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Country Report for Pakistan

Evaluation of South Asia’s Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers’ Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

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Content

Executive summary 6

Introduction and background 13

Country context **13**

Object of the evaluation **14**

Purpose and objectives of the evaluation 16

Scope of the Evaluation **17**

Key Evaluation Questions **17**

Methodology 19

1. Data collection **19**

2. Data analysis **19**

3. Frameworks used to inform data collection and analysis **22**

4. Ethical standards **23**

5. Limitations and mitigation measures taken by evaluation team **23**

Findings 24

1. Current CHW profiles, roles and responsibilities, policies and system support **24**

2. Policy and system support improvements to optimise CHW programmes **39**

3. Prioritized measures to strengthen health policy and system support to optimize the contribution of CHW cadres to PHC **44**

Conclusions 46

Recommendations 46

Annexes 48

Annex 1: Generic KII topic guide 48

Annex 2: KII topic guide for gender 50

Annex 3: References 52

Annex 4: Ethical approval letter 55

Figures

Figure 1: Illustrative theory of change for CHW programme 14

Figure 2: Conceptual framework for gender analysis 21

Figure 3: Gender responsive assessment scale 22

Figure 4: Vision of integrated management of LHWP 30

Figure 5: Roles and responsibilities of LHW 31

Figure 6: Selection, training and management of LHWs 34

Tables

Table 1: Indicative evaluation matrix 18

Table 2: Analysis plan 20

Table 3: Availability and distribution of LHWs 26

Acronyms

ANC	Antenatal care
BCC	Behaviour change communication
BHU	Basic health units
CBV	Community based vaccinators
CHW	Community health worker
CMW	Community midwives
CMNH	Centre for Maternal and Newborn Health
CPD	Continuing professional development
CPR	Contraceptive prevalence rate
DV	Domestic violence
EPHS	Essential package of health services
FMoH	Federal Ministry of Health
FP	Family planning
GBV	Gender-based violence
HPN	Health-population-nutrition
KI	Key informant
KII	Key informant interview
LSTM	Liverpool School of Tropical Medicine
LHW	Lady health worker
LHP	Lady Health Worker Programme
LHS	Lady health worker supervisor
MIS	Management information system
MNHSR&C	Ministry of National Health Services, Regulations and Coordination
MMR	Maternal mortality ratio
NMNCHP	National Maternal Newborn and Child Health Programme
NCDs	Non-communicable diseases
NGO	Non-Governmental Organization
OPM	Oxford Policy Management
PHC	Primary health care
PNC	Postnatal care

PPIU	Provincial Project Implementation Unit
PSDP	Public Sector Development Programme
RH	Reproductive health
RHC	Rural Health Centres
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
ROSA	Regional Office for South Asia
SBA	Skilled birth attendance
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
UHC	Universal health care
UNEG	United Nations Evaluation Group
WHA	World Health Assembly
WHO	World Health Organization

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Executive summary

Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of primary health care (PHC) towards achieving universal health coverage (UHC) and the health-related SDGs. Community health workers (CHWs) are the backbone of PHC and evidence highlights their effectiveness in delivering a range of preventive, promotive and curative services. In the South Asian context of ongoing demographic and epidemiologic changes, there is an urgent need to enhance the contribution of CHW programmes to PHC, strengthening and achieving the post-Astana goals and commitments in the region.

A formative evaluation was conducted of CHW policies and systems support in South Asian countries in order to understand CHW policies and system supports that are currently in place to support the effective functioning of CHW programmes and to determine the key policy adjustments and interventions needed to address any gaps. The evaluation also assessed the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans.

Community-based health workers in Pakistan primarily include lady health workers (LHWs) and lady health supervisors (LHSs), community midwives (CMWs), a recently introduced Health-Population-Nutrition (HPN) Counsellor, community-based vaccinators (CBV), and malaria supervisors, among others. Of these programmes, the most established is the Lady Health Worker Programme (LHWP), introduced in 1994. Following the 18th Constitutional Amendment in 2011, the management of the LHWP has been devolved to provincial governments.

LHWs are deployed across the nation in all four provinces and Federally Administered Territories of Pakistan. Their role is primarily community-based and the scope of services provided by LHWs has grown from an initial focus on MNCH and routine immunization to include participation in large health campaigns (such as polio immunization), newborn care and health education. For Pakistan, the LSTM team, in consultation with UNICEF ROSA and the UNICEF Pakistan Country Office, confirmed that there are currently two CHW cadres active in the country (LHWs and CMWs) who fall within the WHO CHW definition and would therefore be covered by this evaluation.

Objective intended use of the evaluation

The overall objective of this evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes, and the profiles, policy framework and system support required to better serve RMNCAH as well as to respond to primary health care (PHC) reform and strengthening in seven South Asia countries, including Pakistan.

The findings will inform national government plans and enhance UNICEF and partners' advocacy and technical guidance to local governments who are instrumental in PHC priority setting, resource mobilization as well as allocation and the recruitment of the PHC workforce (including CHWs under national decentralization policies).

The evaluation responds to the following three key evaluation questions (KEQ):

1. **KEQ 1:** What are the current profiles, roles and

responsibilities, policies and system supports in relation to each CHW cadre?

2. **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles as well as the roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening?
3. **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

Over the previous two decades, Pakistan has seen an improvement in maternal health indicators. However, there are serious equity concerns as quality services are not available in many hard-to-reach areas, with significant variations among provinces and districts. Since 2000, the burden of disease has significantly shifted from communicable diseases to non-communicable diseases (NCDs). Pakistan has significant gender disparities that serve as a major impediment to economic and social development.

The public health system in Pakistan is divided broadly into three tiers of governance: federal, provincial and district. Following the 18th Constitutional Amendment in 2011, the Federal Ministry of Health (FMoH) was dissolved, and its powers and responsibilities were delegated to the provinces. Due to numerous concerns and issues raised by the absence of an FMoH, the Ministry of National Health Services, Regulations and Coordination, (MNHSR&C) was re-established at the federal level in 2013. At the district level, the health care delivery system includes, Basic Health Units (BHUs) and Rural Health Centres (RHCs), which function as PHC establishments. Overall, Pakistan has one of the lowest densities of health workers in the region and globally.

Methodology

The evaluation used a mixed-methods approach for this evaluation that combined a desk review and key informant interviews. The review examined available national policies, plans, strategies, country reports, peer-reviewed publications, reports from donors/development partners, international and local non-governmental organizations, evaluation reports, training guidelines and CHW databases. In addition, qualitative data was collected through 11 interviews with 11 national level key informants (KIs) involved in the CHW programmes.

