

## PAKISTAN AND HEALTH

POPULATION: 150,694, 740.

AGE STRUCTURE:      0-14 Years: 39.3%      {Male 30, 469,958; Female 28, 726,776}  
                                 15-64 Year: 56.5 %      {Male 43,571,093; Female 41,651, 872}  
                                 65 AND OVER: 4.2%      {Male 3, 051,674; Female 3,229,367}

MEDIAN AGE: Total 19.8 Years. {Male: 19.7 years; Female 20 years }

ENVIRONMENT CURRENT ISSUES:

Water pollution from raw sewage, industrial wastes, and agricultural run off; limited natural fresh water resources a majority of the population does not have access to potable water; Deforestation; soil erosion; desertification.

CLIMATE:

Mostly hot, dry desert; temperate in North West; arctic in north.

POPULATION GROWTH RATE:

2.01%.

BIRTH RATE:

29.59 Births/1,000 Population.

DEATH RATE:

8.79 Deaths/1,000 Population.

SEX RATIO:

At Birth: 1.05 Male (s) Female under 15 Years: 1.06 Male (s) Female 15-64 Years: 1.05 Male (s) Female 65 Years and over: 0.94 Male (s) Female total Population: 1.05.

INFANT MORTALITY RATE:

Total: 76.53 deaths/1,000 live births. Female: 76.09 deaths/1,000 live births.

LIFE EXPECTANCY AT BIRTH:

Total Population 62.2 Years: Male: 61.3 Years, female 63.14 Years.

TOTAL FERTILITY RATE:

4.1 Children born/women.

HIV/AIDS {ADULT PREVALANCE RATE}:

0.1%.

HIV/AIDS {PEOPLE LIVING WITH /AIDS }:

78,000.

HIV/AIDS DEATH:

4,500.

LITERACY:

Definition: Age 15 and over can read and write.

Total Population: 45.7%

Male: 59.8%

Female: 30.6%

INTERNATIONAL ORGANIZATION PARTICIPATION SPECIFICALLY HEALTH ORGANIZATION  
{IN RESPECT OF FINANCIAL AID}:

WB, IMF, ADB, WHO, UNESCO, UNO ETC.ETC.

PATHETIC GENERAL PICTURE:

Significance of improved health status on economic growth and prosperity of a nation was recognized even in the early stages of the development of economic theory. In fact, as early as 1890, Alfred Marshall in his famous book entitled "The Principles of Economics" noted that "health and strength, physical, mental, and moral... are the basis of industrial wealth. Given that physical, mental, and moral health of the labour force are key factors in raising their productivity and that impact of these factors on the economic development is a long term issue, in this paper we have, therefore, empirically tested this proposition within the framework of the recently proposed "co-integration" technique exclusively designed for testing long run relationship. The policy makers should give priority towards controlling the population growth (fertility) and provide better health services so as to improve the life expectancy of the people. Investing society's scarce resources in this health related factors may have a long lasting impact on the country's economic prosperity.

Currently a lot of hue and cry is being made about the so-called inefficiency of the public healthcare system. The government claims that state ownership is to blame!! The truth is that it is inefficient because the government wants it to be inefficient in order to more easily get rid of it! How can any healthcare system be efficient when the money allocated to it in the state budget amounts to only 0.7% of GDP when it should be at least 4 to 6%? Where there should be one nurse for every four patients there is only one for every 40 in tertiary care hospitals. Where there should be one doctor for every seven beds, there is only one doctor for every 60 beds! A doctor should only have to work an 8 hour shift, but doctors usually have to work between 36 and 72 hours in a single shift, mostly unpaid!! To add to this, the recruitment of doctors has now been banned for more than 20 years. How could a system be efficient in these conditions? Instead of giving long awaited jobs, millions of rupees are spent to create boards of governors and dummy universities. In a country where 70 out of 1000 newborn children die and 60 mothers out of 1000 die during childbirth, the lion's share of the national income goes on buying weapons! The majority of people and especially children die of diseases that are totally curable and preventable such as diarrhoea, pneumonia, tuberculosis, etc.

In a country where most people earn less than 3000 rupees per month we have medical colleges charging between 1.5 and 2 million for a medical graduation. However, awareness is growing and the people are now beginning to understand the true nature of capitalism. It should be understood that the health of a nation depends not simply on the provision of doctors, hospitals and sophisticated equipment. It depends on the existence of basic health concepts, not only in the minds of individuals but also in the mind of those who frame policies and enjoy the power of implementation. It is most unfortunate that while we are opening new hospitals and introducing state of the art technology, and human expertise. We are doing nothing about the dismal state of public health in Pakistan.

According to a leading donor agency's report, 'the Health Sector in Pakistan is infested with lack of efficiency, misallocation of resources, leakages, political influence, poor management and centralized financial, administrative and management authority. Thus inefficiency and cost ineffectiveness are perhaps the two basic impediments to a better health care system. A comparison with some other countries in the region shows that Pakistan's performance in the health sector is unfavourable. For instance, the expenditure on health by the government is only 0.2% of the GNP compared to 0.7% for Bangladesh, 0.9% for Nepal and 1.4% for Sri Lanka, each with per capita incomes substantially below Pakistan's. The life is only 59 years compared to 71 years, the Crude Birth Rate is 41, Crude Death Rate is 11 and the Infant Mortality Rate is 97. Comparable figures for Sri Lanka are 71, 21, 6 and 18.

Inefficiency is widely regarded as a central problem in the health and population sector in Pakistan.... (Especially) in the public sector. Resources are misallocated, in part because no investigation has typically been made into the cost-ineffectiveness of various options. Political influence and leakage of equipment and supplies further distort public sector allocations. Poor management and centralized financial, administrative and management authority reduces the efficiency of facility-level staff services. In other words, given the limited available budget, should the public health department (PHD) go for an expanded infrastructure program (developmental expenditure) or hire more health personnel (recurring expenditure) or a combination of both so that there is a real improvement in the health services? Or, even more importantly, what type of wage policy should it adopt if more personnel are needed to work in rural health centres (RHCs), basic health units (BHUs) and hospitals, especially when there are shortages of competent nurses and doctors in the country?

#### HEALTH STRUCTURE IN PAKISTAN:

The health and demographic characteristics in Pakistan are substantially worse than those of other countries in the region. Maternal mortality rate is high (6 per 1000), as is infant mortality (103 per 1000 live birth). Malnutrition is widespread (50% of children are stunted) and life expectancy is certainly one of the lowest in the region (56 years for men and 55 years for women). Pakistan has one of the highest population growth rates in ASIA (3.1% per year) with very little evidence of a fertility decline while this is largely because of poverty, poor sanitation and water supply and low levels of literacy, particularly among women (21%), it nevertheless also reflects serious shortcomings in health policy and the design and operation of health care services and facilities.

Public expenditure on health has been increasing over time, but is only a very small proportion of the GNP. Overall percapita health care spending (inclusive of private expenditure) compares favourably with the other countries in Asia, but the quality is much lower. The private health care facilities are concentrated largely in the urban areas and are used mostly by the well off. Coverage in the rural area is poor, even by the public health care services. The main health care issue, therefore, is how to provide a cost-effective service to the majority of the people. Could this be by increasing public expenditure, ensuring greater cost recovery, improving the efficiency of publicly financed health care, encouraging the private sector where it has comparative advantage and/or encouraging the use of risk-sharing schemes to cover more people? Health policy is determined by the federal Ministry of Health, but services (except for a few specialists' hospitals and clinics) are provided by the provincial departments of Health, Nutrition Policy is determined by the Planning Division, Population and family planning services are provided by both the federal

ministry and the provincial departments of Population Welfare. Coordination is limited. Even though hospitals are continuing to receive the largest share of public sector health expenditure (45%), they often continue to operate inefficiently and ineffectively. Very high out patient attendance at these hospitals is the result of patients by passing the basic health care facilities where the service quality is seen to be very poor, marred by absence of both staff and medication, on the one hand, and poor sitting, on the other.

This depletes the already meager resources available to the hospitals (in man, medicine and facilities) and thus leads to greater inefficiency in the system. The public sector provision of services is further weakened as a large part of the medical personnel, particularly the senior doctors and specialists {read *BUTCHERS*}; own their own hospitals, clinics, MCH Centres and laboratories to which supplicants for their services are directed. The PMDC feels that as much as half or more of the private sector facilities are operated by these “publicly employed” personnel. The Private sector health care facilities cater to about a quarter of the patients treated in hospitals, but the conditions in the smaller hospitals are generally only marginally better than in public hospitals, for instance, patients are expected to provide their own food and attendants and in some instances also medication which may be purchased from on-site “self-owned” pharmacies. Most of these pharmacies, as also all off-site or independent pharmacies and medical stores are staffed by inadequately trained staff. Instances of a qualified pharmacists being jointly by a number of spatially distributed pharmacies is not uncommon.

Similarly a number of doctors, particularly specialists, are found to be on the panel of medical personnel at more than one private sector facility. Private hospitals are mostly concentrated in the nine big cities of Pakistan. These cities account for more than 75% of private sector hospital beds. The qualities of care in the larger hospitals are reasonable to good, but in the smaller hospitals the quality is poor. This is seen from the outdated equipment, the use of rented housing units and the non-availability of sufficient qualified nursing and paramedic staff because of low salaries and insecure employment conditions offered.

Medical professionals conducted a survey in the mid-nineties and the saddest thing is that even in 2004 the situation is not very different.

## **Health Professionals in the Country**

Category	Number
Doctors	33,584
Dentists	999
Nurses	10,554
Lady Health Visitors	2,562
Nurses Midwives	5,275
Sister tutors	290
Ward Administrators	535
Medical Technologists	115

Physiotherapists	119
Dispensers	17,370
Sanitary Inspectors	1,974
Malaria Inspectors	1,601
Pharmacy Graduates	1,743

### **Production of Health Professionals in Pakistan**

Cadre	Demand	Present Staff	10 Year Output	Supply Total	Difference
Medical Specialists	11,365	1,425	3,100	4,500	- 7000
Nurses	23,730	6,050	11,850	18,000	- 5700
Medical Technician	14,400	2,500	7,300	10,000	- 4500
LHV	2,700	1,750	1,900	3,650	+ 1000
Total	52,195	11,715	24,150	36,150	16,200

### **Present Output of Professionals**

Category	No of Institutions	Present Output	Output 1970
Doctors	17	4000	800
Postgraduates	4	150	70
Nurses	47	850	300
Nurse Teachers	1	60	20
Lady Health Visitors	10	600	200
Nurses Midwives	58	675	200

Medical Technicians	26	600	Nil
Dispensers	50	1500	500
Sanitary Inspectors	1	1	100

## Health Facilities

Year	Hospitals	Dispensaries	BHUs	Maternity C.	RHUs	TB C.	Beds H.	R.Dr.
1991	774	4,007	4,384	1,057	464	219	75,552	55,572

Year	R.Dentists	R.Nurses	R.Midwives	R.LHVs	Beds H.	Dr./Pop	Dentists	Expenses
1991	2,193	18,150	16,299	3,463	1,506	2,008	51,789	2,707M

The situation is in state where people have forgotten what public health means and what is the scope of public health measures in the overall well being of the society. One of the basic aspects of public is the formation of and implementation of rules and regulations governing the production, preparation and sale of eatables under hygienic environments and that too with due medical specification. Even after the passage of five decades and above all becoming a “Nuclear Power”, the public health status of the nation has only deteriorated and is one of the worst in the world. When even in a city like Karachi, one can find hospitals a shape which we would not even like to use as a toilet then what to talk of up country. The state has a responsibility to help the community maintain standards of health and avoid the avoidable diseases. Restaurants, hotels, schools, jails, factories, offices and other places where a large number of people live or spend substantial time along with others, provide ample opportunities for the spread of certain diseases. When we cannot even provide clean potable running water to the majority of the people then how can we expect a modern health system in Pakistan?

There exists no system in place to monitor these places or provide the basic know how of healthy living to those who are exposed to diseases. These measures do not cost much but can identify people at risk and teach them as to how to protect themselves. Routine Medical Checkups, of people directly involved e.g. with the food process, needs to be enforced to stop the spread of disease from the infected or carrier subjects to healthy individuals.

Since we call ourselves Muslims and our society an Islamic one then we must follow the maxim “Cleanliness is next to Godliness”. It seems that this motto has been absent from our society and we are virtually living in garbage. For Example certain professionals prone to the spread of communicable disease are barbers, cooks, bakers, and sweet merchants etc. A single baseline medical checkup of these individuals can unmask a number of diseases. Their timely treatment will not only save the lives of these poor bread earners, but will also protect those who are in contact with them. In the complete absence of any monitoring, check and balance and preventive measures, our people are living at the mercy of nature. It is time that various governmental agencies working at different level sense a wake up call and realizes their responsibilities towards the public health of the society. Regulatory authorities do exist at various administrative levels. Unfortunately, they do not live up to their responsibilities. The public’s perception of health revolves around therapeutic modalities only. The masses are unaware of the role played by simple ways and means in disease prevention. They are ignorant of the potential of public health measures. It is simply a shame that a country like ours, with reasonable resources and infrastructure has one of the poorest public health standards in the world.

The medical profession, media and governmental agencies have to act in an integrated way to change this appalling situation. What we are doing in the health sector goes totally to waste in the absence of common sense public health measures. For example city district government of Karachi and Lahore, with sizeable human and financial resources should adopt a comprehensive public health policy. This will act as a model for other cities, towns and tehsils to follow. If we fail to evolve a rational public health system in the country, the huge burden of Communicable Disease will remain our liability in addition to the disease of modern age such as heart diseases, strokes, diabetes and psychiatric illness. According to a leading donor agency "Health outcomes and services in Pakistan have slowly improved over the past 10 years with improved availability of female staff {bias donor agencies in any particular political situation or interest may please be kept in mind} and better access to immunization and family planning services". But Pakistan is still worse off than many other countries in terms of maternal and child mortality, malnutrition, the burden of infectious disease and high fertility. The pathetic public health sector is the main result of very low government expenditure on health services, poor value obtained by the public from what the government spends, because of weak management and corrupt practices such as absenteeism so on, poor quality of care from many private health care providers. Pakistan per capita income is much higher than the average lower-income countries but despite of the govt-and donor-financed interventions, health indicators have been improving with snail pace rather no pace at all.

Communicable diseases such as diarrhea, respiratory infections, tuberculosis, and immunizable childhood diseases still account for the major portion of sickness and death in Pakistan. Maternal Health problems are also wide spread, complicated in part by frequent births. In fact, Pakistan lags far behind most developing countries in women's health and gender equity of every 38 women who give birth, 1 dies. The infant mortality rat {101 per 1,000} and the mortality rate for children under age five (140 per 1,000 births) exceeds the averages for low-income countries by 60 and 30%, respectively. Although use of contraceptives has increased, fertility remains high, at 5.3 births per woman and population growth rates are much higher than elsewhere in South Asia. The underlying problems that affect health---poverty, illiteracy, women's low status, inadequate water supplies and sanitation---persist. Another study opines that the health status of Pakistan is characterized by a high rate of population growth and poor health indicators. Two fundamental problems, which plague the sector, are lack of equity and effectiveness. The provision of health services is highly inequitable; although rural dwellers comprise almost two thirds of the population, the majority of health services and doctors are located in the Urban Areas. Recent attempts to offset this bias by developing primary health services in rural areas have met problems of understanding and under utilization. This has contributed to the lack of effectiveness of investments already made.

#### GOVERNMENT'S SO-CALLED PLANNING AND POLICY.

The Health Sector investments are viewed as part of Government's Poverty Alleviation Plan. Priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on Tertiary Care. Good governance is seen as the basis of health sector reform to achieve quality health care. There are 10 major areas which the Government of Pakistan wants to revamp:

- 1- Reducing widespread prevalence of communicable diseases.
- 2- Addressing inadequacies in primary/secondary health care services.
- 3- Removing professionals/managerial deficiencies in the District Health System.
- 4- Promoting greater gender equity.
- 5- Bridging basic nutrition gaps in the target-population.
- 6- Correcting urban bias in health sector.
- 7- Introducing required regulation in private medical sector.
- 8- Creating Mass Awareness in Public Health matters.
- 9- Effecting Improvements in the Drug Sector.
- 10- Capacity-building for Health Policy Monitoring.

## IMPLEMENTATION OF THE PLAN.

To reduce the widespread prevalence of communicable diseases (i.e. EPI cluster of childhood diseases, TB, Malaria, Hepatitis-B, and HIV-AIDS) following measures are to be taken:

The preventive and promotive health programmes will be implemented as National Programmes with clear cut Federal/Provincial spheres of responsibility. The Federal Government will assist in planning, monitoring, evaluation, training and research activities while the Provincial Governments will undertake service delivery. The National Programme on EPI will be expanded through introduction of Hepatitis-B vaccine. Routine EPI facilities in the Provinces, especially cold-chain equipment will be strengthened through GAVI'S grant assistance over the next 5 years. A National Programme for immunizing mothers against National Tetanus will be implemented in 57 selected High-Risk Districts of the country over 3years. A national programme will be launched against Tuberculosis based on DOTS {Directly Observed Treatment Short Course} mode of implementation. The main feature of this are-training of federal, provincial and district level managers; case detection through sputum smear technology; observed treatment of patients; standardized drug regime and operational research. A new national malaria control programme will be implemented, focusing on malaria microscopy through upgraded basic health facilities; and early diagnosis with prompt treatment. Mass spraying will be replaced by selective sprays only. The current PC-I on HIV-AIDS will be enlarged to incorporate the following components-prevention of HIV transmission through health education; surveillance system; early detection of Sexually Transmitted Infections (STIs); Improved Care of the Affected Persons; and promotion of Safe Blood Transfusion. A uniform law will be enacted to set up Blood Control Authorities in the Provinces.

To address Inadequacies in Primary/Secondary Health Care Services:

The main inadequacies are identified as the deficient state of equipment and medical personnel at BHU/RHC level. Absenteesim is common. At the district/tehsil level hospitals there are major shortcomings in emergency care, surgical services, anaesthesia and laboratory facilities. There is no referral system in operation.

Trained Lady Health Workers will be utilized to cover the un-served population at the primary level. This would ensure family planning and primary health care services at the doorstep of the populationj through and integrated community based approach; 58,000 Lady Health Workers under Health Ministry and 13,000 Village-based Family Planning Workers under Population Welfare Ministry will be integrated to create a cadre of 71,000 Family Health Workers under National Programme for Family Planning and Primary Health Care. This cadre will be increased to 100,000 by the year 2005. Provinces will undertake improvement of District/Tehsil Hospitals under a phased plan. A minimum of 6 specialties (Medicine, Surgery, Paediatrics, Gynae, ENT and Ophthalmology) will be made available at these facilities. District and Tehsil Hospitals will be upgraded to the desired standard through Provincial Master Plans. The Provincial Governments have prepared the following hospitals up gradation plan:

Sindh	11 District Hospitals and 44 Taluka Hospitals at a cost of Rs. 330 Million.
Punjab	25 District Hospitals and 52 Tehsil Hospitals at a cost of Rs. 1665 Million.
NWFP	19 District Hospitals and 11 Tehsil Hospitals at a cost of Rs. 989 Million.
Baluchistan	3 District Hospitals and 30 Tehsil Hospitals at a cost of Rs. 540 Million.

## UNHEALTHY BUDGET FOR HEALTH SECTOR:

Pakistan's share of total health expenditure to gross national product has never exceeded 0.8% per annum [Economic Survey 1992-93], which is significantly lower than many of its neighbouring countries in the

region. If the future is any reflection of past history, then one does not expect substantial public funds to be forthcoming and diverted towards this sector in the immediate medium term future especially when the country is already experiencing large and increasing budgetary deficits. Prudent public policy research in this context, based on realistic pragmatic approach, should then be geared towards an investigation into measures to improve the present Public Health System (PHS) through an efficient, cost-effective reallocation of health inputs within the existing limited budget. The growth of health infrastructure building in the urban area may be pursued but one must give extra resource allocation toward the rural sector. Attractive wage policies be formulated for personnel {doctors/paramedics} e.g. the status of nurses in the Public Health System be elevated by giving them higher BPS. Facilities may be provided as in the case of Armed forces.

Those in government never get tired of telling everyone that economy is not just on the right track, it is in fact, ready to take off. The nation, for sure, has been waiting with fastened seat belts for this promised take off that has yet to come. Jugglery with statistics is something the bureaucracy is quite expert at doing. Give them a target, and they can find a statistic to prove their case. Ask them to show a downward trend in terms of inflation, and they will find a formula to show it is actually down. GNP, GDP, Debt-servicing, tax collection, revenue generation, give them any task; the result will be what you want. That much is guaranteed. All governments have made full use of such a competent bureaucracy and this is the nomenclature of Pakistan since 1947. Even though public expenditure on health has been increasing over time from Rs. 727 Million in 1980 to Rs. 6, 035 Million in 1992, it represents only a very small proportion of the GNP (0.7% to 0.8% over the period). Per bed expenditure in current terms has increased from Rs. 11, 000 per bed-year in 1980 to Rs. 46,000 per bed-year in 1991 that is at annual rate of 14.4%. Expressed as per patient costs the annual increase has been at a rate of 11.2 % in nominal terms. On the other hand, cost recovery ratio is very low declining from 4.9% in 1980 to 3.5% in 1992.

In recent years, many developing countries have invested heavily on the social sector including basic health. This is based on the premise that human capital is vital to the growth and development of a nation. Therefore, keeping the mass healthy is as important as providing them with basic education. Pakistan had an impressive GDP growth rate of about 8% per annum in 1991-92, out of which only a meager 0.2% was spent on the health sector by the central govt. when this figure is translated in monetary value, it amounts to only Rs.2 per 1000/. Rupees of GNP spent on health sector. This amount is very little by any standard and, in fact, the picture is even more dismal when this figure is compared with those of other developing countries of the eight countries selected for comparison, Bangladesh, and Sri Lanka appeared to have spent 4.8% of their govt. expenditure on health as opposed to only 1% by Pakistan. Even a small, poor country like Nepal spends more money (4.7%) than Pakistan on the health sector.

Pakistan's standing in terms of spending on health (either as a proportion of govt. expenditure or GNP) is the lowest which is very discouraging and disappointing. Low public expenditure on health facilities over the years is also reflected in the poor health status of the population and dismal public health sector in Pakistan. Health indicators on life expectancy, crude birth rate, crude death rate and infant mortality rate indicate that Sri Lanka and Malaysia have the highest life expectancy at birth 71 years while, for Pakistan, the figure is only 59 years. In terms of CBR, Pakistan has the highest rate of 41 per thousand populations, which is one of the reasons for the high population in the country. Sri Lanka again has the lowest crude birth rate at 21 per thousand population followed by Indonesia (25), Philippines (28), and Malaysia (29), however, with respect to crude birth rate, Pakistan's standing is little better among one of the three highest countries (i.e. at per thousand population) in the region.

The infant mortality rates across different countries, it appears that more than 97 babies per thousand newborns in Pakistan do not get to see the face of the earth as opposed to only 15 per thousand newborns in Malaysia. Child malnutrition measures the percentage of children under five with a deficiency or an excess of nutrients that interfere with their health and genetic potential for growth. Malnutrition continues to be a major problem for third world countries. More than half of all children suffer stunting and wasting despite the increase in the growth of agriculture and industry, the prevalence of malnutrition in Pakistan remain unchanged. Countries like Indonesia, Philippines, and Egypt have all dramatically lowered their rates of malnutrition in the last 10 to 20 years. It is crystal clear that Pakistan's performance in the health sector is less than adequate. Furthermore, Pakistan's spending for this sector is also one of the lowest in the region.

In the present environment of budget deficits, the critical issue facing the public sector should then pertain to designing health policies which must be cost-effective and efficient.

#### VITAL STATISTICS:

Central Government Expenditure on Health for Selected Developing countries.

Country	% of Total Cent.Govt. Expenditure on Health	% of GNP spent on Health
Pakistan	1.0	0.2
Bangladesh	4.8	0.7
Nepal	4.7	0.9
India	1.6	0.3
Sri Lanka	4.8	1.4
Indonesia	2.4	0.5
Egypt	2.8	1.1
Philippines	4.2	0.8

Trends of Expenditure Outlays of Selected Countries

Country	GNP per capita (US\$)		Military Exp. (as % of GDP)		Public Exp. on Health		Public Exp. on Education (as % of GNP)	
	1966-1990	1966-1990	1960-1990	1960-1990	1960-1990	1960-1990	1960-1990	1960-1990
Pakistan	120	400	5.5	6.6	0.3	4.5	1.1	3.4
India	90	360	1.9	3.3	0.5	3.2	2.3	3.2
Bangladesh	70	210	-	1.6	-	0.9	0.6	2.2
Sri Lanka	170	470	1	4.8	2	2.3	3.8	2.7

Basic Social Indicators for selected Developing Countries.

Country	Life Expectancy at Birth. (in Years)	Crude Birth Rate	Crude Death Rate	Infant Mortality Rate
Pakistan	59	41	11	97
Bangladesh	51	34	13	103

Nepal	53	38	13	101
India	60	30	10	90
Sri Lanka	71	21	6	18
Indonesia	60	25	9	74
Egypt	61	32	9	59
Philippines	65	28	7	41
Malaysia	71	29	5	15

Indicators of Basic Health And Nutrition For Selected Developing Countries.

Country	Population per Physician- Nurse	Babies with low birth weight%	Prevalence of Malnutrition (under 5 Yr)	Daily Calorie Supply (per capita)
Pakistan	2910 4900	25	57	2315
Bangladesh	6730 8980	31	60	1927
Nepal	32710 4680	-	-	2052
India	2520 1700	30	-	2238
Sri Lanka	5520 1290	28	45	2400
Indonesia	9460 1260	14	14	2579
Egypt	770 780	7	13	3342
Philippines	6700 2740	18	19	2372
Malaysia	1930 1010	9	24	2730

The wait for the take off has continued, and it is likely to continue for an indefinite period. Despite the drop in debt servicing liabilities in the wake of loan write-off and rescheduling that came Pakistan's way for its willingness to play the American Hand in the region e.g. the 2003/2004 annual budget shows in ample terms that debt servicing and defense will still make up over half---51.68% to be exact---of the total expenditure in the new fiscal year. In the previous fiscal, the together comprised 51.87% of total expenditure. So, there has been no basic change in approach. The key social sectors like health, education and so on, will thus, continue to get the peanuts that have been their fate for long. Consider the allocation for social services under civil administration spending in 2003/2004, which is Rs. 16.40 billion. Now compare it with the rather whooping Rs. 160.25 Billion for Defence spending, and Rs. 255.96 billion for debt servicing. There is no jugglery of statistics here. These are the figures which are announced and published. A quick glance is enough to suggest the government could have easily slashed the defence and debt servicing budget by, say, Rs 5 Billion each, if not more and put it into social services. That would have made a world of difference, but, then you need to have the right poor people approach to make such adjustments.

Social services carry such enormous sectors like health and education, and the allocation for these specific areas is so minimal even peanuts look too many. Let's just leave education, for health, it is Rs. 4.37 Billion. In contrast population welfare has got Rs. 3.11 Billion, while the importance of population welfare cannot be underrated; the allocation for the sector is just an indication of the kind of competence the budget makers use in the process. Spending in health and education sectors involved much higher structural costs in term of hospitals, schools, facilities and salaries for doctors, paramedics and teachers. It is strange that the allocation for development spending on education is more or less the same as development spending on population welfare, a sector that is not cost-intensive and, in any case, has not produced the results to deserve such an allocation. Forget about employment opportunities for young doctors, for it is like asking the government to do too much, what about, say, the improvement of drug supply to the government run hospitals? They will continue to get what they have been getting in the past, and it is easy to infer that the situation on the ground will also remain the same as it has been for long. As per a news-report quoted the official figures presented in a provincial assembly, showing what the ministers in that province had collectively spent on fuel and maintenance of their cars during last four month: Rs. 900,000. And, this is the case of a province that has the lease-holders of faith running the affairs, and who, according to their supporters, are quite prudent in their spending. What about the other three provincial assemblies, the National Assembly, the Senate, all the advisors at the various levels, the civil and military bureaucrats and all the hangers on?

Give the task to some bureaucrat, and he will sure find a statistic to prove it is all happening the right way, and that the economy is about to take off. The farce continues.

#### CURRENT SCENARIO:

As we have already explained, traditionally it had been the policy of the government - on paper at least - to provide free health care. This all changed under the regime of Nawaz Sharif, when Pakistan officially endorsed the free trade WTO treaties. Mr Sartaj Aziz in his policy address to the national assembly announced that from then onwards the government of Pakistan would divest itself of any state property and that everything would be privatized. Over the last decade each government has been slowly moving towards this goal and trying to make this transition as smoothly as possible. The first step was to highlight the inefficiency and mismanagement of the public sector hospitals. Some high profile cases of mismanagement were publicized in the media and thus the public was brought round to the idea that private would be better. The cure the disease of public mismanagement was said to be "discipline and autonomy". Many welcomed this as they thought an improvement could be achieved by these means.

However, soon the government's intentions were made clear. In the name of "autonomy" the hospitals were asked to maintain their budget by themselves. The result was an increase in the cost of tests and treatment. Free test were withdrawn and there was a marked increase in service charges. The whole point was to convince the public that they did not need big overcrowded government hospitals which were "costly and inefficient". They would be able to get better services from private hospitals by paying only slightly more money. The slogan was "cost for efficiency".

As all these measures were bound to create unrest among the doctors, freedom to hire and fire was granted to the "autonomous" hospitals. A board of governors was created for each of these hospitals bringing it directly under the control of the provincial secretary. Other board members were taken from representatives of the capitalist class such as mill owners. These were made familiar with the workings of a hospital, putting them in a position whereby they could take part in the bidding process. In the medical staff education and training sector the same policy was adopted. Many private medical colleges were allowed to work without reaching the standards set internationally. The PMDC has been transformed into a docile obedient institution. The medical colleges are now charging anything between 1.5 and 2 million rupees for graduation in medicine. Also the fees in the public sector medical schools have been increased to bring them more in line with the levels charge in the private sector. This is so people will feel there is no difference when they are eventually sold off to the private sector.

