

*Country Case Study*

# PAKISTAN'S LADY HEALTH WORKER PROGRAMME



**GHWA Task Force on Scaling Up Education  
and Training for Health Workers**



**World Health  
Organization**



global health  
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## SUMMARY

Pakistan's health sector is characterised by urban-rural disparities and an imbalance in the health workforce, with insufficient numbers of health managers, nurses, paramedics and skilled birth attendants. Through the Prime Minister's Programme for Family Planning and Primary Care, the government created the Lady Health Worker cadre in 1994. The aim was to provide essential primary health services in the community and fulfil the unmet health needs in rural and urban slum areas.

The programme set out to select, train and deploy 100,000 female community health workers, known as 'Lady Health Workers', throughout the country by 2005. These workers, who are residents of the community in which they work, are each responsible for an average of 1000 people. The government spent \$155 million during the first eight years of the programme, of which only 11% came from external donors. The initiative became part of the government's wider efforts to define and meet health workforce needs at all levels of the system, which has included an increase in the number of doctors trained.

Each Lady Health Worker is attached to a government health facility, from which they

receive training, a small allowance and medical supplies. Candidates must be recommended by the community and meet a set of criteria, including having a minimum of eight years of education. They are trained for 15 months in the prevention and treatment of common illnesses: three months in the classroom, followed by 12 months of practical on-the-job training. After training, provincial and district coordinators monitor and supervise this cadre.

An external evaluation of the programme in 2000 found that the population served by Lady Health Workers had substantially better health indicators than the control population. It was estimated that 150,000 Lady Health Workers are needed to cover the country. By the end of 2006, there were 96,000 in the system, with another 14,000 to be trained through an extension of the programme to 2008. While numbers are growing, the coverage is imbalanced. And in some areas the entry-level qualifications are too high, resulting in few or no candidates. Adjustments to entry criteria, and careful targeting of underserved and poor areas, are being considered as the programme expands.

## BACKGROUND INFORMATION

With an estimated population of 160.9 million, Pakistan, a federation comprised of four provinces, is the most populated country in the Eastern Mediterranean Region. Per capita GDP is \$1,085, and 22.3% of the population lives below the poverty line.<sup>1</sup> The National Health Policy (2001-11) described for the first time investment in the health sector as a cornerstone of the government's poverty reduction plan. It has been aligned with the Medium Term Development Framework (2005-10) to achieve the Millennium Development Goals by 2015. The main priorities identified include controlling communicable

diseases, promoting health awareness and prevention, strengthening primary health care (especially in rural areas), developing an equitable health system and good governance, including improving district professional and managerial deficiencies.

As a signatory to the Alma Ata Declaration of 1978, the Government of Pakistan is committed to 'health for all' through the primary care approach. In 1994, the government launched the Prime Minister's Programme for Family Planning and Primary Health Care through the Ministry of

<sup>1</sup> Economic Survey of Pakistan 2007-2008, Ministry of Finance, Government of Pakistan, Islamabad released in June 2008

Health, with the aim of preventing and treating common ailments at the community level in a cost effective manner. The Lady Health Worker Programme is part of this and is backed by a strong commitment from the Ministry of Health in terms of financial ownership and advocacy.

The government is also committed to broader human resources for health strengthening, and there are initiatives to train other types of health workers as well.

## PLAN DEVELOPMENT

A major challenge faced by Pakistan's health sector is the imbalance in the health workforce characterised by a lack of sufficient health managers, nurses, paramedics and skilled birth attendants.

The rapid increase in the number of medical colleges, mostly in the private sector, has improved the doctor to population ratio to an extent. Problems are compounded however, as medical graduates tend to concentrate in the major cities while a large number of trained health personnel migrate internationally. The World Health Organization Country Office assisted the government authorities in defining expectations, tasks and responsibilities at all levels of the health care system related to the defined priority programmes. The particular unmet health needs of rural communities and urban slum populations led in 1994 to the creation of the Lady Health Worker cadre to provide essential primary health care services (health promotion, disease prevention, curative and rehabilitative services and family planning) in the community. The Ministry of Health and WHO are also emphasising community-oriented medical education in order to produce more primary health care physicians in an effort to bridge the current rural/urban disparities.