A semi-structured topic guide and a gender-specific guide, informed by the evaluation framework and analysis plan was used to collect data. Analysis was conducted using NVivo Version 11 based on the following: the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018), the WHO Gender Responsive Assessment Scale (WHO, 2011) and the Steege et al (2018) conceptual framework.

Gender analysis

In addition to the above, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

Findings

1. Current CHW profiles, roles and responsibilities, policies and systems support

The findings below relate to KEQ1.

1.1. Current CHW profiles and roles and responsibilities

In 2017, there were 92,849 LHWs available across the country, all women. More recently, there has been a decline in absolute numbers of LHWs in all regions of Pakistan with the exception of Khyber Pakhtunkhwa. At the national level, despite explicit targets to increase coverage (i.e., 100 per cent in rural areas and 30 per cent in urban areas (mainly slums/densely populated areas), there has been a stagnation in the overall population coverage across Pakistan at just under 60 per cent for the period of 2014-2018.

As originally envisioned, LHWs were not government servants, and instead worked on a contractual basis. Their jobs were regularized in 2012 following a national movement by LHWs, making them salaried government staff. However, due to a series of administrative delays related to the financial burden of the LHWP, it has taken more than four years for the regularization to be adopted by each province. Following regularization, there has been a freeze on recruitment for new LHWs, and the numbers of LHWs have decreased.

In 2007, of a new cadre of skilled birth attendants (SBAs) called community midwives (CMWs) was introduced under the National Maternal Newborn and Child Health Programme (NMNCHP). At the time, the programme aimed to train and deploy around 12,000 CMWs nationwide to increase coverage of MNCH services by skilled providers. There is, however, no data available on how many were actually produced and deployed and are still active today; CMWs are yet to emerge as a significant maternal care provider in rural Pakistan.

1.2. Key policies and the policy environment for CHWs

In 2014, the federal government developed a detailed and ambitious plan (Pakistan Vision 2025) for the overall development of the country. In order to address gaps identified in the vision document, the FMoH developed a detailed National Health Vision (2016-2025). The Pakistan Vision 2025 document also recognizes that gender equity and women's development is strongly linked to a woman's independence to pursue economic growth and exercise her life choices freely.

The recently developed UHC Benefit Package of Pakistan aims to transform the National Health Vision 'into reality' and to steer the health system towards UHC. The Package consists of an Essential Package of Health Services (EPHS) at five platforms, including at the Community and Primary Health Care Centre Level with implementation targeted to commence in 2020 (Ministry of Health & Population, Provincial/Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020). The package of services proposed at the community level are based on community needs, the burden of disease, cost-

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effectiveness of interventions and the contextual factors to ensure the delivery of 'efficient, effective and quality services at the doorstep'. Each provincial/area department of health will prioritize a sub-set of essential health services based on their needs, burden of disease, and fiscal space.

The National Vision for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCH) and Nutrition refers to the role of the LHW in improving the access to and quality of MNCH community-based primary care in rural districts and urban slums. The National Human Resources for Health Vision 2018-2030 provides guidance for deploying strategic measures to combat gaps and challenges in human resources and recommends the scope of work for national and provincial health systems.

Following the 18th Amendment, the provinces took over the implementation of the government vertical health sector programmes, including the LHWP. Under the devolved arrangements, the provinces have responsibility for developing province-specific health strategies, which include both strategic objectives, as well as implementation plans for the delivery of health care in the provinces. While there is a general expectation that these should be aligned with the National Vision, there is some variation across the provinces. However, the handover following devolution was not structured enough to support a smooth transition, since the provinces lacked the technical capacity to support the LHW programme and its related reforms. This affected the quality control of the LHWP. With the transfer of responsibility for strategy setting and programme implementation to the provinces, there has been some divergence in the role that the LHWP is seen as playing in achieving RMNCH objectives, its relation to other programmes and activities, and the functions that LHWs are being asked to perform.

When the FMoH was re-established as the MNHSR&C, a Health Planning Unit (HPU) was created as part of the federal ministry, to reconnect with the MNCH and LHW programme and other programmes by holding regular meetings with all the provinces/regions. A dedicated forum for the oversight of the LHW programme was not established.

1.3. CHW roles and responsibilities and a focus on RMNCAH

LHWs are essential in supporting the provision of PHC and preventive services throughout the country. Though expanded considerably, their primary mandate remains MNCH services, with immunization activities (particularly polio) a core aspect of their work. An LHW will register approximately 200 households, or 1,000-1,500 clients in her community to whom she will offer a range of preventative and promotive services, including family planning. Every working day, she will visit five to seven households, and will ensure a repeat visit every two months. The LHW's services are free at the point of delivery.

However, there are clear challenges faced by the LHWP. The dilution of LHWs' core mandate with additional responsibilities is seen to be one of the leading causes of declining quality in their services. Despite this, the programme continues to have an impact on the long-term health outcomes of the population it reaches. The LHWP missed many marginalized communities, especially because of system support gaps, however, the impact of the LHWP was still strongest for the poorer households that it did reach.

The community midwife cadre was introduced in 2006. Rural women with ten years of education were recruited and received 18 months of midwifery training. They were then deployed back to their home villages, where they were expected to establish private practices and provide domiciliary maternity care to a population of 10,000, in geographically defined catchment areas. However, many CMWs are inactive, particularly in the large, urbanized districts where institutional deliveries are increasing.

1.4. Selection, education and certification

LHWs have to be female, preferably married, a permanent resident of the area, between 20 and 50 years old, with a minimum eight years' schooling (preferably matriculated). She has to be agreeable to her residence being designated as a 'health house'. Following selection, LHWs undergo a 15-month

training course–this includes three months of classroom instruction, followed by 12 months of practical on-the-job training. Training is provided by health department staff at the health facility where the LHW is recruited. LHWs also receive a 15 day-refresher training annually.

There are, however, challenges in the selection and training process (including an inability to fulfil educational criteria, especially in more marginalized communities); changing LHW roles that have not been adapted into the recruitment criteria; increased salary costs following regularization; a lack of updated training curriculum and irregular refresher trainings.

1.5. Management and supervision

LHWs are supervised by an LHW Supervisor (LHS). An LHS is provided with a vehicle and driver and is expected to visit each LHW under her supervision at least twice a month. On average, across Pakistan, there are sufficient numbers of LHSs to cover the current workforce of LHWs. However, these supervisory meetings do not occur with the consistent regularity that they should. A lack of funding, particularly for transportation is a major barrier to the effective supervision of LHWs by LHSs and potentially impact their motivation, performance and the quality of services they provide.

Following devolution, the federal government continued to fund the salaries of LHWP staff in provinces until the fiscal year (FY) 2017-2018. Thereafter, the provinces were given complete responsibility for funding the LHWP from their own budgets, with the federal government retaining responsibilities for funding the LHWP in the regions of AJK, Gilgit-Baltistan and ICT within the MNHSR&C budget. However, this process has come upon several obstacles, including the financial burden on the provinces as a result of the doubling of LHWs' salaries.