According to the official version Pakistan is supposed to have one of the best healthcare systems in the world. This shows what barefaced liars there are in the state. We all know that in practice it is one of the worst and the shift to private healthcare is making it even worse. They show how the Pakistani government is merely a tool in the hands of the multinational drug companies who have no interest in genuine healthcare. Their primary concern is profit. After partition Pakistan inherited a totally inadequate health care system comprising only of one medical college and a few practicing doctors, (a few civilian and military set ups also existed but these were not sufficient). Over time the system was expanded and now it has spread nationally. The system is divided into two, the public sector and the private sector.

With some exceptions the major health needs of the public are catered for by the public sector. The major infrastructure of the public health care system was set up in the 1970s. Pakistan had also endorsed the then Moscow driven "*health for all by 2000*" initiative which had been launched by the World Health Organization. From the villages to the cities different levels of health care were started like the "Basic health units" for the villages. The Tehsil headquarter hospital represented secondary health care, and district hospitals and teaching and referral units represented tertiary care units. Along with this a significant public health campaign was launched for the first time, keeping in view local needs and WHO guidelines to meet the target. These were: An expanded programme of immunization to eradicate the prevalent infectious diseases; Malaria control programme; Tuberculosis control programme; Family planning programme; Diarrhoea and pneumonia control programmes; and many others. To monitor all these and to achieve further improvements and make sure the policy was being applied the *national institute of health* was created.

Thus although subsequent governments, like Zia's, built major health complexes they completely failed to deliver to the people what they really needed. The basic healthcare units built in large numbers were in far flung places where there was very little population and the support structures, such as schools and residences were never built so doctors and other medical staff never wanted to work there. They existed as ghost units. Nevertheless under every government the "*health for all by 2000*" remained official policy for the state-owned health system. And despite all the corruption and mismanagement it provided a big relief to the people of Pakistan. At present there are two exclusive health cultures. One is illness behaviour of people which which is initiated, maintained and terminated by their own dynamics and the other is health delivery culture with perceptions and behaviour of the providers determined by their established approach. The concept of health of common man is considerably influenced by the bio-medical model. It can best be understood by the behaviour of the patient and the physician.

In developing countries whooping cough, measles, tetanus, polio and tuberculosis needs protection from vaccination but diarrhoea, dysentery, malaria, parasitic infestations, respiratory diseases, and viral encephalitis, are rampant and fill majority of hospital beds. In developed countries where such disorders have been controlled, the focus is on new killers like HIV, AIDS, Heart Disease, Vascular Lesion of Nervous System, Mental Illness, Obesity and accidents. None are likely to be amendable to any vaccine. It is therefore necessary to look far beyond a pill and even beyond a physician.

If you look at the statistic given by various international agencies, it makes for very glum reading with Pakistan's major health indicators clearly demonstrating a large unmet need. Estimated infant mortality is 85 per 1,000 live births, under 5 mortality is 103 per 1,000 live births, and maternal mortality is 533 per 100,000. Contraceptive prevalence is only 28% and the population growth rate is 2.2% per year (compared with India's 1.7%). Immunization rates are low with less than 60% of one year olds fully immunized. Twenty-six % children under 5 are moderately to severely underweight; only 1% of young children receive Vitamin A supplementation; and only 19% of household use iodized salt. Despite 5,000 graduating doctors every year, and no proper policy of control on medicines, there are some six hundred thousands quacks going about happily with their medical business. The subsequent governments as well as the Pakistan Medical and Dental Council have dismally failed in their endeavor to control the problem. And despite the National Health Policy's vision based on the health for all approach, the Expanded Program on Immunization seems to be in doldrums. In fact, the coverage of immunization for six preventable childhood diseases has declined. We have not been able to protect our people against hazardous diseases or upgrading curative care facilities. Even after 33 sessions of Polio Campaigns, the Health Ministry has been unable to

eradicate it. Pakistan is among the 22 countries that carry almost 80% of the global T.B burden. In effect, if we look at our health indicators we are, among the underdeveloped nations, perhaps just a little better off than Afghanistan and the Sub-Sahara region. According to a WB report on WOMEN HEALTH IN PAKISTAN, every year, some 30,000 women die for not getting the basic health facilities and 375,000 pregnant women suffer from various pregnancies related problems. It is a lack of good governance and non-implementation of policies.

The government without any parliamentary debate formulates policies and the politicians are hardly bothered. Health care depends directly on economic growth, our economic system is messed up, with the result that there is rampant poverty. Poverty often breeds corruption and this is true in health sector, too, where, money given by international agencies is smoothly siphoned off from legitimate projects. The poor have large families as they see children as their insurance. Some will die and others will be undernourished and the mother's hemoglobin will drop to as low as seven after each pregnancy. Yet, the vicious circle that they are caught up in continues. Give these same people safe, clean water, a working sewerage system, provide them with latrines and you will see half of our problems will go out of the window. Provide them with education as well, and 80% problems will be solved. It's a very simple formula.

## **PROFESSIONAL PERSPECTIVE:**

### **AILING MEDICAL EDUCATION:**

Medical students all over the world grumble about unceasing pressure, torrents of material, lack of time to think much less for relaxation. They are, let us say, only one of the party who so complain. The aggrieved party of patients gripe that the products of the present system, the current crop of doctor have no compassion, run their practice like assembly line and are more fascinated by tests and procedure and gadgetry display than the needs of the human being they treat. The third complaining party, the Medical School teachers as a whole are worried about turning out sub-standard, narrow minded, unenthusiastic graduates impatient to attain name fame and fortune without going through the process of tedious time factor hard labor and without suffering painful process or trial of wits, losing sweat and tasting pangs and pain for reaching expected heights. This may be partly due to irresponsibility, aggressiveness, poor discipline, absence of mutual respect, give and take of teachers and taught, and most dishonest and vicarious assessment of merit and examination system prevalent. Under-standibly, it has many roots and is out come of the break down of moral structure, selfish attitude and undesirable social order. On all counts without any doubt Medical education is in bad shape and in chronic bad health. As usual there is no consensus on diagnosis and treatment and all concerned have their own prescription of fixing what is wrong and provide suggestion of some way out of it. At least in Pakistan, medical education as a means of providing an end to workable, meaningful, indigenous and economic health care system has definite morbid pathology, which surely needs medical surgery.

### **BASIC CAUSES:**

The most crucial need is to orient the system to serve the needs of the overwhelming rural majority. This must involve a reduction in manpower and influence of the foreign trained specialists and consultants who have so far dominated both medical policy making and medical practice in Pakistan. The Health services in developing countries have been largely designed by doctors modeling them on experience gained while being trained or working in developed countries. Without exception, these medically qualified health planners have chosen as a high priority the training of doctors in large teaching hospitals, and with exception of a few small countries have invested large sums in building of this disease palaces (hospitals). The running cost of tertiary care hospitals usually amounts to at least quarter, sometimes a third and in some countries absorb half of the total national health expenditure. Tying up such recurrent expenditure has crippled attempts to provide a more enlightened health service. Tertiary care hospitals produce skilled personnel that they act as referral center, and that they will mostly take care of complex conditional teaching hospitals are (like a national air lines) also built as a matter of national prestige.

The doctors are produced on Curriculum as prevalent in Europe or America, which too is fast deteriorating in quality in our country. Recently this was pointed out by Federal Minister of Education while briefing a visiting group of American educationists by admitting that "Our education system is falling apart." Medical education has to its credit highest rating country wise and is socially prestigious and economically safe investment at cheaper cost and absorbs high proportion of best science students from schools. Once qualified these doctors see a more promising career if they specialize and the majority spend many years chasing higher qualification either in the country or overseas and only take up general practice by force of circumstances with frustration or apathy.

#### NEED OF THE HOUR:

Clearly, the developing countries need large number of general duty medical officers and not large number of specialists for practical health care system. It is necessary to identify the most common of population ailments and modify with importance the teaching in out colleges and arrange training in out hospitals. Most of our prevalent diseases are Water and Food borne and due to lack of sanitation and result of malnutrition. According to an official survey 64% of disease are due to infection and parasitic disease. 11% due to Malaria, 8% due to congenital abnormality, birth injuries and peri natal mortality, 6% due to other causes including heart, diabetes and surgical problems. The association of American Medical Colleges representing 27 institutions in USA and all 16 in Canada (same number as in Pakistan) after conducting a 3 years survey and spending one million dollar have agreed as to " what is the education that all physicians need and how to make the process less brutal." At least on one point there is a general consensus that after World War II the curriculum is bursting at the seams and there is simply too much for young doctors to learn. Memorization, that's what it is all about in a densely packed education, Ironically much of the information pushes on medical students will be of limited use when they become practitioners. This is due to very fast changes in scientific discoveries and that there is no point in trying to teach every little fact. Steven Mullar, Chariman of Johns Hopkins University and its hospitals wants to pare down the curriculum so that students can concentrate on the fundamentals of medical sciences and practice. Similarly Dr. Thomas I. Leaman, President of "Society of Teachers of Family Medicine" symbolizes the teaching and training in medicine for the people and community to an amateur farmer in the early spring who, with great enthusiasm and anticipation plants, lettuce, parsley, okra, artichokes, oregano, radish and guards, but neglects to leave room for staples; beans and potatoes, Leaman feels that" we need to recognize in ourselves and in our teaching that first and foremost we must be superb clinicians and we must continually have our own clinical sills. These are our basics," Our beans and potatoes" (Dal roti)

#### CONCEPTUAL SHORTCOMINGS:

In Pakistan, Pakistan Medical and Dental council has been assigned at its first responsibility as listed in its publication " Code of Medical Ethics", to " public interest by maintaining medical and dental standard". But as it is, so far it has not yet touched on the subject, which is understandably, the health care needs of the community. Neither it has made any beginning to prepare doctors to tackle 80% of the disease of the people, which is only possible through teaching, and training is Family medicine. By all imaginations, arguments, sense of proportion and fairness to the people this basic duty and responsibility of such supreme and august body as P.M.D.C., has remained neglected and Council has failed to assign itself to offer instructions, teaching training and continuing education in family medicine which besides health care, embraces how to foster sympathy, how to communicate better with those being treated, how to deal with patient and his families with compassion and his whole life rather than the fragmented pieces of content of sub specialties ignoring" Whole person medicine" and community needs.

#### WHAT IS FAMILY MEDICINE:

Family medicine in the past, called general practice has now in the age of specialization and explosion of technology and piling of by products of scientific research after Second World War and greater demand by the community for quality and content of modern age health care needs has acquired specialty status all over the world. It is an academic discipline and a clinical entity. It embraces a wide range of diagnostic and therapeutic skill while leaving to the various specialties more complex technical problems and procedures.

It is concerned with the earliest alterations from normal health and factors that influence or provoke such alteration. A properly trained family physician should have a firm grounding in basics, behavioral and social sciences, a broad knowledge of medicine, extensive training in internal medicine, and selective training in each of the specialty and special training in psychological medicine. Family medicine as a whole is the provision of primary, personal, comprehensive, preventive and continuing total health care to individual of either sex, of all ages, their families and the community. It is a discipline in breadth in contradiction to other specialties, which are disciplines in depth.

#### **INEVITABLE CURRICULUM CHANGES:**

In many countries these changes are occurring in medical education and particularly in Pakistan it is inevitable and overdue. Increasing emphasis should be given to restructure undergraduate curricula to community practice, family medicine and social sciences. The students need more orientation to patient and his needs rather than disease process and drug culture. The doctor in making, through out his career, is burdened by the threat of examination by specialist teachers and is denied of chances to be taught and trained in community and Family medicine and thus remains ignorant and unaware of the burden of his future responsibility to the national health care delivery. Essentially for such responsibility he is unprepared. Basically he has to be a good clinician, health educator, community leader and able to continuously educate himself and his subordinates. Learning experience should be relevant to clinical, family and community practice. It should be problem oriented with motivation for regular assessment and auditing and compulsive continuing education and vocational training. In summary, one feels most despondingly that such needs as given above have not yet realized by authorities or any attempt made for changes in the colonial system or medical education.

#### **THE STATE OF THE CHILDREN:**

The political and economic changes of recent years have made it clear that a new world order is evolving. UNICEF submitted ten propositions for the agenda of that new order - from the point of view of a world wide organization, which comes into daily contact with some of humanity's most acute problems. Excerpts from it, which are relevant to us in Pakistan are reproduced below. The ten propositions are as follows:

1] That the promise of the World summit for children should be kept and that a new world order should bring an end to malnutrition, preventable disease, and illiteracy among so many millions of the world's children.

Fact:

A quarter of a million young children die every week; millions more live on with malnutrition and almost permanent ill health. Approximately half of all cases of malnutrition, disease and early death are caused by five, or six specific illnesses which can now be prevented or treated at very low cost. This is not a threatened tragedy or an impending crisis. It happened today. It will happen again tomorrow. And by any objective standard of scale or severity, this issue would rank in importance with any on the human agenda. But in practice, such problems have had little purchase on priority because they are primarily the problems of the poor and the powerless.

2] That the principle of first 'call for children' - meaning that protection for the growing bodies and minds of the young ought to have a first call on societies 'resources' - should become an accepted ethic of a new world order.

Fact:

In many nations of the developing world, the lack of this principle has meant that the debt crisis of the 1980s has been translated into rising levels of child malnutrition and falling levels of school environment. In many nations of the industrialized world, the lack of this same principle has meant that the rising affluence of the 1980s has been accompanied by a sharp increase in the proportion of children living in poverty. Some nations have shown, in recent years, that it is possible to begin putting this principle into practice. The Republic of Korea has ensured, in each of the temporary economic reversals of the 1970s and

1980s that specific policies were in place to prevent rising oil prices or falling agricultural output from being translated in to worsening level of health, nutrition, or education among its children. The government of Indonesia, under economic pressure from the slump in oil prices in the early 1980s took a conscious decision to cut back spending on industrial projects and on hospital building in order to maintain expenditures on rural health clinics, immunization programmes, and primary schools.

3] That if the issue of malnutrition, preventable disease, and widespread illiteracy are not confronted as a new world order evolves, then it will be much more difficult to reduce the rate of population and make the transition to environmentally sustainable development.

Fact:

Reducing child deaths gives parents more confidence in family planning. Most of the developing nations are now entering or approaching the stage at which further declines in child deaths are associated with much steeper declines in birth-rates. Doing what can now be done to protect the health and save the lives of millions of children will therefore help, not hinder, efforts to slow population growth.

4 That the growing consensus around the importance of market economic policies should be accompanied by a corresponding consensus on the responsibility of governments to guarantee basic investments in people.

Fact:

On average, only about 12% of government spending in the developing world is devoted to basic investments such as primary health care and primary education for the poor majority. World Bank studies have shown that raising the average educational level of the labor force by one year can raise GDP by as much as 9%. Better adult and child health has been shown to save millions of lost workdays. Correcting child malnutrition and iron deficiency anaemia have been shown to reduce absenteeism, increase attention spans, and improve schools results.

But for the present purpose, such studies are like striking matches in laylight. The evidence that investing in people lays the foundations for economic growth looms large before us in the shape of those countries which have succeeded in achieving rapid and sustained progress in the postwar world. Liberating people's potential via land reforms and universal health and education services has been fundamental to that success in countries and region such as Japan, South Korea and Taiwan. All of these have shown that basic education and health for all are not just social expenditures but economic investments, not just indulgences which can only be afforded after countries have become prosperous but the foundations without which widespread prosperity will not be achieved.

All for some:

Of the resources which are allocated directly to health and education, more than half is allocated to relatively high cost services for the few, and less than half is allocated to low-cost services for the many. It is estimated, for example, that 80% of the \$12 billion allocated each year to water supply systems is spent on putting private taps in the homes of the relatively well-off, at a cost of approximately \$600 per person served, and that only 20% goes to the public wells and stand-pipes which can bring clean water to the poor majority at a cost of \$30 to \$50 per person served, deallocating even a proportion of total expenditures in favor of the poor would therefore liberate enough resources to achieve the goal of safe water supply for almost every community in almost every country by the 2000.

Education:

Such distortions of public spending in favor of the better-off are also evident in national education systems. Despite decades of research findings which regularly demonstrate that investment in primary education yields significantly higher returns in both social progress and economic growth, government spending in

almost all developing countries is heavily biased toward higher education for the few rather than basic education for the many.

The necessity of importing primary education is vital. In both Japan and South Korea, for example, universal primary education preceded economic take-off. And in both, this basic investment in people was made at a stage when their per capita incomes, in real terms, were lower than in most developing countries today. Japan moved rapidly towards universal primary education at the end of the last century. South Korea ensured that almost all its children were in primary school at a stage when its per capita GNP was little more than \$100 per year. Emphasis on secondary and higher education came later and was not made at the expense of primary education for the great majority.

Many other countries have taken the opposite course, financing higher education disproportionately with the result that up to half of all children fail to complete four years in primary school while secondary and tertiary education absorbs an exaggerated share of the budget in order to produce many more graduates that the economy can usefully absorb.

If aid to secondary education, as opposed to primary, is excluded, then that proportion drops to below 5%. Only about 1% of international aid goes to the primary health care systems which could prevent or treat 80% of the disease, malnutrition, and early deaths in the developing world. Only about 1% goes to the family planning services which could do so much to improve the lives of millions of women and children. And considerably less than 1% goes to primary education which as we have seen, is both basic human need and one of the best possible investments that any country can make in its own future.

The principal difficulty in shifting social expenditures in favor of the poor majority is usually a political one; increasing the proportion of the budget spent on primary health care or primary education represents, in effect, a transfer of resources from the better-off and the politically influential to the poor and the powerless. Where affluence is inseparable from influence, that transition will be very difficult indeed.

6] The international action on debt, and trade should create an environment in which economic reform in the developing world can succeed in allowing its people to earn a decent living.

Fact:

The continuing debt crisis means that the poor world is now transferring \$50 billion a year to the rich nations. Protectionism in the rich world costs the poor world a further \$50 billion a year in lost exports.

7] That a process of demilitarization should begin in the developing world and that, in step with that process, falling military expenditures in the industrialized nations should be linked to significant increases in international aid for developing and for the resolution of common global problems,

Fact:

The amount now spent on the world's military exceeds the combined annual incomes of the poorest half of humanity. The goals of the world summit for children - including drastic reductions in malnutrition and disease and a basic education for all children - could be met by reallocating 5% of military expenditure in the developing world and 1% in the industrialized world.

8] That the chains of Africa's debt be struck off and that the continent be given sufficient external support to allow internal reform to succeed in generating the momentum of development.

Fact:

Africa today is only managing to pay about one third of the interest due on its debts. Even this is absorbing a quarter of all its export earnings and costing the continent, each year, more than its total spending on health and education of its people.

9] That a new world order should oppose the apartheid of gender as rigorously as the apartheid of race.

Fact:

More than a million girls die each year simply because they are born female; the cause of death is the disease of discrimination. It is commonplace that the developing world's women bear and care for its children, fetch and carry its fuel and water, cooks its meals and shop for its homes, and look after its old and its ill. It is less widely known that women grow and market most of the developing world's food, earn and increase; proportion of its income, and work, on average, twice as many hours a day as men.

In return for this disproportionate contribution, the women the developing world are generally rewarded with less food, less health care, less education, less training, less leisure, less income, less rights and less protection. The practical costs of this bias are the reduced effectiveness of almost every other aspect of the development process. But to discriminate against girls in the matter of educational opportunity is perhaps the biggest practical mistake of all. Over many years and in many countries, the education of women has been shown to be associated with the [confidence to adopt new ways, the propensity to make greater use of social service, the ability to earn higher incomes, the improvement of child care and nutrition, the reduction of child deaths, the acceptance of family planning, the reduction of average family size, and the literacy of the succeeding generation.

10] That the responsible planning of births in one of the most effective and least expensive ways of improving the quality of life on earth - both now and in the future - and that one of the greatest mistakes of our times is the failure to realise that potential.

Fact:

Over 50,000 illegal abortions are performed each day. Several million children die each year because they were born too soon after a previous birth or because they were born to mothers who were too young to give birth safely. Over 100,000 young women die every year because they do not have the knowledge or the means or the right to plan the number and spacing of their pregnancies of all women could exercise that right, the rate of population growth would fall by approximately 30%.

#### **ENVIRONMENT AND HEALTH:**

Human beings require a healthy environment to flourish and to enjoy optimal health. Durability to live longer, and healthier, human body and the environment in which we live. The essential factors and variables that determine our increased life expectancy include;

- 1) what we eat,
- 2) what we breathe,
- 3) what we drink,
- 4) where we live- our environment,
- 5) what work we do,
- 6) our genetic make up,
- 7) our life styles, and many other factors that can affect our health and longevity.

Since the 16th century Renaissance to the modern industrialized, urbanized, technologically advanced and commercialized world today, Humankind had strived for more comfort, more health, more money, more knowledge, more control of his or her life, and environment. However, in this process of "advancement" we have created ( and are exposed to horrendous environmental hazards and threats to ourselves. Examples of our Environmental Destruction include:

- 1) Air pollution,
- 2) Ozone depletion,
- 3) Acid rain,
- 4) Water contamination,
- 5) Urban smog,
- 6) Deforestation,
- 7) Soil erosion,
- 8) Disappearing species,
- 9) Concentration of carbon and
- 10) Hazardous waste, to name a few.

Three quarter of the 49 million people whose deaths are registered each year, are killed by illnesses related to &poor environment, and an unhealthy life style according to a WHO Director-General Report in March 1992.

Increased pollution levels in the environment may lead to poor health and also decreased life expectancy. The intensity of exposure depends mostly on the extent of the emission, the location of the source, the duration of the emission, and the transport and transformation processes that occur between the source and the exposed individual or segment of the population.

The dose of the pollutant that individuals with in a community receive, depends not only on the general levels of pollution in the food, air and water they drink, but also on a whole range of other personal variables- the time spent in the working and home environment, the time spent to and from the work place, the individuals eating and drinking preferences, social habits, cultural norms and personal life styles. The total exposure of an individual is therefore affected by age, gender, culture, occupation, location, environmental hazards, the route, the duration, the concentration of pollutants, and a whole range of personal activities within his or her environment.

Risk assessment of human, exposure requires detailed studies of individuals and their life styles; to complement the environmental levels at point locations- in soil, air and water. The exposure of an individual to a pollutant, and its intake, can be measured by direct monitoring, or estimated by indirect monitoring. Biological indicators of exposure can be obtained by analysis of breath, body fluids and tissues such as- blood, human milk, serum, plasma, hair finger nails, teeth, stool, urine and sweat, for pollutants and their concentration.

#### A Working Definition of "Hazardous Waste"-RCR Act 1976

It is defined as a waste, or combination of wastes, which because of its quantity, concentration, physical or chemical, or infectious characteristics may;

- 1) cause, or significantly contribute to, an increase in morbidity or mortality or an increase in serious irreversible or incapacitating reversible illness or
- 2) pose a substantial present or potential hazard to human health or, the environment - when improperly treated, stored, transported or disposed of or otherwise managed.

Note: - By-products of this treatment of any hazardous waste are also to be considered hazardous, unless they are specifically excluded.

Hazardous wastes have four characteristics:

- 1) Ignitability
- 2) Corrosivity
- 3) Reactivity
- 4) Toxicity. Any one or a combination is enough to label any waste" hazardous."

#### Chemicals, Lifestyles and the Environment

For the past 50 years, there has been a tremendous increase in the production of organic chemicals to satisfy our demand for consumer goods, as well as an increased demand for valuable heavy metals, for both personal and industrial use. As we enjoy the benefits of consumer goods, we must also learn to deal with the challenges that go along with them. The chemical industry has produced a side variety of products that have much improved our standard of living and generally increased human life expectancy . However, associated with these benefits are the risks of accidents, contamination, pollution, spills and more hazardous wastes all of which could endanger human health, leave harmful residues in our environment, which can or may affect fish and wild life, viruses and bacteria or impair the fragile balance and harmony of nature and the very precious environment that we live in.

### Examples of Environmental Hazards affecting Health Occupational Causes of Cancer

Etiology	Site of Malignancy
Arsenic	Lung, Skin and Liver.
Asbestos	Mesothelioma, Lung.
Benzene	Leukemia.
Benzidine	Bladder.
Chromium	Lung.
Radiation	Numerous Location.
UV Light	Skin, Eyes.
Vinyl Chloride	Liver Angiosarcoma.
Coal tar	Scrotal Cancer.

### Environmental Lung Disease

Inorganic Dusts	Organic Dusts
Asbestos exposure	Cotton dust, flax
Silicosis	Grain dust-farmers, Ship crew member, Barge.
Coal worker's pneumoconiosis handlers.	Mouldy hay-Farmers Shepherds-animal
Siderosis	
Lead exposure	
Mica.marble dust.	

### Toxic Chemical affecting Lungs

Acid Fumes; (Nitric, Sulfuric, Hydrochloric acid)	All of these can cause mucous membrane irritation. Violent coughing. Dyspnea Pulmonary chronic bronchitis. COPD.
Ammonia	
Cyanide	
Formaldehyde	
Halide (Cl, Br, F)	
Hydrogen sulfide	
Nitrogen dioxide	
Ozone	
Phosgene	
Sulfur dioxide	

### Toxic to eyes

Lead  
Arsenic  
Thallium  
Tobacco  
Methanol  
Quinine  
Carbon disulfide  
Formaldehyde

Ozone  
Heat, x-rays  
Ultra violet rays  
Neutrons  
Drugs

#### Kidney Nephrotoxic Substances

Mercury  
Gold  
Cadmium  
Lead  
Lithium  
Bismuth  
analgesics  
carbon Tetra Chloride  
Cyclosporine  
Snake venoms  
Heroin, Amphetamin-Antibiotics (some) -Radiation

#### Liver Hepato Toxic Substances

Carbon Tetra Chloride  
Trichloroethylene  
Yellow Phosphorous  
Mushroom (Amanita, Galerina)  
hydrocarbons  
solvents  
Steroids  
oral Contraceptives  
Anesthetics  
Analgesics  
Radiation  
Tranquilizers

#### Neuro Toxins Nerve Damage

Snake venom (cobra, viper etc.)  
Snails  
Lizards  
spiders  
shellfish (dinoflagellates)  
Fish (Stingray, Toad fish etc.)  
Insects (Ticks, Centipede etc.)  
Cis-Platinum  
Isoniazid  
Acrylamide  
Buckthorn (Toxic berry)  
Carbon Dioxide  
Diketone Hexacarbon  
Lead  
Thallium  
Organophosphate  
Sunlight- UV rays

### Skin Dermato Toxins

Temperature change  
Phenols  
Germicides  
Heavy metals  
Solvents  
insects  
Chemotherapy agent  
Antibiotics (many)  
Steroids  
Gold  
Pesticides  
Fumigants  
Toxic gases  
Acids- Alkalies  
Most medications could  
Arsenic  
Mercury  
Radiation

### Bone Marrow Toxins

Benzene  
Radiation  
Anti-metabolites  
Arsenic  
Gold  
Insecticides  
Mitotic inhibitors  
Anthracyclines  
Sulfa drugs  
venoms  
Nitrosoureas  
Alkylating agents  
Chloramphenicol  
Heavy metals

Besides toxic and industrial waste, we have many other environmental hazards like:

- Automobile Accidents.
- Noise Pollution
- Radiation Injury
- Gun Shot Injury
- War Injury
- Physical Violence- Domestic and others
- Infectious Diseases
- Natural Disasters- like floods, earthquakes etc.
- Sports Injuries
- A.I.D.S.
- Occupational Injuries and Hazards
- Psycho-Social Problems- Drugs, depression, suicide etc.

Note :

There are 5 million known chemicals, 60,000 of which are used commercially, it is a few hundred chemicals that are very hazardous and can cause significant harm.

Some Concluding Thoughts:

This earth that we live on is the only planet that we human beings have. Let the laws of nature rule, not the laws of greed. Let us keep our planet free from unwanted pollutants, sow the seeds for our future generations. As scientists and physicians we can measure how clean is clean, how green is green. After all, it has been said that "A healthy body has a healthy mind". How can we have healthy bodies if our environment is not as clean as it used to be?

It's time we all asked...

1. How clean is the air we breathe ?
2. How pure is the water we drink ?
3. How wholesome is the food we eat'?
4. What are the pollutants and environmental hazards where we live or work ?
5. How much radiation are our bodies getting ?
6. What other hazards will be introduced in our world in the future and for what reason ?

Remember:

The flip side of industrialization, urbanization and modernization is always pollution, pollution and pollution. Today, we cannot afford to pollute, pollute and pollute any more. It's our responsibility to prevent our precious planet earth from all hazardous wastes and hazardous thoughts that are endangering our lives and also the lives of other living things.

### **FAMILY PLANNING:**

Almost 1,500 women die each day, half a million every year, as a result of causes related to pregnancy and childbearing. Nearly 99 percent of these deaths occur in the developing world, particularly in urban slums and rural villages where women experience poor health, ignorance, poverty, low social status and limited access to essential health care. In these areas, maternal mortality rates range from 300 to 800 per 100,000 live births. The lifetime risk of dying because of a pregnancy-related condition is one in 25 for women in developing countries, compared to only one in several thousand in the developed world. In Pakistan, it is estimated that around 500 maternal deaths occur per 100,000 live births.

Women who have had five or more pregnancies and women who are over age 35 also face substantially higher risks. The risk of death during pregnancy or childbirth is five to seven times higher for females under age 15 than for those in the 20-24 age group. Women who become pregnant within two years of giving birth face higher risks than women who space births more than two years apart. Additionally, frequent pregnancies can exacerbate many pre-existing chronic conditions such as heart disease, hypertension, diabetes and hepatitis, all of which can indirectly cause maternal death.