The Lady Health Worker Programme was initiated to scale up human resources for health at community levels both in rural areas and urban slums. The most innovative aspect of the programme is that this approach to health care is implemented at the community level. Lady Health Workers are community based and work from their homes (called health houses), within an area of 200 houses.

They are attached to a health facility and interact with the health service delivery system for specific interventions, such as referral of complicated deliveries. The programme was implemented in parallel with an expansion of other types of health professionals (almost doubling the number of physicians and nurses in 15 years), but these workers were still not reaching the rural communities. For this reason, the Lady Health Worker Programme was designed.

Lady Health Workers register the population of their service area, focusing on the priority age groups such as children under five and eligible couples for family planning. They act as a liaison between the formal health system and the community and disseminate health education messages on hygiene and sanitation.

The programme is strongly rooted in the primary health care concept and it aims to achieve universal health coverage. Each Lady Health Worker serves around 1000 individuals. Approximately 75% of the serviced population lives in rural areas. The target is 150,000 Lady Health Workers, or one Lady Health Worker per 1000 population. The table below shows how the number of lady health workers has increased between 1990 and 1994, along with a simultaneous expansion of doctors and nurses. Furthermore, by 2007, more than half of the population had access to primary health care service through the programme. By the end of 2008, another 14,000 workers will have been trained and deployed, bringing up the total to 110,000.

# HUMAN RESOURCES AVAILABLE FROM 1995 TILL 2007

Category	1995	2000	2007
Registered doctors	70,692	92,824	127,859
Registered nurses	22,299	37,528	62,651
Population per doctor	1,718	1,473	1,225
Population per nurse	5,448	3,642	2,501

Source: Economic Survey of Pakistan 2007-2008, Ministry of Finance, Government of Pakistan, Islamabad released in June 2008 using data from the *Pakistan Medical and Dental Council and Pakistan Nursing Council (PNC)*, Islamabad

## PLAN IMPLEMENTATION

The Ministry of Health is implementing the programme through the National Programme for Family Planning and Primary Health Care, in collaboration with donors, particularly in the area of training and vaccination.

The WHO Country Office provides policy and strategic guidance in this context, and also supports implementation through technical assistance including development of manuals, training activities, improved supervision and monitoring, resource generation and capacity building of Lady Health Workers, supervisors and district health managers.

The programme is funded by the Federal Government of Pakistan. The allocated budget for the first eight-year phase of the programme was about \$151 million, but the actual expenditure by 30 June 2003 was approximately \$155 million. In January 2004 an extension of the programme was

approved for 2003-08 at a cost of \$356.6 million. Currently the Government of Pakistan is the largest contributor of funds to the Lady Health Worker Programme, with only 11% contributed by external donors.

Each Lady Health Worker is attached to a government health facility, from which they receive training, medical supplies, a small allowance and supervision. Their salary is about \$343 per year. They are not strictly allowed to engage in other paid activities, so that they do not neglect their duties. However, about 15% have been found to do so without any obvious impact on the quality of their work.

The total cost of each worker per year is approximately \$745, and as she is providing services to approximately 1000 people, the actual cost per person per year is less than 75 cents.

### Planned and actual cost per Lady Health Worker (USD\$)

	Planned Cost		Actual Cost	
	(PRs)	(%)	(PRs)	(%)
Salaries	\$308.40	31	\$ 280.56	62
Drugs/contraceptives	\$393.22	39	\$63.59	14
Lady Health Worker training/kit	\$120.02	12	\$17.14	4
Supervision	\$132.82	13	\$61.57	14
Media and Health Education	\$24.31	2	\$ 7.84	2
Administration and Health Management Information System	\$24.31	2	\$19.30	4

Source: Oxford Policy Management 2002. *Lady Health Worker Programme: External Evaluation of the National Programme for Family Planning and Primary Health Care*; Islamabad.

