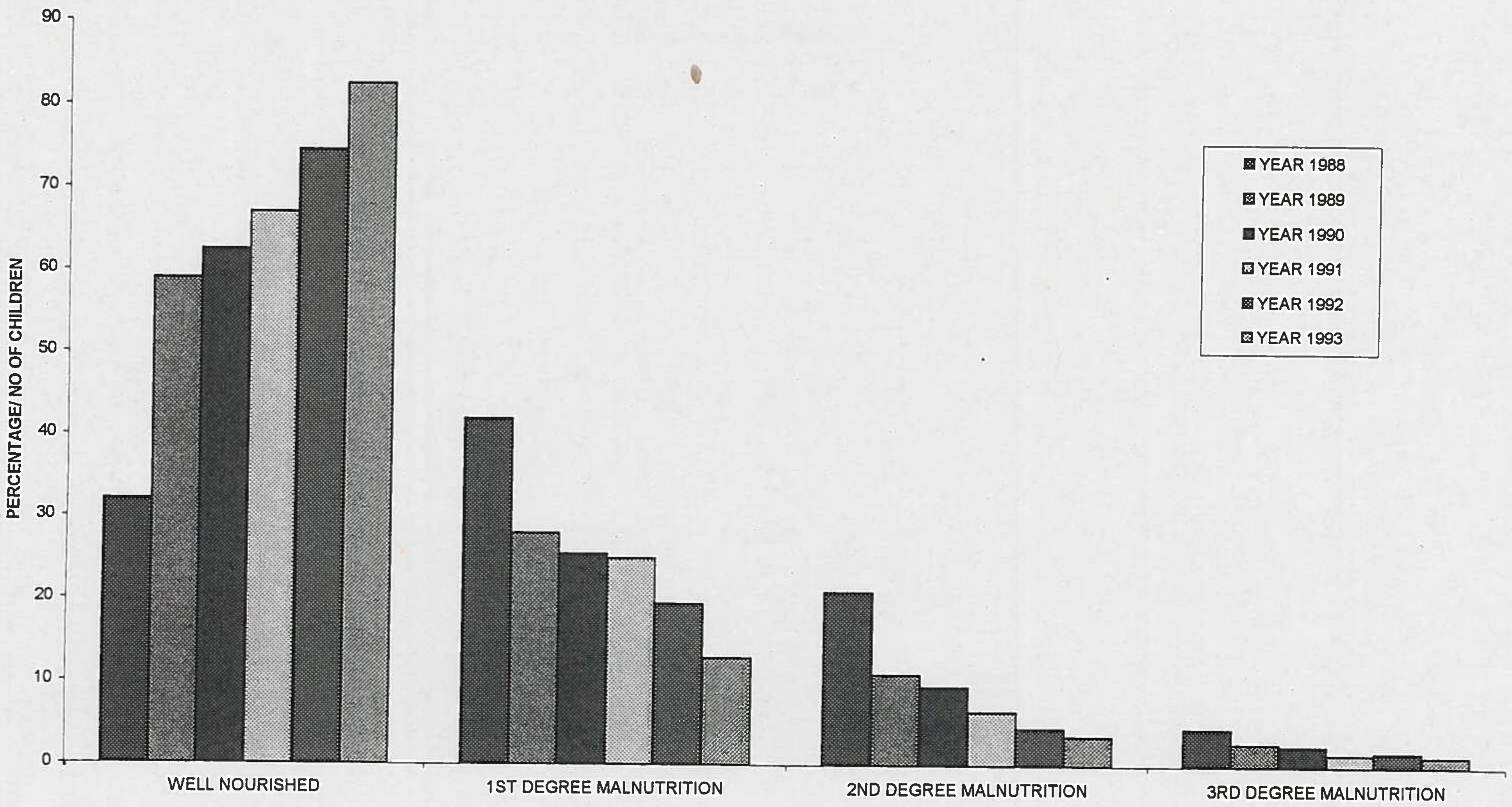
DELIVERIES

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
rmal deliveries	395	572	122	1098
ill births	7	11	6	24
ñormal delivrties	2	15	1	18
tal deliveries	400	587	123	1110
tal live births	393	576	117	1086
mplication:haemorrhage fection	-	-	-	-
rineal tear	-	-	1	1
emature babies	4	7	2	13
bies weighing Under 3 k	8	28	13	49
liveries by trained staff	400	575	111	1086
liveries by untrained	2	12	12	26