Family Planning: An Essential Tool in Preventing Health Care:

To improve maternal mortality, access to information and family planning services must be ensured. All couples should be able to decide freely and responsibly the number and spacing of their children, as a basic human right. Health services that provide the information, counseling and means needed to facilitate the adoption of the concept of family planning should be widely available and accessible, especially for the most deprived population group. A woman who lacks family planning services and does not want to continue an unplanned pregnancy may have only two options - an unwanted child, or an induced abortion. The rise in the number of women resorting to abortion testifies to the failure of family planning services to keep pace with the demand. The toll is great: complications from abortion kill an estimated 200,000 women per year. The best way to prevent abortion is to make family planning accessible to all women and men.

Implementing Family Planning Programmes

Successful family planning programmes generally have most of the following characteristics: effective political support; wide spread, easily accessible services; multiple public and private delivery systems; a broad choice of contraceptive methods; personnel systems ensuring that the labour force is adequate and motivated; sound strategies for financing programme activities; adequate information, education and communication efforts; logistics systems that result in timely provision of supplies and equipment; strategic planning and flexibility; effective supervisory system and well-functioning management information systems and research and evaluation mechanisms.

To be successful, a family planning programme must have political support at the highest governmental level, in the relevant ministries (Health, Education, Planning, etc.) and also at the provincial and district levels. Political support is required not only for the initiation of these programmes; the commitment must be sustained to ensure that both laws and resources continue to support improved programme implementation.

Worldwide experience has shown that easily accessible services are necessary if programmes are to achieve relatively high coverage. In many developing countries, governmental social services focus disproportionately on "elite" group, in particular on the urban middle class. Scarce financial resources in the health sector are often concentrated on support for curative services in urban hospitals.

Most of these countries need to change priorities in order to: extend the service network; increase health coverage by targeting population group most in need; and introduce preventive health care approaches, including family planning, within the set of basic health services. In particular, more efforts should be made to reduce the still conspicuous urban-rural differentials in contraceptive use.

In Pakistan only 6 percent of rural women currently use contraception compared with 31 percent of women living in major cities. By contrast in Indonesia, for example, the contraceptive prevalence rate is higher in rural than in urban areas. The type of provider and mode of delivery also affect the accessibility of family planning services. Pressure to keep physicians in control of some aspects of primary health care, including family planning, has slowed progress in making services widely available. Abundant evidence demonstrates that trained non-physicians can safely and effectively deliver barrier and hormonal (oral and injectable) contraceptives, as well as perform IUD insertions.

Geographic constraints, underdeveloped basic infrastructures, and dispersed populations are, among others, important factors affecting programme achievement. The 1990-1991 Pakistan DHS reports that nearly 40 percent of women would have to travel more than one hour to reach the nearest source of family planning. The inaccessibility of family planning is likely to discourage women from obtaining family planning methods or advice. Successful programmes have risen to these challenges by developing "multi-source" strategies to promote services and make them widely available. Such strategies usually include supplementing clinical services with post-partum family planning services at all facilities where births are attended, forming community-based networks to distribute contraceptives and involving the private sector in furthering government goals.

The private sector has proved a vital adjunct to government efforts to extend the accessibility of services and to improve contraceptive prevalence. Family planning associations and other NGOs, private pharmacies, physicians and social marketing schemes are responsible for half or more of the existing contraceptive prevalence in many countries.

Contraceptive accessibility and programme progress have been restricted by a limited choice of contraceptive methods. Programmes should make all methods widely available. This does not mean offering many varieties of each method; a few representatives of each should be carefully selected. Factors that inhibit broadening contraceptive alternatives include uncertainty about safety, religious objections and socio-cultural resistance to certain methods. Disseminating international data on the safety and efficacy of family planning methods, conducting small-scale pilot tests of methods and retraining personnel to combat misconceptions and rumors are effective measures to overcome these problems.

Acceptance of family planning requires that services be adapted as much as possible to local customs and "user perspectives". Service agents and the contraceptive mix must be selected in accordance with cultural patterns; respect for privacy, modesty and anonymity are also important. Acceptability also encompasses "quality of care" factors. Among the chief mechanism for improving quality are a broadened range of available contraceptives, easy access to information and counseling, training of personnel, adequate technical capacity and the existence of follow-up mechanism.

### Special Challenges

Family planning programmes have typically focused on married women; other groups have been less thoroughly addressed and sometimes neglected. Correcting this shortcoming constitutes a special challenge for the 1990s, as does the rise of AIDS and other sexually transmitted diseases (STDs). Adolescent reproductive behaviour is an issue with great potential for controversy in most societies. The comparative risks of morbidity and mortality for the adolescent mother and her child are unacceptably high. In addition to health risks, evidence is mounting that too early childbearing disrupts female education and reduces a women's opportunities for personal growth. Unfortunately, not much progress has been made in providing services to adolescents; where this has happened at all, it has tended to be on a modest, experimental scale in a few major urban areas.

It has not been determined whether separate services must be established to win the acceptance of young people, whether programmes can use traditional agents to promote services, or whether separate messages are required to reach males and females, the married and the unmarried. However, it is clear that adolescents should be a priority group for family planning programmes. Among the main issues that must be addressed are how to change traditional attitudes favouring early childbearing and how to overcome the ambivalence (or actual resistance) of general society and service personnel towards the provision of services to adolescents. In Pakistan for example, although the majority of the people do approve of family planning, yet a substantial number (38 percent of women) still disapprove of contraception, many of them citing religion as an opposing force against the use of contraceptives.

To date, most efforts directed towards men have been limited to attempts to win their support for contraceptive use by their wives, through exposure to information about the negative impact of unregulated fertility on the health and socio-economic status of the family. Much more than mere acquiescence by men is needed; they must play a far more active role in promoting, supporting and using family planning methods. The need for such an active role by men is important in a country such as Pakistan where husbands usually have a predominant role in family planning decision. Moreover, men are more resistant to the idea of family planning than women. The family programme should increase efforts to provide and make easily accessible services tailored to men's reproductive needs.

Induced abortion remains highly controversial. It is estimated that between 25 million and 40 million induced abortions occur annually in the developing world - approximately one for every three to five live births. Between 10 million and 20 million occur where abortion is illegal or where hygienic and affordable services are relatively inaccessible. Complications of abortions performed under unsafe conditions may be responsible for 10 to 50 per cent of maternal deaths in developing countries. The promotion and expansion of family planning services can lessen the resource to abortion. Family planning programmes will increasingly come under pressure to address the accelerating menace of STDs in general and AIDS in particular. Promotional home visits, clinic educational efforts and family life and sex education programmes present natural opportunities to inform the public on prevention of STDs. The provision of condoms and spermicide, a traditional responsibility of family planning programmes, may be expected to increase as the campaign against AIDS intensifies.

Health, population and development

Health, population and development are closely interwoven. High fertility rates and decreasing levels of mortality, for instance, are the main determinates of rapid population growth. Population dynamics, the environment and socio-economic development are also intimately linked. All of them, in turn or in conjunction, clearly affect the health status of a population. The world population reached 5.5 billion by mid-1992 and will reach 6 billion by 1998. It is growing faster than ever before: three people every second, more than 250,000 every day. The "medium variant" or most likely projection for 2100 is now 11.2 billion. This is 10 per cent larger than what was predicted in 1982. Growth is not expected to stop altogether until the year 2200, when world population may stabilize at approximately 11.6 billion - over twice its present level.

Approximately 95 per cent of the population growth is occurring in the developing countries. By 2000, the developing world will grow to nearly 5 billion, out of an expected world total of 6.26 billion. Continued rapid growth has brought human numbers into collision with the resources required to sustain them. Increasing populations add to demands on land, air and water resources, making it more difficult to support growing numbers of people. Decisions leading to more healthy fertility patterns that can positively affect population dynamics, socio-economic development, the environment and health require an adequate provision of family planning services, but involve other factors as well. The success of family planning depends on decisions made by billions of individual women and men. How parents greet the birth of a new child, whether a girl is as welcome as a boy, whether girls and boys are reared with equal chances of health and education and whether parents choose to plan the birth of a subsequent child all affect the opportunities and aspirations of the whole family. And these factors will have a bearing on how future generations perceive choices in their own family lives.

#### Conclusions and Recommendations

It is hardly necessary to labour the point that family planning represents an essential tool in preventive health care, in enhancing women's autonomy and in lowering population growth rates. Yet, the fact remains that even today, approximately as many as 300 million couples in developing countries do not have access to family planning services. Survey data indicate that at least half of these wish to use some method of family planning either to space or limit births. In Pakistan, 41 per cent of currently married women have expressed a need for family planning: 27 per cent to stop childbearing and 13 per cent to space their children. Since only 12 per cent of married women are currently using contraception, 28 per cent have unmet need for family planning services.

On the other hand, the experience of the past 30 years strikingly underscores that progress with respect to population concerns and socio-economic development is highly correlated with a number of factors, including population growth. Economic expansion and improvement of the quality of life have been fastest where population growth rates are moderate and family planning services readily available.

Thus, acknowledging that family planning can play a significant role in promoting maternal and child health as well as in contributing to moderate population growth rates, it is essential that appropriate initiatives be designed to facilitate access to and increase the availability of quality family planning services. Further improvements in maternal and child health and decreases in population growth rates in developing countries will depend on the coverage and quality of maternal and child health services in general and family planning services in particular.

In order to achieve this goal, it is imperative that political commitment to family planning, which has waned in some countries and regions, be rekindled. Other considerations that government officials and programme managers in developing countries must keep in mind include:

- Family planning programmes must promote the concept of informed choice and a wide variety of methods, high quality services, full information to users and leave the choice of method to users.
- Considerable effort must be devoted to increasing the availability of family planning services, including wider use of the community-based distribution and social marketing programmes, without compromise quality.

- The private sector should assume a greater share of the responsibility for providing family planning services. Governments should consider delegating considerable responsibility to the private sector, while focusing government resources on under served subgroups.
- Programme managers have to identify the particular needs of target populations. Education and services for adolescents should be priority. More effective approaches are needed to better involve in family planning.
- Family planning programmes must play a more active role in preventing sexually transmitted diseases in general and AIDS in particular.
- Women in the developing world must become the designers and managers of family planning programmes, rather than remain pas siv beneficiaries of services, or serve only as low-level programme staff.

#### PRIVATE MEDICAL COLLEGE:

The issue of private medical colleges in Pakistan has been a subject of serious debate on professional forums uses like Pakistan Medical and Dental Council and Pakistan Medical Association. It is a dilemma between projected need of the country (on the assumption that Health for all by the year 2000 will be pursued) and the pace of infrastructural development in the health sector.

In the absence of a comprehensive policy of future health delivery system there is no rational basis to calculate the number of doctors required. As such the present increase or decrease in the number of admission in medical colleges is arbitrary and subjective. 1972 before the opening of Sindh Medical College in the premises of Jinnah Postgraduate Medical Centre for entirely different reasons, there were only 9 medical colleges with 1568 admissions. (Highly trained clinical teachers were under-utilized for lack of enough postgraduate students. They were the hey days when going to UK or USA was not so difficult as today). Yet another plea frequently made by the government for not providing comprehensive medical cover was that there are not enough doctors and that they don't go to rural areas.

More due to political expediency in the considered plan, taking the example of Sindh Medical College (requiring minimum basic sciences component with limited funds of Rs.18 lac or so), two more colleges were setup, one at Larkana and the other at Nawabshah. Other provinces took the one from Sindh and as a matter of prestige new colleges were proposed up in Punjab, NWFP and Balochistan. The Armed Forces also decided to setup a college to overcome the resistance from the young doctors towards compulsory services. So by 1981 there were 16 colleges admitting 4239 students and producing approximately 3552 doctors every year. The number of admissions have now reached 4500.

The result of such disjointed action (not policy) was surplus doctors with little job opportunity or adequate postgraduate training programme. It coincided with doors firmly closed by Britain and United States. In the seventies His Highness Aga Khan made an offer to donate a medical college. It was time when the bureaucracy stile explained away the deter mating health scenes to lack of doctors. By the time Aga Khan Medical University was given a charter in 1985 the scene had changed radically. Yet the number of seats and the quality of education was maintained by them, and the first private medical college gave a better

image while setting a precedence of feasibility of other colleges. We were at a threshold of an upsurge in the proliferation of medical colleges. The door was wide open.

We have the example of medical colleges at Dominican Republic and Sri Lanka. It caused problem to the quality of medical practice in Pakistan. The PMDC had to decide about re-examination of those graduates. This was inspite of an adverse report submitted by a committee of PMDC who visited the Dominican Republic. The Indian scene of private medical colleges was totally non-available. At present the decapitation fee in many so called Medical colleges there runs as several lac of rupees. They have problems in containing a large number of spurious 'institution' through a small number setup by philanthropists are functioning very well. They are based on public service and charitable point of view rather than profit making ventures.

The Pakistan Medical Association in 1987 pointed out the problem and demanded legislation to this effect. The Federal Ministry of Health or the PMDC had no legal grounds to check. (In Punjab various so-called medical colleges were operative without any hindrance). Today the situation is that anybody can start a medical college if certain paper requirements are provided to the university. Some political clout can facilitate the process. The worse is that medical college can be started, admissions made while the application remains pending with the university. We have similar situation at least in Karachi. Such fraud can be much worse than the Investment Company or cooperative financial scandal. Pakistan Medical Association conducted at seminar and formulated recommendations. Besides proposing the content of the curricula and the community oriented teaching the recommendations were made about the number of seats in medical colleges. They were spelling out a policy by the government where new medical college could be opened yet the total number of seats should not be increased. After providing balance and checks through amendment in PMDC and University charter. The overcrowded medical colleges in state sector could surrender 50-100 seats to a newly approved college. This could also improve the standard of education in the current colleges.

#### Recommendation for Admission in the Medical Colleges

The number of admissions to the medical colleges should be based on the need of the community or in accordance with the projected commitments of public and private sector for the health needs of the country. This should be the overall consideration. Moreover the admission should also be related to a suitable ratio between number of students and teaching and training facilities at a certain medical college. For this criteria it is suggested that in one basic department for a batch of 60 students, there should be the following teaching staff:

Professor -1, Associate Professor 1, Assistant Professor 1, Lecturer 1 and Demonstrators 4.

In clinical subjects there should at least be 2 units of medicine, surgery, obstetrics and gynecology and pediatrics and one unit for each specialty. Each unit in clinical side should have similar teaching staff as suggested for basic sciences. The paramedical staff, the secretarial staff, library and audiovisual facilities should be complementary. Criteria for Admission

Age should not necessarily be a criteria for admission. The emphasis should be on basic education background and capability. Eligibility for admission should be intermediate science (pre- medical group) or equivalent. Besides the minimum qualification it is suggested that MCQ computerized tests based on subjects of physics, chemistry, biology and general knowledge divided into equal parts to be conducted simultaneously at national and provincial level. Successful candidates physically and mentally fit and qualifying the exam are admitted according to merit. The object is that apart from educational qualification, motivation and proven ability to work hard should be made the criteria. Having suggested that we do realize that there is no foolproof method of selecting future doctors.

#### MEDICAL EDUCATION:

##### **Recommendations**

Medical education is a continuous process. It begins with under-graduate studies and continues throughout life. The physician has to be a life-long student. The administration, the medical institutions and the profession should collectively shoulder the responsibility of achieving and maintaining the required standard of under-graduate and post-graduate medical education and the quality of healthcare.

The following pre-requisites to establish and maintain certain standards for medical education are proposed:

Pre-Requisites Teaching of health-related subjects be introduced at school level.

Selection of students must be based on individual's aptitude, qualifications and achievement, irrespective of age, sex and race. It should be free from political considerations or regional bias.

Students should be made to understand well the minimal level of competence and the basic goals they are supposed to reach within specified periods.

Number of colleges should be reviewed keeping in view the requirements of various regions. New colleges may be opened without increasing the present total number of seats for MBBS. Available infrastructure and trained manpower be evaluated and expanded while others strengthened to undertake clinical teaching. The ideal number of students admitted in a class and/or lecture should be 100, but in any case, should not exceed 150. Specific areas which need attention are curriculum, training facilities and evaluation methods. Postgraduate education deserves a comprehensive plan based on national requirement and organised teaching and training programme.

#### Curriculum

- i. Radical change should be made in the curriculum of under-graduate studies in order to keep it in line with the actual health needs of the country. Inclusion or deletion of a certain part in the curriculum does not serve well. Instead, what is actually required is a conceptual and qualitative change so as to widen the mental horizon of the student.
- ii. The change should help prepare the student for administrative and leadership roles and not to make him a mere pill-prescribing clinician. Social sciences (including psychology, sociology and anthropology) and health economics must be part of the curriculum.

#### Training

- i. To provide for adequate training facilities for undergraduate students, as also to meet the future need of well-groomed physicians, the district and other suitable non-teaching hospitals in the public sector should be properly staffed and equipped and affiliated to nearest medical college. The qualified personnel in such institutions should be given due recognition and title of teachers. Thus the clinical component of a given college should be spread over various parts of the surrounding area in the shape of satellite campuses.
- ii. After being taught in the pre-clinical courses, batches of students should be placed in the district and other suitable non-teaching hospitals in rotation. The additional advantage of this and the preceding recommendation would be an improvement in the healthcare of the masses.
- iii. Part of the undergraduate clinical training should be imparted in settings outside the premises of hospitals, as majority of the graduates will eventually be working outside the hospitals. Placing of teachers and students in the community-level health programme is absolutely essential.

#### Evaluation

- i. The method of evaluating the students' attainment should be uniform, objective and dependable. Expectations from students must be clearly laid down before training and evaluation.

ii. Frequent assessment of students' progress should be given more importance than the end-of-the-year examination. Record of the grades achieved should be maintained and given weightage in final assessment.

iii. Quality of professional teaching and training should also be frequently assessed at regular intervals in evaluating the evaluators. Pakistan Medical Association should be member of the assessing committees.

#### Postgraduate Education

There is a pressing need of specialists in various fields. According to an estimate, Pakistan should produce 1300 specialists every year till 1993. Necessary resources will have to be geared to achieve this goal.

Emphasis should be laid on the following points relating to post-graduate education:

i. Actual need of specialists in the country should be assessed, through field research, keeping in view the job opportunities for them in public and private sector.

ii. Fresh graduates should be provided with expert advice regarding their aptitude and aspirations.

iii. Dependable information should be available on the future need of all specialists for a rational choice of a particular speciality.

iv. Uptodate list of specialists working in various fields should be available.

v. Training and examining bodies should be independent and separate but complementary.

vi. Training programme should have a built-in system where the trainees, if they want/realise, have the freedom to opt out.

vii. All the trainee posts should be for a specified period, based on the length of training required for various specialties/examinations.

viii. All posts in teaching hospitals should be filled in through peer review and not through Public Service Commission. They must be on contract basis and not permanent. Renewal may be allowed, subject to satisfactory performance and peer review.

ix. More institutions (other than the existing postgraduate training centres) be created/upgraded and accredited by the examining bodies, so that the burden on the existing facilities is distributed and more specialists are produced.

x. Failure in postgraduate studies must also be considered a failure of the training programme. The training programme should be evaluated in case of persisting failures of postgraduate trainees.

xi. The end-of-the-year examination system should be discarded and] regular evaluation, based on objective procedures, be adopted.

xii. Teachers should be trained in educational methodology and in scientific method of assessment.

xiii. Foreign qualifications, which are not registerable in their own countries, should not be registered in Pakistan. PMDC should evolve a comprehensive method of evaluating other foreign degrees/diplomas.

xiv. According to a well-drawn plan, acquiring postgraduate qualifications in foreign countries should gradually be discouraged and only training in reputed centres abroad be encouraged.

xv. The pressing and urgent need of popularising Family Medicine should be realised. Continuing medical education and post-graduate diploma in this field should be established. Training in this area should be imparted in community setting rather than in hospitals.

xvi. Doctors with postgraduate qualifications acquired in Pakistan should be sent to the centres of excellence abroad for training for a period of six months to two years.

xvii. A programme of continuing medical education should be set up for the graduates and incentives in the form of credit be given for knowledge acquired. The credit be counted for postgraduate training.

### **POST GRADUATE TRAINING IN PAKISTAN:**

A fresh M.B.,B.S. graduate of a Pakistani medical college is not fully ready to start independent work. This is irrespective of whether the individual wishes to become a specialist, or a family physician, or a teacher, or an administrator. All of them need further training, before they can work proficiently and productively. Thus, all M.B.,B.S. graduates need postgraduate training. The type of training that one needs will depend upon what the individual wishes to do.

The various career options open to MBBS graduate are to become a:

Health administrator

Specialist

Family Physician/General Duty Medical Officer

Teacher

Researcher

The above categories are not absolutely watertight. An individual physician could move from one to another with additional training. Similarly an individual could train to be a specialist and then train to become an administrator or a teacher as well. Postgraduate training can be a formal course (diploma) or an approved training programme (fellowship) or it can be on job training alone (Administration).

The different postgraduate training programmes available in Pakistan are:

For Health Administrators:

The university of Islamabad has a course in Hospital Administration but most of the individual who go for administration get on job training. Many do administrative courses in NIPA and other places along with other administrative cadres.

For specialists in clinical subjects:

The options are fellowship and membership of the college of Physicians and Surgeons Pakistan (CPSP) and M.D., M.S. or Diplomas of different Universities. For those wishing to specialize in Basic Medical Sciences there is the M.Phil and PhD programme.

For Family Medicine:

CPSP has a Diploma a Fellowship programme.

For Teacher:

There is no diploma or degree programme so far in Pakistan. CPSP is planning a Masters in Health Professional Education in collaboration with the University of Illinois at Chicago. However, the Department of Medical Education and National Teacher Training Center at CPSP conducts a number of 3-6 day workshops on educational methodology. The PhD, M.phil, M.D. and M.S. programme are based on research work and thus provide training in research.

Institutions offering postgraduate programme:

CPSP was founded in 1962 by an Ordinance and its major mandate is to raise the standard of medical practice in Pakistan. The college is patterned on the lines of the Royal Colleges of UK except that unlike UK there is single college for all disciplines. The college through its 27 Faculties lays down the training requirements of each specialty, the minimum standards for recognition of an approved training unit and the format of the examination. The training programmes are structured and logbooks have been introduced to keep a record of the day-to-day activities of the trainee. The FCPS trainee is also expected to submit a dissertation on a subject of their choice. The length of training varies between 3 to 5 years depending upon the particular specialty. In addition to the fellowship program, CPSP also has membership programme in 19 specialties. The training required for membership examination is 1 to 2 years. In addition, CPSP also offers a Diploma in Family Medicine.

A number of universities offer a 2-year M. Phil programme in basic medical sciences. This programme was first established in 1959 at Basic Medical Sciences Institute (BMSI), Karachi. Later Punjab University and some other universities have also established M. Phil, programmes in basic medical sciences. This programme has provided basic sciences teachers to all the medical colleges of Pakistan. BMSI has also produced about a dozen Ph.D. in Biochemistry, Pathology and Pharmacology. To the best of my knowledge, no other university of Pakistan has started a Ph.D. programme in basic medical sciences.

Most of the universities with a medical faculty offer an M.D. and M.S. programme. The exact requirements of this qualification vary from university to university and it lacks a structured training programme. The popularity of this qualification has had its ups and downs. At the moment it is most popular in Punjab. The Universities also offer Diplomas in a number of specialties. These are courses of 9-10 months duration in which the major emphasis is on didactic teaching with some practical training. The standards of the diploma vary between different universities.

#### **PRIVATE SECTOR AND MEDICAL EDUCATION:**

In respect of public health facilities Pakistan is one of the most backward countries of the world. Health has remained neglected in every Five Years Plan, because of lack of interest by the government and the economists in favour of industry and commerce. The influence of vested interests has always prevailed over social concerns. Economists have considered health as "non-productive area" which does not deserve extensive financial allocations that are necessary to produce a significant change in the health situation. Wastage of medical manpower due to emigration has reached a situation where half of all fresh graduates leave the country within a few months of their qualifying.

#### **The Shift towards Western Medicine**

The social, cultural, economic and political changes that followed the introduction of British rule in India dealt a fatal blow to the practice of Indian medicine. Almost every facet of life including the medical public health services were subordinated to the commercial, political and administrative interests of the Imperial Government in London. In developing health services for certain limited purposes (for example, the army), the emphasis was shifted from Indian systems of medicine to the Western. The decision to make this change appears to be amply vindicated by the spectacular advances in the different branches of Western medicine during the 19th and 20th centuries. The Medical Education in Pakistan is really a legacy of these very colonial times. There have been some additions to the quantum of curriculum but there have not been any changes in the basic approach, either in the method of teaching, or the objective of that education so far as the end product is concerned. Essentially the tendency has been to try and produce a medical graduate who is trained to perform ideally in a hospital setting. Because he is trained for a hospital he is trained for a good hospital with all the sophistications. The kind of training that is required to train him is very different to the actual objective situation that this young medical graduate will find in the field in the urban or in the rural areas of Pakistan. The cultural situation, the economic circumstances and the general pattern of life that he finds is very different to what he has been trained to work in. Again the requirements of entrance are such that it may attract the most talented candidate by the standards of examinations, as at present held yet this is not the candidate that will be motivated to serve in the rural

areas of Pakistan. The kind of doctor that will serve him in these areas with dedication may or may not have the academic distinctions, which have been made essential.

Also, the kind of orientation towards the Society and its cultural pattern that is given to the student in his medical education is totally divorced from the existing realities with the result that his motivation in practice of medicine end up by becoming a pure mercenary. No wonder that the large majority of medical graduates produced in this country in the last 25 years have emigrated, and those that are still here are constantly agitating to leave the country. Before we go any further it is necessary that the reader has some ideas of the economics of health care. The total expenditure on health by the Federal and Provincial Governments is Rupees Nine billion. This constitutes 1% of the GNP. Non-development expenditure is 5 billion and development expenditure 3 billion. In 1991 the Federal Government spends 550 million as development and 800 million as non-development, a total of 1.35 billion. Of the total GNP in Pakistan 75% is with the private sector, while 25% is with the Government, less than 5% with the Provincial Government. Of the 25% with the Government half i.e., 12-1/2 percent goes to defence, debt, servicing and subsidies.

Indicated below are some of the Areas where change is absolutely essential:

1. The medium of instruction
2. Duration of the Pre-Medical Course
3. The Entrance Examination has become essential
4. The Teachers and their Qualifications need a total revision
5. Teachers training programmes
6. The quantum of Education and its Content
7. The location of training in medical education
8. The System of Examination
9. Use of teaching aids are now considered absolutely essential
10. Teaching a whole time profession must be adequately recomposed.

It is obvious that the public sector will be unable to make all the contributions where change is considered essential. With the present resource constraint it is unlikely that Government Institutions will be able to find resources that our need is to develop postgraduate training programme in institutions, which are already in existence. The possibility of starting new institutions is even more remote. Entrance examinations which have now become essential because of the wide spread problems in the existing examination systems will have to be a private sector enterprise if it is to have any degree of credibility. A model for this exists in many countries. In India, a National Board holds an examination for entrance to the medical colleges. In the US the Association of American Medical Colleges holds a nation-Wide examination called MCAT, which is essential for entry into any one of the medical colleges. The Government of Pakistan has recently advertised seeking offers for holding national examinations, which will be in the private sector. Similarly teacher-training programmes will be needed more than the presenting available facilities can possibly provide. The quantum of medical education and its content is a longstanding debate. It will have to be released from the shackles of bureaucratic control if medical education has to make any progress. Finally, the two compulsions of needs, which must be fulfilled, and the present worldwide climate of encouragement to the private sector are compelling reasons for recognizing the increased role of private sector in medical education in Pakistan.

#### **FAMILY MEDICINE POSTGRADUATE TRAINING IN PAKISTAN:**

Since the creation of Pakistan the majority of its citizens have had limited access to effective and affordable basic health care services. Economic under-development, political instability and low levels of literacy have hindered process in the equitable distribution of health care services particularly to poor and rural

inhabitants. Thus while 70% of population is living in rural areas, 85% of physicians and 95% of hospital beds are situated in urban areas of the country.

The Indo-Pak sub-continent has a long history of traditional healers including pirs, hakeems and village birth attendants or 'dais'. These traditional healers have provided access to health care when other options might not be available and vary in their effectiveness in treating psychosocial and biomedical problems. "Quacks", as labelled by the Pakistan Medical Association, have no formal medical qualifications but portray themselves as bonafide practitioners, are estimated to provide nearly half of the general medical care in Pakistan. This low quality of health care coupled with limited access to clear water, sewage facilities and a poor public health infrastructure has resulted in Pakistan's continued high burden of infectious diseases, maternal and child mortality and needless suffering.

In partial response to the above problems, Pakistan and its medical profession have emphasized the production of more doctors. The number of medical graduates has risen dramatically from only 1300 doctors per year in 1977 to over 3800 per year in 1988. Unfortunately despite this increase in the number of doctors there has been relatively limited improvement in the health status of the population. This is reflected by the fact that Pakistan ranks 34th out of the 131 nations of the world with the highest infant mortality rate, which dropped from 160 per thousand in 1960 to 106 in 1989. Additionally, infectious and parasitic diseases continue to account for more than two thirds of all deaths in the population.

Pakistan is experiencing transition in disease patterns secondary to demographic and socioeconomic shifts which have important implications for the provision of adequate primary health care. The high fertility rate (eight children per women during her child bearing years) and improved child survival has led to one of the highest rates of population growth in the world (nearly 3%). There is also substantial growth in numbers of the elderly. By 2020, the segment of the population over age 65 will increase by 10 million. A rapid trend towards urbanization is occurring. It is projected that by the year 2000, 50% of the population will be living in the urban areas as opposed to the current 30%. Initially, the diseases of under development such as malnutrition and infectious disease predominated. Now, in addition to the diseases of under development, the diseases of development such as hypertension, diabetes, coronary vascular diseases, cancer and drug addiction are emerging as important contributors to morbidity and mortality.