In the initial period after regularization motivation levels for LHWs had increased across all regions of Pakistan, mainly as a result of a perceived sense of job security. However, due to the poorly-planned process of regularization, this initial boost to motivation has been undermined by the lack of a career advancement structure, lack of access to the full benefit package (including pensions or medical allowance) enjoyed by other government civil servants and considerable delays in the payment of salaries across all regions. LHWs do not have access to a structured system of career progression.

1.6. Integration into and support by health systems and communities

Integration into and support by the health system post-devolution has varied across provinces. However, there seems to be a lack of coordination between LHWs and CMWs on the ground. The expansion of the LHW caseload from a maximum of 1,000 residents to 1,500 residents was reportedly undertaken without a careful assessment of the capacity and capabilities of LHWs. The expansion of the LHW's role to include participation in other activities, such as polio programming, also did not consider the implications of taking an LHW out of her community and diversifying her efforts away from her core RMNCAH functions. These have negatively affected LHWs' performance and the quality of the services that they deliver.

Post-devolution, procurement is undertaken at the provincial level. Continuing issues with the LHWP logistics management system have resulted in significant gaps in the provision of basic supplies and equipment, with frequent stockouts.

Progress in upgrading the LHWP Management Information System (LHW-MIS) varies across provinces. Effective quality control mechanisms and enforcement of reporting on all indicators are lacking across most regions. Consequently, MIS data does not appear to be used systematically to inform programme strategies in any region. The lack of a harmonized logistics management information system (LMIS) for all LHWP supplies, and the lack of capacity to fully implement the LMIS where it is available, severely limits the ability of the LHWP to adequately plan the distribution of supplies.

Community response to LHWs work is reportedly positive and they enjoy an elevated status within the community as a result. The recruitment criteria that require LHWs to be recruited from the communities in which they live means that they are known, and more likely to be trusted, by the communities in which they work. However, LHWs are being asked to engage in programme activities that force them to work outside of their communities, and LHWs may struggle to be accepted by communities where they are not known.

1.7. Financing

Prior to devolution, the LHWP, like all vertical health programmes, had been funded federally through the Public Sector Development Programme (PSDP), and had been to a large degree fully funded, with relatively minimal delays in the release of funds. Since devolution, however, the LHWP across all regions has faced considerable financial challenges in large part due to the regularization of LHWs, with the per LHW cost more than doubling, with an associated and significant decline in funds allocated to non-salary expenditure. Risks to funding and the financial sustainability of the programme vary across the regions.

1.8. Private sector involvement in CHW programmes

Low levels of public expenditure on health care in Pakistan has meant that the private sector plays a large role in the delivery of health services. While the LHWs might refer someone to a government health facility, often patients do not always find the services they need and revert to the private sector at a high-cost with limited quality of care. However, there are no formal mechanisms nationally within the health sector for engagement with the private sector.

2. Prioritized measures to optimize the contribution of CHWs to respond to post-Astana requirements and PHC strengthening

The findings below relate to KEQ 3.

2.1. Policy support measures

PHC policies and reforms

To transform the National Health Vision into reality, the basic PHC system in Pakistan needs to be strengthened, which will require expanding the existing infrastructure. While there has been no overarching policy shift, some provinces have begun testing updated frameworks.

- **Political commitment and stakeholder participation:** Sustained political commitment and robust and transparent leadership that promotes multisectoral stakeholder participation and engagement at all levels will be vital for operationalizing and institutionalizing the UHC Benefit Package and the delivery of the EPHS at all levels.
- **Inter-sectoral linkages:** Strengthening partnership with actors from other government sectors, the private sector and development partners will enhance efforts to mobilize the necessary human, financial and technological resources for effective PHC strengthening and UHC. Stronger partnerships will also potentially enhance collaboration and promote teamwork across the PHC workforce.
- **Transparency:** There is a need to establish effective coordination and communication mechanisms and monitoring standards and systems, which will promote transparency and provide quality and reliable information to help allay stakeholders' fears and concerns about the effects of the UHC benefit package on the PHC and community levels.
- **Sub-national leadership:** Building robust leadership and management capacity of sub-national leaders, managers and supervisors at provincial, division and district levels will be critical for ensuring a smooth transition to effective local governance and the management of community-based services and the community workforce.
- **Community engagement:** Community engagement, education and empowerment are necessary conditions for the effective use of PHC services. Harnessing the potential of LHWs, who have established trusting relationships, accumulated significant social capital and achieved the status of influential social actors and change agents, will enhance such engagement as well as improve the coverage, reach and equity of PHC programmes.

Health workforce policies

Within the HRH Vision 2018-2030, a number of steps are outlined that target the development, expansion and support of CHWs. Recommended interventions including the development of training and recruitment plans should be acted on to address the identified workforce challenges.

Financing

Pakistan needs to invest more in the health sector to improve social protection and the health of the population. Resource constraints in the LHWP have resulted in major gaps in capacity building/training; supervision and MIS; governance and planning and the procurement of supplies/equipment. Policy makers should encourage more stable and flexible financial plans, along with an increased budget allocation, taking into account the priorities of the health sector.

CHWs and the PHC workforce

Fostering collaborative and cooperative relations across the evolving BHU teams (including the CHW cadres who are vital members of these teams) will help realize the ambition of quality for integrated PHC services. Improved availability and mix of skills in the PHC workforce as a result of the reorganization of the PHC could also provide opportunities to explore options for the creation of specialist roles, a team-based PHC workforce and career pathways for LHWs and CMWs.

Gender transformative policies

An inclusive health workforce policy should consider how women's competing gendered responsibilities affect their ability to take up training or opportunities provided to retrain for new positions or to advance professionally in their careers. They should also consider how the gendered responsibilities and gender-specific needs of women and men affect their employment needs and preferences.

2.2. System support measures

While the well-established network of LHW cadres across the country contributed to the achievement of positive RMNCAH outcomes in a cost-effective manner over the years, of late a decline in the quality of services offered by the LHWP has been noted. This is due to a variety of factors, chiefly related to ongoing issues stemming from the devolution of health care services to the provinces. Several system support measures to address these gaps are suggested below.

Optimizing CHW roles and responsibilities

There is an urgent need to refocus the attention of the LHW programme towards RMNCAH and to safeguard the role of the LHW in the provision of these critical services. Maintaining a focus on improving the quality RMNCAH services should be a key consideration for future PHC planning, budgeting and programming.

