

Lady Health Workers and Social Change in Pakistan

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Pakistan's Lady Health Workers' programme has trained over 1,00,000 women to provide community health services in rural areas. Not only has the programme revitalised the primary health care system, it has also helped overcome the gendered division of public and private space that is a major obstacle to women's access to basic services, including education, and employment opportunities. However, there are a number of shortcomings that need government intervention to ensure that it fulfils its aims.

In 1994, the Pakistan government launched the Lady Health Workers (LHWS) programme, otherwise known as the National Programme of Family Planning and Primary Health Care. It aims at training women to serve as community health providers in rural areas across the country. Today there are over 1,00,000 such workers, and the success of the programme has led to plans to double the figure. The programme provides opportunities at many levels; for government it is a vital pillar of support to an otherwise troubled primary health care service delivery network; and for women who work in the programme it is a catalyst in their empowerment.

Programme Achievements

The LHWS website states, "LHWS are essentially the nexus around whom all primary health care initiatives converge for service delivery to the community. Therefore in addition to their stipulated tasks, an important role of the Lady Health Workers is to serve as a conduit for implementation of almost all national and international community health initiatives."¹

The fourth comprehensive review of the programme found that as compared to communities not served by the LHWS, the served households were 11% more likely to use modern family planning methods, 13% were more likely to have had a tetanus toxoid vaccination, 15% more were likely to have received a medical check-up within 24 hours of a birth, and 15% more were

likely to have immunised children below three years. The improvements in health indicators among the populations covered by the LHWS were not attributable to the programme alone; researchers noted that other positive changes such as economic growth, increased provision of health services and better education services helped to enhance the impact. While the programme had managed to sustain its impact despite its large expansion, evaluators found that serious weaknesses in the provision of supplies, and equipment and referral services need to be urgently addressed (Oxford Policy Management 2009: 4-8).

Millennium Development Goals

Pakistan's progress towards meeting its Millennium Development Goals (MDG) has shown mixed results, in part due to the negative influence of the economic downturn and deteriorating security situation within the country. The under-five mortality rate and infant mortality rate both declined since 1990-91 but not fast enough to meet the MDG targets for 2015. The proportion of fully immunised children rose from 53% in 2001-02 to 78% in 2008-09, which is in part attributed to the efforts of the LHWS who have been tasked, in addition to their regular duties, with giving their time to the ongoing polio campaigns. The one target that may well be met is that of complete coverage of the population by LHWS, at a ratio of one LHW serving a population of around 1,500 or 150 households (Centre for Poverty Reduction and Social Policy Development 2010: 55).

Millennium Development Goal 4: Reduce Child Mortality²

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

Millennium Development Goal 5: Improve Maternal Health

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Table 1: Selected MDG Indicators for Goal 4

Indicators	Definition	1990-91	2006-07	2008-09	MDG Targets 2015
Under-five mortality rate	No of deaths of children under five years of age per thousand live births	117*	94**	n/a	52
Infant mortality rate	No of deaths of children under one year per 1,000 live births	102***	75**	n/a	40
Lady health workers' coverage of target population	Households covered by LHWs for their healthcare services (%)	n/a	76	83	100

* Data from National Institute of Population Studies, Government of Pakistan.

** Data from Pakistan Demographic and Health Survey 2006-07.

*** Baseline set by Health Section, Planning Commission, Government of Pakistan.

Table 2: Selected MDG Indicators for Goal 5

Indicators	Definitions	1990-91	2006-07	2008-09	MDG Targets 2015
Maternal mortality ratio (MMR)	No of mothers dying due to complications of pregnancy and delivery per 1,00,000 live births	533*	276**	n/a	140
Proportion of births attended by skilled birth attendants	Proportion of deliveries attended by skilled personnel (medical officers, midwives, Lady Health Visitors)	18	37	41	>90
Contraceptive prevalence rate	Proportion of eligible couples for family planning programmes using one of the contraceptive methods	12	29.6**	30.8	55
Total fertility rate	Average number of children a woman delivered during her reproductive age	5.4***	4.1**	3.75	2.1
Proportion of women 15-49 years who had given birth during last three years and made at least one antenatal care consultation	Proportion of women 15-49 years who had given birth during last three years and made at least one antenatal care visit during their pregnancy period from either public or private providers	15	53	58	100

* The Pakistan Reproductive Health and Family Planning Survey 2000-01 has quoted MMR as 533 based on the sisterhood method.