## EXPANSION OF EDUCATION AND TRAINING CAPACITY

The minimum entry requirement to the Lady Health Worker programme is eight years of schooling. Other entry requirements include: a) local residency; b) possession of a Middle School Pass; c) preferably married; d) minimum age of 18; and e) recommended by/acceptable to the community.

A 15-month training course is provided. Three months consist of classroom instruction, plus some practical learning (health education, charts, videos), followed by 12 months of practical on-the-job training, which includes one day per month in the classroom working on problem-based modules.

Lady Health Workers are prepared to support maternal and child health services, which include family planning, HIV/AIDS and treatment of minor illnesses. The services they provide include: health education and promotion of healthy behaviour, including the use of basic preventive health services; family planning services,

including contraceptives; and basic curative care and with training to identify and refer more serious cases.

Lady Health Workers provide essential drugs for treatment of minor ailments such as diarrhoea, malaria, acute respiratory tract infection, intestinal worms, etc., as well as contraceptive materials to eligible couples. They strengthen the EPI Programme to improve vaccination status of the women and children. They provide antenatal and postnatal care and referral service to mothers for safe motherhood, by working in close coordination with traditional birth attendants and other skilled birth attendants including midwives, and in conjunction with the nearest health facility.

No management or leadership training is provided Lady Health Workers, except for drug and patient management including record management.

## MONITORING AND EVALUATION

The Lady Health Worker Programme has its own monitoring system, independent from the Health Management Information System. Monitoring includes quarterly review meetings and analytical feedback on health records from Lady Health Workers. Provincial and district coordinators perform frequent monitoring and supervision of these cadre.

A third-party evaluation conducted in 2000-01 by Oxford Policy Management (OPM) found that the population served by the programme have substantially better health indicators than the control population. A wide range of measures related to maternal and child health demonstrate this, including the use of antenatal services, medical assistance at births, use of family planning, health

knowledge, the use of preventive child health services and the treatment of childhood diseases. A number of breastfeeding measures are also better. Where they can be compared, indicators in the served population are often better than the national population. For example a 2006 study in Punjab province showed Lady Health Workers contributed to a reduction in the maternal mortality rate from 350 to 250 per 100,000 live births and in the infant mortality rate from 250 to 79 per 100,000 live births.

The OPM evaluation also showed areas for improvement however, under-funding is a problem and coverage needs to be increased with as many as 40% of eligible families still not being served by a LHW.

From July 2005 to June 2008 the focus is on capacity building at the provincial and district levels. During these three years, different models for the development of a sustainable and viable structure for the programme, including the possibility of transferring management functions to the provinces and the districts, are being piloted in select districts. At the end of this period, there will be another evaluation of the programme, which now covers almost all districts in Pakistan.

Based on the strategic plan and the findings from the implementation of the programme and the pilot initiatives, a comprehensive plan for the future structure and activities of the programme will be prepared in consultation with major stakeholders and the provincial governments. By the end of 2011 it is expected that a viable structure will be developed with assured sources of funding to sustain the Lady Health Worker Programme.

## LESSONS LEARNT AND POLICY RECOMMENDATIONS

In the actual implementation of the programme, which was considered a good policy decision, there were operational factors that posed some problems:

- In some areas, the entry level qualifications were too high, resulting in few or no candidates.
- There was insufficient communication between federal, provincial and district level, leading to drug supply problems and monitoring gaps.
- In some regions, there was insufficient integration into the health system, with traditional health cadres looking down on Lady Health Workers.

Despite these problems, the evaluation found that there is a case for an expanded programme, but future expansion should redress the current imbalances in programme coverage. This will require targeted expansion policy, recruiting new Lady Health Workers from underserved and poor areas.

Improvement of supervision is necessary, through improving supervisors' access to vehicles, and increasing the effectiveness of supervision.

## REFERENCES

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Launched in 2006, the **Global Health Workforce Alliance** is a partnership dedicated to identifying and implementing solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations. The Alliance is hosted and administered by the World Health Organization.

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