Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

PROGRAM SPOTLIGHT

PAKISTAN'S LADY HEALTH WORKERS

A National Model for Delivering Primary Healthcare and Peer Support

PROGRAM OVERVIEW

History
Initiated in 1994 through the Prime Minister Bhutto's Program for Family Planning and Primary Care. Implemented by the Ministry of Health.

Primary Healthcare Service Delivery
LHWs provide primary healthcare services (health promotion, disease prevention, curative and rehabilitative services, and family planning) to the residents of rural areas and urban slums. 75% of the serviced population lives in rural areas.

Recruitment & Training
Candidates must be recommended by the community and meet a set of criteria, including a minimum of 8 years of education. Training is delivered over 15 months: 3 months in the classroom, followed by 12 months of on-the-job training. No management or leadership training is provided except for record management.

Supervision & Organization
LHWs work from their homes, also known as health houses. They serve an area of 200 houses; an average of 1000 individuals. LHWs are supposed to visit each household in their coverage area monthly .The average annual salary is $343 and they are not allowed to engage in other paid activities. Each LHW is attached to a government health facility, from which they receive training, a small allowance, and medical supplies. Provincial and district coordinators monitor and supervise the LHWs. The ratio of supervisors to LHWs is 1:23.

Size of LHW Workforce
110,000 currently deployed. Target is 150,000.

Costs
Total cost per worker per year is $745.

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Mrs. and Mr. Yaqub visit Shahnaz Kousar, a Lady Health Worker at her home office in Punjab Province, Pakistan.

The Lady Health Worker (LHW) program is a key part of Pakistan's strategy to meet its Millennium Development Goals and support its underdeveloped primary healthcare system. One of the largest community health worker programs in the world, the LHW program demonstrates a successful phased scale-up with clear policy planning and health system integration. What lessons can we gleam from the scale-up of this ambitious program? What are the challenges that remain?

Background

Pakistan is home to 182million people, making it the 6th most populous nation in the world. With the highest population growth rate in South Asia, 35% of its population is under the age of 15. As in many developing countries, wealth and health are unequally distributed in Pakistan. Health indicators are particularly poor for women and children. In 1994, Prime Minister Benazir Bhutto launched the Lady Health Worker program to bring essential healthcare services to these vulnerable populations.

Since then, LHWs have been deployed in nearly all districts of the country, providing services such as family planning, health education, immunization, case management of acute respiratory infection, growth monitoring, mental health screening, and referral to local healthcare facilities. The LHW workforce has grown from 40,000 in 2000, to 90,000 in 2008, to its current level at 110,000.

In 2009, the fourth comprehensive review of the program conducted by Oxford Policy Management found that LHWs had a substantial positive impact on family planning, antenatal care, neonatal check-ups, and immunization. Program impact is greater for poorer households, indicating that they are reaching the targeted populations. One unique characteristic that makes LHWs so effective is their peer identity. Rooted in the communities they serve, LHWs operate in the space between healthcare providers and the community. LHWs understand their communities more than an outsider could, enabling them to navigate the local customs, language, social relationships, and community resources to achieve their goals.

Empowering Women

An external review of the program reported that the program is having a positive effect on the well-being and empowerment of the women it employs. Empowerment is conceptualized as enhanced access to resources and increased agency, or ability to make choices in important areas of their lives.

In many cases, the LHW's monthly stipend is an important source of income for the entire family. And, as LHWs gained access to training and healthcare resources, it boosted not only their knowledge and skills, but their self-image as well. They took pride in providing life-saving services and helping women in their communities control their reproductive destinies. They connected with fellow LHWs in other communities. Collectively, they began to make demands.

Starting in 2002, LHWs and their supporters have made headlines by organizing protests, demonstrations, and sit-ins. According to Ayesha Khan, "These protests have coalesced into the beginning of a movement, based around issues like delayed and insufficient salaries, regularization of service as government employees, reimbursement of travel expenses, perceived exploitation, and cases of harassment." The LHWs have scored major victories in their advocacy efforts. After campaigning for three years, the prime minister approved the regularization of their service in early 2013.