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
rmal deliveries	435	584	150	1,169
ill births	3	13	3	19
normal delivrties	0	14	0	14
tal deliveries	435	598	150	1,183
tal live births	420	570	141	1,131
mplication:haemorrhage fection	-	-	-	-
rineal tear	-	-	-	-
emature babies	5	5	3	13
bies weighing Under 3 k	6	7	24	37
liveries by trained staff	431	597	148	1,176
liveries by untrained	4	1	2	7


NUTRITION STATUS OF CHILDREN
UNDER-FIVE YEARS : THREE CAMPS
PERCENTAGE/ NO OF CHILDREN
90
80
70
60
50
40
30
20
10
0
YEAR 1988
YEAR 1989
YEAR 1990
YEAR 1991
YEAR 1992
YEAR 1993
WELL NOURISHED
1ST DEGREE MALNUTRITION
2ND DEGREE MALNUTRITION
3RD DEGREE MALNUTRITION

(ARC) BHUs AND PRIMARY HEALTH CARE PROGRAMME

COMPARATIVE STATEMENT OF ACTIVITIES

1993 COMPARING TO PREVIOUS YEARS

ATTENDACE AT OPD IN 3 BHUs

1990

		BAGHICHA	GANDAF	KAGAN	TOTAL
MEN	:	3,880	2,639	1,222	7,341
WOMEN	:	7,472	8,078	3,566	19,116
CHILDREN	:	15,501	12,889	6,948	35,338
TOTAL	:	28,453	23,606	11,736	61,795

1991

		BAGHICHA	GANDAF	KAGAN	TOTAL
MEN	:	3,439	2,683	1,153	7,275
WOMEN	:	8,288	9,635	3,354	21,277
CHILDREN	:	17,020	14,856	6,747	38,623
TOTAL	:	28,747	27,174	11,254	67,175

1992

		BAGHICHA	GANDAF	KAGAN	TOTAL
MEN	:	2,110	2,339	1,054	5,503
WOMEN	:	6,515	10,650	3,734	20,899
CHILDREN	:	11,010	14,872	6,076	31,958
TOTAL	:	19,635	27,681	10,864	58,360

1993

		BAGHICHA	GANDAF	KAGAN	TOTAL
MEN	:	2,038	1,917	1,193	5,201
WOMEN	:	7,467	9,902	4,345	21,714
CHILDREN	:	10,136	12,587	7,485	30,208
TOTAL	:	19,641	24,459	13,023	57,123

Note: Since Malaria patients started to be treated in Malaria section in October 1991, figures for Malaria are not included in the tables for 1992 and 1993.

NURSING ACTIVITIES

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Injections	362	1,828	411	2,601
Dressings	2,677	5,164	1,851	9,692
Minor Surgeries	974	165	66	1,205
Ear Lavage	444	126	174	714
Total	4,757	7,283	2,472	14,212

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Injections	579	1,613	437	2,629
Dressings	2,230	4,000	1,696	7,926
Minor Surgeries	994	209	93	1,296
Ear Lavage	638	232	141	1,011
Total	4,441	6,054	2,367	12,862

SPECIMENS EXAMINED IN THE CAMP LABORATORIES

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Stool	4337	3992	1874	10203
Urine	4266	1972	1536	7774
Blood excluding Malaria	4518	8430	1690	14638
Sputum	1347	1257	534	3138
Other	348	93	117	558
TOTAL	14816	15744	5751	36311

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Stool	4,345	4,086	1,777	10,208
Urine	6,233	2,927	1,468	10,628
Blood excluding Malaria	5,223	5,430	1,896	36,119
Sputum	1,563	1,437	603	3,603
Other	266	70	79	415
TOTAL	17,630	13,950	5,823	60,973