The reasons for slow improvement in health are complex and inseparable from the problems of under development in Pakistan; However, an important factor which has not been systematically addressed by the profession is the lack of orientation of medical education at the undergraduate and postgraduate levels to meet the needs of primary health care. Though the Pakistan Medical and Dental Council states that the objective of the M.B.B.S. curriculum is to prepare a general-purpose community oriented doctor, only 10 hours of the overall curriculum time is officially assigned to the teaching of general practice.

While the teaching of primary care, family medicine, preventive and community medicine is limited in most medical schools, provision of this care become more complex. While medical students receive limited training at the undergraduate level in the delivery of primary health care, even less is available at the postgraduate level. While over 50,000 doctors graduated from the 17 medical schools in Pakistan from the period of 1979 to 1991, less than 1000 acquired postgraduate qualifications from the College of Physician and Surgeons of Pakistan. In Pakistan to date, there has been no organized system of postgraduate training or certification that would prepare a physician to address the basic primary health care needs of communities in both urban and rural areas.

### Family Medicine

Family medicine is one of the primary medical care specialties. Like internal medicine and pediatrics, it is a specialty of first contact with patients and serves as an entry point for patients into the health care system. Family medicine, however, is not restricted by age or sex and is devoted to providing comprehensive preventive, promotive and curative care with emphasis on the family unit including the community and social environment. It is a specialty of breadth rather than depth and requires familiarity with all medical

and surgical sub-specialties especially internal medicine, pediatrics and obstetrics and gynecology. It also includes familiarity with community, preventive and behavioral medicine.

Family physicians are trained to care for the majority of common health problems, recognize their limitations and make referral to specialists or for hospitalization when indicated. A family physician personally takes care of most of an individual's health needs or selects appropriate consultants, coordinating all necessary health services. In some areas, some family physicians maintain active hospital and obstetric practices, while in other areas their practice is limited to outpatient care. The expansion of family medicine has been an international movement over the last two decades. After World War II, there was global trend towards medical specialization linked to rapid advances in medical sciences and technology. Associated with this increase in medical sub-specialization was a decrease in the availability of high quality primary medical care, particularly for the rural and urban poor.

Responding to this trend, in its guidelines for training of health professionals, the World Health Organization has stressed the need for more family physicians and specific postgraduate training programmes to adequately prepare family physician for the needs unique to their communities. The shortage of adequately trained general physicians has been approached in different manners in various countries. Some have developed specific postgraduate residency training programmes from two to four years in duration and specialty board examinations and certifications. Others have emphasized general training in the undergraduate curriculum and some have not addressed this issue at all.

In Canada, residency training in family medicine lasts two years after graduation from medical school and over half of all Canadian doctors are family physicians. Additional training in surgery or anesthesia is available for doctors planning to practice in rural areas. In the USA, a long process of work recognition of the specialty resulted in establishment of the American Academy of Family Physicians, a three years residency training programme and requirements for continued recertification throughout the family physician's career. Fifteen percent of doctors in the USA are family physicians and there is greater demand for family physician than any other medical specialist. In Britain, 40% of doctors are general practitioners (the British equivalent of family physicians) who complete a two to three years postgraduate training programme. Training programmes in Central and South America and in the East have been implemented and are underway. Egypt, Lebanon, India, Korea and Japan to name a few.

### **SOCIAL CONSIDERATION:**

Pakistan, like most Afro-Asian countries has been at a crossroads that has turned into a challenge for development. Here, tradition and modernity wrestles for domination, and in the process vulnerability of the vulnerable deepens. The crossroads bristles with efforts and frustrations. Many a mirage is created by efforts that are sometimes well intended, but often made with a pathological indifference that is accepted either helplessly or cynically. To compound the state of being stuck at a cross-roads, the acceptance of pathology of indifference has become pathological!

At this crossroads where modernity and tradition wrestle, a deeper struggle is also taking place. It is the struggle for survival by the most vulnerable. Here, categories of tradition are often the better-known allies, even as they are crowded by categories of modernity. The latter compete for short-term solutions that are oriented to individual behavior, and tend to overlook the long-term advantages of social cohesiveness - hence our greater emphasis on clinical work, and our enchantment of the high-tech services. Categories of tradition as allies in the struggle for survival are to be found in the existing social support systems. These, however, need to be separated from those categories of tradition that are detrimental to people and their health ~ for example, negligence on the basis of sex, and social status. Such considerations seldom attract health planners and practitioners, perhaps because choices have been made - i.e., modern are the best, and needs no social support.

Separation of categories of tradition and modernity, and differences within these two trends are often not easy. It requires the resolving of an inner conflict in those who plan, provide, and also in those who receive Health care. The conflict is nebulous because of its rooting in very deep socio-cultural trends and values. It is the conflict of what we think are the solutions, and the magical quality are cribbed to medicine and

medical technology, and yet feel dissatisfied with what modern medicine has to offer. Many interventions, representatives of modernity, bypass the inner conflicts, and often fail to accommodate them even when community participation is explicitly declared as an objective and strategy. And in so doing they also treat community participation as medicine to be dispensed to cure an ailment.

In Pakistan, efforts for health care development need to be seen in the context of Pakistan's political instability that has been dominated by the manipulation of resources by the vested interest for its own interest. Efforts have focused more on developing physical infrastructure, especially in the rural areas, and furnishing it with tools of modernity in terms of both equipment and modern medical knowledge.

What these intervention ignored were the inner conflicts the people, especially the more vulnerable, face when attracted by the glitter of modernity but unable to avail it because of internal and external constraints. To expect that factors governing people's behavior will be automatically transformed at the sight of modernity is to commit two fallacies. Both can be called fallacies of false assumption. One assumes that socio-cultural factors are weak enough to wither away at the sight of modern services. The other false assumption has to do with the strength of modernity ~ i.e., that its mere presence would, as if by magic, bring about a social transformation that would make modern interventions effective. In view of the unsatisfactory results of the intervention made for the promotion of people's health, it seems imperative the larger social milieu is seriously examined and considered at every step of health planning and interventions. Just as it is not enough to have a technically sound ship and no understanding of the sea, in health system development technically sound interventions are not enough, understanding the social context is imperative.

The social context of Pakistan, and especially of its troubled province of Sindh, can be seen with the help of the following two notions:

i) The mind-set of people — i.e., how people think and behave when powerful or powerless.

In the case of Sindh, a feudal form underlies most behavior. In this pattern the aspirations and expectations of the powerful and the powerless are governed by the traditional pattern of feudal relationship, whereby the powerful believes that he must get whatever he wants. On the other hand, the powerless avoids displeasing the powerful, avoids confrontation and accepts the misappropriation of his rights. (But this is not to say that he is not resentful, even if his distrust and anger are well hidden).

This behavior pattern is to be kept in mind for understanding the attitude and behavior of health providers, and also his/her clients — especially the poor. In Health System Development, the interaction between the two is crucial for ensuring the functioning and efficacy of the system.

ii) Two basis of behavior-patterns

People, whether they be health-providers or planners, or those who are supposed to avail the health services, have two sources of behavior:

- (a) traditional power-base of those concerned
- (b) gender differences as the basis of behavior.

Gender differences though highly visible in health statistics, seldom attract specific intervention for gender sensitization. Similarly, though women are a major concern for all health planners, women's issues, especially those universally recognized as affecting their health are seldom addressed — except as platitudes! Women's social status and its relationship with women's health has been studied, but most health programmes do not integrate women's programmes into health-programmes, at best they assume the nature of token-activities on the periphery. Similarly, though quality of interaction between providers and clients is a major determinant of health-services utilization, it is seldom if even integrated in the training of medical staff. Finally, only a few questions can be raised. Who is to identify the role of social sector development in health care development? Who will take the lead ~ a few individuals, or some institutions?

## WHO AND PAKISTAN.

{Note: Graphs and Statistics would be enclosed as Annexure "B" (6 Leaves)}

### CRITICAL NOTE ON WORLD HEALTH ORGANIZATION:

One must keep this in mind while discussing the role of leading donor agencies that the Multinationals / Pharmaceuticals are also based in the same countries from where these aid agencies originate.

A case study of WHO's shenanigans.

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Paul Dietrich was visiting Mozambique's capital city, Maputo, during its civil war in 1984, when an educational billboard taught him a lesson he never forgot.

Dietrich, a former publisher of the old weekly Saturday Review, was in Africa working with a Catholic charity. He was driving in his Land Rover, the only working motorized vehicle for miles. Poverty-stricken people surrounded him, most of them on foot, though a lucky few rode oxen. The billboard was the only one he'd seen in all Mozambique. Though most of the chaotic, war-torn country was plagued by regular power outages, the sign had its own electrical supply. This billboard was paid for by the [World Health Organization](#) (WHO), the international bureaucracy created, in the words of its constitution, to "promote and protect the health of all peoples."

It urged the people of Mozambique to remember to buckle their seatbelts.

It also helped cement Dietrich's doubts about WHO's vision and mission. After seeing that billboard, and contemplating what it said about WHO's priorities and goals, he became one of WHO's most vocal critics. In the early 1990s, Dietrich served on the development committee of the [Pan American Health Organization](#) (which functions as an American branch office for WHO). He has also been president of the Institute for International Health and Development. Dietrich wrote about WHO frequently for The Wall Street Journal, and provided material for exposés of WHO shenanigans on 60 Minutes and various TV documentaries in Europe (where WHO's activities are minded far more closely than in the United States, even though the U.S. provides 22 percent of the organization's regular budget).

Dietrich publicly and repeatedly complained that WHO was a bureaucracy for bureaucracy's sake, mired in useless statement-making and conference-giving. He thought it focused too much on First World concerns - - such as seatbelt campaigns and smoking -- and not enough on the developing world's sick and poor.

For his troubles, Dietrich became the target of a WHO-sponsored investigator who dug into his and his wife's background, finances, and politics. Dietrich only learned of the investigation when a mole in WHO's Geneva headquarters faxed him a copy of the final report. WHO singled out Dietrich, now an investment banker, in an August 2000 report that received heavy play in the New York Times and Washington Post. The report, dedicated to the tobacco industry, claimed Dietrich's motives were purely mercenary. He was named as a paid agent in a sinister international tobacco industry scheme to discredit WHO. The truth, Dietrich tells me, is far less sexy: A law firm he had worked for did work for tobacco companies, along with almost every other Fortune 500 company. To WHO, which claims to be devoted to science in the name of public health, Dietrich's observations and conclusions should be nullified by its ad hominem assault. Dietrich's primary complaint, though, will resonate with anyone who assumes that an international health organization's resources should be primarily aimed at the direct control and eradication of infectious diseases, rather than at behavior modification programs concerned with such matters as seatbelts and smoking.

But WHO's agenda is more ambitious than merely bringing medical care to the world's disadvantaged. Health, in a definition the group adopted over 20 years ago, is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." That is a totalist vision, and an alarming one. Armed with a bureaucrat's mentality, an arsenal of questionable data and conclusions, and a

billion dollars in taxpayer money donated by governments around the world, WHO's goal seems not so much to bring the world "health" as a physical condition as it is to bring the world under the control of the international mavens of "public health," the sociopolitical discipline.

But WHO is more an organization fighting for its life than one fighting for real power. As curable infectious diseases become a less significant factor in world mortality rates, WHO's budget has stagnated at around \$1 billion a year for nearly a decade now. Various other huge bureaucracies -- such as the U.S. Centers for Disease Control and the World Bank, whose budget on international health matters is slightly higher than WHO's -- have poached on its turf.

Why, to borrow Paul Dietrich's question, is WHO concerned with seatbelts and smoking when the world's poor are still dying of measles and tuberculosis? Public choice analysis -- which presumes that government agencies, like their private-sector counterparts, seek to grow their market share -- suggests an answer: Since the WHO's funding is mostly from First World governments, making them its relevant "customer base," it caters to First World concerns. WHO's recent history has been a vivid example of bureaucratic mission creep. In expanding its purview far beyond the merely medical, WHO is trying to stave off extinction.

### **Amazing Journey**

War, the radical journalist Randolph Bourne wrote, is the health of the state. Bourne meant that war creates a sense of crisis and embattlement, making citizens ready to cede their liberty to gain a sense of security.

But governments continually seek new excuses to expand their authority. Nearly a century after Bourne wrote his famous words, risk protection has become a central mission for governmental bodies. As Sheldon Richman, editor of the libertarian journal *Ideas on Liberty*, has put it, health is now the health of the state. Richman's observation deserves to be carved in marble in the plush Geneva offices of WHO.

WHO was founded in the wake of World War II, in a wave of optimism over the ability of international bureaucracies to create and direct a safe and sane world. With its mission concentrated on managing or eradicating infectious diseases worldwide, the group had some notable successes and some near-successes. It helped coordinate the international effort to eliminate smallpox, officially vanquished as of 1977. A WHO document uses clotted official prose to describe the group's role in the smallpox battle. WHO says its contribution was in "its energy and prestige as a catalyser of global efforts bringing together scientists, governments, health workers, and ordinary citizens," and that "technical difficulties -- were overcome through prompt WHO-coordinated research." The group also stressed the importance of "its neutrality and independence of national rivalries and suspicions."

WHO also played a major coordinating role in controlling yaws in the late 1940s and onchocerciasis ("river blindness"), leprosy, and polio in the past three decades. A WHO-organized Malaria Eradication Program in the '60s made substantial progress in stemming that disease. As late as 1964, WHO publications expressed optimism that malaria would be wiped out. Alas, malaria resisted eradication and the disease still kills over 1 million people a year. (The demonization of the U.S.-banned pesticide DDT, the cheapest and most efficient tool for killing the mosquitoes that spread the disease, bears a large part of the blame for the continued death toll.)

WHO's main success story remains its role in eradicating smallpox. Sometimes, though, it seems to believe the world will be impressed with the sort of thing that really occupies it these days. One WHO propaganda book lists five things we'd be missing in "A World Without WHO" -- presumably what it considers its most important achievements. None of them had to do with curing a single disease in a single person. Instead, they aver that in "a world without WHO -- national health officials would not be able to count on global moral support in their battle against tobacco addiction," and "there would be no unifying moral and technical force to galvanize, guide and support countries in achieving health for all by the year 2000."

By the end of the 1970s, WHO's official rhetoric about its core purpose began to shift from simple disease eradication. In 1978, at a joint meeting of WHO and UNICEF in Kazakhstan, in the former Soviet Union, WHO adopted "World Health for All by 2000" as its goal. This conclave of international bureaucrats vowed that, by the close of the 20th century, "All governments will have assumed overall responsibility for the health of their people -- through influencing lifestyles and controlling the physical and psychosocial environment." An "equitable distribution of health reserves, both among countries and within countries -- is therefore fundamental to the strategy." This plan was "part of that fundamental reorganization of human relationships in the world through the search for a New International Economic Order."

### Meet the New Boss

By the mid-1990s, WHO was mired in what the British Medical Journal called "a morass of petty corruption and ineffective bureaucracy." Under Director General Hiroshi Nakajima, a Japanese pharmacologist, WHO was so widely understood to be mired in cronyism and financial irregularities that such longtime boosters as Denmark and Sweden slashed their contributions; even the group's official auditor resigned in disgust. Nakajima's prominent position was important to Japanese self-esteem, so Japan embarked on a campaign in 1993 to make sure he was re-elected to a second five-year term. Among other gambits, the Maldives and Jamaica were warned that Japan would stop importing anything from them if Nakajima didn't get their vote.

Nakajima got his second term, but in 1998, with WHO morale and reputation at an all-time low, he was replaced by Gro Harlem Brundtland. With a masters in public health, Brundtland had spent most of her career as a politician, serving three terms as prime minister of Norway. She had also founded and led the UN's World Commission on Environment and Development. As WHO's new head, she promptly announced such vital-to-health goals as ensuring that six of every 10 new hires would be women.

In a world still fighting infectious disease, Brundtland's WHO has issued statements, studies, and reports on such topics as blood clots in people who sit still on airplanes too long, helping people remain active while aging, the hazards of using cell phones while driving, the importance of debt relief for poor countries, how tobacco is "a major obstacle to children's rights," and rates of alcohol abuse among European teens. The Lancet, the respected British medical journal, summed up her priorities thusly: "Brundtland has so far set out a conspicuously political agenda: her targets are poverty, underdevelopment, and social inequality."

To her credit, she has tried to reduce the amount of money spent at WHO's posh headquarters. She has succeeded in lowering her own annual office expenses by \$4 million over the next two fiscal years. She has also moved malaria control back near the top of the group's agenda. Not to her credit, she has continued WHO's turn from combating disease in its traditional -- and curable -- definition of infectious biological entities to an agenda of social control meant to stop people from indulging in freely chosen, if risky, pleasures.

Hence, when Brundtland launched two "cabinet-level" priorities, one was a "Tobacco-Free Initiative" that now costs \$14 million a year. (Malaria control is the other.) What does WHO expect to accomplish in aiming its resources and rhetoric at tobacco smoking? In characteristically vague WHO language, the initiative is meant to "galvanize global support for evidence-based tobacco control policies," to "accelerate -- strategic planning," and to "integrate tobacco into the broader agenda."

More specifically, the initiative's goal is to browbeat member nations into banning cigarette advertising and massively increasing cigarette taxes (never mind that such a policy may lead to black markets and attendant criminality). Backing WHO on this are several major pharmaceutical companies that have traditionally been enemies of the organization, which has long criticized what it considered the companies' brutal hegemony over poor nations. The pharmaceutical companies are thrilled that an international agreement might create an enforced market for non-smoking nicotine delivery devices, allowing drug makers to rip a chunk of the nicotine market from the grip of the tobacco barons.

In its war on tobacco, WHO has attempted Orwellian moves of almost absurd incompetence. In 1998, for instance, the group was supposed to release an enormous 10-year study on second-hand smoke's links with lung cancer, the largest ever done in Europe. A small mention of it was printed in a WHO report before the whole study was available. The British Sunday Telegraph tried to get a copy of the study, since the brief reference intriguingly implied that it could not find a statistically significant link between second-hand smoke exposure and lung cancer. The Telegraph implied that WHO was trying to bury the report since its results went against their official anti-tobacco stance.

WHO and other anti-tobacco groups were outraged. One group, Action on Smoking and Health, filed an official complaint with Britain's Press Complaints Commission over the supposedly erroneous reporting. (The commission found in the Telegraph's favor.) WHO responded to reports that its study did not find a statistically significant link between second-hand smoke and lung cancer in a press release headlined, "Passive Smoking Does Cause Lung Cancer, Do Not Let Them Fool You" -- strange, strained language from a supposedly scientific organization.

Underneath that colorful headline, the press release states, in italics, that "passive smoking causes lung cancer in non-smokers." Then, in the very next paragraph, it clarifies, "The study found that there was an estimated 16% increased risk of lung cancer among non-smoking spouses of smokers. For workplace exposure the estimated increase in risk was 17%. However, due to small sample size, neither increased risk was statistically significant." In other words, the Telegraph report was exactly correct: The study had found no statistically significant link between second-hand smoke and cancer.

As for the "suppressed" part, WHO insisted that the paper was merely being peer-reviewed, not hidden. Yet three years later, you'll still find no mention of the report on WHO's list of "Comprehensive Reports on Passive Smoking by Authoritative Scientific Bodies."

### **Is WHO a Bargain?**

Treating the behavior of tobacco smoking as a "disease" that must be eradicated by international bureaucrats is bizarre enough. But WHO's full agenda of social control is even more starkly evident in documents surrounding one of their biggest research projects of the 1990s. The project was done in collaboration with the Harvard School of Public Health. (WHO is almost never the sole element in any of its programs.) It was a study on the "Global Burden of Disease and Injury," an attempt to calculate out to the year 2020 what will be the major causes of ill health and death all over the world.

The document is essentially an extended *cri de coeur* to the world not to let WHO fade away, even as infectious diseases shrink in global significance. (Strangely, WHO has never been a leader in the fight against AIDS, the most-discussed infectious disease of the past 20 years; the group has been relegated to simply one bureaucratic partner, along with the World Bank, UNICEF, and others, in the umbrella program UNAIDS.)

As a result of its embattled position, WHO has a skewed vision of medical progress. Most observers see the shift in leading causes of death -- from communicable diseases such as smallpox and measles to noncommunicable ones such as heart disease and cancer -- as a sign of success. If everyone has to die, better that it should come from being too fat or too old. The shift from communicable to noncommunicable diseases as causes of death reflects general increases in wealth and lifespan. But for WHO, such progress is life-threatening to its own organization.

In the "Global Burden" summary document, WHO admits that its entire 10-volume edifice of quantification is built on a foundation of sand. It claims to be calculating what will end the most lives worldwide by 2020. Yet it admits, "In many countries, even the most basic data -- the number of deaths from particular causes each year -- are not available." Further, "estimates of numbers killed or affected by particular conditions or diseases may be exaggerated beyond their demographically plausible limits by well-intentioned epidemiologists who also find themselves acting as advocates for the affected populations in competition

for scarce resources. If the currently available epidemiological estimates for all conditions were right, some people in a given age group or region would have to die twice over to account for all the deaths that are claimed."

The study relied on a bit of numerical chicanery, originally developed by the World Bank: the "disability adjusted life year" (DALY). This is a complicated bit of scientism designed to quantify the effects of illnesses in terms of years of life lost. The DALY is based on the principle that a year living with certain conditions isn't really like a year of living. It allows WHO to make a big deal about "unipolar major depression," which it predicts will be the number two cause of "disease burden" by 2020, even though the ailment is not known to kill many people.

DALY is not objectively verifiable -- WHO came up with its numbers by asking a bunch of health workers how much they thought certain ailments reduced the value of a year of their life. So now science has demonstrated that below-the-knee amputation is somewhere from 0.22 to 0.36 "severity weights" more terrible than vitiligo (the "whitening" disease famously suffered by Michael Jackson) on your face. A small group of people's raw opinions were transformed through WHO's alchemy into hard public-health science.

It is only through the DALY that WHO can weigh mental illnesses as high on their global burden of disease as they do. Emphasizing such illnesses -- WHO claims that 16 percent of "years lost to disability" in sub-Saharan Africa are due to mental illness -- fits in well with the group's totalist agenda. After all, treating such illnesses often requires doing things to the "patient" against his will. At a point in history when its rationale is thankfully diminishing, WHO is maniacally reinventing itself as the agency that might solve every problem that hurts or disables anyone. (They emphasize traffic accidents and injuries in this report, though it is uncertain what a health authority can do to stop them.) The shoddy numbers and tendentious definitions -- smoking, drinking, and sex are all classified as "risk factors for disability or death," a rhetorical trick to disarm anyone who would defend someone's right to indulge in them -- enable an agenda of massive social control.

### **Let's See Action**

When reading WHO's reports, press releases, and other documents, one struggles to find non-abstract nouns and verbs representing actions a human being might need a body to perform. While infectious diseases are thankfully becoming a less significant cause of death globally, they do still kill at least 3 million children every year, so one might expect WHO's rhetoric to be dominated by talk of inoculation and cure. Instead, one overwhelmingly finds talk of forming coalitions to manage and monitor systems that lay the groundwork for plans to coordinate actions to develop the knowledge and skills necessary to begin the process of forming coalitions, repeat as necessary.

WHO's 2000 annual report was dedicated not to improving health, but to improving health systems -- a permanent task for bureaucracies. "Ultimate responsibility for the performance of a country's health system lies with government. The careful and responsible management of the well being of the population -- is the very essence of good government. The health of people is always a national priority: government responsibility for it is continuous and permanent," Director General Brundtland wrote in her introduction. This emphasis fits perfectly with WHO's love of the bureaucratic and managerial, as opposed to the medical and action-oriented. (Unsurprisingly, WHO ignores the findings of health economists that health care systems qua health care systems don't appear to account for more than a handful of the years of additional lifespan that human beings have gained on average in the past century.) Given the group's agenda, it's no shock that the portion of WHO's budget dedicated to communicable disease prevention, eradication, and control is set to fall by \$30 million over the next two fiscal years.

To WHO, health systems are more important than health outcomes. Its rhetoric sometimes acknowledges this, as in a WHO document that avers its activities are aimed to "strengthen the health sector at a country level." And the health of WHO's own system might be the most important thing of all. An analysis of WHO's 1994-95 budget, done by economists Richard Wagner and Robert Tollison, found that WHO

spending on meetings and its executive board equaled its spending on immunizations, tuberculosis, and diarrheal diseases combined. (A more recent analysis of spending on bureaucracy vs. programs would be harder to do, since WHO's official budget figures are now broken down only in terms of countries and disease clusters, not what the money is actually spent on. Given that, there's no way to know whether money is spent on, say, a conference dedicated to discussing a disease or actually going into the field to treat it.)

WHO's obsession with system over result can also be seen in the fact that, although the U.S. populace is in most respects healthier than that of Third World countries that try to centrally manage health care, WHO wants to eliminate fee-for-service medicine entirely.

If anything, WHO seems proud of the excessively bureaucratic nature of its work. It issues press releases celebrating its role as middleman between a pharmaceutical company donating needed drugs and the organization Doctors Without Borders, which actually goes into the field to administer them. WHO is an organization by and for bureaucrats and health ministers -- for whom it provides jobs, fellowships, and chances to go to conferences in exotic vacation spots -- not the world's sick. At its worst, it is an active proselytizer for aiming national and international health resources at things irrelevant to actually fighting disease. If the world wants a transnational organization funded from tax dollars to propagandize and nag us about our chosen behaviors, let them try to sell such a proposition openly.

WHO officials defend themselves against accusations of uselessness by stressing that healing the sick isn't really what they are all about. "We're a scientific agency," Dr. Anthony Piel, a former chief advisor to WHO's director general, told a British television reporter. Asked why they keep their headquarters in cushy, elegant, and quite healthy Geneva, Piel said, "We have looked into moving the WHO to other poorer countries -- where the cost would be lower. -- But the last time we studied that we considered, for example, Yugoslavia, we considered Lebanon, Jordan, Tanzania, and Rwanda. -- " WHO seems to have a hard time thinking of any cheap place closer to real health problems that isn't a war zone.

WHO's flaws and misdirected ideology, however sinister their potential implications, are more a matter of bureaucratic turf-building and feather-bedding than a fiendishly executed world control agenda. Faced with the reality that as a science and research organization they are more of a clearinghouse; that as an international researcher and advisor on health matters they often take second place to the World Bank (WHO's own reports are far more likely to cite substantive research done by the World Bank than any of its own original work, of which there is very little); and that in their First World-oriented agenda they are merely another bureaucratic layer echoing already existing national health ministries and the initiatives of other non-governmental organizations and international bureaucracies, WHO is scrambling frantically for its life. But it needn't worry too much. Bureaucracies, once created, almost never leave the stage, as their own will to live energizes them to a degree that surpasses their opponents' interest in eliminating them.

Nothing condemns WHO's current agenda more than some of its own pronouncements. In a 1999 press release, WHO declared that six illnesses accounted for 90 percent of all infectious disease deaths among people under 44 years: malaria, tuberculosis, measles, diarrheal diseases, acute respiratory infections (including pneumonia), and AIDS. The same press release declared that "the tools to prevent deaths from each of these six diseases now cost under \$20 per person at risk, and in most cases under \$0.35. Yet these diseases still caused over 11 million deaths in 1998."

Leaving aside the questionable belief that existing AIDS therapies, still mired in uncertainty, are reliable "tools to prevent death," we have WHO declaring that 11 million deaths -- 90 percent of all infectious disease deaths for people under 44 years -- could have been easily prevented with an expenditure of, at its lowest, \$3.9 million, and at its highest, \$220 million. That is, anywhere from 0.4 percent to 20 percent of WHO's budget for one year.

Wagner and Tollison's analysis of WHO's budget in the mid-'90s found the group's spending heavily weighted toward conferences and headquarters expenses and away from actual on-the-ground aid in

disease-fighting. They noted 70 percent of the budget then went to administrative overhead and the Geneva headquarters. In 1995, Tollison observed on British TV that "the World Health Organization is famous for its conferences, but I think that any ordinary person complying with a decision to spend on those conferences or to spend on senior executives in Geneva versus looking at real public health problems in the field, where little children are dying for want of a shot, I don't think anybody would make any other decision than to say, get the resources out of Geneva, quit having the conferences. Inoculate those children."

But as Paul Dietrich first began to realize over 15 years ago in the hot Mozambique sun, buckle-up billboards -- along with phantom studies on second-hand smoke and warnings about driving while talking on cell phones -- are higher priorities to the public-health mandarins in Geneva. In pursuit of perpetual bureaucratic life, WHO has changed its mission from eradicating disease to a lunatic bid for never-ending social control. In a strange way, in extending its own life, WHO has rendered itself moribund.

#### SO-CALLED REFORMS IN EDUCATION BY LAKHA COMMISSION (INCLUDES MEDICAL COLLEGES):

Even our medical colleges have not been free of Political unrest. The principals do not enjoy any authority. From admission to getting a lectureship, all fall under the purview of the provincial governments. Why does the "Reformers in the Govt" claim that fees for students will not rise to the point that they are prohibitive, not surprise anyone? Perhaps because we know that the Commission would find itself in a slightly awkward position if it acknowledged that very soon, the policy will eliminate all those 'unlucky' enough to be born rich. They will be relieved of the onerous job of going to classes and getting an education. Fees in some of the Lahore colleges where some version of BOGS has already been implemented now range from Rs. 32,000 to 40,000 per year, with the result that a student who topped her F.A. exams was unable to study at the prestigious Kinnaird College for Women (where fees currently stand at Rs. 38,000). It is not hard to see that this trend will and can only grow, depriving middle and lower middle class students of a decent education. Since most of the BOGS are composed of members of private corporations (some of which call themselves educational institutions), the members are lavishly paid with the salaries of some as high as Rs. 300,000 a month. Instead of the state supporting students, the students will end up supporting the BOGS.