There is a contrary view among some key informants that suggests expanding the scope of work of the LHWs, particularly in the areas of communicable and non-communicable diseases. If LHWs are to play a role in NCD prevention and control efforts within the scope of their current roles and responsibilities, appropriate systems support, including training, supervision, remuneration and an enabling environment to address deficiencies that have been identified will be required. Any additional tasks and expectations related to NCD health promotion and education or other services, should be clearly defined and should not interfere with or undermine their ability to undertake their core RMNCAH and other functions. However, the recently introduced Health-Population-Nutrition (HPN) Counsellor, may reduce LHWs' current workload. This cadre is expected to provide community level health awareness and education sessions in collaboration with the LHW and also support facility-based health care providers to organize health education sessions for clients visiting the facility. In addition, the recent recommendation which proposed the introduction of a new cadre of multi-purpose male workers (e.g., vaccination, school and adolescent health, NCDs), may also reduce the pressures on the LHW. However, efforts should be made to ensure the cost of these new and proposed cadres does not further constrain the resources available for the LHW and the RMNCH services she provides.

Selection, education and training

A key priority of the LHWP should be to ensure that the selection, deployment and transfer of LHWs, as well LHSs, is based on merit. Any further expansion of the LHWP should be

informed by reliable information on the areas with the poorest health outcomes, a lack of access to health care facilities and high rates of poverty. Skills development, capacity building and supportive supervision are key priorities for ensuring LHWs have the latest knowledge and skills to provide quality services and for strengthening the overall LHWP.

Management and supervision

The regularization of LHWs has created significant human resource management challenges as it was not accompanied by the definition of an adequate service structure nor a careful assessment of the workload of an LHS or LHW relative to the remuneration offered. These need to be immediately addressed. Career mobility opportunities need to be built into CHW programming to encourage and enable LHW and other CHW cadres to advance to higher levels of the health system, as well as leadership positions, if they so desire.

Building the capacity of LHS supervisors and providing adequate support to enable them to provide effective and regular supportive supervision, on-the-job training and mentoring of LHWs is urgently needed.

CHW integration into the health system and community

Strengthening the integration of the LHWP and improving coordination mechanisms across all provinces will help to ensure LHWs can continue to play a central role in the provision of family planning and RMNCAH services. Engaging LHWs in programme activities outside their communities where they are not known may be challenging for this cadre and should be well managed.

Making the CHW programmes gender transformative

The LHWP is perceived to be supportive of the empowerment of both LHSs and LHWs in terms of their improved economic status and greater social status in the communities in which they work. LHWs also increase women's access to services. These need to be supported and strengthened. There are numerous barriers to the prevention of and response to Gender Based Violence (GBV) in Pakistan. However, there was no publicly available data to determine the role of CHWs in countering GBV and SGBV in the country.
The Domestic Violence (Prevention and Protection) Act, 2012 does not make mention of LHWs or any other CHWs. The UHC **Benefit Package and Essential Package of Health Services (EPHS)** is largely silent on gender, with only one of the prioritized interventions for the BPHS at community and PHC Centre-level gender related as follows: **'post gender-based violence care including** counselling and referral' for adolescents. LHWs are well placed, with the appropriate training, sensitization and support, to play a key role in preventing GBV and supporting survivors.

Recommendations

Given the system-building nature of the recommendations, all recommendations must be spearheaded by the Government of Pakistan. UNICEF and other development partners should play a key role in providing technical and financial support to the Government for implementation of the recommendations.

Recommendation 1: **LHW programme should continue.** They have a key role to play in increasing the utilization of services at PHC level. Their utilization and retention will also ensure that the investments and reform efforts achieve the expected health outcomes.

Recommendation 2: Efforts should be made to **strengthen inter-sectoral linkages to mobilize the necessary human, financial and technological resources** for effective PHC strengthening and UHC. Strengthening the partnership with actors from other government sectors (the Ministries of Interior, Finance, Education, Planning and Development, Ehsaas, Human Rights, Law and Justice, Inter-Provincial Coordination, amongst others), the private sector and development partners will also potentially enhance collaboration and promote teamwork across the PHC workforce.

Recommendation 3: The Government of Pakistan **should invest more in the health sector, organize health financing and create strong supply chains** to improve social protection and the health of the population. Policy makers should encourage more stable and flexible financial plans, taking into account the priorities of the health sector.

Recommendation 4: Given the devolution of authority to the subnational level, **building robust leadership and management capacity of sub-national leaders, managers and supervisors at provincial, division and district levels should be done** to ensure a smooth transition to effective local governance. Subnational stakeholders will also need the support, resources and in some cases, the authority to make decisions, to ensure PHC reforms, associated workforce polices and CHW programmes respond to local realities and the needs of the population.

Recommendation 5: The evaluation recommends a **strong monitoring and evaluation system, supervisory mechanisms, skills development and capacity building** for ensuring LHWs have the latest knowledge and skills to provide quality services and for strengthening the overall LHWP. The capacity building of LHS supervisors and adequate support to enable them to provide effective and regular supportive supervision, on-the-job training and mentoring of LHWs is urgently needed.

Recommendation 6: In order to increase the attractiveness of CHW jobs and careers, **career mobility opportunities should be built into CHW programming to encourage and enable LHW and other CHW cadres to advance to higher levels** of the health system, as well as leadership positions, if they so desire.

Recommendation 7: Efforts should be made **to foster collaborative and cooperative relations across the PHC workforce,** including between the LHW and other community-based cadres, who are vital members of this workforce.

Recommendation 8: An inclusive **health workforce policy should consider how women's competing gendered responsibilities affect their ability to take up training or opportunities** provided to retrain for new positions or to advance professionally in their careers and consider the gendered-specific needs of women and men.

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Recommendation 9: The LHW programme should refocus **the attention of LHWs towards RMNCAH** and safeguard the role of the LHW in the provision of these critical services in order to improve the quality of RMNCAH services. If LHWs are to play a role in NCD prevention and control efforts, appropriate systems support, including training, supervision, remuneration and an enabling environment to address areas where respondents have identified deficiencies, will be required.

Recommendation 10: A priority should be **renewed strategic thinking on improving the availability and distribution of LHWs across the country,** especially in rural and hard-to-reach areas with the poorest health outcomes, a lack of access to health care facilities and high rates of poverty. This should ensure that the selection, deployment and transfer of LHWs, as well LHSs, is based on merit.

Introduction and background

Country context

Pakistan (including Gilgit-Baltistan and Azad Jammu and Kashmir) is the 5th most populous country in the world, with a population of 227.5 million people (2020) with an additional 1.4 million Afghan refugees. The current population growth rate is estimated to be 2.1 per cent.