DENTAL ACTIVITIES

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Extraction	1266	1290	567	3123
Caries	655	927	165	1747
Fillings	919	794	407	2120
Abscesses	738	344	186	1268
Gingivitis	752	300	465	1517
Other	578	250	416	1244
TOTAL	4908	3905	2206	11019

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Extraction	883	497	114	1,494
Caries	161	84	16	261
Fillings	408	461	48	917
Abscesses	460	404	44	908
Gingivitis	356	178	28	562
Other	923	172	31	1,126
TOTAL	3,191	1,796	281	5,268

ANTENATAL CARE

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Cases left from last year	143	216	51	410
Registered	461	575	162	1198
Discharged	440	605	141	1186
Cases at end Of December	164	186	72	422
Referred or Repatriated	31	21	11	63
Lost	4	0	0	4
Abortion	5	1	7	13
Total Visits	2,152	2,465	597	5,214

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Cases left from last year	164	186	7[illegible]	422
Registered	428	652	1[illegible]1	1,201
Discharged	[illegible]	[illegible]	[illegible]	[illegible]
Cases at end Of December	[illegible]	[illegible]	[illegible]	[illegible]
Referred or Repatriated	13	[illegible]	[illegible]	25
Lost	1	-	-	1
Abortion	5	1	1	7
Total Visits	2,279	2,969	622	5,870

UNDER-2 CLINICS

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Left from Last year	827	1,085	225	2,137
New cases regist-ered	419	583	168	1,170
Discharged	524	566	148	1,238
At end of Decmber	722	1,102	245	2,069
Total Visits	7,475	9,667	2,386	19,510

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Left from Last year	722	1,102	245	2,069
New cases regist-ered	455	618	173	1,246
Discharged	427	548	139	1,114
At end of December	750	1,172	279	2,201
Total Visits	8,477	10,954	2,942	22,373

UNDER-2 CLINICS MALNUTRITION

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
1st degree	1471	1620	638	3729
2nd degree	264	392	245	901
3rd degree	97	217	50	364
Well nourished	5643	7438	1435	14516
Total	7475	9667	2368	19510

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
1st degree	848	1,113	883	2,844
2nd degree	149	340	338	827
3rd degree	101	161	42	304
Well nourished	7,379	9,340	1.679	18,398
Total	8,477	10,954	2,942	22,373

EPI - CHILDREN IMMUNIZED

1992

Estimated numbers of children under 1 year. mid 1992: 1087

	BCG	Polio				DPT			Measles	Fully Immunized
		Birth	1	2	3	1	2	3		
nder Yr	1179	1098	1137	1130	1105	1137	1130	1105	1070	1067
ver Yr	28	0	37	35	33	37	35	33	59	17
otal	1207	1098	1174	1165	1138	1174	1165	1138	1129	1084

1993

Estimated numbers of children under 1 year. mid 1993: 1149

	BCG	Polio				DPT			Measles	Fully Immunized
		Birth	1	2	3	1	2	3		
nder Yr	1274	1158	1252	1257	1239	1252	1257	1239	1166	1154
ver Yr	34	0	41	24	34	41	24	34	43	17
otal	1308	1158	1293	1281	1273	1293	1281	1273	1209	1171

EPI - WOMEN IMMUNIZED

1992

Estimated numbers of women aged 15-45, mid 1992 : 4057

Women (15-45)	Total dosews - 2768				
	T.T. 1	T.T. 2	T.T. 3	T.T. 4	T.T. 5
Pregnant	174	164	83	147	76
Non-Pregnant	456	414	394	463	397
Total	630	578	477	610	473

1993

Estimated numbers of women aged 15-45, mid 1993 : 6820

Women (15-45)	Total doses - 2729				
	T.T. 1	T.T. 2	T.T. 3	T.T. 4	T.T. 5
Pregnant	236	178	75	157	153
Non-Pregnant	486	473	445	251	275
Total	722	651	520	408	428

MALARIA : NEW CASES

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Slides examined in BHU laboratories	19,539	14,196	8,854	42,589
P.Vivax	3,992	3,504	963	8,459
P. Falciparum	715	367	186	1,968
Mixed	22	37	13	72
Total	4,729	3,908	1,162	9,799
Slide positive rate	23%	27%	13%	22%