The fact is that with the government clearly not having any intention of increasing spending on education, further fee rises are inevitable in spite of current government reassurances to the contrary. Mr. Lakha insists that parents must know the "true" cost of educating their children. In an interview to Herald, a monthly magazine, he said "we must inform them that even if their tuition fee is say Rs. 2000, the actual cost of education is around Rs. 80,000 and the state is paying as much as Rs. 78,000". How will parents be informed of these "true costs" if not by bearing them, is anybody's guess. The Model University ordinance has creatively spelt out all its activities in detail that will lead to privatization, without mentioning that word once. It must be commended on that. What is truly ironic is that the private universities themselves, upheld as examples would be unable to be what they are if it were not for government subsidies (access roads, electricity connections), international aid (CIDA, USAid) or simply the benevolence of their founders (e.g., the Agha Khan for AKU). And LUMS, AKU, GIK and IBA represent less than 1% of the total privatized educational institutes in Pakistan. The rest have no facilities, no open spaces, no libraries worth talking about, almost no permanent staff and produce lower quality graduates than the public institutions, while charging higher fees.

That the quality of Pakistan's public universities will go down with these reforms is a foregone conclusion. Pakistan is not the first country to undergo privatization of education. In other developing countries, privatization has already reduced access and declined quality (see for example, Martin Carnoy and Patrick McEwan's (both of Stanford University) study of Chile's educational reforms). With universities and colleges being encouraged to become 'sustainable', they often have no resort but to drastically cut the number and quality of teachers. Although an individual teacher may earn much more, the student/teacher ratio increases in each class and teachers are unable to do anything more than deliver carbon copy lectures all day. A case in point: Since being privatized, the English literature department at Government College

has laid off most senior staff to reduce costs. They now hire recently graduated girls, who are not paid more than around Rs. 5000, or retired professors who again are happy to work for a pittance. There is no continuation, no commitment to research, and no quality control since teachers change from term to term. Similarly, in hospitals junior doctors with little or no experience are in charge as higher grade and senior doctors have been forced to retire to reduce costs. The quality of both education and health are being jeopardized under the new system. How the Commission has promised to be able to pay the new salaries to doctors and teachers without making fees for students and patients prohibitive (remember the common man whose average income is Rs. 2000 supports a family of at least four) is beyond human calculation.

As part of these reforms, educational institutions have been forced to introduce self financed seats. The idea is that students who may not have made it on merit to the prestigious state universities can pay extra for the privilege to study and since they would pay so much they would value their education more. One can only imagine how competitive and inspiring one can expect one's fellow student to be given that 30-50% of them will have 'won' their seats in an auction. And expectedly, the 'self-finance' (a phrase which has a perverse, and no doubt deliberate resemblance to 'self-made') fee amount is now only the bare minimum that students seeking admission have to pay. The more they can "donate" above and beyond that, the better their chances of admission.

The fact is that the problems highlighted by the Lakha commission which is being taken as the basis for all these reforms, are not related to public spending vs. private but to the suffocating hierarchy that is present in all our institutions. The Model University Ordinance further consolidates that hierarchy by consolidating unprecedented power at the top, in addition to privatizing education. The key to useful change is not handing over government responsibility to BOGS but in fact diverting more state resources and responsibility to health and education. At a paltry less than 3% of GNP each it is a joke. There is no doubt that there are numerous problems within this system. However, the fact that these institutions are able to deliver any quality at all at these contribution levels from the government is a testament to the dedication of many within these institutions. In the final analysis, it would be naïve to consider only the Commission as the perpetrator of these reforms. These are a logical extension of the larger privatization agenda that is operative in the country, and driven by the IMF and World Bank. There is not just operational evidence like the meetings between the Higher Education Commission and World Bank officials reported in various newspapers, but also the imprint of the World Bank/IMF world view where so called "subsidies" to health and education are being trashed.

Subsidies to health and education are not just that, they are subsidies to the development and independence of a nation. We in Pakistan are well on our way towards the fate of country's like Zambia where the World Bank practiced its privatization policies in health and education with predictably disastrous results. As it is the government currently only supports approximately 30% of the education sector and roughly the same of the health sector. The rest has been privatized already. This 30% of the overall health and education facilities has to support around 60% of our population that lives on or below the poverty line and another 20-30% that is marginally above it. There are already privatized schools, colleges, universities, and hospitals that provide services to the upper middle class onwards. Thus 70% of the health and education facilities already cater to the less than 10% of Pakistan's population that constitutes the upper middle class and beyond. Privatizing the remaining facilities will not provide substantial gains to these upper classes but will mean absolute destitution for those below.

It is in this recognition of the role of IMF and World Bank, in this stance against the privatization of health and education and the imposition of corporate rule leading to further sharp divisions within the society, that the movement of these teachers, doctors and lawyers has taken on the role of a political movement. Widespread protests against these reforms are taking place in all major and smaller cities all over Pakistan. A Joint Action Committee representing teachers, doctors and lawyers has been set up that is leading these protests. While media reportage of this movement has been extensive in the vernacular press, English dailies have tended to accord it less space. It would be foolish to dismiss these protests as the protests of the inefficient in the system who are going to be thrown out by the reforms. A case in point is the leadership of the movement in Punjab, which includes Dr. Yasmin Rashid, a renowned gynecologist in Lahore, a professor at Fatima Jinnah and King Edward Medical colleges and who has made important research

contributions. She was the first person in the world to isolate the gene located in microcephaly. She has been performing in-utero transfusion for free for poor patients and this is a procedure that costs around E 10,000 at the Cromwell Hospital in London. She is also associated with Ganga Ram hospital where she and some other doctors have been arranging for all patients in her ward to receive free lunch for the last three years. She and others leading this movement have very little to gain from this rebellion but a lot to lose. As of November 26th, Dr. Yasmin Rashid, Prof. Nazim Hussain (chairman of the JAC) and five others in JAC leadership have been dismissed from their positions.

These reforms are being pushed through at such speed and with such fierce disregard for the opinion of the all stakeholders that most people have not even had the time to realize exactly what the reforms will mean for the Pakistani society. Of course, the government has not helped matters by not releasing any details to maintain a level of ambiguity about the reforms. At the same time, this very disregard for whatever concerns they have voiced is making the protestors angrier by the day. These reforms strike at the heart of whatever meagre gains the middle class and below had made in the last fifty years in Pakistan. There is increasing awareness among the protesting groups that it is not just any other reform to the system but one which will mean massive disenfranchisement and a complete catastrophe for the fragile remnants of a civic society that exist in Pakistan.

The movement has made some significant gains including the reversal of a denationalizing order that was due to be implemented in July 2002. During the first week of December 2002, President or General Musharaf, depending on how he wants to be known that day, stated that the Model University Ordinance will not be repealed even though they are open to making some changes. All of this is significant for a protest movement that is trying to make inroads in a highly depoliticized society, in a country where none of the major political parties has shown any commitment to their demands. More importantly, the movement has the tide of history with it to some extent. All over the world, people are rebelling against the New World Order that has been plundering their resources and taking away any gains that might have been made in the 60s.

The result that anyone can open up a medical college in any apartment or a house and run it. Recently, when the King Edward Medical College principal refused admission to a son of a notable, he was forced to resign. These are not isolated incidents; these are links in a chain of events that betray our incapacity to behave modern nations. There are some poor countries where the Health Care System is impeccable and free of cost. They have primary and emergency health services available and their health care system is based on the premise that prevention is better than cure, like the immunization of preventable diseases. There is nothing wrong with over three-tier system with a Basic Health Unit (BHU), a Rural Health Centre (RHC) at the Tehsil level, and then a tertiary-care hospital in the urban area, but the problem is that these units are not equipped. In the BHUs, there are no doctors or even compounders. An RHC should ideally have a physician, a gynecologist, a blood bank, transportation etc. but none of these basic facilities are there. If you see the 250 bed district hospitals in Thatta, you would be horrified. After partition West Pakistan only had one medical college, the King Edward medical college in Lahore. Later on the Nishtar medical college was set up in Multan. During the Ali Bhutto government a policy was adopted to increase the number of medical colleges, some of which were actually built while Bhutto was still in power and some were built by the subsequent regimes. As the plans of the Ali Bhutto government were subsequently taken up by those who did not believe in them, the whole of the public sector suffered from corruption and mismanagement. This was also consciously favoured by the government, as it played a role in undermining the ideas of nationalization and planned economy.

The standard of education in these colleges was maintained to some extent due to the hard work of the doctors, but they never really enjoyed government support. In order to maintain the high standards of medical training the Ali Bhutto government had improved and revitalized the Pakistan Medical and Dental Council (PMDC). During the subsequent decades it also became a token institution used merely to reward loyal people with well-paid jobs. Now the government has allowed the setting up of private medical colleges with the excuse of improving medical training as the public sector institutions are inefficient and corrupt.

## HEALTH PROFESSIONALS:

The health professionals have an inelastic response to wage rate increase in the urban health facilities. In other words, the professionals will be less enthusiastic in offering their services for employment in the urban health facilities let alone rural even if wages are increased. However, their response to such an increase for service in rural health facilities would be positive. The doctors and nurses in private medical facilities treat more out patients daily, and are paid on average less, than their counterparts in public sector medical facilities. This seems to indicate that public sector medical personnel are underutilized and that the govt. is less efficient in providing health care than the private sector. A majority of doctors and nurses in the private and public sector augment their earnings by doing part-time work in clinics in addition to their regular job. In fact, it appears that for most doctors the motivation for working in hospitals is to develop clientele for their private practise. The earning from part time work is not captured by the survey or by the statistics on the public health sector. It appears that the wages paid to doctors in hospitals is not considerably more than the wage rate of the unskilled or semiskilled worker. It is certainly not more than that of the average graduate who work in the corporate sector as a clerk.

One than has to ask why there is such a high supply of doctors in the market we produce more than our share of doctors. Unfortunately, the 70-80% of them goes abroad as the nation cannot offer them anything. The bright among the remaining Are often without financial aid, and prefer to stay only in the cities. That's another distorted truth. Even getting a job in a rural area requires getting through tiresome red tape. There is so much unemployment among doctors that they would readily take up a job anywhere. Anyone who say our doctors are unwilling to rough it out in the villages. Give them respectable pay, comfortable living quarters {like you give to BPS-17 Military and Civil Mandarins} and a reasonably equipped BHU, and such doctors are in thousands can be scored up who are jobless and are willing to go anywhere. After all, these are the same doctors who serve the uncultivated and completely uncouth Bedouins in the deserts of the Arab World, because they get proper facilities. In the absence of significant monetary incentives one fails to understand why individual spend a considerable amount of time and energy in medical college?

In other words, we need to know whether the labour market is operating rationally or not. Lack of cost effectiveness and inefficient allocation of resources combined with institutionally fixed wage rates makes the plight of the health system even more arduous in Pakistan where the allocation of public funds for this sector are already one of the lowest in the region as indicated earlier. There doesn't exist an unlimited inflow of doctors and, especially at the institutionally set low wage rates, many of these health professionals are reluctant to offer their services to the public health system.

Forget the remote areas, there are plenty of "Goths" and slums within an hour's drive time from Karachi alone with population in the range of two to three lakhs, and there is not single doctor in sight. Why can't the government post doctors and staff in such areas? The government does not have the resources. Our health and education budget together makes for one % of the total. While there is no denying that the govt. has periodically increased the Health Budget, has it benefited the poor? Then some 60% goes into the slot of salaries, and the remaining is siphoned off into the slots of pilferage and corruption. No doubt that the Private sector may be providing about 50% of all health care services in Urban areas, but in rural Pakistan, 70% of health services are still met by the govt. health provider.

The statistics show that there are 600 students per 520 beds per year when ideally there should be 15 beds per doctor per year. The obvious result is that there is absenteeism and people work in a disorganized manner. And while we have so many doctors, in direct proportion, we have an acute scarcity of nurses with one nurse for eight doctors as opposed to the ideal 15 nurses for on doctor. Our Paramedics and technicians are also in short supply. The mandarins in the power corridors do not have any idea about even the "H" of Health Policy. Our health policy is in a mess and is not addressing the real issues.

If we would keep formulating the Health Policy like the present one we won't be able to have health care for all even in the next fifty years. We need revolutionary changes, working at the grass roots. The policy makers are working in a world of their own, away from the ground realities. There have to be stringent measures for checks and balances in place, and the govt., if it aims at health for all, has to increase the health budget. We must also attach the hospitals in the periphery as well as those at the Taluka level to the

tertiary care hospitals so that the excess of doctors serving in the latter hospitals can bend to the former. We also need to invest in the nursing profession and give it the status it duly deserves. We need to have more quality training institutions for paramedics and technicians. And, lastly, the unpleasant elements need to be weeded out from the medical colleges. Only if the government's priority shifts from making atomic bombs, beefing up the army, buying submarines and F-16. In England, the budget for health and education from 22% and 26% respectively, and 18% on defense. It is easy to see what we are doing with whatever money we have. The main deficiencies have been identified as the ineffectiveness of the district health office to supervise health services in a district. DHOs generally lack in essential qualifications and management skills. A large number of male and female doctors and paramedics at the primary and secondary health facilities are vacant, as well as specialist positions in district and tehsil hospitals. Mega-hospitals are managed in an adhoc manner.

#### OF QUACKERY AND QUACKS:

It is common knowledge that more than half a million quacks are practicing across Pakistan. They pose a major health hazard to society and are responsible for jacking the mortality rate in the country. Over the past more than five decades, health ministers, health secretaries and DGs of health divisions have not had the time to take the stock of the havoc these quacks have wreaked on society. The extent of menace is such that it requires the immediate establishment of a task force to make real impact on the situation. In the city of Karachi alone, there are about 40,000 quacks. The irony is that even if caught, a quack, under the existing laws, is required to pay only Rs. 200 inj fine. This, practically speaking, is just a tool in the hands of the law-enforcers to make a quick buck at the cost of public health even human life in the so-called Islamic Republic of Pakistan.

The situation, needless to say, is quite in contrast to what happens in the developed world. In Edinburgh recently, a doctor was de-registered by Scotland's medical council for doing an operation despite the fact that he knew that he had Hepatitis B. In Pakistan, on the other hand, the PMDC has always been loath to punitive action against doctors indulging in malpractice, what to talk of quacks. Take, for instance, the case of the victims of psychological illnesses. Among the uneducated and the unsuspecting, the trend is to take patients to one quack or another who treat the problem as one of demonic possession, and subject the patient to often brutal exorcism at the hands of Pirs and other of the ilk.

Far too often, the cure is worse than the disease. In many such cases, somebody with a mild problem is pushed over the edge; in others, the incarceration with mental patients drives almost normal people into insanity. The situation is no different when it comes to physical problem. A WHO mission recently compiled a report stating that the main reason for the rising number of Hepatitis-C cases in Nowshehra (NWFP) is the presence of a large number of quack doctors. It was reported to WHO office in Islamabad that there was an outbreak of Hepatitis in Hotikhel Village of Nowshehra district. The Islamabad office had earlier sent a team to the area to ascertain the gravity of the situation and compile a report and later asked the Peshawar office to send a mission to the area and launch an awareness program.

The mission met 32 patients diagnosed as positive for Hepatitis by local physician; 21 of them had Hepatitis-C and the rest were infected with the B type. The main reason was found to be the practice by quacks who administer several injections to the patients with the same syringe. The main road of Hotikhel had a lot of drug shops run by unqualified people who give all types of treatment to the residents of the area. The world health agency now plans that in collaboration with the Department of Health and certain NGOs working in the area, it may embark on a program of health education for prevention of Hepatitis.

Contribution to the spread of Hepatitis-B and C is also made by quack dentists and barbers. The use of unsterilized instruments for tooth extraction and other dental procedures by the quack dentists, who operate their mobile clinics on the roadsides, should be taken note of by the authorities. Similarly the barbers share different people with the same razor and blades, and do not take proper precautionary measures.

While the quack dentists need to be removed from the roadsides, the barbers need to be trained through proper and intensive guidance and follow up checks not to play with the lives of their customers. It should be one's fervent hope that the govt. must undertake a campaign with all seriousness it deserves to eradicate the menace of quackery once and for all.

**PUBLIC HEALTH CARE DELIVERY (government & private sector):**

The most topical issues in the delivery of health care in the developing countries relate to the efficiency of public health care delivery systems and the role of the private sector. In Pakistan, the services in the health care system range from the preventive care programs operated by the govt. to the curative health facilities operated under both the public and the private sector (the latter ranging from the pure commercial operations provided by the specialists to the free facilities operated by public spirited trust and charities). In the public health services the growth of infrastructure has been much higher in rural areas. Private sector health facilities are largely urban based and curative. Private sector health care facilities cater to about a quarter of the patients treated in hospitals, but the conditions in the smaller hospitals are generally only marginally than in public hospitals.

The health care services require a number of improvements, the most important of which are related to management and institutional changes. A number of management problems originate with general regulations. For instance, the delegation of financial and personnel powers would require either special exemptions or changes in over all govt. regulations. A second area of concern is planning for health care services. Current practice doesn't use any form of analytical methods either for projections or the analysis of alternatives. Instead, decisions are based on opinion. The third area of concern is the remuneration structure. The quality of services provided by the private sector need also to be monitored and controlled.

Inefficiency in the delivery of public health care stems from the need for the govt. to react to demands rather than do what should be done. It has been argued, within the framework of public choice theory that the chief agents in govt. act to maximize individual utility rather than social welfare. Thus, politicians may be seen to maximize their own chances of staying in power, military and civil bureaucracy not only do that they also maximize their budgets and the individuals to use govt. to maximize their real income through exploiting the direct provision of services and transfers. The private sector health care facilities account for the bulk of the services offered, with private spending accounting for nearly 60% of all health expenditure. The services are largely urban based and curative, are used mainly by the richer segments of society and have a large variation in quality. This latter is the result of the heterogeneity in the sector, ranging from for-profit to non-profit institutions all sizes, and also due to weak regulation. Even though the private spending is large, financial, insurance and other pre-paid health care mechanism are underdeveloped. Although, public sector allocations to health care are exposed to grow, it is expected that these will be at a much lower rate than the growth in demand, thus there is a need for a greater participation by the private sector. It is therefore critical to improve private sector health care so that it is able to meet needs more equitably.

**A Comparison of govt. and private medical facilities:**

	WageRate of Doctors	Wage Rate of Nurses	Recurring Exp Per Bed	Number of Out Patient Per Doctor Per Day	Number of Out Patient Per Nurse Per Day
Private Hospitals	5,100	1,550	12,700	23.7	25.6
Non-Profit	3,800	-	11,600	25.5	20.8

## Hospitals

Government Hospitals	5,372	1,969	22,000	3.7	5.36
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### PRIVATE SECTOR:

Although it was the public healthcare system that was providing the greatest relief for the poor (if there is at all), it was precisely this sector that each successive government has tried to undermine. Especially under general Zia, the public sector entered a period of decay, when ghost units were being built to siphon funds away from the state to private contractors. Thus the private sector became increasingly active. His government systematically destroyed the public sector, especially in healthcare. This was a deliberate policy. A dilapidated public healthcare system prepared the ground for introducing private healthcare. The idea was that instead of protesting, the public would thank him. Thus we had the emergence of rampant corruption in the public sector, which contributed to a worsening of the service provided. In the meantime a vibrant private healthcare sector flourished like mushrooms. Now a parallel healthcare system exists in Pakistan. It is efficient and equal in standard to anything in the west but as it is run on purely business lines it has no ethical values. It is totally unaffordable for the general public and has become one of the most successful businesses in Pakistan. The policies of all successive governments have been to destroy the public healthcare system and favour the private sector.

Health is a fundamental right and this has been well documented in Alma Ata Declaration of 12<sup>th</sup> December 1978 and Pakistan is a signatory to it with conviction that health for all by year 2000 is the solemn responsibility of the government. How we take care of our nation's health is evident from the fact that Seven five year plans and over a dozen recommendations of Health Ministry are rotting on the shelves of Health Ministry better to be disposed to "Garbage Dealer" as they are redundant and obsolete. Ad-hocism is in practice and remained so throughout. At present government is hardly for name sake, offers approx 17 to 25% of the succor to its suffering humanity through its public sectors. Over 80% of the needs of the community mainly in urban areas is undoubtedly provided by private sector. The private hospitals and clinic through their loud voice, resources and rapport and in conspiracy with the bureaucrats have got themselves declared as representing private sector in health care system. Orientated to money incentives far less to service and solace and practically out of bound to all sufferers except the rich and influential in big cities only, they are prosperous and thriving as health providers. Majority of them are an apology to the noble name of hospital and are really "sick places". But there are some honorable exceptions as well. They are needed as a necessity of life and will flourish because it is human instinct to live, preserve life and desire for freedom from pain and fear of death.

The process of building a partnership between the public and private sector is rendered difficult by the general climate of mistrust that prevails between the two parties. On the one hand, the govt. sees the private sector as being motivated primarily by profit maximization considerations, fundamentally in conflict with the objective of increasing the outreach of health services to essentially poor unserved populations at lowcost. On the other hand, the private sector sees the government as being restricted by bureaucratic red-tape, which tends to slow down decisions and retard innovation. Perhaps, even more importantly, government functionaries are seen as being notoriously prone to corruption in their dealings with the private sector. There are number of promising areas for public-private partnerships in the health sector of Pakistan. One such model would involve the leasing out of a government hospital at the district / tehsil level to the private sector, with the proviso that investment would be made to upgrade the facility, strengthen the medical staff and collect reasonable user charges.

### PRIVATE-PUBLIC SECTOR PARTNERSHIP:

The govt. should consider innovative mechanism of inducting the private sector and the local govt. into expanding their role. For the latter, however, the question of resource generation is of paramount importance. There two ways in which this can be achieved. The first is by increasing yield from existing

sources through improvements in tax administration. The second is by broadening the tax base. Since, higher levels of govt. already take away [Defense Budget] the more buoyant and elastic sources which may be tapped, provincial and local govts are left with a very narrow tax base. This, in most instances is the levy of a special; surcharge for health, such as contributions by employers in the urban areas to social security. A similar charge should also be levied in the rural areas, where the land owning families should be made to pay for the welfare of their employees. This would to a large extent introduce some equity to the financing of health services. This however needs to be examined in depth.

The private sector is making considerable inroads into the delivery of health services to households in the lower end of the income range; govt. should encourage this in a number of ways. The first could be a Tax Holiday for investment in new facilities or by providing access to land at full market rates coupled to a loan for construction and purchase of equipment at a subsidized lending rate. This should however be restricted to only registered NGOs, Trusts and Foundation with a sound record of public service and a track record of operating at least four or more health facilities. The second could be by broadening the scope of support through the health foundations. The third could be by encouraging the private sector into taking over the existing public health care facilities, while retaining title, thus relieving the govt. of a considerable recurring expenditure liability which would be used more productively in improving primary health care.

This should be the prime responsibility of govt. Thus there could be a clear demarcation of responsibilities, the public sector responsible for primary health care and the private sector responsible for curative health care. Thus this could be a policy of withdrawal from the latter stages of health care leaving this entirely in the hands of the private sector. This could however be supplemented by a system of grants for the poorer segments of society.

#### PRIVATIZATION OF HEALTH / MULTINATIONALS:

To get greater control over the future of the students, the government thought up of a stunt. They created the University of Health Sciences and all the medical colleges in the Punjab were asked to affiliate to it. Interestingly the elite colleges such as the King Edward and the Fatima Jinnah medical colleges were exempted from doing so. This "university" is not recognized internationally and it can destroy the careers of medical students whose degrees will not be accepted abroad. The sole purpose of this operation was to centralize the results and examination system so that if any students were to rebel against privatization they could easily be victimized directly from the central "parent school" in Lahore.

The inadequate private medical colleges that do not fulfill the requirements of other universities could easily get recognition through this dummy "university" which actually lacks any facilities of its own! Part of the government's maneuvering has also involved an attempt to increase ethnic tension between the southern and northern Punjab so as to divert the attention of the people away from these problems and thus confuse them and stop them from adopting any progressive thinking.

The general Zia regime and all subsequent regimes have attempted to stifle any kind of political activity in the colleges. It was in fact totally banned. Student unions are still banned to this day and after the experiences of the past the people, and especially the students had developed apathy and hatred towards "politics". But when the government started to actually implement the above-mentioned steps, such as the increase in fees and the setting up of the "University of Health Sciences", the student spontaneously protested. Student strikes took place in some colleges for the first time in twenty years!

It has to be said that initially the students clearly lacked any political motivation. Years of political inactivity and repression had imbued them with not such a progressive. But this was now about to change. This protest was the first step towards breaking the code of silence and fear. Students are now clearly moving towards some form of political orientation. This movement is in its early stages and reveals all the weaknesses of lack of experience and leadership. Sometimes the students even use reactionary and passive forms of resistance to try and win some concessions. But as they do not understand the real motives that lie behind these measures and do not apply the correct tactics they fail.

However all experiences teach, and as time passes the movement will clearly take a progressive turn. We have carried out some political work among the students and have achieved some great results. This shows that this movement could be the first step towards a more general politicisation of Pakistani workers and youth. The students have learnt one thing: for the first time they have seen how important resistance is. Although minor, they were able to win some concessions by standing up to the authorities. Soon they will understand the limits of their methods adopted so far and will move to the left. We are constantly working toward this goal!!!

Gen. Musharraf's regime virtually became an ordinance passing factory last year, trying to force through as many laws as possible before the current period of quasi-democracy started in October 2002. Pressure by the International Financial Institutions (IFIs) was often the primary motivation behind these laws, with the Punjab Health Ordinance being no exception.

The Punjab Health Ordinance was passed in great hurry in January 2002 and has led to the formulation of Boards of Governors (BoG) in teaching hospitals in the whole province. Similar ordinances were proposed in all four provinces in Pakistan but the Sind and Baluchistan governments refused to impose them. Given the fundamental changes promised by the Punjab Health Ordinance, the absence of any consultative process in its making has disturbed large sections of the society. Now that some of its implications are being felt on an everyday basis, it has become a key mobilizing issue for the anti-globalization movement.

Ostensibly the ordinance is a response to the demands by medical colleges and doctors for greater autonomy. As will soon become clear, however, the ordinance in fact reinforces and expands the hold of the local and international private interests and government bureaucracy on the health care sector in Pakistan. It is pertinent to note that increasing the hold of both government and private interest are not contradictory in the Pakistani context, since the government is in essence only a facilitating body for large private interests. The preamble of the ordinance states the following objectives for passing this ordinance, "... to provide quality and affordable health care with special dispensation for the poor and vulnerable sections of the society and for enhancing the quality of education in Health Sciences". Let us take the issue of affordability first. The immediate effect of the implementation of the BoG in Punjab teaching hospitals has been the levying of user charges for various investigations e.g. x-rays, blood tests. Tests that used to be free now cost on average Rs.50-60 (approximately \$1) each. Registration fees have similarly risen from Rs.2 to Rs.10-20.

Perhaps these charges represent some perverse incentive for people to remain healthy. However, such illusions are soon put to rest when one considers the costs of normal medical procedures such as giving birth. A quick round of the Ganga Ram Hospital maternity ward showed that patients had spent around Rs.2000-2500 (approximately \$42) for a normal delivery and approximately Rs.5000 (approximately \$84) for a cesarean. This for giving birth, which is not a disease and does not normally require prolonged hospital stay or complex procedures. Ganga Ram Hospital has also imposed Rs.100 charge for the birth certificate without which the mother will not be discharged. Infant and maternal mortality is bound to increase as more people avoid seeking professional medical care for deliveries. These charges must be put in context. Until the 1980s hospitals provided medication, meals, clinical care, beds and clothing for patients. In fact, at some hospitals poor patients also received fare to go back to their homes. Now, a patient entering any hospital in Pakistan, private or public, has to provide his/her own medication, food etc. Medication of course is the most expensive part. It is useful to remember that it was during the regime of General Zia in the 1980s that the Pakistani policy making came under increasingly influence of the IFIs.

After the changes in the 80s, the only service that the government provided for free to the patients until Jan 2002 was the consultation of the doctors and the investigative procedures for indoor patients in government hospitals. Within six months of the implementation of BoG in these hospitals, investigative procedures now bear a "user fee". However, nominal this charge may seem in dollar amounts, to the 60% of Pakistani population that is struggling to eat two decent meals a day, along with the charges for medicines, this is tantamount to a complete denial of health care accessibility. The supporters of the new policy argue that free health facilities are also used by many who can afford to pay, and this puts a strain on the public exchequer. This argument does not hold much water either. First, due to meager funding and inept

planning, standards of government hospitals have deteriorated to such an extent that anybody who can barely afford private care, already avoids going to public hospitals. This is despite the fact that the quality of doctors and support staff in lower tier private hospitals is often worse than the government teaching hospitals.

Similarly, while it is true that there is an expense attached to providing medication and consultation to the public free of user charges, we should realize that it becomes a strain as a result of distorted priorities. Approximately 38% of Pakistan's 2002 tax revenue is spent on defense, and another 51% on interest payments. Is it too much to ask for a 2% increase in healthcare spending which stands at a measly 2.8%? Unlike the spending on defense and interest payment for debts that the people of Pakistan had no role in borrowing, the spending on health has direct a contribution towards the development of the society. Public health care is not a matter of charity or benevolence but of building and maintaining the working capability of the people in an organization or a country. Effective management of human resources for productive uses requires that some basic needs are taken care of and people don't have to waste energy and time trying to organize them individually. This is why the Pakistani army, for instance, has a well-developed hospital and school infrastructure. Similarly, the developed nations especially in Western Europe, where the level of productivity is very high have realized this. Without a good public healthcare system Pakistan's industrialization will suffer.

A healthy, vibrant society cannot comprise of beggars. The government claims that deserving patients will get Zakat, the compulsory contribution to charity under Islamic law. First, the amount of Zakat funding for health care is limited. Second, the procedures involved to prove one's destitution force people to act like beggars. By actively encouraging charity and forcing more and more people to become dependent on it, the government is producing a nation where people have to sacrifice self-esteem on a daily basis. Even worse, it might be argued that in a way the privatization of health and education produces an incentive system that engenders corruption in a society. If your child is ill and you have to pay Rs.5000 (\$84) for her medication, or if the only chance she has of getting a decent education is for you to pay Rs.2000 (\$34) a month in fees, then how else do you make your Rs.2200/month salary (based on the official figures for per capita income; approx. \$36) stretch to cover these? The increased "burden" on the exchequer of providing user charge free health care is more than offset by the increased productivity and efficiency of a nation.