Geographically, Pakistan is the 33rd largest country in the world, spanning 881,913 square kilometres. The country is divided into four provinces, Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Balochistan, and three federating areas of Gilgit Baltistan (GB), Azad Jammu & Kashmir (AJK) and Islamabad Capital Territory (ICT). The areas previously known as the Federally Administered Tribal Areas (FATA), a semi-autonomous tribal region in north-western Pakistan, have been merged with KP, through a constitutional amendment in 2018.

In Pakistan, 63.57 per cent of the population lives in rural areas, while 36.43 per cent of the population is urban. Only Sindh and ICT have more than 50 per cent of their population residing in urban areas. As per the 2017 Census, the sex ratio in the country is 106 males: 100 females (103.7 in rural areas and 107.4 in urban areas). Of the total population, 64 per cent is below the age of 30, while 29 per cent is between 15 and 29 years old.

The provinces/areas are subdivided into administrative 'divisions'- 10 in Punjab, seven in Sindh, seven in KP, six in Balochistan, three in GB and three in AJK. Divisions are further subdivided into districts, tehsils/talukas and finally union councils. The divisions do not include the ICT, which is counted at the same level as the province.

More than 74 languages are spoken as first languages in Pakistan. Amongst them, five languages are spoken by more than 10 million speakers each – Punjabi, Pashto, Sindhi, Saraiki and Urdu. Pakistan's national language is Urdu, which, along with English, is also the official language.

Despite challenges, the economy of Pakistan was able to maintain its growth momentum above 4.0 per cent every year since 2013-18, with highest growth in 10 years at 5.79 per cent recorded in 2017. The rate declined to 1.9 per cent in 2018-2019 and (-)0.38 per cent in 2019-2020. Per capita income is an indicator of economic well-being and has increased from US$586 in 2002-2003 to US$925 in 2006-2007 and to US$1,641 in FY 2017. However, a decline to a level of US$1,388 is observed in 2019-2020, since the economic situation is under stress mainly due to fiscal crisis and more recently as a result of the COVID-19 pandemic (Ministry of Finance, 2013).

According to Pakistan's first official report on multidimensional poverty released in 2016, nearly 39 per cent of Pakistanis live in multidimensional poverty, with the highest rates of poverty in (the former) FATA and Balochistan. Pakistan's Multidimensional Poverty Index (MPI) showed a significant decline, with national poverty rates falling from 55 per cent in 2004 to 39 per cent in 2015. However, progress across different regions of Pakistan is uneven. Poverty in urban areas is 9.4 per cent, while in rural areas this can go as high as 54.6 per cent. Disparities also exist across provinces. The report found that more than two-thirds of people in FATA (73 per cent) and Balochistan (71 per cent) live in multidimensional poverty. Poverty in KP stands at 49 per cent, Gilgit Baltistan and Sindh are at 43 per cent, Punjab at 31 per cent, and Azad Jammu and Kashmir at 25 per cent (Ministry of Planning, Development and Reform, et al, 2016).

Pakistan is a lower-middle income country, having primarily an agrarian economy. Market driven factors have resulted in diversification of occupations and the services sector has recently surpassed other sectors. Share of the agriculture sector in the 2017-2018 GDP was only 19 per cent, industrial sector 21 per cent and that of services sector was 60 per cent. Wholesale and retail trade are the largest (31 per cent) subsector of the services sector followed by transport and communication (22 per cent).

Over the previous two decades, Pakistan has has made impressive progress in many of the targets within the sustainable development goals (SDG) for health and well-being. There have been an improvement in the reported maternal mortality ratio, with 140/100,000 live births in 2019 from 306/100,000 live births in 2000 and significant improvements in other indicators especially skilled birth attendance (69 per cent in 2017-2018) and institutional deliveries (66 per cent). However, there are serious equity concerns as quality services are not available in many hard-to-reach areas, with significant variations among provinces and districts and the country faces challenges to achieve the 2030 SDG targets.

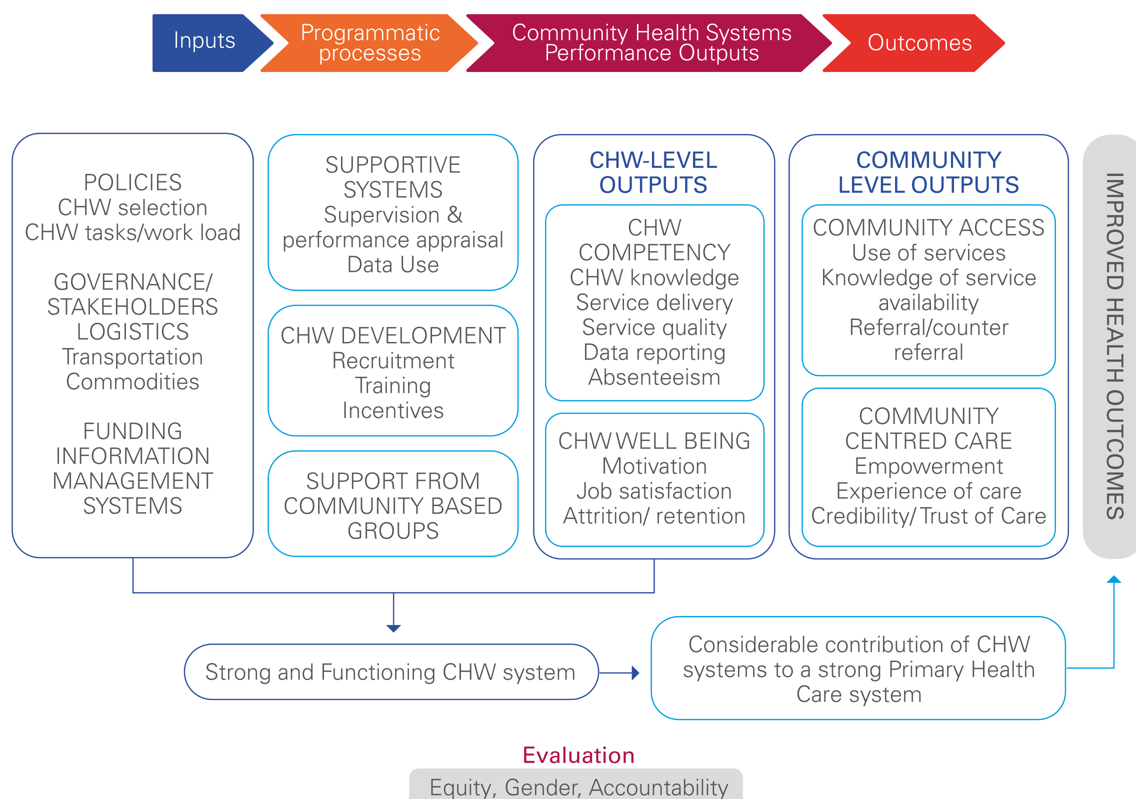
Unfortunately, there has been no progress in contraceptive prevalence rate with only 25 per cent of couples using modern contraceptive methods (PDHS 2017-2018). In Pakistan, eight per cent of pregnancies are among adolescent girls of age 15-19 years (Pakistan Bureau of Statistics, 2019).