** Pakistan Demographic and Health Survey 2006-07.

*** Estimates by Ministry of Health.

Target 6: (a) Reduce by three-quarters between 1990 and 2015, the maternal mortality ratio, (b) Achieve universal access to reproductive health by 2015.

While the maternal mortality ratio is coming down, as is the total fertility rate, the pace is not fast enough to meet the MDG targets. Unfortunately, the overall share of deliveries in the country attended by skilled personnel actually fell from 48% in 2004-05 to 41% in 2008-09. The contraceptive prevalence rate has taken a curious turn, appearing almost to stagnate in recent years. This despite the fact that there is almost universal knowledge about family planning methods among women of reproductive age in Pakistan, leading experts to conclude that supply-side issues may be the most serious constraint to contraceptive use along with social barriers to access of services (Centre for Poverty Reduction and Social Policy Development 2010: 67, 69).

The reasons for the absence of progress in part stem from the low government expenditure on health. As a percentage of GDP the real expenditure on health has remained stagnant at 0.6% against a target of 0.92% (Centre for Poverty Reduction and Social Policy Development: 58). The new

budget for 2011-12 presented recently in Parliament allocated Rs 15 billion to finance different vertical health programmes, including the Lady Health Workers programme and the Expanded Programme for Immunisation; Rs 4 billion were set aside to run the federally financed programmes for population welfare. The rest of the health expenditure will have to come from the provinces, since health has recently been devolved from a federal to a provincial subject (Finance Division 2011: 6).

Even so, there are many management and governance issues in the health system that need to be addressed, as do the broader social and behavioural constraints that prevent women and children from accessing services. It is obvious how important LHWs are for overcoming so many of these constraints, particularly those that involve women's lack of access to services and low contraceptive use. For example, their key responsibilities are to conduct screenings of pregnant women and increase the referral rates to clinical services as needed. LHWs distribute condoms and oral pills and refer women to government services for tubal ligations; the government has also begun to train them to administer injectable contraception too.

According to the external evaluation report of 2009 "the programme is having a positive effect on the well-being and empowerment of women it employs" (Oxford Policy Management 2009). These findings corroborate those from my own research conducted in 2007,³ which revealed how context and circumstance positively affected various dimensions of their lives. The concept of empowerment (Kabeer 2001) involved women's enhanced access to resources along with their increased agency, or ability to exercise choices in strategic areas of their lives. In the case of my research, empowerment was explored with respect to the effect of paid work on women's lives.

I studied a small group of LHWs in rural and peri-urban settlements across Sindh and the Punjab in order to understand if their role as paid workers had led to empowerment in any dimensions of their lives. Some critics did not expect any dramatic difference, after all the government was paying them a stipend of Rs 2,500 per month and had invested only three months in training them to visit homes and administer basic vaccines and medicines. They were expected to cover 100 households in a month through door-to-door visits, during which they were to record pregnancies and births, offer basic family planning, and refer women to basic health units or hospitals in the districts as needed.

The position of LHW was often the only form of non-agricultural paid work open to women in their villages. Neighbours and relatives of LHWs asked for more employment opportunities such as this since they were ready to work. Health officials said that whereas in the mid-1990s (when the programme first started) it was difficult to recruit women (education up to the eighth standard was one requirement), now there were hordes of women lining up for interviews.

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There is no doubt that poverty was one of the factors responsible for the village women demanding more jobs. The Rs 2,500 per month "stipend" for LHWs was sometimes the sole source of income in a household and almost always an extremely important part of the family's livelihood strategy. These earnings were spent on the family, especially children's needs, in a household where often the LHW's husband brought in no income at all. Other studies have noted that the LHWs are most likely to be drawn from among the more privileged in a community – educated girls who are permitted to work outside the home. But in my fieldwork I saw little of this privilege. The decision to work was made only in part by the LHW herself; if she was married her in-laws would actively push her into applying and were willing to look after her children. Those LHWs who were unmarried said it was their fathers who encouraged them to apply. These men could not support their households only on their earnings and wanted their daughters to make something of their education.