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Slides examined in BHU laboratories	17,867	15,046	9,107	42,020
P.Vivax	992	1,100	339	2,379
P. Falciparum	110	151	108	421
Mixed	1	6	6	13
Total	1,103	1,257	453	2,813
Slide positive rate	6.1%	8.3%	4.9%	6.6%

MALARIA: SLIDES EXAMINED IN SPECIAL LAB

1992

P.Vivax	2,622
P.Falciparum	339
Mixed	46
Negative	14,130
Total	17,137
Positive Rate	16.3%

1993

P.Vivax	893
P.Falciparum	259
Mixed	7
Negative	22,411
Total	23,570
Positive Rate	5.2%

TB. THREE BHUs

1992

	Pulmonary			Extra Pulmonary
	Smear Pos	Smear Neg	Total	
From 1991	8	3	11	7
New cases this year	19	2	21	13
Recurring this year	-	-	-	-
Transfered in this y	-	2	2	1
Total input	27	7	34	21
Completing treatment	15	3	18	7
Died	1	1	2	-
Transferred out	1	-	1	-
Lost	1	-	1	2
Total output	18	4	22	9
Under treatment end December	9	3	12	12

1993

	Pulmonary			Extra Pulmonary
	Smear Pos	Smear Neg	Total	
From 1992	9	3	12	12
New cases this year	15	4	19	10
Recurring this year	0	0	0	0
Transfered in this y	1	0	1	0
Total input	25	7	32	22
Completing treatment	14	4	18	14
Died	1	0	1	0
Transferred out	1	0	1	0
Lost	0	0	0	0
Total output	16	4	20	14
Under treatment end December	9	3	12	8

SCHOOL HEALTH

1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Students examined	431	395	174	1000
Students treated	269	167	110	546
Follow up treatments	13	33	17	63
Meetings with teachers	22	27	23	72
Stool examinations	431	395	118	944
Urine examinations	5	1	-	6
Blood examinations	30	2	4	36
Sputum examinations	1	1	1	3
Other examinations	7	-	-	7
Total investigations	474	399	123	996

1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Students examined	289	752	163	1,204
Students treated	177	325	122	624
Follow up treatments	3	0	2	5
Meetings with teachers	22	6	16	44
Stool examinations	285	752	152	1,189
Urine examinations	6	0	0	6
Blood examinations	10	0	5	15
Sputum examinations	1	0	0	1
Other examinations	0	1	0	1
Total investigations	302	753	157	1,212