Since 2000, the burden of disease has significantly shifted from communicable diseases to non-communicable diseases (NCDs), accounting for 55.3 per cent of total deaths as reported by Global Burden of Disease (GBD) data for Pakistan in 2019. Among NCDs, cardiovascular diseases (CVD), which includes ischemic heart disease, stroke, rheumatic heart disease, and hypertension, constitutes 22.7 per cent of total deaths in Pakistan (National Institute of Population Studies and ICF. 2019). The increase in NCDs in Pakistan is projected to continue due to the rapidly increasing population and largely unhealthy lifestyle of the population.

It is important to note that Pakistan and neighbouring Afghanistan are the only countries left in the world where the poliovirus continues to threaten the health and well-being of children. Since 1994, the Pakistan Polio Eradication Programme has been committed to ending polio virus transmission in Pakistan. Through its efforts, case numbers have declined by up to 99 per cent from the 20,000 cases that were reported in the early 1990s. However, a myriad of obstacles, chief among which is the spread of misinformation regarding the vaccine has caused the poliovirus to remain a major concern in Pakistan. According to the Independent Monitoring Board, there have been 61 wild poliovirus cases so far in 2020 (as of 31st July) compared to 56 by this time in 2019 (Independent Monitoring Board of the Global Polio Eradication Initiative, 2020).

The above context and status of SDGS affect the implementation of CHWs and their subsequent performance.

Figure 1: Illustrative Theory of Change for CHW programme



Adapted from Agarwal et al.[1]

Specific Linkage to the SDGs: The SDGs call for an accelerated return to principles of a more holistic PHC approach. This evaluation is more directly related to the following SDGs: SDG 3 ('Ensure healthy lives and promote well-being at all ages') and SDG 5 ('Achieve gender equality and empower all women and girls'). The WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes, which was the key framework for the study also notes that 'policy and investment decisions on health workers have broader implications on several other targets of the SDGs, including job creation, economic growth, gender empowerment and education'.

Object of the evaluation

CHW programmes and cadres in Pakistan

In 2018, the Astana Declaration reaffirmed PHC as the most inclusive, effective and efficient approach to enhance people's health and set PHC as the route to universal health coverage (UHC) and the health-related Sustainable Development Goals (SDG). In this context, Community Health Workers (CHWs) play an important role in advancing health protection and promotion and timely care seeking at PHC level. Part of this declaration focuses on strengthening the PHC health workforce and thereby CHW programmes.

The Astana declaration envisioned the following:

1. Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
2. Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
3. Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;
4. Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

Relevant Theory of Change

While the evaluation is not theory based, the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes, which was the key framework for the study, Organizes the contribution of CHWs to PHCs around three broad areas, namely: 1) selection, education and certification of CHWs; 2) management and supervision of CHWs; and 3) integration into and support by health systems and communities. The assumption is that with the necessary policy and system support related to these broad areas (i.e. supportive policies, investment, quality education, supervision and management systems and improved integration of community health into formal health systems), there will be improved contribution of CHW programmes to PHC strengthening. Governance, investment (financing), and monitoring and evaluation are also key to ensure that these investments lead to expected improvements in PHC service provision and health outcomes.

There is need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post Astana goals and commitments. It is therefore important to

[1] Agarwal et al., A conceptual framework for measuring community health workforce performance within primary health care systems, Resources for Health (2019) 17:86

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understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to help existing CHW cadres' transition into effective contributors to RMNCAH and to the PHC of the future in South Asian countries, including in Pakistan.

To contribute to knowledge generation in this area, the Centre for Maternal and Newborn Health (CMNH) at the Liverpool School of Tropical Medicine (LSTM) was commissioned by the UNICEF Regional Office for South Asia (ROSA) to conduct a formative evaluation of Community Health Worker (CHW) policies and systems support in South Asian countries, and their readiness for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans. This regional evaluation covers seven of the eight South Asian countries that fall under the remit of UNICEF ROSA: namely, Afghanistan, Bangladesh, Bhutan, the Maldives, Nepal, Sri Lanka and Pakistan, and assesses CHW policies and system support at national level only.

One of the initial activities of the evaluation was a desk review, for which the LSTM evaluation team reviewed peer-reviewed publications and policy documentation, relevant to CHWs programmes, with a focus on the provision of Reproductive Maternal, Newborn and Child Health (RMNCAH) services. A key output of the desk review was the mapping of the available CHW cadres in each of the seven countries, which was then shared with and validated by stakeholders in each of the countries, including the UNICEF country offices.

Right holders and duty bearers

Community based health workers in Pakistan primarily include Lady Health Workers (LHWs) and Lady Health Supervisors (LHS), Community Midwives (CMWs), a recently introduced Health-Population-Nutrition (HPN) Counsellor, Community Based Vaccinators (CBV), and malaria supervisors, among others. Of these programmes, the most established is the Lady Health Worker Programme (LHWP), introduced in 1994. Following the 18th Amendment, the management of the LHWP has been devolved to the Provincial Governments.

LHWs are deployed across the nation in all four provinces and Federally Administered Territories of Pakistan. Their role is primarily community-based and the scope of services provided by LHWs has grown from an initial focus on MNCH and routine immunization to include participation in large health campaigns (such as polio immunization), newborn care, and health education.

The LSTM evaluation team adopted the WHO definition of a CHW as follows: 'Health workers based in communities (i.e., conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours' (WHO 2018).

For Pakistan, the LSTM team, in consultation with UNICEF ROSA and the UNICEF Pakistan country office, confirmed that there are currently two CHW cadres active in the country as follows:

- Lady Health Workers (LHWs)
- Community Midwives (CMWs)

It was agreed that these two CHW cadres fell within the WHO CHW definition and would be covered by this evaluation.

In 2014, the Federal Government developed a detailed and ambitious Pakistan Vision 2025 for the overall development of

the country. In order to address gaps identified in the Vision document, the FMoH developed a detailed National Health Vision (2016-2025). The recently developed UHC Benefit Package of Pakistan aims to transform the National Health Vision 'into reality' and to steer the health system towards UHC. The National Vision for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCH) and Nutrition refers to the role of the LHW in improving the access to and quality of MNCH community based primary care in rural districts and urban slums. The National Human Resources for Health Vision 2018-2030 provides guidance for deploying strategic measures to combat gaps and challenges in human resources and recommends the scope of work for national and provincial health systems.