The ordinance also proclaims that 'quality' healthcare will be provided to the masses. This can hardly be possible when all the doctors and nurses, critical to providing it are enormously frustrated with the changes the ordinance is bringing. Their frustration is understandable. On the one hand the formation of BoGs denies completely the achievement of years of hard work by doctors in setting up a service structure for themselves, and on the other the alternative offered is in complete negation of their aspirations and ground realities. Doctors agitated for years to be made part of a government service structure that provides some security of a defined process of promotions and pay scales etc. As the pay offered in public sector is low, the only reason many doctors chose to stay on is because they can see some career path for themselves.

By the authority vested in the BoGs, they can hire or fire as they wish which is a complete negation of the terms of employment stipulated in the service structure for doctors. More importantly, there have been no public service commission exams in Punjab since 1995 and hence all the new doctors working in the public sector are effectively working on contractual basis. The ordinance does not clarify their position at all and the experience of BoGs so far has shown their preference for keeping doctors in this destabilized and dependant position. The new ordinance further demoralizes doctors by giving the Boards authority to fire without stating cause. The termination of Dr. Mehmood Ali Malik as the chairman of BoG for Ganga Ram Hospital is a case in point. Dr. Malik, a former Professor and Principal of the prestigious Kind Edward Medical College, and one of Pakistan's most renowned physicians, was appointed chairman of the BoG for Ganga Ram Hospital. In his now famous address, during which the governor of Punjab and Health Secretary were also present, he dared to criticize the faulty formation of the BoGs and their implications for patient welfare and quality of health care and health education. He was promptly removed from his post and to this day has not received any official notification detailing reasons for his removal. Doctors are being told that their pay will rise ultimately and there will be no need for them to have a private practice. In fact, the ordinance is being promoted as a step that will rid Pakistani society of the menace of private

practice. Of course this touches a responsive chord within the public who pay heavy private consultation fees. However, in actual practice the ordinance compounds the problem of privatization of health care rather than solving it.

While pay raises for new doctors have been announced in some hospitals they have not yet materialized. In the spirit of market-oriented policies, we are told that the top tier of the hospital management must be paid corporate rates to attract talent. If we try to calculate the cost of the top four executives, the Principal Executive Officer (PEO), Deputy Dean, Medical Superintendent (MS) and Finance Director we see that just covering that cost is beyond the means of these hospitals and drains their resources to the extent that no other investment is possible. Average PEO pay and perks include around Rs.2, 50,000 pay+car+residence+share in hospital income in some cases. That amounts to around Rs.400, 000 to 500,000/month (\$8,333). The Deputy Dean costs around Rs.200, 000, (\$3,333) Medical superintendent around Rs.100, 000 (\$1,667) and Finance Director around Rs.50, 000 (\$833). All in all, just these four posts cost around Rs.8-900,000 (\$15,000) per month. Before the introduction of this pay scale for the top four, teaching hospitals spent around 80% of their budget on establishment i.e. salaries, building maintenance etc. and 20% on the day to day care of patients. With pays like these just for the top four posts we can rest assured that more than 100% of the hospital budget will be spent on establishment.

In hospitals where various service charges have been levied already, the big question being asked is, where is this money and why have we not seen an improvement in facilities for patients? Why are doctors in these hospitals still forced to get basic medical supplies like syringes for the destitute through their private contributions out of their meager paychecks, let alone a pay raise? Hence, to expect these doctors to stay and work in Pakistan should they get the slightest chance to work anywhere else in the world is unrealistic. This means the most well trained doctors in our hospitals today are ready to leave. These are the people who could have taught the next generation, in addition to providing experienced care to the patients. Obviously this does not bode well for the quality of health care or health education, in the short or long term. Effectively the three objectives highlighted in the preamble of the ordinance are nothing but fantasy. The cost of care to patients has actually gone up, quality of healthcare and health education is bound to suffer as experienced doctors leave the public sector and new doctors have no incentive to remain in Pakistan. Experience in other countries and other sectors has shown that the stage is being set for a rapid deterioration in the standards of these hospitals to the level that privatization may seem like the only option. In fact, the ordinance states that the BoG "may pass on any functions of hospitals to any person or persons it deems fit". This is a clear indication of the real intent, which is privatization.

It would be naïve to assume that this ordinance is a well meaning but misguided attempt at reforming the health care sector in Pakistan. There has been considerable criticism of the ordinance focusing on implementation issues and perhaps not so much on the spirit of it. The implementation oriented criticism has focused on issues like the way the BoGs have been hand picked by the government, and the way rules laid down in the ordinance regarding selection of PEOs/members of board have been ignored to select either the most pliable doctors or the most influential industrialists.

In the final analysis, these details should be looked at against the backdrop of the wider picture. The fact of the matter is that government of Pakistan, like many other developing countries, is under pressure to declare to the WTO in March 2003, whether its health and education sectors are open to foreign investment or not. The haste with which both the Health Ordinance and the Model University Act (see Znet article: Anti-Globalization Protests in Pakistan by Iqtidar) have been passed, the connivance of World Bank in forming these policies and the imprint of International Financial Institution's free market ideology on these so called reforms, points only to the fact that the health and education sectors are being prepared for further privatization. Thus while claiming to stamp out private practices; the government is actually paving the way for making the whole health sector private. The 'solutions' imposed by the 'saviors' of Pakistan's economy, the IFIs, are bound to create more divisions in the society, deprive Pakistan of its talent pool and make one of the key sectors in the country subservient to foreign investment interest. The doctors agitating against the BoGs are gaining public support and appreciation for taking a principled stand. The historic coalition between doctors, teachers and lawyers currently agitating all over Pakistan is a unique

development. The middle and lower middle classes have come together in Pakistan to resist the snatching away of the meager gains that they were able to make in the 60s and 70s.

While many in this movement may not think of themselves as part of the larger anti-globalization movement, the leadership is increasingly making this link clear. There is a clear understanding of the role that the IFIs have played in the deterioration of public services in Pakistan. This understanding forms the basis of a resistance movement that goes beyond the limited scope of the party politics currently practiced in Pakistan. Echoes of the world wide discontent with globalization are currently being heard in Pakistan. A widespread movement sparked by the so-called reforms that the government of Pakistan has introduced in the health and education sectors ostensibly to improve the quality of both sectors, is increasing in momentum, and disrupting governmental plans to quietly privatize both. Very simply, and without any reference to the 'p' word (privatization), the government has decreed the setting up of a board of governors (BOG) in each hospital and educational institution (universities, colleges and schools) that would comprise of approximately 20 members drawn predominantly from the private sector. This BOG would have complete control over sale and management of all assets including property, hiring, firing and salaries of all staff, setting of fees for students and patients, in addition to any other acts that the BOG may feel is suitable for its purvey. There is no recourse to appeal to the decisions of the BOG. Each BOG would be headed by a chairperson who would have CEO type authority in making these decisions and implementing them.

In the case of education, a Model University Ordinance has been promulgated that encapsulates reforms suggested by a Commission that was headed by Mr. Lakha, the chairman of the private Agha Khan University. The commission which has now been given a permanent position as the Higher Education Commission, vigorously denies that the reforms will lead to privatization and points to the fact that this word is not mentioned once in its report. It is claimed that BOGS will make the system more efficient. This is undeniable. BOGS will certainly be an efficient instrument to enforce the draconian reforms while perpetuating the power of those behind them. That it will completely kill the 'effectiveness' or the raison d'être of the education system is of course besides the point. Efficiency and profits are the holy grail of the new world order and BOGS will probably do its job admirably in order to increase both for the private sector. BOGS' efficiency will be guaranteed since it won't be responsible to anybody in the ultimate analysis and there have been no guidelines set to evaluate the performance of BOGS.

Old government schools, universities, colleges and hospitals occupy acres of prime property. The Punjab University, for instance, has approximately 2800 acres of prime property. Some in the education bureaucracy who have publicly supported the ordinance are no doubt looking forward to having access to these resources to generate funds for the institutions i.e. themselves as members of the BOGs. Nothing in the history of various boards in Pakistan and the careers of these people leads us to believe anything other than this is possible. Indeed, according to Prof. Nazim Hussein, Chairperson of the Joint Action Committee leading the protests, one of the old government schools in Raja Bazaar in Rawalpindi recently placed under this system has now been 'efficiently' replaced by shops that were allegedly sold for Rs. 1 crore each. Although the school is no longer, the BOG for that school still stands and of course the members need their pay. While media reports focus on numerous countries grappling with the outbreak of SARS, it by no means represents the principal threat for healthcare in the third world. For all its menace, SARS pales in comparison with the much more dangerous threat that is posed by the increasing subjugation of our healthcare systems to the greed of the international pharmaceutical and health management industry.

The rapid privatisation of healthcare being undertaken by IMF's clients is threatening to leave large numbers of people around the world vulnerable to various diseases as proper health care moves out of their reach. Medical journals boast of unprecedented advances in scientific knowledge of the human body, but millions of people around the world are dying of entirely treatable ailments such as tuberculosis and malaria. While the world's attention was focused on Iraq and the discrediting of one international body, namely the UN, the wilful undermining of another international body by the US has gone all but unremarked. The WTO has, in the current unilateralist view of the Bush administration, outlived its usefulness, and the pharmaceutical industry's lobby provided the impetus to make this break.

Admittedly, both the UN and the WTO are largely tools of US policy. They serve the useful purpose of legitimising decisions made in corporate headquarters in New York or in Washington as the will of all the countries involved. However, by the very fact of having a membership wider than the World's Sole Superpower, both the UN and the WTO are sometimes forced to reflect the tide of world opinion that is rising against wars and unfettered corporate globalisation respectively. This is the sin for which they have been sidelined by the impatient Bush administration. In the case of the WTO, pressure building up since Seattle 1998, had forced the WTO to ratify an agreement in Doha 2001 whereby poor countries could import generic drugs if there was a major public health concern like AIDS in Africa. There are 29.4m mostly very poor people currently afflicted with AIDS in sub-Saharan Africa. Many lives can be saved if they have recourse to generic drugs that are often a hundred times cheaper than what the big pharmaceutical companies charge.

After initially agreeing to the Doha Declaration, which was the result of desperate pleas from afflicted countries as well as sustained activism by grass roots organizations, the US decided to unilaterally withdraw from it in Feb, 2003. The \$60 million donated by the pharmaceutical industry to Republican electoral victory has not been in vain. The influence of corporate interests in the White House is immense. Pfizer, the US based largest pharmaceutical company in the world, was one of the companies lobbying energetically against concessions over Doha. The VP Corporate Affairs for Pfizer, who used to work in the office of the US Trade Representative, declared that Pfizer is "comfortable with the position that the US government has taken..." What is at stake here? The pharmaceutical industry is one of the most profitable in the world, with profit margins at 18.5%. Pfizer, for instance, is not just the leader of the pharmaceutical industry, but one of the biggest companies in the world. With a stock market value of \$180bn, Pfizer ranks fifth among the world's biggest companies.

The pharmaceutical industry owes its wealth to extremely high barriers to entry, including high expenditures and the patent system. Ostensibly patents are granted to pharmaceutical companies to allow them to recoup the resources invested into R&D. For decades, pharmaceutical companies have justified the exorbitant prices of drugs by citing the tremendous resources that are required to finance their development. However, it has been established over several years now that their R&D figures are bloated, and that they spend more on marketing than on R&D. Analysis of the industry's tax information shows that in 2002 Merck used 13% of its profits on marketing and only 5% on R&D, Pfizer spent 35% on marketing and only 15% on R&D, and the industry overall spent 27% on marketing and 11% on R&D.

In fact, during the 80s-90s management fad of focusing on core competencies, many pharmaceutical companies identified marketing and branding as their core competence rather than R&D or manufacturing. They were happy to outsource some R&D to subcontractors. In addition, R&D is often subsidized by research done in universities or through government grants to the industry, which the industry includes in the total cost. For instance, the group Medicines Sans Frontiere (Doctors without Borders), an organization of volunteer doctors who work in the poorest countries, has suggested that while the pharmaceutical industry claims that it costs \$800 m to develop a new drug, research by the Global TB Alliance, puts it at around a maximum of \$240m and average of \$40m.

Thus, when consumers around the world, but especially in developing countries like Pakistan pay the exorbitant prices for patent protected medicine they are paying largely for the marketing that the pharmaceutical companies have done to promote those brands rather than for the research. This falsifies the fundamental justification for patent protection. The Doha round allowed some, not all, poor countries to bypass paying for patent protection. Looking at it from the pharmaceutical company perspective one realizes that there is a real danger in this. In the short term this would have saved a few million lives in the third world. But in the long term it could have strengthened the demand for generic medicines and changes to patent protection, the source of these corporate giants' wealth. The maths just did not add up for the pharmaceutical companies and so they pulled the plug on the Doha agreement. The move by this industry to protect their 18.5% profit margins, at the cost of millions of lives in the developing world is made only more grotesque when one looks at what the top executives are paid for formulating such policies. GlaxoSmithKline, the second largest company in the world after Pfizer, is proposing to pay its CEO £22million in severance pay. He was the highest paid executive in Britain in 2002.

In order to deflect some criticism, in highly publicized moves, the pharmaceutical companies have recently donated some medicines to a few countries. Such moves do not make any difference whatsoever to the systematic manner in which big pharmaceutical companies turn misery into dollars. According to Medecins sans Frontieres. "We're talking about systematic long-term medicines provision for about 90% of the world's population. You can't possibly deal with that on a donations basis. It is not realistic. The solutions need to be found in the trade area." And it is in the trade arena, the only arena with long-term implications, that these companies resist any changes that would allow greater access to the third world. These mega pharmaceutical companies are aided in their project by other stalwarts of international healthcare who are eager to make similar profits at the expense of desperate patients. As the manufacturing sector's potential for growth diminishes, it is in the service sectors, like health and education, around the globe that international capital is looking for openings.

A first step towards complete privatization has been taken in Britain for instance, in the form of Public Finance Initiatives (PFI), which legitimize the investment of private capital into the public sector. Although these initiatives have largely failed, the British government is strangely persisting against popular opinion. In 2002, George Monbiot, a British journalist, pointed out that this seemingly irrational behaviour might be because PFIs are fast becoming a big export market for UK. They need to be kept alive in some form in UK in order to be sold overseas. He documents how since 1996, the British government has been sending delegations to convince the South African government that the private finance initiative was "maximizing efficiency" in hospitals etc. One of the key selling features to other countries is the fact that "the full spectrum of techniques" has been "tried and tested in the UK". Soon after coming into office Tony Blair's government sent the biggest UK health care trade mission ever to South Africa to clinch the deal. In 2000 South Africa signed the first contract for PFI hospital schemes. Of course, companies that had "tried and tested" the model in Britain gained lucrative contracts.

And while it continues to support privatization of health care in developing countries, the UK government, under pressure due to the failures of PFIs at home, continues to explore other options. In 2000 the UK government dispatched a team to study the health care sector in Cuba. Cuba has a social welfare system where health care is free to all and the overall quality of its system is among the best in the world. It is extremely cost effective and patient centric, precisely the results the UK NHS is looking for. Healthcare costs £750 a head annually in UK compared to £7 in Cuba. There is one family doctor per 500-700 people in Cuba, compared to one for 1,800-2,000 in UK. The much smaller Cuba has 21 medical schools, whereas Britain has 12.

Mainstream corporate media will not let us compare the relative merits or demerits of the Cuban health care system, while presenting privatization as the solution for problems that have more to do with adequate funding by the government than the inherent weakness of a public welfare system. As we in Pakistan, allocate a meager 2.8% of our budget to health sector while a whopping 40% goes to defense we need to re-assess these priorities. The government imposed Boards of Governors in teaching hospitals in Punjab, which marked the beginning of widespread and continuing agitation. The BOGs have huge discretionary powers especially relating to hiring/firing of staff and doctors, sale of all property and assets, and significantly the hiring of any other body to perform any of the functions of a BOG. The protestors claim that these BOGs are the first step in the privatization of public hospitals brought upon by the WTO deadline to Pakistan and other countries to declare whether our health care sector is available for international investment. In response to these protests the Punjab government set up a commission under Justice Mujadid Mirza, which submitted its report to Punjab Chief Minister Chaudhry Pervaiz Elahi on Jan 31. It is widely believed that the commission recommended abolition of BOGs. The Punjab government has predictably repressed the publication of this report so far. If the formulation of BOGs in teaching hospitals in Pakistan is not motivated by international and local pressures to open up the health sector to private investment, the government has nothing to lose by publishing the commission report. If it believes that there is a viable case for privatisation of hospitals, it should open the field for discussion on that issue.

PHARMACEUTICAL COMPANIES:

The age of the modern medicines begin with aspirin in 1899 and thereafter it was, the pharmaceuticals industry that ruled the roost before the entry of pharmaceutical the doctor himself was the most important therapeutic agent. Billions of dollars are poured each year by the pharmaceutical bosses in research and development to enhance the cure as well as profit. Now the medicines are more plentiful, more powerful and more dangerous; packaged beautifully, coming in fancy colors like candies. People must swallow, chew and gulp down capsules of one kind or the other, every day- a status symbol of upper class culture.

In 1962, when the FDA of the USA began to examine the 4300 prescription drugs that had appeared since the WW-2, the only two out of five were found effective. Many of the new drugs are dangerous among those that met FDA standards, a few were demonstrably better than those they were meant to replace after incurring a huge amount on research. This state of affairs remains unchanged since then. Pakistan's drug scene is intrinsically no different, except that the size of the market, as the industry man lament, is small and expanding fast. However, the facts are different. In 1988, it was Rs. 10,000 Million. The pharmaceutical market is dominated by the multinationals accounting for about 67% share. Their net scales of 1225 products in 1990 stood at Rs. 7687 million. The local is not faring well in the face of the highly competitive, advanced, and powerful foreign pharmaceutical companies which enjoy great edge. These are about 30-40 multinationals and nearly 200 nationals, but some 40 of them being of some significance, engaged in the manufacturing operations which are mostly of processing and packaging character. A fact not accepted by them.

Despite of the fact that the Ministry of Health carry out the same old vigilance and try in vain to implement rules of the various stages of production, import and distribution of pharmaceutical products in addition to regulation of prices. Yet there exist no ethics and system. An atmosphere of anarchy features the market of medicines, and even the functioning of state-run hospitals because the Ministry officials, excluding a few are corrupt, act like parasites and demand bribes as a matter of right. Even the core issue of drug prices which every government in Islamabad whether Military or Political always pledge to keep in check but it didn't happen and people were denied the affordable prices of drugs. The Price Control on Drugs is severely resented by the Multinational (read pharmaceuticals) as they consider it a major deterrent to their plans of investment and expansion. They want complete freedom of decision-making in fixing prices of their products and often threaten to pack up and leave this country if it is not conceded to. They contend that their prices in Pakistan are the lowest- a claim that remains controversial. The Pharma companies say that they are willing to lower the prices as desired by the govt., provided the govt. must stop treating their industry as a "Luxury Industry" and leading it with all kind of taxes and regulations. The local companies have a bonafide grievance against the multinationals; they want the over the counter drugs like Vitamins, cough mixtures, lotions, analgesic and other common medicines like paracetamol and aspirin, which happen to be their bread and butter should be left to them as is a practice in several developing countries and that MNCs should play big brother's role in marketing more important, newly discovered medicines. But the plea has fallen of deaf ears.

The MNCs are, in fact, seriously interested in any, small or big, medicines which brings sizable profits. Their love for profits-though not immoral, not ignoble under the gospel of market capitalism which is inspired by them-is so ingrained that some of them do not mind even spices and dates. Another concern over the indifference of these pharmaceuticals to the local research and production of basic drugs. The multi-nationals are required to spend 1% of their profits annually on medical research and development of medicines from local raw materials, but they have contributed nothing since long, at least since 1979. This is a legal requirement. Under an agreement between the government and the MNCs, the latter undertook to make the contribution and in return were given certain facilities. One major facility they are blessed with is the adjustment of "transfer pricing" under which they charge exorbitant prices for the raw materials they import from parent office. The difference between their price and the international market price is sometimes hundred times higher in their favour. So, before marketing a certain drug-a much higher, lucrative profit is already exacted and transferred to the parent office. This causes a heavy burden on the exchequer for the amount paid is in foreign exchange. But since this practice is done on legal grounds and to some extent on moral ones, and is prevalent the world over the losses thus suffered are not protested against by the host governments. But there are malpractices as well which the MNCs resort to particularly in methods on calculation in third world countries e.g. Pakistan where there is no check and balance.

The government must incur blame for its failure to design a practical package of incentives which could induce basic manufacture by Pakistani companies or through joint ventures with the MNCs to promote an advanced chemical industry. In the past efforts to manufacture basic drugs, with a few exceptions, did not prove a success because of flawed policies. However, it is too important a matter to be left to bureaucratic whims because not for too long the country can afford huge import bill-both for raw material and finished products.

Pharmaceuticals are one of the worst sectors in the healthcare scene of Pakistan. It is the monopoly of a few giant pharmaceutical multinational brands that exploit the poor people of Pakistan and the present government is fully supporting this in the name of the sacred "free market economy". Soon after the deregulation of the industry by the Nawaz Sharif government the prices of drugs multiplied a hundred times. The multinationals are raking in as much as 500 times the actual cost of production of some medicines. The safe and tested drugs, which are on national and international essential drugs lists, are usually withdrawn from the market so that expensive alternatives can be sold. Many cheap life-saving drugs are constantly in short supply. The prices of some drugs are so high that even the middle class can't afford decent antibiotics. Dangerous and irrational drugs that have been banned in the West are sold in Pakistan. Local doctors are misled by the pharmaceutical companies to prescribe junk drugs. And the government remains silent and allows this to go on so as not to offend the WTO and the icon of "free trade".

During Ali Bhutto's government this policy was analysed and the problem was identified. It was agreed that drugs must be cheap and affordable. In order to achieve this the Ministry of Health introduced the famous and radical *Generic Drugs Act* ***{in the same Generic Drugs Scandal Surgeon Naseer Sheikh of the same Bhutto regime made billions}*** which was aimed at breaking the back of the multinational monopolies and actually managed to bring the prices down to a very low level. The problem with this reform, as with all the others, was that, as the capitalist system was not transformed completely, it was soon to be reversed.

In spite of this even the subsequent government managed to maintain some degree of control over the prices. This, however, was lost when the Nawaz Sharif government signed the WTO free trade treaties. After the endorsement and introduction of the notorious T.R.I.P.S (trade and intellectual property rights) it has now become impossible to produce cheap generic drugs. The fate of the whole of the so-called Third World has been doomed by "free trade"!

#### SPURIOUS / COUNTERFEIT / BANNED DRUGS:

Another curse the Pakistani drug market suffers from is the presence of spurious, counterfeit and banned drugs in large number. According to the Burhanuddin Commission Report 1984, "Let there be no misunderstanding. Medicines and drugs once produced are not going to be dumped into the sea; they are going to be swallowed by the people whether they need them or not". For example, some 40, 000 dextrose drips which were rejected the Public Sector Hospital in Karachi in 1987 after discovery of deadly organism in them, causing six deaths and returned to the supplies, reappeared elsewhere in the country and were sold in the open market. It is an irony that the medicines which are de-registered for some reasons are not publicly notified by the government, thus keeping the doctor and the people in dark about them, and the medicines concerned are thus ultimately sold and consumed. Regarding the production, marketing and dispensing of sub-standard medicines, such malpractices can be checked only if an effective monitoring system and quality control at the manufacture's and exists. The monitoring by drug inspectors under the Drug Act is a farce. Needless to stress, the medicines cannot be treated as ordinary consumer items. These are the means to restoration of health to the people. Nor their prices can be left at the mercy of the manufacturers. Unless the buying capacity of the average Pakistani expands, the prices need to be tamed.

## PRICE FACTOR:

It is generally accepted that the willingness to pay for any commodity or service is determined by the utility of this to the consumer. It has been argued that households, irrespective of their position in the framework of society, would be willing to pay for curative health care as without this in an emergency the cost to the family would be substantial, particularly in the case of the bread-winner, and that this would not be constrained by the affordable limits. However, if the user charge is greater than the affordability level of any household, then equity is said to have been violated. On the other hand, a user charge at the maximum level of the willingness to pay places a considerable stress on the household in adjusting the basket of expenditure to cater for the specific service.

Many deaths in developing countries could be avoided if essential drug prices were lowered. The cost of medicines has a significant impact on healthcare in developing countries. Overwhelmingly, poor people in these countries pay for medicines out of their own pockets. They make enormous sacrifices to get treatment, sometimes at great financial risk to their families. One month's course of fluconazole in Kenya, for example, costs more than an average year's salary. But without it, cryptococcal meningitis and oral thrush are the painful fates awaiting many people infected with HIV. Reducing prices could mean extending a parent or income-earner's life by a month, a year, or more. In the case of patient being cared for by a VSO doctor in Uganda, the extra time allowed her to finalize pension arrangements to guarantee financial security for her children. Some companies have started to lower prices in the past 18 months, which is a welcome development. But such price offers have not always brought the cost of medicines down to the lowest levels, nor is the range of drugs on offer best suited to meet each developing country's healthcare needs.

A more systematic approach is needed, one that ensures low-cost supply to these countries and assures companies that lower priced products will not undermine their core markets. This places a special challenge on healthcare users in the UK and other wealthy countries. According to a National Opinion Poll commissioned by VSO last year, 87% of the general public feels that developing countries should pay lower prices for drugs to treat diseases such as HIV and AIDS. Now it is to the UK govt. and companies to respond. The companies, governments should be made accountable for their role in meeting the health needs of the majority of the world's population, specifically the population of the poor countries. Assessment of the corporate social responsibility of pharmaceutical companies in developing countries should include demonstrable commitments against the following shenanigans:

### Pricing:

The company should support calls for systematic, global approach to pricing overseen by an international public health body, to address the needs of developing countries. It policies should support substantial lowering of the price of medicines in developing countries, and it should publish a list of pricing offers made to developing countries, including details of any condition on offers. Price reductions should not be limited to one or two flagships drugs but should cover a range of products that are relevant to health priorities in developing countries.

### Patents:

The company should refrain from enforcing patents in developing countries where this will exacerbate health problems, and should support lifting the agreement on Trade-Related Aspects of Intellectual Property (TRIPS) restrictions on the export of generic versions of patented medicines to developing countries where a patent is not in force, in line with the Doha Declaration. It should not lobby governments for stronger patent protection than that mandated by TRIPS, or for weaker public health safeguards. It should disclose to shareholders its lobbying position on patents and its expenditure on such lobbying.

#### Joint public private initiative:

The company's approach to joint public private initiative (JPPIs) should be clearly stated as part of an overarching corporate social responsibility policy that addresses all issues surrounding access to medicines, including patent protection, pricing and R&D. The company's JPPI's should involve ongoing commitments to resolving targeted health problems as part of its long term business plan, and it should ensure that its JPPIs do not exclude vulnerable sectors of society. Its JPPIs should state objectives to integrate with, and strengthen, national health systems, and the company should report on their impact. It should also provide transparent information on its involvement in the governance of JPPIs including details of any conditions.

#### Research and development:

The company should publish target expenditure for its R&D on infectious disease and should support and participate in JPPIs that address such research. In developing countries, it should forego patent rights of drugs developed under such JPPIs, and its pricing policy should ensure that products developed as part of JPPIs are affordable to developing countries.

#### Appropriate use of medicines

The company should have a policy that supports and complies with the World Organization's guidelines for good clinical practices for trials on pharmaceutical products. It should publish the full results of all clinical trials in a registry accessible to third parties. The company should have a policy that supports and complies with WHO ethical criteria for medicinal drug promotion and report to shareholders on complaints upheld.

#### AIDS/HIV AWARENESS:

The fact that HIV/AIDS is spreading because of lack of knowledge, denial, ignorance and poor access to health facilities was underlying the message at the South Asia Interfaith Consultation on Children, Young People and HIV/AIDS, held in Khatmandu, Nepal in 2003. The aim of this consultation was to provide a platform to various faith based leaders in this region so that they could discuss issues related to HIV/AIDS, share their experiences, and enhance role, responsibility and future actions of faith based communities in relation to prevention among children and young people, along with mitigating the impact of HIV/AIDS on those infected and affected. The need for combined efforts to help eradicate this menace was stressed.

Prevention is fundamental to defeating HIV/AIDS. Every person in every country must know how to avoid contracting and spreading the disease and should be empowered to act on this knowledge. To prevent infection through sexual intercourse one should follow the ABCs of prevention: ABSTINENCE (not having sexual relations); BEING FAITHFUL (having sexual relations with only mutually faithful uninfected partners); and if neither the first two conditions can be met it is important to use CONDOMS correctly and consistently. Blood transfusion should be made only when essential and one should ensure that the blood or blood products have tested negative for HIV. Similarly the spread of HIV through needles, syringes and cutting instruments can be prevented by avoiding injections whenever possible; not sharing needles and syringes; using only new, sterilized, disposable needles and syringes whether in immunization, health services or elsewhere, and sterilized surgical equipment.

An overwhelmingly negative attitude towards the disease and discrimination against women is an important factor in the spread of the disease. HIV/AIDS is also tied to economic, social and cultural conditions, values and practices that create a fertile breeding ground for the virus. The combination of poverty, social exclusion and gender inequalities make women and children more vulnerable to infection. Children and young people are at a greater risk as they are mostly victims of innocence. Conservative cultural values prevent young people from getting the accurate knowledge they need. Young people are not expected to discuss sex outside marriage. Religious leaders often feel reluctant to introduce the subject of HIV/AIDS to children or young adults and as a result the focus is only on the active adult population.