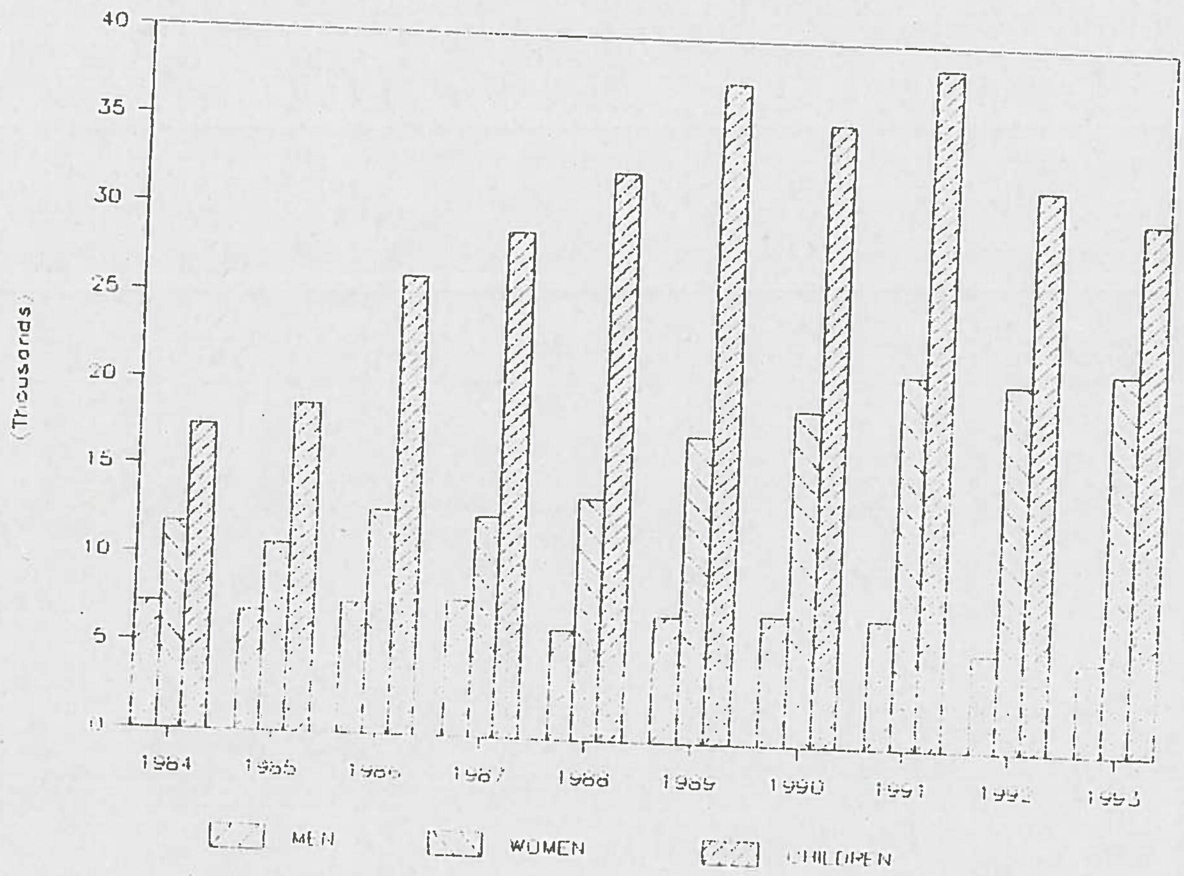
NUTRITIONAL REHABILITATION

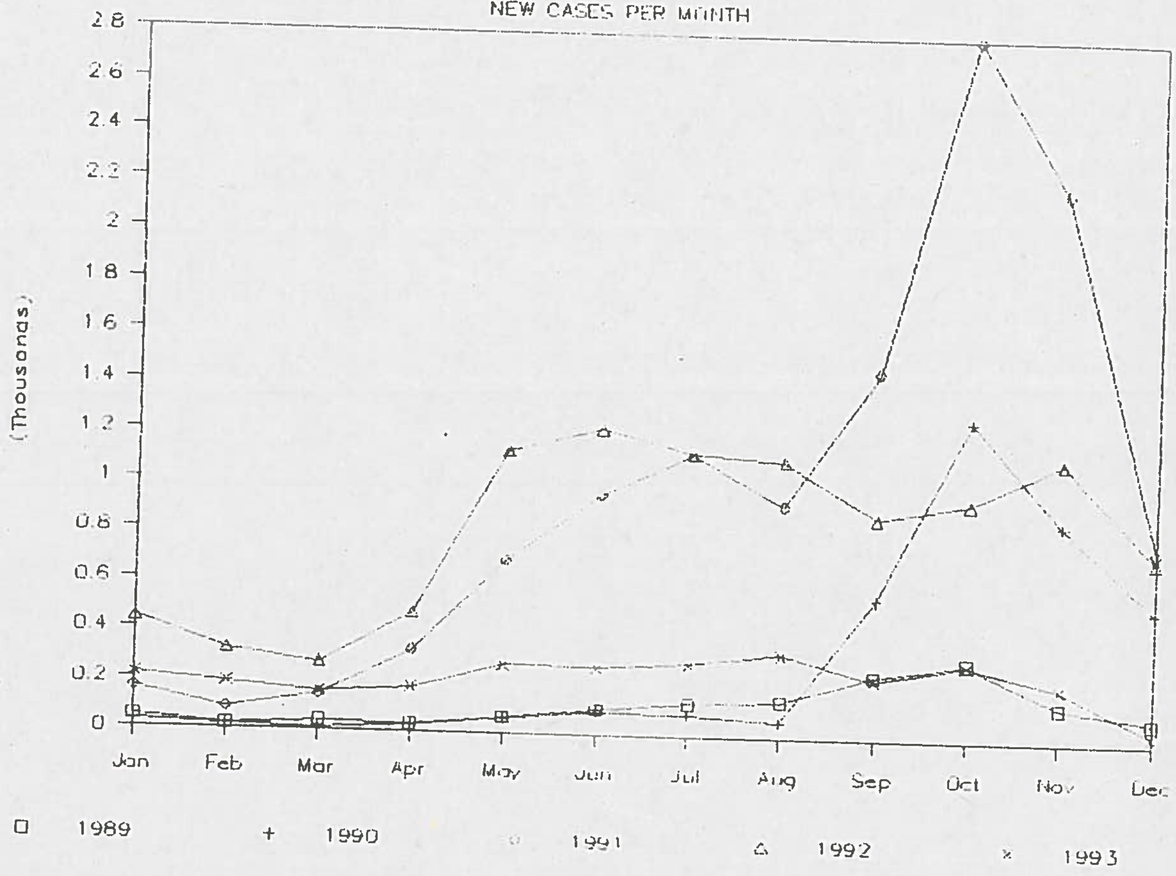
1992

	BAGHICHA	GANDAF	KAGAN	TOTAL
Left from last year	8	7	6	21
New cases	23	55	8	86
Recovered	25	43	12	80
Being treated 31 december	6	19	2	27