One LHW, Fatima, a mother of three living in a village in rural Sindh, had evolved into an influential community leader because she managed to build upon social advantages she enjoyed. Being a member of the dominant caste of the village, she had access to the landlord's women relatives in a professional as well as social capacity. She helped them to invest in buffaloes to earn on their own. When a micro-credit bank came to the village looking for a community contact, she was selected to organise women to take advantage of the loans on offer. Her husband had no steady income, and her in-laws were clearly pleased by her success, saying, "We should have put her to work long ago".

One LHW, a young mother of four living in peri-urban Karachi, was married to a drug addict. They lived in two rooms that housed 17 people. She had only begun to use contraception after receiving her LHW training. Her home was a designated "Health House" in the community, as the homes of LHWs are meant to be places that women and children can come to for services. The open sewer in front of the house entrance seemed to mock the whole concept of community health.

Although she was bright and motivated, she was fighting a losing battle. One of her young children was born with a cleft palate and needed multiple surgeries while another died during the course of my research. Her father-in-law died within weeks of the child's death. Amidst all this, she did not deny her husband – continuing to give him small amounts of money to service his addiction.

A peri-urban community near the fast-growing industrial city of Faisalabad, in Punjab, was palpably different. The LHWs there spoke about how times were changing for girls in Pakistan. They were getting education from the city, they watched television and they expected much more from their lives. One young LHW, married to a police officer, saw herself as part of that new trend. She gained community acceptance in part through the government-sponsored advertisements on television explaining the value of LHWs; she, in turn, wanted even more for her three young daughters and hoped that they would have careers in medicine.

The LHWs I met did seem to have greater decision-making powers within the home due to their paid work. They also had improved access to vital knowledge resources through their training, and had, in turn, become a resource themselves for their catchment communities. The services they offered, particularly

related to child survival and contraceptive distribution, helped other women to access better information regarding important areas of their lives, and act upon this knowledge to control their own reproduction if they so desired.

Collective Action

The circumstances shaping the experiences of the LHWs are diverse. The obvious question before me was if they had joined together in any way to strengthen themselves as workers and to draw more benefit from their positions as emerging community leaders. As Kabeer (2001:48) points out: "individual empowerment is a fragile gain if it cannot be mobilised in the interests of collective empowerment". During my fieldwork there were few signs of this. There had been disparate stories in the press occasionally, suggesting that some sort of support networks were being developed among the LHWs. For example, in 2002 the LHWs and district health department staff protested in Nawabshah, Sindh, against the non-payment of their salaries for five months (*Dawn*, 20 November 2002).

But more recently these protests have coalesced into the beginning of a movement, based around issues like delayed and insufficient salaries, regularisation of service as government employees, reimbursement of travel expenses, perceived

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Training Workshop on Resettlement Management

The Council is pleased to announce its next one-week annual training programme on the above noted subject. This is scheduled to take place in New Delhi from 21 to 25 November 2011. The broad objective of this workshop is to build capacity and awareness of resettlement planning and management issues confronting development projects that involve land acquisition and resettlement of the affected population. It has been planned keeping in view the training needs of senior/middle level government officials, industry managers, NGOs, academics, and also those working on internationally-funded projects. The fee for this programme is Rs 5000.00 per participant, which includes course material, lunch, mid-morning and afternoon tea/coffee. The last date for receiving nominations is 31 October 2011.

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exploitation, and cases of harassment. The LHWs now want to become full-time government servants, rather than temporary or “ad-hoc” employees who receive a stipend and no other benefits. They resent the fact that the government asks them to become short-term service providers for a number of other health activities it runs intermittently throughout the year, such as its expanded immunisation campaigns. The LHWs are vulnerable to the violent controversy over polio vaccinations that is linked with the political context in Pakistan. In the tribal district of Bajaur, bordering Afghanistan, tribesmen abducted and beat 11 LHWs in the mistaken belief that the vaccination campaign was a US plot to sterilise Muslims (*Daily Times*, 8 August 2007).