Overcoming Cultural Barriers and Capacity Constraints

Today, the LHW program is lauded around the world as an effective, affordable, and scalable approach to extend primary care services to underserved populations. However, the program's success was hardly foreseeable from the start.

For one, the political environment has been unstable, as power shifts from one regime to the next. Programs launched by one political party are usually rolled back by opponents once they come into power. However, since its launch, the LHW program has enjoyed the support of every government that has led the country.

In addition, Pakistani society is conservative and strictly hierarchical, with traditional Islamic values shaping the realms of personal and professional relationships. Even including the term "family planning" in the name of the program was a tenuous proposition with respect to its acceptability within Pakistan's conservative culture. LHWs often encountered negative community perceptions at first, but over time, they've won nearly universal acclaim.

In a society where men are the major decision-makers, no health program can succeed without involving the men of the household. Therefore, the program set up a protocol to help female workers engage the men in their communities. Every LHW is supposed to organize a health committee within her catchment population, comprised of local notable men and women. This committee supports the LHWs in executing her duties, particularly in interacting with men. Despite these efforts, LHWs still find it difficult talking about contraception and family planning issues directly with men.

As demand for LHW services rises, the supply of drugs, medical supplies, transportation, professional medical staff, and funding for salaries is not keeping pace. Ongoing support and backup of LHWs in the field is critical for program success. When healthcare resources are not present to back up the LHWs, it undermines trust in the LHWs and erodes their morale.

Lessons Learned

The Lady Health Worker program has made a remarkable impact on the health of women and children in Pakistan. A byproduct of the program has been the empowerment of LHWs and the women they serve. In a conservative culture with limited social mobility, the LHW program provides a valuable opportunity for women to earn money and improve their status in the community. LHWs have mobilized on a national scale, taking collective action to advocate for their interests.

Initial reservations about cultural barriers and program acceptability were quickly overcome through a combination of strong political will and communities experiencing the benefits of LHWs firsthand. After the initial investment on program development and scaling up, it has proven to be extremely cost-effective, costing an average of 75 cents per person per year.

As the LHW program transitions from the scaling up phase to the maintenance phase, quality improvement has become a priority, especially with an eye toward incorporating innovations. The Human Development Research Foundation has been working in close collaboration with the LHW program since the last decade. In their experience working with the program, Director of Research Dr. Siham Sikander shares, "It takes a bit of advocacy and a bit of campaigning at the program level before they fully are convinced to take on and test a new approach or a new intervention for their LHWs to deliver, with the implication of scaling it up if the results show promise. And once they overcome this part, then they take ownership of the research idea and the results that eventually come out of the studies."

Findings from the program show us that concrete steps can be taken to improve the quality and efficiency of community health worker interventions. First, LHW retention has been a serious problem with inconsistent payment of salaries and lack of career advancement opportunities. The regularization of LHWs may lead to greater professionalization and more career opportunities, but raises new concerns about adequate funding at the provincial level.

As we have observed in many other peer support and community health worker programs around the world, ongoing support, supervision, and backup are critical for program success. LHWs work best when they complement professional healthcare providers, but they cannot be expected to be a permanent substitute in lieu of a stronger primary healthcare system. The shortage of medical staff at referral facilities and inadequate distribution of drugs and medical supplies have undermined the efforts of LHWs.

Furthermore, integration of LHWs with local healthcare systems is inconsistent across the country. While LHWs are trained to carry out their duties independently, operating as a team with professional medical staff could improve quality of care and promote greater buy-in from the medical establishment.

While innovations and changes can be difficult to implement on a national scale, the LHW program's dedication to monitoring and quality improvement gives us a lot of hope for the future of the program. It is also exciting to see the empowerment of LHWs as they become a force for positive social change. Peer supporters and community health workers around the world can learn from their mobilization and advocacy efforts.

Acknowledgement

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