Children of parents affected by HIV/AIDS lose their family and identity, are left to fend for themselves, face psychological stress, have decreased opportunities for education, and are afflicted by increased malnutrition and loss of health. In order to protect themselves they should be empowered with knowledge and information on sexuality and sexual and reproductive health. This would enable them to understand how their body functions and make informed choices about their behaviour. Evidence shows that the more educated young people are about sexuality and responsible sexual behaviour, the better the chances are that they will delay having sexual relations or will properly protect themselves if they do.

They need knowledge about transmission, risks and prevention of HIV, and about the choices available to them, including the avoidance of sexual relations before marriage. The knowledge about voluntary and confidential counseling and testing for HIV, as well as care, support and treatment for those infected are also of vital importance. They should also be aware of the economic and social pressure that makes girls particularly vulnerable to unwanted and unsafe sex. For this they need skills and confidence to negotiate difficult situations, whether it is refusing unsafe or unwanted sex, or resisting peer pressure to use alcohol or drugs.

Young adults need an environment that offers them a place within their faith community to talk openly and without fear of criticism about their feelings regarding HIV/AIDS, sexuality, death and other issues. They should have a voice and a meaningful role in community decision making and programmes, especially regarding HIV/AIDS prevention strategies for young people. In our part of the world AIDS is perceived as the disease of others, of people living on the margins of society whose lifestyles are considered perverted and sinful. The disease is seen as a sin and punishment from God. It has a strong association with prolonged illness, death, sex and drug use- issues that most of us find difficult to talk about openly.

It is important that people realize that AIDS is a disease like any other disease which can be prevented rather than looking at it as a retribution for one's sin. Correct knowledge about the modes of transmission will help to remove the stigma. The people affected by HIV/AIDS need care and compassion rather than discrimination. Strict tenets around sexual behaviour, relationships and promiscuity, which are immediately associated with HI, prevent people from sharing their concerns, particularly their HIV status. This further leads to a sense of shame and fear amongst individuals, who might be in need of the support of faith, its leaders and its congregations. Religious leaders play an important role in the lives of people, particularly the masses. They are respected in their community, have an influence over the people who listen to them, and often seek their advice. Because of this religious leaders are in a unique position of being able to alter the course of the HIV/AIDS epidemic. They can shape social values, promote responsible behaviour that respects the dignity of all persons and protects the sanctity of life, and they can increase public knowledge and influence opinion.

They can also support enlightened attitudes, opinions, policies and laws in this regard; redirect charitable resources for spiritual and social care, raise new funds for prevention, care and support, and promote action from the grass roots up to the national level. Above all they can speak out against all forms of stigma and discrimination, and ensure care, compassion and support for all people infected and affected by HIV/AIDS.

The tradition of serving those who are poor, sick and dying has been passed down for ages in all religions. Mosques, temples and churches are not only centres of worship; they are centres of learning, a nuclei of social activities and custodians of culture and tradition. In addition to meeting spiritual needs, they undertake many services, including religious education for children and youth, counseling, caring for the poor and the sick, with selfless support for people suffering from a multitude of serious and even contagious illnesses. Due to this important and unique role in shaping social values and public opinion, attempts must be made to involve religious leaders in the fight against HIV/AIDS.

Religious leader can review spiritual writing, beliefs and tradition to support HIV/AIDS prevention and care. They can talk about the spiritual dimensions of Human Sexuality and about the need to protect others from harm, particularly young people who may be the victims of abuse, violence, exploitation, discrimination and trafficking. They can try to find ways to help people renew their duty to alleviate suffering, to affirm personal faith and to lead a life that fully respects the dignity and rights of others.

## MENTAL ILLNESSES:

The determinants of a national priority vary from country to country. The inferences depend on the spectacles one uses. The health scenario focuses on economics and building of national character. Sound health plays a pivotal role in this regard and mental health is behaviour. Mental Health is unique in several ways. Most of the persons suffering from a mental health problems apparently “look well” except a handful except a handful who have had problems since early life. According to the WHO, 450 million people in the world currently suffer from, some form of mental or brain disorder, including alcohol and substance misuse. Within this huge number, 121 million people suffer from depression, and more than 800,000 people die of suicide each year, with young people accounting for well over half of these. Projections from 1990 to 2020 suggest that, in future, the proportion of the global burden of disease accounted for by mental and brain disorders will rise to fifteen%.

There is a huge gap between “West” and “East”. The West is preoccupied with human rights, political correctness, development of new and expensive drugs, the rights of minorities, life skill, education, stigma, sophisticated technology, quality of life etc., whilst in the East, due to extreme poverty, various kinds of severe deprivations, chronic stress and diseases forgotten in the West (like for example, vitamin deficiency), people and professionals have other priorities like hunger, survival, ad hoc diagnostics, and traditional methods of living. Many countries of, the East are characterized by severe socio-economic deprivations despite availability of natural resources but otherwise flooded with war, conflicts, debts, and man-made disasters of various kinds at the expense of “Health Dollar”.

Mental Illnesses are among the first diseases to have been recognized as discrete illness, the oldest medical document in existence, the Eber Papyrus (probably composed in 1900 BC) contains references to specific syndromes such as depression. Biblical writings also contain references to Saul as failing into serious depression. Hippocrates related mental illness to brain and Galen and his followers believed that mental illnesses were due to imbalances in quantities of body fluids. Depression has been calculated as one of the costliest illness of the world. Of the ten leading causes of the world in persons between the age of 15 and 44 years, four relate to mental illness namely unipolar depression, alcohol use (in case of Pakistan drug/substance abuse), manic depressive (bipolar) illness, and schizophrenia. If one includes self inflicted injuries (i.e. Suicide), violence and infliction war and other manmade disasters, the morbid behaviour will exceed 75% of the shared cost to society.

Growing consensus on bio-psycho-social mode of diseases has evolved into the concept of holistic medicine thereby incorporating all kinds of health professionals on one platform. The diseases can now be fought with people and professional together. Such a revolutionary change will require additional as well as re-allocation of resources. Investment in “Health” is invisible but highly rewarding. Neither govt. nor philanthropy alone can generate funds as the affordability criteria keeps on changing. Promotion of healthy lifestyle is both inexpensive and guaranteed form of primary prevention. Alternatively pharma industry will continue to bat on crease. “The success of our people in all walks of life depends upon the cultivation of “Sound Minds” the natural concomitant to “Sound Bodies”. {Late. Muhammad Al Jinnah}.

## THE HAND THAT ROCK THE CRADLE:

Pakistan’s health problems have been considerable and women’s health problems even more so. Until recently, the entire focus of the country’s healthcare system was curative and tertiary care oriented, with little attention to primary health care. The combination of severe fiscal constraints, political instability, lack of political will, discriminatory customs and traditions, growing inflationary trends and minimal attention to developmental needs have inevitably had a devastating impact on women’s health. The inverted sex ratio, prevalent in the South Asia region, still exists in Pakistan. The latest census (1998) while showing slight improvement over the previous 1981 census (111:100) still shows a sex ratio of 108:100. There is no national record or study to explain/identify the reasons for these missing girls and women - particularly pertinent given girls’ biological advantage at birth.

The consequences on women's health and lives have been characteristic of other features of low development: high population growth rates, unending poverty cycles, and high levels of infant and maternal mortality. Anaemia and malnutrition in women, especially pregnant and lactating women, continue to remain unacceptably high, even according to government statistics. Generally around 45% women in the reproductive age group of 15-49 years are anaemic. Pakistan's population is in the transitional phase of diseases, encountering both communicable and non-common diseases. Strong, concerted and sustained effort to achieve real change in women's lives has not been apparent, with no policy direction, planning or clear-cut national mechanisms. During the 1990s, promises of land reform were unfulfilled and attention was diverted by distribution of small parcels of state land to poor land-less agriculturists. Despite vociferous demands from the women's movement, women were never the beneficiaries and since the inputs to make such lands productive, such as water and credit were not provided, women could not benefit even indirectly, despite their continued toil. With the diversion from food to cash crops, food prices soared, which again hit women and children the hardest.

State patronage of traditional socio-cultural attitudes has created dichotomies in the nature of change necessary to meet the challenges of poverty, national development, and improvement in the status of women. There is resistance to creating a positive image of girls and women in the content of education and curricula, and textbooks continue to reflect patriarchal norms and values. Attempts to change the image of girls and women through interventions in existing textbooks have been only partially successful in the NWFP and to a lesser extent in Balochistan. In Punjab discussions have been held but no formal changes have been introduced in the textbooks. In Sindh, the exercise has yet to start. Issues pertaining to girls with disabilities have not been addressed. The development of gender sensitive learning materials developed by the government under the Punjab Middle Schooling Project is encouraging. NGO initiatives have focused on highlighting education as a basic human right and educating educators in women and child rights issues.

Failure of the state to respond to the widening gap between male and female perceptions of their roles is reflected in the increasing sexual harassment of girls and women as they move through public space to access educational and employment opportunities. With the exception of the NWFP, the media has played an ambivalent role in creating a favourable environment for promoting awareness about education and employment needs of women. Stereotyped images of women help reinforce the perspective that women should only receive training in fields related to traditional gender roles.

Regrettably, despite the above advances, negative indications still exist: nowhere is the impact of inadequate health facilities and low status of women so stark as in the high rates of maternal illness and death. Pakistan's maternal mortality rate continues to be amongst the highest in the world. It is estimated that for every woman who dies, approximately 16 survive with reproductive tract diseases, sometimes chronic and long drawn out. The worst among these are vaginal and rectal fistulae, mostly untreated due to lack of facilities. When combined with restrictive social norms, these can render women social outcasts.

In these circumstances, advocacy and implementation of the life-cycle approach, with improved healthcare and nutrition programmes for girls and women, promotion of ante and post-natal care, and enhanced provision of emergency obstetric care spell national challenges. It is noteworthy that all, except the life cycle approach, are identified in the above-cited RH package.

The need to incorporate gender equality and equity in all RH programmes and services is imperative; but unfortunately, the RH package is focused towards provision of basic

health/women's health services, and Information, Education and Communication (IEC). It does not address gender equality. The programme also remains largely demographic and target-oriented, aimed at achieving lowered fertility rates, despite the Government's endorsement of the ICPD-PoA which seeks to eliminate such target-setting, and particularly the targeting of women.

For a large proportion of the population, even access to these services is not enough. Retrogressive customs and traditions still hold sway, hindering current efforts for progress. Legal provisions guaranteeing women's reproductive rights are still conspicuous by their absence; their impact on women's RH remains unrecognized. While specific actions to remedy this situation are included in CEDAW, the NatRep, PfA, and the NPA, and most importantly in the COIW Report, implementation is still absent.

The wide-ranging attitudinal changes needed to rectify this situation have not been addressed. While there are Family Planning/Reproductive Health centres, negative traditions and customary practices, severely limiting women's independent mobility, even in case of serious illness or the critical stage of high-risk pregnancy. (See also Chapter <>on Violence Against Women)

## **Reproductive Rights Issues**

Six years after Cairo and five years after Beijing, national plans to ensure recognition of the integral link between the status of women and their RH have remained only partially addressed. A few positive steps taken in 1995-96 enhance this recognition were subsequently hindered by a lack of political commitment to addressing women's reproductive rights' concerns during 1997-99. Women continue to suffer from attitudes that violate their reproductive and other human rights, while discriminatory legislation further disempowers and marginalizes them. A specific illustration is that government and private clinics alike continue to demand written proof of the husband's consent before married women can obtain tubal ligation, whereas a wife's consent is not required for vasectomy. Abortion continues to be illegal (the only exception being in good faith to save the life of the woman or providing necessary treatment to her), and this is particularly discriminatory and unjust in the case of rape, especially where unmarried girls/women are doubly victimized. The categorisation of rape and adultery as sub-sections of a single section, and the wide license given to law enforcing agencies, mean that women complaining of rape run the risk of being charged under adultery.

The negative reproductive health consequences of increasing violence against women include physical and psychological trauma, clinical, emotional problems, and increased susceptibility to infection, including reproductive tract infections (RTIs), STDs and HIV/AIDS. These remain largely unacknowledged and thus unaddressed.

Although no national statistics on domestic violence are available, sample survey reports indicate that incidence is high, affecting all socioeconomic strata of society. The pernicious impact of domestic violence/wife-battering/marital rape on women's physical, reproductive and emotional health, and on non-permission for contraceptive use, are well-documented. Women with disability are especially vulnerable to violence and abuse, and are frequently unable to protect themselves (e.g. blind or mentally handicapped women being beaten or raped - both occur).

These severely violative and retrogressive trends threaten the comprehensive, progressive implementation of health programmes (or at best limit their benefits). In short, the strategic objectives of the PfA have only been partially addressed. A major obstacle in meeting all objectives is that while integration of services in the health and population

sectors is in process, the contribution of the Ministry of Women's Development (MoWD) remains the missing link. The recent merger of this Ministry with others has further diluted efforts for improvement of women's healthcare, particularly RH and RR. In the Beijing +5 review, Balochistan, Sindh and Punjab identified the lack of political will and commitment, inadequate coordination between government and civil society, and mismanagement of resources as serious deficiencies.

The GoP Social Action Programme (for education, health, rural water and sanitation, and population welfare) is meant to strengthen national developmental efforts and soften the impact of structural adjustment programmes. However, an independent study of SAP-1 by the Social and Policy Development Centre, showed little progress. Staff attendance was low; mechanisms to ensure implementation of safe motherhood programmes, treatment of RTIs and STDs, and prevention of unsafe abortions were insufficient. Review/assessment of SAP-2 has not taken place as yet. Also, given the simultaneous negative impact of structural adjustment programmes, it is difficult to assess the benefits of the Social Action Programme as a whole.

While there is no evidence of any decrease in the forms of VAW identified in the NatRep, there has been an alarming increase in violence and murder allegedly in the name of honour over the past years. Additional research and monitoring also resulted in bringing more information on the subject to public attention. Among other factors, this is indicative of a reformulation of the traditional discourse of honour as a means to justify the murder of women for social and economic reasons. Practices that were earlier confined to rural pockets in feudal and tribal belts have now spread to urban centres, indicating retrogressive social attitudes not only among the law enforcement agencies and the judiciary but also among the highest political decision-makers in the Senate and Assembly. After a particularly horrific incident - the globally reported Samia Sarwar case - an opposition Senator introduced a resolution in the Senate condemning honour killings after a protest outside Parliament by women's rights activists. The resolution was signed by a significant number of persons from the Treasury bench as well as the opposition. It was therefore all the more shocking when, on 2<sup>nd</sup> August 1999, not only was the resolution thrown out, but Senators in their speeches also used abusive language about women and even supported the practice of 'honour' killings.

The failure to punish, even condemn, such behaviour encourages acts of violence against women. This happens both in instances where women attempt to exert their decision-making with regard to choice in marriage, mobility and/or work and in cases along more traditional patterns where women have served as scapegoats in male fights over property or other resources. In both instances the recourse to 'honour' and inherited lacunae in the law relating to bodily hurt and murder and the provisions for compromise (instituted since 1990) have led to a gross miscarriage of justice and at the same time provided a viable cover to criminal acts. Additionally, even though the clause 'grave and sudden provocation' reducing culpability no longer exists on the statutes, biased judgements are trying to resuscitate the provision.

Every year scores of women are trafficked to Pakistan either to work in the local sex trade or to be sent on to the Middle East. These women are brought mainly from Bangladesh, India, Burma (via Bangladesh), and recently from the Central Asian states. It is important to distinguish between trafficking and illegal migration since there is substantial trafficking of women within the country, and trafficking cannot simply be defined as cross-border migration. The repatriation of Bangladeshi women is impeded by the Bangladesh Government requiring documentary proof of their origin. Trafficking of women is also a problem amongst the refugee community. (See Chapter E on Women and Armed Conflict)

Prostitution is illegal, with laws making it easier to penalise the women engaged in prostitution rather than the brothel keepers/pimps, procurers and clients. Lengthy imprisonment terms combined with dual standards of sexual morality block rehabilitation of women caught in this trap. The illegal status of trafficked women makes it even more difficult to establish rehabilitation initiatives for them.

Women engaged in the sex trade are at high risk of STDs, HIV/AIDs and other health hazards but remain entirely ignorant of the threats posed by HIV/AIDs in particular. The official policy of ignoring this sector as non-existent impedes efforts for the safety of the women concerned.

The area of VAW continues to be plagued by the existence of negative legislative provisions, and the negative attitude of police and judiciary. In addition is the non-compliance with positive specific rulings of the superior judiciary particularly on when cases should not be registered under the Hudood Ordinances and how to proceed when such cases are registered. Superior Court rulings directing branches of the administration, hospitals and the police to comply with standards and directives regarding procedures for medico-legal units have not been circulated or are being willfully ignored. There is also no internal monitoring and supervision to ensure compliance or to take action against police found to be violating these directives.

An amendment in Section 167 of the Criminal Procedure Code provides for women's safety with respect to the mode of arrest and detention of women by the police. But this provision cannot be effectively followed or implemented in the absence of necessary supporting initiatives, e.g. the training and gender-sensitization of the police or the induction of many more women in the police, that have not been carried out. The medico-legal units linking the police and hospitals are a serious continuing problem. The units are few and far between, the conditions for examination appalling and the attitudes of those in charge extremely insensitive and often hostile to women, especially victims of sexual abuse and/or domestic violence. They lack skills, equipment and orientation. They are also not complying with standard procedures. As a result, legal redress for women victims of violence is difficult and they often end up further traumatized by the experience of examination.

On the positive side, the establishment of women's police stations and women police cells seems to have increased women's access to police (especially in the NWFP). In Sindh, the Woman Superintendent of Jail in Karachi has taken initiatives to improve the conditions of women prisoners and institute some programmes for rehabilitation. Unfortunately there is an appalling lack of data on the number of women currently in different jails, the nature of their crimes/cases and whether they are under trial, pre-trial or convicted. A proper database would facilitate the release of many women.

## **Violence at the Workplace**

As more and more women enter the workplace, it has become increasingly important to consider the relationship between female and male employees, particularly as sexual intimidation by male co-workers has become more visible. Organizations in Pakistan, especially in the public sector, tend to perceive the idea of sexual harassment as a 'Western plague' that threatens to spoil 'natural' relations between men and women. Sexual harassment is rarely codified as a criminal offence. While private sector organizations have labor codes or human resource policies that mostly include only piecemeal stipulations that women can use to ensure a safe working environment, public sector policies have no safeguards against harassment at the workplace. Despite efforts by women's organizations, no discussion has been initiated on policies or legislation that can assist women in combating harassment.

All forms of armed conflict make women more susceptible to physical and sexual violence, expose them to various forms of deprivation, and impact on their physical and psychological health both as direct and indirect victims. Therefore armed conflict is understood to encompass the situation of women during times of armed conflict of any kind - whether interstate or intra-state, religious, sectarian or ethnic, tribal or political armed conflicts. Unfortunately, and despite the presence of a large number of refugee women from Afghanistan and Kashmir and the continuing impact of armed conflicts within the country, this is an area where the level of activity on the part of the State and non-state actors has been extremely low in the past five years. In the meantime, the need for disarmament and peace has acquired new proportions following the 1998 nuclearization of the region, accompanied by a glorification of war and weapons of mass

destruction and a militarization of state ideology. There has been increasing attention to gender based-disparities in the health, nutrition and education status of girls in Pakistan, as well as to socio-cultural practices that reinforce the gender bias against girls and perpetuate discrimination. However, given the overall vulnerability of children in Pakistan, and the socio-economic disadvantages facing women and girls, the situation of the girl-child calls for a renewed focus.

Social conditioning projects girls as being of lower status, weak, vulnerable, dependent, subordinate to males, and in need of guidance and protection. Coupled with the inadequate educational system and negative media portrayal, this leads to girls having a low self-esteem, minimal awareness of their rights, very few opportunities and limited aspirations. Development planning for the girl-child is exacerbated by a lack of clarity on the age definition of the 'girl-child'. The CRC defines a child as one below 18 years; the Majority Act in Pakistan defines those below 18 as minors. However, the minimum legal age for marriage is 16 for girls and 18 for boys. In child labour legislation, anyone below the age of 15 is defined as a 'child'. Finally in some criminal matters (specifically sex-related crimes), females are defined as being adult at puberty, exposing the girl-child to criminal liabilities and severer punishments at an earlier age than boys. The contradiction in definitions of adulthood under different laws deny the girl-child rights available to a boy of the same age.

### **Girl-Child and Early Marriages**

Girls, especially in rural areas, tend to attain puberty at ages ranging from 9-12 years. Data gathered by demographers over the past decade shows a steadily rising age at marriage even for girls. Other sociological and anthropological research, however, points to a continuation of the cultural norm of early marriage, especially in rural areas (where 68% of Pakistan's population resides), and the presence of 12-14 year old girls who are either pregnant or already mothers. To circumvent the law, parents record their daughters' age as 16 in the marriage certificate (a legally required document). Since a birth certificate is not yet a legal requirement for marriage in Pakistan, there is no way to check falsification of age on the marriage contract.

Early marriage has serious implications for girls' reproductive health, especially when added to low literacy levels, inadequate access to basic reproductive health services (BRH), information and counseling. Adolescent girls enter the vicious cycle of too early, too frequent and too many high-risk pregnancies, resulting in morbidity, child-birth complications and maternal mortality. This robs the child of her childhood, the right to play and recreation, the right to knowledge of options and choices – in short the right to recognition as a human individual in her own right.

### **Child Labour**

Various initiatives on child labour issues focus on rehabilitation and providing access to both formal and non-formal educational opportunities. While these are not girl-child specific, they do reach low income urban and peri-urban girls in selected locations. There is now a need to take such worthwhile initiatives to scale, and, more important for the Government to take over ownership for long-term sustainability. A positive step in this direction is the Government's recognition of the issue of child labour, and specifically girls within this.

Such initiatives have far-reaching consequences in terms of impact on future generations. By increasing awareness, they also supplement and strengthen other initiatives that focus on reducing gender disparities in BRH, nutrition and education. Foremost in this is the Social Action Programme, (SAP), which has achieved considerable success in these sectors, especially education, through the increased enrolment of girls in primary schools, as well as non-formal education centres, in which NGOs also participate.

Child Domestic Labour: An issue that has consistently been ignored in development planning/programming, is that of child domestic labour. The category of domestic servants is not covered under any of the labour laws, thereby exposing domestic servants to all forms of abuse. Sexual abuse and exploitation is also a common problem for child domestic workers, particularly girl servants, along with economic exploitation, a fact substantiated by findings from several research studies that analyzed the psycho-social environment of child domestic servants and its impact on them.

## **Child Abuse**

There has been an alarming increase in the incidence of child sexual abuse in Pakistan. While this includes both boys and girls, unfortunately, it is the latter who suffer greater atrocities. Violence and sexual abuse continue to play a strong role in disempowering the girl-child. Despite strict penalties for rape and gang rape, and processing gang rape cases in the specially constituted Anti Terrorist Courts, lacunae in the law combined with the attitude of law-enforcing agencies, discourages the registration and prosecution of such cases. While stringent laws were formulated for rape and child sexual abuse, including the amendment in the Haddood Ordinance to award the death penalty to convicts of gang rape, the intricacies involved in the problems of reporting child sexual abuse and rape remain unaddressed. NGOs feel that capital punishment cannot serve as a deterrent to these heinous crimes if the prime focus does not go beyond this to emphasize restructuring of the system of redress.

Studies have also been conducted on the sexual abuse of the girl-child. Importantly, a donor-sponsored study on child sexual abuse in NWFP was officially recognized by the Provincial Government.

Adopting the life-cycle approach has had a major impact on refocusing development efforts on the girl-child in the health sector. Initiatives range from addressing the communication gap between mothers and daughters on issues surrounding puberty, to greater awareness of the nutritional needs of the girl-child ('tomorrow's mother'). Hitherto taboo subjects such as sexuality and reproductive health are being taken up by NGOs, and moreover, are being received positively by communities. While these NGO initiatives have major implications for healthier mothers and babies in the future, they are catalytic, and need to be taken to scale for a broader impact at a national level.

**BAD ECONOMY MEANS RUINED SOCIAL SECTOR (READ HEALTH).**

**GDP:**

Purchasing Power Parity- \$ 311 Billion.

Real Growth Rate- 4.5%.

Per Capita: Purchasing Power Parity- \$ 2,100.

**GDP Composition by Sector:**

Agriculture: 24%

Industry: 24%

Service: 51%

**Population Below Poverty Line:**

35%

**HOUSEHOLD INCOME OR CONSUMPTION BY PERCENTAGE SHARE:**

Lowest 10%: 4.1%

Highest 10%: 27.6%

{Note: All the tables/graph/statistics given in HIES survey would be enclosed here as Annexure "A" (15 leaves).

#### DISTRIBUTION OF FAMILY INCOME :

41.

#### INFLATION RATE {Consumer Prices}:

3.9%

#### UNEMPLOYMENT RATE:

7.8% Plus Substantial Underemployment.

#### BUDGET:

Revenue: \$ 12.6 Billion

Expenditure: \$ 14.8 Billion

#### DEBT EXTERNAL:

\$ 32.3 Billion

#### ECONOMIC AID RECIPIENT:

\$ 2.4 Billion

#### DISMAL ECONOMY:

Pakistan, an impoverished and underdeveloped country, suffers from internal political disputes, low levels of foreign investment, and a costly, ongoing confrontation with neighboring India. Pakistan's economic prospects, although still marred by poor human development indicators, continued to improve in 2002 following unprecedented inflows of Foreign Exchange Reserves have grown to record levels, supported by fast growth in recorded worker remittance. Trade levels rebounded after a sharp decline in late 2001. The government has made significant inroads in macroeconomics reform since 2000 but these are all tall claims as majority of the population living under back breaking poverty and no benefit of much talked about International Aid has trickled down to the common man. Although it is in the second year of its \$ 1.3 Billion IMF POVERTY REDUCTION AND GROWTH FACILITY, Pakistan continues to require waivers for politically suicidal reforms. Long terms prospects remain uncertain as development spending remain low, regional tensions remain high, and political upheaval weakens Pakistan's commitment to hinge on Corps Performance dependence on foreign oil leaves the import bill vulnerable to fluctuating oil prices; and efforts to open and modernize the economy remain uneven. One of the key themes identified was globalization and its attendant Structural Adjustment Programmes (started in Pakistan in 1988). Together with an increasing national debt, loans and conditionalities, the roll back of the state and push towards privatization, these have had a major impact on the local economy and on Social (can be read as Health) through increased poverty and the erosion of safety nets. The contradictory policies of international financial institutions, and to a lesser extent, those of bilateral and multilateral agencies, contributed to the problem.

The same institutions supporting or implementing social reform programmes also had agreements with the Government of Pakistan introducing conditionalities that are unhelpful, or that actually undermine the

ability of people to cope with negative developments. These further marginalise the Social development (read health). Existing global economic structures and the New World Order continue and intensify the depletion of natural resources through unsustainable development policies. Globalization has also led to financial and human mismanagement of available national resources and a mismatch between indigenous needs and allocations as well as a brain drain out of the country. There was also concern at the donor-driven nature and/or dependency of many, if not all, of the initiatives for women. These are therefore resisted by government/state implementors and also not sustainable beyond the support cycle. They are further disadvantaged by being generally perceived as part of the "western", "donor" agenda, incompatible with religio-cultural social norms and traditions, and, thereby, unworthy of GoP ownership and commitment. At the national level, globalization entails a roll back of the state in certain sectors. The abdication of the state from its primary responsibilities of providing for the basic needs of and security of its citizens is furthered by imposed policies which call for (a) the privatization of social sector services such as water and health, and (b) the removal of protective social sector measures (e.g. subsidies ensuring food security). In Pakistan, the situation is made worse by a highly centralized administrative and taxation system, the concentration of power and resources in the hands of a small minority, and bureaucratic hurdles that impede institutionalization of efforts. Indeed Pakistan is witnessing erosion of state institutions and their capacity. Additionally, efforts promoting women's empowerment have to contend with frequent political changes that negatively impact on policies and interventions and an ad-hocism in planning and implementation that prevent continuity.

## Poverty:

In view of the many forms of deprivation that people from lower income households suffer, the NatRep emphasized the need for a multi-sectoral strategy to facilitate common man's access to productive assets, technology and raw materials, in addition to common man's greater participation in decision making at the policy, planning and implementation levels. Improved research is a must on self-employment opportunities, and a special focus on the needs/development of rural and agricultural sector as well.

Poverty and the economy are precisely such areas since they cut across and impact all others. In fact, it may not be an overstatement to categorize them as the very foundation of all sectors of national development. They are obverse images of one another, inter-linked in an inverse relationship – the higher the levels of poverty, the lower the indicators of economic progress, and the more difficult to quantify "progress".

It is also very difficult to discuss progress achieved over the past five years when essentially nothing has changed a great deal over the past five decades. Despite some tinkering around the edges of the economy, and despite the veneer of "modernization", industrialization and information technology, the underlying macro-economic system remains intact and untouched. Rooted in feudalism, and increasingly negatively impacted by globalization, it is inherently biased against the interests of rural areas, women, peasants and urban workers. Hence, it is not surprising that poverty levels have demonstrably and measurably risen. Concurrently, the economy has plummeted, with the foreseeable result of lender/donor-imposed structural adjustment programmes and stiff IMF conditionalities. These have affected the poor most of all – the vast majority of whom are rural agricultural and low-income urban/slums. The current economic situation in Pakistan has its historical roots in the introduction of western farming methods that led to the "Green Revolution" producing unprecedented bumper crops. In the preparatory stage towards industrialization, it was decided that large-scale farming and capital formation (in this case in the agricultural sector) was necessary, even to the detriment of the social sectors and the less-advantaged citizenry. Thus, rural, and subsequently urban, poverty was exacerbated by conscious state policy (with technical assistance from the US-based Harvard Advisory Group) in the 1960s.