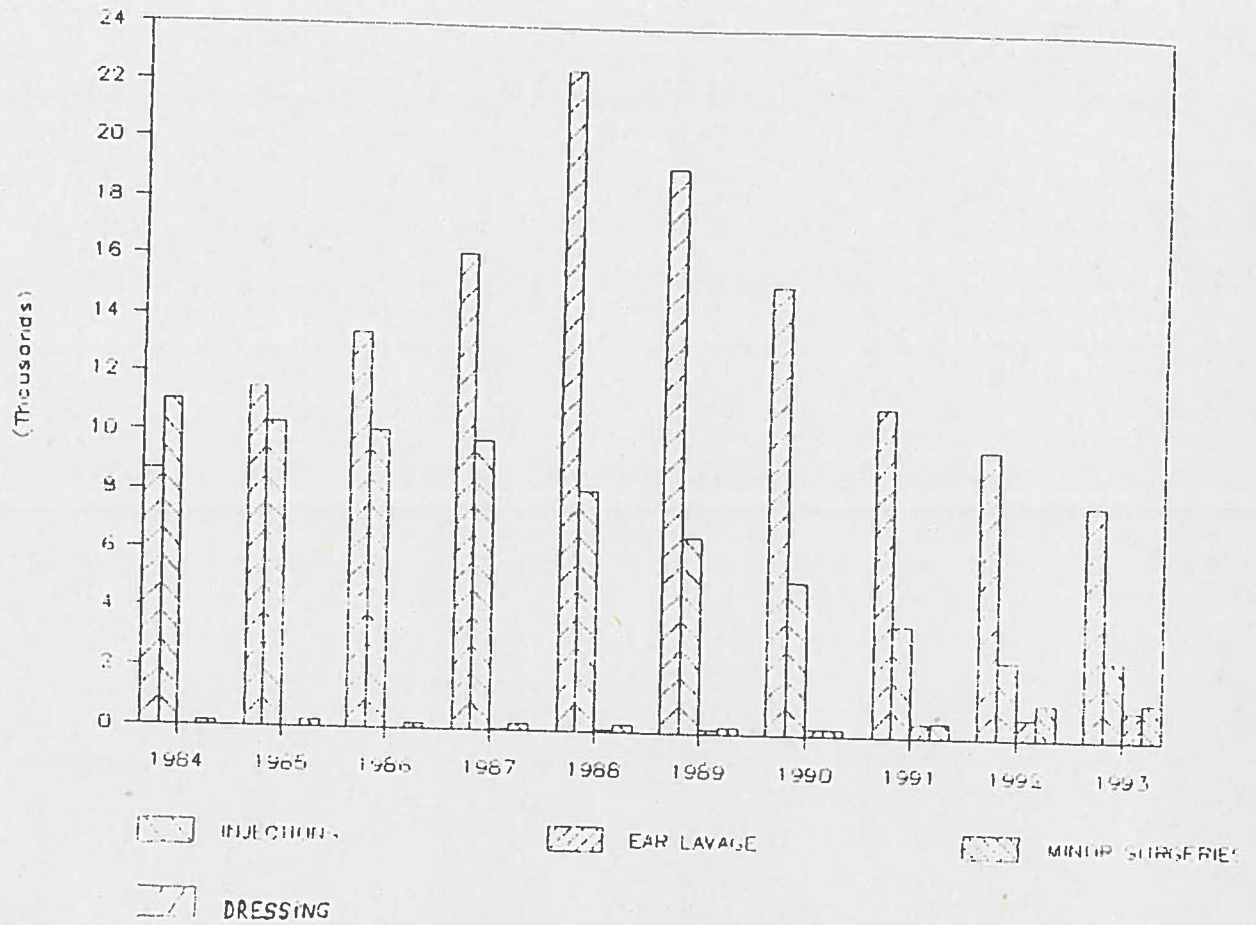
1993

	BAGHICHA	GANDAF	KAGAN	TOTAL
Left from last year	6	19	2	27
New cases	31	32	15	78
Recovered	30	43	15	88
Being treated 31 december	7	8	2	17


OPD - THREE CAMPS
40
35
30
25
20
15
10
5
0
(Thousands)
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
MEN
WOMEN
CHILDREN


MALARIA THREE CAMPS
NEW CASES PER MONTH
(Thousands)
2.8
2.6
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
1989
1990
1991
1992
1993

NURSING ACTIVITIES – THREE CAMPS



XXI

POPULATION MOVEMENT - FROM MAY 1992

BAGHICHA, GANDAF AND KAGAN REFUGEE CAMPS

	BAGHICHA				GANDAF				KAGAN				TOTAL			
	OUT		IN		OUT		IN		OUT		IN		OUT		IN	
	This Month	CUM.	This Month	CUM.	This Month	CUM.	This Month	CUM.	This Month	CUM.	This Month	CUM.	This Month	CUM.	This Month	CUM.
Upto Dec 1992	-	934	-	218	-	820	-	425	-	312	-	473	-	2066	-	1116
Jan '93	14	948	-	218	25	845	66	491	-	312	22	495	39	2105	88	1204
Feb '93	-	948	-	218	-	845	44	535	-	312	22	517	-	2105	66	1270
Mar '93	-	948	11	229	5	850	18	553	10	322	13	530	15	2120	42	1312
Apr '93	25	973	33	262	25	875	31	584	28	350	17	547	78	2198	81	1393
May '93	-	973	42	304	23	898	62	646	8	358	8	555	31	2229	112	1505
Jun '93	172	1145	38	342	50	948	65	711	-	358	-	555	222	2451	103	1608
Jul '93	-	1145	56	398	112	1060	44	755	59	417	34	589	171	2622	134	1742
Aug '93	34	1179	27	425	10	1070	50	805	-	417	10	599	44	2666	87	1829
Sep '93	7	1186	26	451	23	1093	49	854	-	417	-	599	30	2696	75	1904
Oct '93	26	1212	10	461	17	1110	44	898	47	464	19	618	90	2786	73	1977
Nov '93	22	1234	18	479	23	1133	33	931	87	551	33	651	132	2918	84	2061
Dec '93	0	1234	16	495	26	1159	84	1015	-	551	28	679	26	2944	128	2189

(ARC) BHUs & PRIMARY HEALTH CARE PROGRAMME

GRADUATES TRAINED IN DIFFERENT SKILLS

Year	Traditional Birth Attendants (TBAs)	Community Health Workers (CHWs)	Vaccinators	Malaria Supervisors	Laboratory Technicians	Dental Nurses
1984	-	33	-	-	-	-
1985	24	36	-	-	-	-
1988	13	-	-	-	-	-
1989	45	106	-	-	-	-
1990	-	-	23	22	11	-
1991	-	-	-	20	9	19
1992	-	-	-	-	10	19
1993	-	-	-	-	19	10
Total :	82	175	23	42	49	48