Following the 18th Amendment, the provinces took over the implementation of the government vertical health sector programmes, including the LHWP. With the transfer of responsibility for strategy setting and programme implementation to the provinces, there has been some divergence in the role that the LHWP is seen as playing in achieving RMNCH objectives, its relation to other programmes and activities, and the functions that LHWs are being asked to perform.

Key stakeholders, their contributions and roles

Countries in South Asia have large numbers of CHWs whose training, duties and retention schemes form a rich and confusing tapestry. Across South Asia, CHWs play a substantial role in PHC: through individual counselling; in community education and engagement; in the establishment of trust based bridges between communities and health service planners and providers; and, in the facilitation of evidence generation and use at the micro-community level. Most are female CHW cadres developed to support promotion of desirable family planning, maternal and child health, immunization, nutrition, sanitation and hygiene practices. Due to insufficient funding, village based volunteers were replaced by volunteers or minimally remunerated CHWs with assigned catchment areas covering multiple villages. Neither they nor the health centres they were affiliated with provide either the range of services or the quality of care that is acceptable for the Primary Health Care (PHC) reforms underway. Community health workers work with diversity of partners, Ministry of Health being a critical partner.

The beneficiaries of CHWs' services are socio economically depressed communities who are disproportionately affected by a wider range of illnesses and their health needs remain largely unaddressed. The Astana declaration therefore reiterated the need for promotive, preventive, curative, rehabilitative services and palliative care to be made accessible to all. Too many vulnerable individuals, families and communities fall into deep poverty due to health conditions that are largely either preventable or more likely to have better outcomes if diagnosed and treated early. The global health community therefore reaffirmed the need to accord higher priority to community-based health promotion and disease prevention, early diagnosis and care at the PHC level. They also decried the system-wide inefficiencies and the poor accountability of service providers that maintain the levels of out-of-pocket health expenditures highest among those who can least afford them, in exchange for what is strikingly fragmented, poor-quality care.

Severe shortages and markedly uneven distribution of health workers are a major impediment to the attainment of the ambitions stated in the Astana declaration, especially at the PHC level and in areas where communities are socio-economically depressed. The following comprises of the general list of stakeholders

- Ministry of Health department and programmes at national and sub-national levels
- Other government agencies – including local government, etc.
- Professional Councils
- Training institutions
- Development partners
- Donors and multilateral agencies
- Formal/facility based health workers
- Not for profit organizations and community groups
- Civil society/Communities

As a key partner in the Community Health Roadmap – a global collaboration to accelerate investment in community health – UNICEF works with Governments and other development organizations to elevate community health in national agendas. UNICEF's approach integrates service delivery across sectors – including health; nutrition; early childhood development; social protection; education; and water, sanitation and hygiene.[2] UNICEF strengthens community health systems and provides promotive and preventive care to remote communities around the world. UNICEF also supports and trains community health workers to provide essential services, prevent the spread of diseases and respond to humanitarian crises.

Purpose and objectives of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in RMNCH programmes, and the profiles, policy framework and system support required to better serve maternal and newborn health, and to respond to PHC reform and strengthening in seven South Asian countries, including Pakistan.

The specific objectives of the evaluation are presented below:

- Evaluate current existing policy and system support in terms of the 15 areas of the WHO Guideline, including a gap analysis, to develop country-specific, prioritized recommendations for action. This should provide insight on how governments and partners can redesign and/or strengthen CHW programmes while ensuring that the quality of RMNCH service delivery is protected and enhanced.
- Identify and prioritize ways in which the WHO recommendations can be translated from vision to action in a manner that creates functional integrated CHW teams within functioning support systems, in decentralized and non-decentralized national political and administrative systems that are aligned with the objectives, context and architecture of the national health system in each country.
- Consider how the process of strengthening CHW policies and system support can be made dynamic,

[2] (source: https://www.unicef.org/health/community-health)

responsive to context-specific evidence, linked to social accountability systems, and promote local, area specific, and national learning and innovation.
- Evaluate the extent to which the content of proposed national and provincial PHC and CHW related policy adjustments currently articulate effective transition management, to enable CHW cadres to be effectively reoriented into integrated and functional teams that are expected to cover expanding sets of community health services for the Post-Astana vision of community health systems strengthening for universal health coverage.

In addition, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies. See specific details below and in the attached gender analysis report

Intended Utilization and Users

The findings of this evaluation is expected to influence the community health systems strengthening plans. Evaluation findings will be used for UNICEF's community health agenda and priorities and its partnership building and leveraging of technical and financial resources to strengthen national CHW programmes in Pakistan to accelerate the strengthening of community health systems within ongoing or planned PHC reforms. The findings will also inform national government plans and enhance UNICEF and partner's advocacy and technical guidance to local governments who, in many of these South Asia countries, are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

Moreover, the evaluation will be used to support the identification of priorities and sequencing of long to medium term health systems strengthening initiatives to ensure that system support functions, such as training, management, and supervision to enable CHW programmes function effectively. Such initiative will also support their integration and support from health systems and communities to enable CHWs contribute within PHC teams, as well as be effective members of their communities, helping to address the social determinants including gender, that affect the health and well-being of the communities they serve. In addition to UNICEF, government of Pakistan other users will include implementing partners and other stakeholders who support programmes aided by CHWs.

Scope of the Evaluation

Subject of the evaluation

The evaluation adopts the definition of a CHW used in the WHO guideline (WHO, 2018) and focuses on the two identified CHW cadres in Pakistan – the Lady Health Worker and the Community Midwife – and the policies and system support that enable and guide their work. Other health workers to whom CHWs relate are described for context where relevant, and to the extent that they form part of the support structure for CHWs, but they are not covered by this evaluation.

Geographical scope

The evaluation in Pakistan assessed CHW policies and system support primarily at the national level, however, due to the devolved nature of the health sector in Pakistan, areas where Provincial policies diverge have also been highlighted. The evaluation team conducted interviews with key informants in Islamabad, and in Punjab and Sindh provinces to elicit their views and explore their perspectives on CHW policies, system support and on any planned or ongoing PHC reforms in the country.

Temporal scope

The evaluation is primarily focused on existing policies or policies under design and therefore covers the period from early 2018 onwards, with reference to historical CHWs policies, where necessary.

Key Evaluation Questions

The evaluation responds to the following three key evaluation questions (KEQ):

1. **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
   This is a descriptive KEQ. The key framework used to address this evaluation question was WHO Guideline as described below. All the data collected and analysed to address this question adopted a gender lens.
2. **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or Primary Health Care (PHC) reforms and strengthening.
   This evaluation question entailed assessing actual or prospective country level commitments driven by the Astana declaration and/or planned or ongoing PHC reforms, and the implications for existing CHWs policies and system support. A gender lens was also adopted in responding to this KEQ to ensure gender-responsive efforts/strategies can be identified.
3. **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?
   This evaluation question entailed synthesizing the key findings from KEQ 1 and KEQ 2, and assessing what possible reforms, including gender-informed reforms are necessary and should be implemented, in order to enhance the contribution of CHW programmes to PHC, and to ensure gender equality, equity and responsiveness, given the individual country contexts.