In 2008, the LHWs held demonstrations for an increase in salaries, gathering in various cities during seemingly unrelated events around the country.

Intermittent protests grew into a countrywide boycott of the polio campaign scheduled in February 2010. Sindh was especially active; there was even a major demonstration at the mausoleum of Benazir Bhutto, where the LHWs demanded that the promise made by the late prime minister to regularise them should be fulfilled (*Pakistan Christian Post*, 15 February 2010). In September, the chief justice of the Supreme Court ordered that LHWs be paid the minimum wage of a skilled (full-time) worker, i.e., Rs 7,000 per month.

The All Pakistan Lady Health Workers Employees Association president, Bushra Arain, told the press, “Whatever success Pakistan has achieved towards bringing down infant and maternal mortality rates, or in meeting the targets for the Millennium Development Goals four and five would not have been possible had the LHWs not been going door to door”.

The Sindh provincial government was forced to delay the launch of its three-day polio campaign because the LHWs staged a protest sit-in in Karachi (*Dawn*, 30 January 2011). The association called for a boycott of the government’s polio campaign in March this year. More than 2,500 LHWs staged a sit-in on the national highway which was broken up by the police after 16 hours with the use of lathis and teargas (*Dawn*, 7 April 2011). The protests attracted

further media attention due to the presence of some women politicians at the sit-in (*Dawn*, 30 March 2011). As of now, the association has promised to hold off on its protests until the next population census is completed later this year.

An Opportunity

While the LHW programme is an excellent initiative in primary health care, the manner of its implementation leaves much to be desired. Besides keeping the LHWs low-paid and as ad hoc employees, the government is running its primary health care programme as a federal initiative that is implemented alongside provincial and district-based health service provision. The federal initiative includes the expanded immunisation programme (EPI), which was not intended to be part of the LHW programme. By placing some of the EPI’s responsibilities on the LHWs, along with others pertaining to family planning, it has caused them to be overburdened and added to the perception that they are being exploited. As an LHW explained, “When we started we didn’t have to work in the polio and measles campaign. If there is a tuberculosis patient in our community, we have to go and give the drug to him or her every morning” (ipsnews.net 28 April 2011).

Both the successes and the challenges facing the LHW programme offer an extraordinary opportunity for the government of Pakistan. LHWs have played an important role in revitalising the moribund primary health care system and taking the country a few steps closer to achieving its MNG. Although the programme suffers from inefficiencies it is widely seen as a successful initiative operating alongside an otherwise underperforming district health system. The 18th Amendment to the Constitution and the National Finance Commission Award have created “larger fiscal space for the health sector” (Sabih et al 2010) at the provincial and district level. It would further strengthen the efficacy of the LHW programme if this space was taken advantage of to build stronger service delivery units at the district level.

The LHWs have had a social impact as well. They are developing into community leaders, particularly in rural areas, in a context that offers few spaces in the public domain to women. Unintentionally though

it may be, by providing essential health services door-to-door, the government has helped to overcome the gendered division of public and private space that has been a major obstacle to women’s access to basic services, including education and employment. By stepping into homes to register pregnancies and births, and assist in clinical referrals for deliveries, the LHWs are helping to end the hidden plight behind Pakistan’s dismal maternal health statistics.

The LHW programme has become a major employer of women in the formal sector, and is scheduled to be doubled in size if budgetary allocations can be sustained. If universal coverage is achieved, every community in the country will have at least one LHW, i.e., one working woman and potential leader, who could serve as a catalyst for positive change for women in her community. This puts the government of Pakistan in the unusual position of facilitating social change in favour of women’s empowerment.

NOTES

- 1 <http://www.phc.gov.pk/site/component/content/article/48-the-national-programme-for-family-planning-a-primary-health-care-an-overview.html> (accessed 7 June 2011).
- 2 The study was part of the multi-country research consortium entitled “Pathways to Women’s Empowerment” funded by the UK Department for International Development with additional financing from the Norwegian and Swedish Ministry of Foreign Affairs and from UNIFEM. (www.pathwaysofempowerment.org).
- 3 Tables 1 and 2 are taken from *Pakistan Millennium Development Goals Report 2010*, pp 55 and 67.

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