This ill-advised pattern of development and continued neglect of the rural areas set off a migration to the cities in search of livelihood that continues to this day. Small land-owning farmers either sold off their land to the large landowners or were relegated to tenant farming or waged labour. While entire families suffered, women and children were the most hard hit for they were no longer able to benefit from the food they themselves produced even as sharecroppers, resulting in under- and malnutrition and greater poverty. The

situation was further complicated by sustained macro-economic growth rates, along with agricultural production and rapid industrialization in the 1960s-1980s. During this period, the imbalances in income distribution and poverty levels tended to be masked by using the conventional indicators of "hard core" economic development, by ignoring the glaring disparities among and within the provinces, rural and urban areas and in the social sectors; and also, by heavy infusions of expatriate workers' remittances and external economic assistance (both loans and grants) from donors. These issues only surfaced in the 1990s when the traditional World Development Report indicators were overshadowed by the UN's Human Development Reports, with the socio-economic indicators used in the HDI.

With the start of the economic downturn in the mid-to-late 1980s and the visible effects of the IMF-led Structural Adjustment Programme, which slashed social sector budgets, and the macro-economic "reform" agenda, came the realization of the "shocking" nature of social indicators, particularly the statistics on gender inequalities. The most unfortunate feature of successive Governments' economic policy is that there has been no concerted move towards the uplift of the masses below the poverty line, or in restructuring the economy to launch self-help activities, while simultaneously correcting economic and social damage. The focus has hitherto been primarily on (a) macro-level "crisis management", "damage control" and "stabilization" of the economy – primarily on balance of payments - through monetary controls to revive foreign investment, which had decreased, inter alia because of political and bureaucratic corruption and lack of security, both physical and financial; and (b) tokenism for the masses.

### **Emerging Trends, Initiatives and Constraints:**

The incidence of poverty has been see-sawing, but is back on the increase. Various reliable estimates put it at 38% in 1980, down to 20% in 1990, back up to over 30% in the mid-90s, to a current estimated range of 35-38% (but with a Poverty of Opportunity Index of 44% in 1995). The bulk of the poor are rural and female. With an annual population growth rate of 2.4-2.6%, and an estimated annual economic growth rate of around 3%, any macro-level gains achieved are negated by the sheer size of numbers being added every year. The urbanization rate is close to 4% per annum, putting increased pressure on already weak social sector services in cities and towns (rural-urban ratios are 67.5:32.5%). Mounting debt service payments and military expenditures leave very little for social sector investments. Government expenditures on the social sectors have averaged less than 3% of GNP. This explains to a large extent why economic growth in Pakistan had little or no impact on human development. In addition, factors such as skewed income distribution; the absence of land reforms and agricultural income tax; an overwhelming reliance of fiscal policy on indirect taxes; rampant inflation; a weak public sector and weak or mal-governance have caused gender and social indicators to remain unacceptably low and have perpetuated and exacerbated geographic disparities.

### **Government Policies:**

Pakistan's having become party to the World Trade Organization in 1998 (without any public debate or consensus) has (a) imposed unfair rules and quota systems, and (b) forced open Pakistan's markets, industry and the entire territory to foreign investment. Large-scale chemical/High Yield Variety/mechanized, cash (vs. food) crop agriculture continues to be intensified to earn foreign exchange for external debt repayment. There appears to be very little scope for alleviating the abysmal conditions of the poor. During the 1990s, promises of land reform were unfulfilled and attention was diverted by distribution of small parcels of state land to poor land-less agriculturists.

### **Poverty Alleviation and Social Action Programmes:**

Over the past five years, the initiative of the Poverty Alleviation (note: not 'eradication', as pledged by the Government at the WSSD/Copenhagen 95) Programme, like the vague term "social safety nets", is perceived by many as being another attention-diverting gimmick, as it would be spreading relatively too little money too thin. The requisites for poverty alleviation are no different from those of basic development: primary and reproductive health care, potable water and sanitation, education and skill

training, employment, and credit. They must all proceed in tandem - providing one or two without the other will produce poor or no results. If the Poverty Alleviation Programme is restricted to artificial job-creation with no permanent prospects or to extending micro-credit alone, the prospects for success are dim. As long as the concept of poverty alleviation lies in making a little discretionary funding available to the poor majority after having allocated most state/taxpayer money to infrastructure and services for the middle-class and upper class minorities, the programme will be little more than tokenism, because the same outlook pervades planning today that was introduced by the Harvard Advisory Group decades ago.

The objective of the Social Action Programme (SAP) launched in 1992, at a total cost of US\$7.7 billion, of which donors provided 10%, was to expand and improve the delivery of social services in four major sectors: basic education, primary health care, population welfare, and rural water and sanitation. The second phase, SAPP-II (1998-2002) has now evolved to consolidate and improve upon the outcomes of the first phase. Though this appears to have had a positive impact in specific areas of health and education, there is no visible impact and all seems to be gone in vain. A common problem in poverty alleviation and creating economic employment for common poor folks in the countryside is that they can only be solved by addressing long-standing structural problems: the lack of the basic infrastructure and services which middle-class urbanites (also rapidly vanishing) take for granted. The other obstacle is that providing infrastructure and services separately will not kick-start economic activity either unless they are created simultaneously.

**Future Actions Needed which will ultimately some difference not only in Health but in every sphere:**

1. Redistribute available arable state land with access to water, credit and roads, to landless peasants.
  2. Carry out land reforms and provide disincentives and incentives for effective implementation; (e.g., strict non-availability of credit to large landowners who have not repaid previous loans; no credit for tractors and harvesters purchase)
  3. Encourage gainful employment of rural people by providing a cash incentive (such as partial interest refund on bank-credit) for those who pursue labour-intensive cultivation.
  4. Levy a progressive agricultural income tax on all landowners of holdings above subsistence acreage, care being taken to keep taxes on smallholders low and affordable. For example tie tax rates to size of acreage farmed, and substantially increase the rate for those using tractors.
  5. Create employment for the rural skilled and unskilled, through projects of needed physical infrastructure (e.g. farm-to market roads, storage silos, wholesale market facilities.
  6. Provide credit and incentives for peasants/smallholders growing food other than wheat and sugarcane (vegetables/fruit for at least one season) and cash crops strictly for the domestic market.
- Provide greater credit and incentives for those who exclusively grow food crops.
  - Make credit available for other agro-based entrepreneurs.
  - Make personal credit available to eliminate the ills and steep charges of non-formal moneylenders (up to 120% annually) that entrap men and women in perpetual debt in rural and urban areas.
1. Help combat water-logging, salinity and soil deterioration by avoiding the causes, namely use of High-Yield Variety seeds that require huge quantities of water; and the use of chemical fertilisers, pesticides, herbicides and weedicides, that destroy vital organisms and nutrients in the soil that are essential to soil health.
  2. Remove (a) heavy subsidies to big farmers that virtually amount to free credit and are a disincentive for diversification in commodity agriculture towards value-added goods, b) Institute proportionate cash rewards/incentives to revenue and irrigation officials by performance as measured by criteria requiring the receipt of water entitlements by all farmholdings (including the smallest) falling under their jurisdiction.
  3. Adopt a new concept in multi-purpose education/training/ extension services in the form of primary agricultural schools/centres with a rural/agricultural based curricula that includes organic

farming, livestock management, soil and water management, and nutritional and self- healthcare knowledge.

- These would double (by shifts) as children's schools and adult training centres.
  - building/s should be low-cost and of indigenous materials and built by local contractors using local labour.
  - A minimum of 50% of the trainees/pupils/ beneficiaries must compulsorily be women and girls.
  - They must compulsorily be located in the village-centre and not on any feudal/private landholding.
1. Ensure 50% allocation for female headed households in all public and private sector land and housing programmes.
  2. Take into account the special needs of women with disabilities in the aforementioned macro- and micro-level agricultural policy and programme measures.

Other poverty reduction measures (N.B: recognizing that these are only temporary stop-gap measures and not a substitute for socio-economic development programmes).

1. Take affirmative action to accord priority to low-income members of the society in disbursement of funds and provision of social services, e.g., Zakat and Bait-ul-Maal funds,
2. Promulgate labour laws and rights to cover the majority of Pakistani labour, i.e., low-paid contract and informal home-based workers, or non-unionized industrial workers, who are denied minimum wages and facilities under sub-contract mechanisms arranged by large and medium industrial concerns, including multinationals, to circumvent the law.
3. Reduce or alleviate the triple burden of women's work: reproductive, domestic (unremunerated) and productive (remunerated), through sharing and reducing child-care responsibilities and household work, including water, fuel, fodder, food preparation, preservation and storage, livestock and traditional craft-work.
4. Provide support to urban working women, especially factory workers, in the form of facilities e.g. child-care, transport, hostels, trade unions, relaxation of age of entry/re-entry into the labour market.
5. Recognize and address the special needs of female-headed households, including the right to formal record, title deeds of land ownership, credit, education, vocational skills training and affirmative action in employment. Also, extending these rights to women in traditional male-headed households.
6. Address other dimensions of poverty, including bonded labour . Establish public-private-NGO partnerships to enlarge, expand and replicate some of the successful NGO initiatives and pilot programmes over the past 5-10 years.
7. People with Disabilities:
  - Ensure that all poverty alleviation programmes specifically address the needs of people with disabilities;
  - Devise alternative employment that requires skills that can be adapted in line with the limitations and special needs of people with disabilities;
  - Make available skills training to all disabled people;
  - Provide credit to those with disabilities on softer terms.

#### CRITICAL ANALYSIS OF PAKISTANI ECONOMY {A COMPARISON WITH ARGENTINA}

Pakistan owed \$2.07 billion to the IMF at the end of March 2003. This represents a sharp rise from \$1.55 billion in June 2000. The power that the IMF exerts on our policy formulation as a result of this immense and increasing indebtedness cannot be underestimated. Almost everyday, newspapers report the pressure that the IMF is exerting on Pakistan to make policy decisions that have become a dogma with the IMF and

are recommended to country after country regardless of its particular situation. Just in the month of May, the IMF has linked disbursement of loans in Pakistan to privatization of a bank, submission of a fiscal responsibility law in parliament, and elimination of tax exemptions. IMF has also asked the Pakistan government to impose 15 per cent General Sales Tax in the 2003-04 budget on bricks, cement blocks, computer hardware, software, specific machinery etc.

Predictably, a recent World Bank and IMF Joint Staff Assessment (JSA) report cited by local several newspapers identifies four risks to the implementation of reforms in Pakistan, including political opposition to reforms, lack of continuity, insufficient institutional capacity and exogenous shocks. No mention of the failure of these policies in countries all over the world from Latin America, to South East Asia. Argentina is a prime example of a country that followed the policy recommendations of the IMF to the letter and now that the country is economically, politically and socially a complete basket case, the IMF has, as in other cases, abdicated all responsibility. We can do no better than to learn from the experience of Argentina to temper our enthusiasm for the IMF and a blind obedience to its dictates.

When Argentina erupted on the international news scene in 2001 for committing the biggest default by a sovereign country on an international loan corporate media focused on fixing the blame on Argentina. In reality, Argentina's case is a particularly good illustration of how a healthy, rich country was devastated under IMF tutelage. Conversely, Argentina today can also be an inspiring example of how ordinary citizens can organize themselves to rise above the problems created for them by local and international elites.

Argentina's economic and political health was dealt a deathblow not because it did not follow the IMF dictates closely enough, but because it was indeed doing everything according to IMF agenda. All through the 1990s, opinion makers like the Financial Times hailed Argentina as the 'star pupil' of the IMF. The GDP rose by 60% over the decade, and foreign investment poured in. However, this glorious facade hid a crumbling edifice. The wealth flowing into Argentina during the 1990s was a combination of speculative finance and one-off sales: the phone company, the oil company, the post, rails, and airline. Between 1989 and 1999, national debt rose by \$80bn and un-employment soared from 6.5% in 1989 to 20% in 2000. Today 57% of Argentina's population lives below the poverty line.

Just before the default and right afterwards as well, mainstream economics machinery pounced on the country for plunging itself into international isolation, a sin beyond redemption according to the gods of globalization. The real fear underlying this hysteria was that Argentina might set a bad example for other countries caught in the debt spiral. Other indebted countries could also default and use default on multilateral debt as a bargaining chip with creditors.

### **The fall of Argentina**

Arguably the most developed country in Latin America, Argentina had an adult literacy rate of 91% in the 1960s. It has also been, historically, a highly politicized and unionized country. During World War II the country reaped huge gains from commerce with allied and Axis powers. Peron, a left leaning politician became president soon afterwards. His politics was laden with nationalist and anti-imperialist demagoguery, and although his achievements in office did not match up to the rhetoric, his rule did result in significant gains for the working and middle class in Argentina. Popular demands not completely satisfied, unrest in the country continued. Ultimately a military coup in 1976 led to a fierce clamp down. This was a period of immense brutality in which at least 30,000 activists, students, teachers and workers 'disappeared'.

Argentina's dictators, instead of being shunned by 'democratic' institutions like the IMF, in fact received massive doses of loans and advice on how to re-organize the economy. The generals were rewarded handsomely for their policies. In 1976 and 1977 Argentina received more than \$2bn in foreign loans, more than the country had received in all of the preceding six years combined. After the disastrous war in Falklands, it became unsustainable for global finance to support a military dictatorship. The reins of power were handed over to a ruling clique that continued the implementation of IMF dictated policies. The country's external debt had increased from \$8 billion to \$43 billion under the generals. Therefore, while

they were no longer in power, their legacy ensured that the hold of international finance remained firm on Argentinean policy making. President Menem, a Peronist, where the insinuated affiliation to a popular regime in the past is just a cover, rather like Bhutto and his daughter in Pakistan, only implemented IMF policies with increased vehemence.

Menem brought in a former banker Cavallo to manage the finances of the country. Cavallo followed the directions of the IMF to the letter. Argentina privatized state enterprises (which are now facing bankruptcy), raised interest rates to ward off inflation, cut public sector salaries by 35 percent, and then fired 40 percent of its public employees. Under President Menem's rule, class discrepancy increased dramatically. Cavallo, with IMF approval, also imposed fixed parity between dollar and peso, which was to strangle exports. The country entered a recession in late 1990s. Tens of thousands of firms went bankrupt leading to mass unemployment. By the time a centre-left president, Fernando de la Rúa, was elected in October 1999, democracy was a charade in this neoliberal show state, ruled by an extremely corrupt government. In March 2001, the parliament gave Cavallo special powers and in July a zero deficit law was passed. Among other measures, civil service salaries and some pensions were further reduced by 13%; and the draft budget for 2002 proposed to cut spending by 18.6%, \$9.2bn less than in 2001. With all these changes, the country was IMF's prize disciple, with 90% of its banks and 40% of its industry in the hands of international capital. By this time, Argentina's external debt stood at \$132bn in 2001 and the \$40bn that the state collected from privatisation had 'disappeared'. Unemployment had risen to 20%, the number of people in extreme poverty from 200,000 to 5 million, those in poverty from 1m to 14m, and illiteracy from 2% to 12%. Purchasing power had almost halved in the five years leading to 2001.

### **The straw that broke the back of the middle class**

The final blow was the government's decision in December 2001 to limit all bank withdrawals to \$250 per week in a country where most salaries are deposited and credit cards carry 30% interest rates. Under increasing international pressure to service the external debt, the government's move was supposedly intended "to stem the hemorrhage of capital". The average Argentinean was not to take out more than \$250 a week in cash, although more than \$136bn had been taken out of the country by the big national and international speculators, the ruling elite. This move hurt the newly impoverished middle class the most. Small and medium sized businesses could not access their accounts to meet business transactions. Millions among the salaried middle class struggled to buy basics of food. The strains of this hollowed out economy ultimately led not just the working class, but this increasingly impoverished middle class to turn out into the streets. This so-called Argentinazo was a spontaneous outpouring of the people and not organized by any of the main political parties. People just left their homes to gather in the capital banging pots and pans, or to block highways refusing to go the government to negotiate, asking instead for the government to come to them. This started on Dec 19, 2001. Within the next 12 days, the country went through five presidents and defaulted on \$95bn of its debt, the largest default in history.

### **IMF's Star Pupil**

Anoop Singh, IMF Director of Special Operations, heading the delegation to Argentina declared in April 2002, "In our view, failures in fiscal policy constitute the root cause of the current crisis." However, a review of Argentina's economic data shows that in fact the crisis could not have been caused by the fiscal policy. Inherent in IMF's declaration is the view that the government should not have increased public spending, which is exactly what Argentina had done. Not only had public spending not increased, it had actually been cut between 1993-2002. The only increase in government spending had been on interest payments on loans. In reality, the crisis was rooted in many of the policies that the Argentinean government had followed on the recommendation of the IMF including pegging the peso to the US dollar, which made Argentinean exports un-competitive, and lifting barriers to capital flow. This meant that Argentina was extremely vulnerable to any interest rate increases in the US. The exogenous shocks of US Federal Reserve's decisions to raise short-term rates in February 1994 from 3% to 6%, and the Mexican, and Brazilian financial crisis from 1995-1999, all had a devastating impact on the economy of Argentina.

The IMF contends that policy decisions are made by the governments of client countries and are not its responsibility. This argument completely ignores the fact that the IMF actively pressurizes governments into policy directions through threats of loan recalls etc. We can see clearly in the pattern of negotiations between the IMF and Argentina's government since 2002 that the IMF does and did refuse to allocate new loans, or even provide instalments of previously agreed loans, unless Argentina agreed to damaging new policies, which included re writing its laws to interpret the constitution. The power that IMF exerts stems not just from the loans that it can dole out but also because of its close relationship with the US Treasury department and its role as the head of a creditors cartel than can deny any developing country, access to sources of credit. It is assumed that if the IMF is willing to invest in a country other private investors will also follow suit. Finally, the sister organization World Bank is the carrot attached to IMF's stick. The World Bank withheld previously approved \$700 million in loans for social programs from Argentina until it agreed to IMF's new conditionalities after the default.

Many economists have argued that Argentina had a good chance of stabilizing its economy without assistance from the IMF. The country had in 2002, a sizeable balance of credit due to massive shrinkage in imports. The devaluation of peso had made their exports more competitive and the country could invest its surplus in public works to reduce unemployment. Once the economy has started to recover, foreign investment will flow in since investors no longer need to fear a break down. In fact, this is precisely what the US government itself has undertaken in recent recessionary times. However, to make this a reality, the government would need to stem the flow of capital outflow, which would mean some kind of currency control. This is in direct conflict with the IMF's dogma, which places financial deregulation at a high priority. This means in fact, that the so-called assistance from IMF, given its terms and conditions, is likely to slow or even negate the recovery that Argentina is capable of.

### **Life After the Default:**

More significant than Argentina's decision to repudiate the IMF, to whose fold its hapless politicians are moving again, and its ability to get some debt written off, are the changes going on in the society that are likely to have a much longer lasting influence. As middle class Argentines lost their purchasing power and their illusions about growth in an economy at the mercy of international capital, the search for alternatives intensified. Argentines have started re-organizing from the smallest scale. "Asambleas barriales" or neighbourhood meetings take place as frequently as every two days or every week, not just in working class areas but also in the middle class localities. These meetings discuss anything from how to run the collective kitchen, to what the effect of years of de-politicisation has been. Most significantly a generation of young activists has been politicised almost by necessity. A vibrant underground barter economy is also flourishing in neighbourhood markets where people are allocated credits for goods and services they can provide. The paucity of resources available to these millions in poverty is alleviated by their creativity and spirit of solidarity.

The movement of the unemployed workers called "piquesteros" is gaining momentum. Workers have taken over several businesses that went bankrupt during the current crisis and are managing them themselves. Often the items produced are bartered for other goods or services. They are finding larger and larger networks to barter with. In 2002, around 150 factories have been taken over by their workers and turned into cooperatives or collectives. These include tractor plants, supermarkets, printing houses, aluminium factories and pizza parlours. Decisions about company policy are made in open assemblies, and profits are split equally among the workers. In recent months, the "fabricas tomadas" ("taken factories") have begun to network among themselves and are beginning to plan an informal "solidarity economy". For instance, garment workers from an occupied factory, sew sheets for an occupied health clinic; a supermarket in Rosario, turned into a workers' cooperative, sells pasta from an occupied pasta factory.

Most neighbourhood assemblies and the various small-scale political groups decided not to participate in the elections that concluded on May 18, 2003 with the appointment of Nestor Kirchner, a relatively unknown governor with links to previous regime, as President. It is important to realize that unless the Asambleas barriales and the piquesteros do not form a cohesive front at the political level their potential for

radical change will remain limited. The government has increased the violent crushing of the piqueteros recently.

### **The relevance of Argentina's experience**

Argentinean (or Pakistani) citizens are not unique in having military/civilian dictatorships imposed upon them, which are then sustained by massive doses of international loans. Around the world, this recursive relationship between dictators and global capital serves the purpose of enslaving people through increased indebtedness while forcing them to open up their markets for increasing the profits of large multinationals through threats of loan recalls etc. The insecurity of dictators and their need to silence all opposition is a well-calculated advantage in this relationship to international capital. An added advantage is that once the dictators have been deposed, the people of that country remain indebted as the loans were taken in their name, regardless of the fact that beyond lining the pockets of the ruling junta these loans served little developmental purpose.

As the IMF imposes devastating demands for privatisation of public resources that will increase social polarization, our government only responds with pleas for patience. The IMF pushes through sale of Habib Bank Limited, and the only resistance the Pakistani government can offer is that the process cannot be completed within the deadline specified by IMF, June 30. At the same time we are told that the government is set to increase the budget for 'law and order'.

The increased violence in our society is a direct result of the incredible polarisation that has gone on as schools, hospitals, two square meals and the prospect of employment have moved out of the reach of an increasing number of Pakistanis. The service that our public hospitals and schools provide in spite of a pitiful budget allocation, barely 5% for health and education combined, is remarkable (51% of our budget is used to service loans). We can only imagine how much better the system could be with adequate funding. Throwing more people in jails, and more policemen on the streets is likely to only increase the magnitude of the problem. As Delia Garcilazo de Ríos, whose son was killed by prison guards, claims, "Police repression and low salary are forms of having social control. When the people ask for things in a blockade or in a march and there's a kid who breaks a window, we are violent. But I ask what's more violent, a youth dying of starvation, a kid being shot from behind, or if we break a window? A window is a material thing, you can fix it, life you can't ever get back."

### **CRITICAL ANALYSIS OF NGOS:**

In Pakistan, the word 'NGO' has become a controversial one. For the common man, it represents a foreign-funded organization (read West) where good looking, educated men and women work together in huge offices and drive expensive vehicles. Such people are often referred as the 'mummy-daddy-group' or the 'burger-family'. Lay people make fun of them in their private sittings - thus gaining pleasure and inspiration both at once. Is there any truth to the theory that NGOs have always been confused about their identity in society? NGOs undoubtedly face resistance from many corners of society for their alleged weak points.

In the post 9/11 era, the NGO-phenomenon has undergone big changes. Many NGOs are being showered with unaccountable sums of money, some are banned and others have had their accounts frozen. Although the scenario is not yet clear since the dust of terrorism is not settling down, let us analyze the phenomenon. Sociologists have defined a non-governmental organization (NGO) as "an independent, flexible, democratic, secular, non-profit people's organization working for assisting in the empowerment of economically socially and socially marginalized groups."

According to the World Bank an NGO is a "private organization that pursues activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development." In wider usage, the term NGO can be applied to any non-profit, value-based organization, which depends, in whole or in part, on charitable donations and voluntary services. NGOs

range from large charities such as IUCN, CARE, Oxfam, World Vision, Islamic Relief and the Aga Khan Development Network to community based small and self-help groups.

They also include research institutes, mosques, churches, temples, professional associations and lobby groups etc. NGOs are operating in almost all countries of the world. A good proportion of NGOs are based in the US and Europe. Besides these, Far Eastern and Middle Eastern based and home-grown NGOs are also present. They mostly work in Africa, Asia and Latin America, but are also operating in Europe and North America with a different methodology.

Many of the NGOs have relationships with inter-governmental organizations such as the United Nations, the World Bank, IMF, the Asian Development Bank, the European Union, International Labour Organization, the World Trade Organization and International Committee of the Red Cross. The majority of NGOs work primarily on three issues: environmentally sustainable development; human rights and women in development. They have been classified into many categories which are involved in advocacy and lobbying, policy issues and debates, emergency relief, rehabilitation and implementation of development projects/programmes.

They also work in the fields of children/youth, communications, conflict resolution, disarmament, disaster relief, drug abuse, education, environment, ethics/values, family, health/nutrition, human resources, law, natural resources, peace, security, religion, trade, finance, transport, population welfare, refugees, science and technology.

With the process of globalization and free market economy, societies around the world have changed a lot over the years and NGOs are being encouraged as packets of change. Governments and international organizations consult them in matters of public interest. A major part of development aid is channeled through NGOs, which has made a significant impact on the social, economic and political activity of a country or a region involved, particularly in the developing world. Consequently, NGOs have become influential in world affairs. The pros and cons of NGOs have been discussed since the very beginning - not only amongst people but also in the corridors of power. The nature and quality of NGOs varies greatly and it is extremely difficult to make generalizations about the sector as a whole.

Generally NGOs have strong grassroots links and field-based development expertise. They have the ability to innovate and adapt to society through their process-oriented approach to development. Participatory methodology, long-term commitment, emphasis on sustainability and cost-effectiveness are the main features of NGOs.

These organizations have the ability to experiment freely with innovative approaches and, if necessary, to take risks. They are flexible in adapting to local situations and responding to local needs. Therefore, NGOs are able to develop integrated and sectoral projects.

They enjoy a good understanding with people and can render micro-assistance to their needs. They have the ability to communicate at all levels, from the neighbourhood to the top levels of governments. They are able to recruit both experts and highly motivated staff with fewer restrictions than the government.

As is true of other social organizations NGOs have flaws too, which are often pointed out from the public and are highlighted in the media for the benefit of the public. The most commonly identified weaknesses of NGOs include: non-representative ness, paternalistic attitude, limited financial and management expertise, limited institutional capacity, low levels of self-sustainability, isolation and lack of inter-organizational communication and coordination, small-scale interventions and lack of understanding of the broader social or economic circumstances.

Since the mid-1970s, the NGO sector has experienced a rapid growth, not only in the developed countries but in developing ones as well. In Pakistan, NGOs mushroomed in the early 1980s. It was a tumultuous

period for the country. The cold war between the US and the Soviet Union was at its peak after the latter's invasion of Afghanistan.

Pakistan was hosting the world's largest number of refugees - 35 million Afghans. Thus, despite ambiguity and suspicions, a mushroom growth of NGOs with different motives took place in the country.

It is widely believed that there are 70,000 plus NGOs present today. Most of them are believed to be fake; some allegedly have vested interests and others are said to be not sound technically. Only a few NGOs are practical and have the analytical skills and detailed local knowledge of the complex social, economic and political processes of the country.

These NGOs changed traditional social life and gave rise to a new breed of people - especially in the rural areas. In a society where once a scholar or a teacher was admired and respected, there has been a change and those with high wages, big vehicles and lavish lifestyles have become role models.

The once invisible line between the "haves and have nots" have now become prominent. The influential have hijacked some NGOs and made them a source of income. There are allegations that there are many NGOs which exist on paper only. Some politicians and civil and military bureaucrats are allegedly involved with the NGO business.

Some of them have taken NGOs directly under their wings. They grant definite favours to certain NGOs when in power and get executive posts when retired. For the last few years there is this new trend that serving bureaucrats are taking long leave from their government jobs and joining top NGOs with lucrative packages.

Such NGOs come under the government's influence directly and thus are no longer non-government organizations in spirit. Some intellectuals claim that after joining NGOs their fellow intellectuals became moneymaking machines. They also say that NGOs were used against democracy and in an engineered way Pakistan was depoliticized - never let democracy flourish in the country.

In the 1980s, General Ziaul Haq had given representation to the NGO lot in his cabinet and General Pervez Musharraf did the same after coming to power. NGO people have never been happy with elected governments and have always been under direct attack.

The fundamental question for the NGOs is how to move from the current position as unhappy agents of a foreign aid system, to vehicles for international cooperation in the emerging global arena. Looking at the rapidly changing world today, it seems as though the NGO phenomenon is in a state of inertia - whatever it has done or achieved in its prime time over the last few years is now a thing of the past, nothing special has happened nor is expected to.

For many NGOs it has become a big challenge to continue or maintain their past works/achievements; thus they are facing a lot of threats. Maintenance and consistency of projects and donations are the main problems for NGOs today. Meanwhile there are some multinational companies which have taken the work of NGOs directly into their hands.

For example, some oil exploration companies operating in Sindh and Balochistan are also doing community development work and initiating social welfare in their areas of operation. They have opened schools, training centres, health centres, assistance with irrigation, installation of hand pumps, and construction of water canals and supply of portable water to the public on a daily basis. There are companies which are donating a certain amount of their income to charities. This seems a new and growing market strategy of the process of globalization, and may be an effort to cool down the growing anti-globalization movement.

NGOs are in a deep crisis administratively as well. The visionary pioneers and experienced lot are out, or no more remain active as projects are being terminated and down/right sizing of employees is creating chaos in society. The social, psychological and economic impact of NGOs is very complicated.

Despite the bleak situation in this new century there is plenty of excitement regarding new possibilities. There is a need to think and act globally. It is difficult to say how NGOs will re-shape themselves. After the tragic events of 9/11, a change in the activities of NGOs and in the behaviour of the donor agencies is being observed. The donors have somewhat assumed that their funds in developing countries were misused in the past at different levels, and they don't want a repeat of the same pattern. Nowadays the West and developed countries are more interested in the economic strength of their own societies. So a shift of direction has become obvious. In future the well-established or self-sufficient NGOs may be able to continue their development works and social reforms. Others may go out of sight and out of mind soon (the intelligent ones are tailoring themselves according to the changed world).

Many donor agencies are taking the work of NGOs directly into their own hands and at the same time some NGOs have started successful businesses. What will be the role of NGOs in the changed world? Governments, non-governmental organizations, communities and the private sector have to redefine their role in the new world.

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DATE: April 1, 2004

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