The evaluation was informed by the indicative evaluation matrix below (see Table 1). The matrix was developed – pre-data collection. However, not all aspects achieved and/or addressed by the evaluation for various reasons. For example, although the original intention was to identify and analyse gaps in existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans, unfortunately there was little or no information available (from secondary or primary sources) on these areas. At the time of the evaluation, few countries had articulated or developed stand-alone post-Astana commitments or PHC plans that covered community health systems.

Table 1: Indicative Evaluation matrix

<table>
<tr><th>Evaluation questions</th><th>Primary Data Sources</th><th>Secondary Data Sources</th><th>Data Analysis & evidence generation</th><th>Outputs</th></tr>
<tr><td>KEQ 1: What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?</td><td rowspan="2">Key Informant interviews with UNICEF Country Office staff.
Key informant interviews with national level stakeholders including representatives from Ministry of Health, Ministry of Gender, Ministry of Women's Affairs, & other relevant line ministries; health policy makers, health planners and RMCAH programme managers; professional associations and regulatory bodies; international NGOs; international service providers (ISPs), local NGO; development partners; and funders.</td><td rowspan="2">These data will be extracted and analyzed as part of a desk review, but also revisited and expanded once the desk review is completed and the second phase of the evaluation is being carried out to triangulate findings wherever possible.
Sources include:
• National Policies
• National plans and strategies
• National Reports
• Peer reviewed literature
• Donor reports
• Evaluation reports
• Training guidelines
• CHW databases</td><td rowspan="2">Narrative synthesis of findings from key peer-reviewed and grey literature from across the eight countries produced from desk review.
Synthesis structured around the 15 components of the WHO CHW guideline, gaps identified and options for improvement as well as further study in the second phase of the evaluation proposed.
A framework (informed by the 15 components within the WHO Guideline; selected health systems strengthening/ building blocks (leadership and governance; service delivery; and financing); as well as factors related to gender and equity, engagement with the private sector; alliance-building; and resource mobilisation) and on-going or planned post-Astana reforms or PHC strengthening plans was developed during inception phase to guide the data collected and analyzed from the key informant interviews.
Throughout, key challenges and areas for adaptation and strengthening will be identified by participants. Data will then be synthesised by cadre, across cadres within a country, and across countries to generate top-level findings at the regional, national, and cadre levels.
The analysis will involve transcript familiarisation, coding and synthesis of relationships between themes.</td><td>Map of CHW cadres to be assessed in each country, validated and finalised with countries.

Map of policies related to community health worker programmes to be assessed for each country validated and finalized.

Map of available information for each country against the 15 core components in the WHO Guideline, key health systems building blocks and other factors including private sector involvement, alliance building, and resource mobilisation created and validated.

Framework for analysis constructed informed by WHO Guideline, key health systems building blocks and other factors and identified gaps.</td></tr>
<tr><td>KEQ 2: What policy and system support improvements are needed to realistically optimise the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the-post Astana or Primary Health Care (PHC) reforms and strengthening.</td><td>Map of post-Astana commitments for each country where available.

Map of ongoing and planned PHC reforms and PHC systems strengthening plans.

Gap analysis of existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans.</td></tr>
<tr><td>KEQ 3: What prioritized measures can be taken by government and partners to strengthen health policy and system support to optimize the contribution that each CHW cadre is able to make to PHC.</td><td colspan="2">Data sources as per KEQs 1 and 2.</td><td>Synthesis of analyzed data from KEQs 1 and 2.</td><td>Recommendations and reform options to enhance the contribution of CHW programmes to PHC systems strengthening within the country context using relevant levers in the WHO and UNICEF[3] Operational Framework.
Set of feasibility and prioritization criteria to support countries in developing an action plan aimed to optimize the contribution that each CHW cadre is able to make to PHC.
All recommendations and options adopt a gender lens and are gender responsive.</td></tr>
</table>

[3] Primary health care: transforming vision into action. OPERATIONAL FRAMEWORK. Draft for consultation A World Health Organization and the United Nations Children's Fund (UNICEF), 2018.

Methodology

The LSTM team used a mixed-methods approach for this evaluation. This formative evaluation is intended to help with the on-going strengthening and evolution of the PHC components of national health systems. It is not an impact evaluation that seeks to measure the impact of CHWs, CHW programmes or the health system. This distinction has guided the selection of the methods to be used for this Evaluation.

1. Data collection

Desk review

The LSTM team undertook a desk review of available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local non-governmental organizations, evaluation reports, training guidelines, and CHW databases. The review focused particularly on CHWs programmes and CHW cadres involved in RMNCAH service delivery. Data extracted and analysed as part of the desk review were revisited and expanded on during the implementation phase of the evaluation to triangulate findings wherever possible.

Specifically, the desk review mapped out and validated existing CHW cadres, their roles and responsibilities and system support across the seven countries and identified any post-Astana or PHC strengthening plans. It reviewed international literature, and regional and national CHW policies, strategies and programmes against the WHO 15 policy options and recommendations, health system building blocks and highlighted gaps. A key aspect of the desk review was the analysis of the extent to which CHW programmes are gender responsive. It also generated a list of key international and national references and resources that were used to guide the overall evaluation process, which was circulated to all the country offices to enable them to identify any additional secondary data sources that the team should examine.

Key informant interviews (KIIs)

The desk review was complemented by qualitative data, collected through interviews with national level key informants (Kis) involved in CHW programmes. For Pakistan, LSTM, in consultation with the UNICEF Pakistan Country Office drew up a list of the Kis to be interviewed in Islamabad, and in Punjab and Sindh provinces, which comprised federal and provincial level government health officials, representatives from UN agencies, and training and research institutions. To save on resources and manage the time available for the study, key informants were sampled purposively to generate a diverse sample of participants, to ensure that data derived from KIIs were as rich as possible, and to ensure the inclusion of a gender-balanced range of organizations, cadres, and stakeholders.

A semi-structured topic guide and a gender specific guide, informed by the evaluation framework and analysis plan (shown below), were used by the LSTM evaluator to collect data to respond to the three KEQs, and to validate and triangulate the desk review findings, as well as collect any information not availed through the desk review. Using these guides the LSTM evaluator sought to elicit and explore key informants' views and perspectives on a range of topics including national CHW programmes, cadres and health system support; the policy environment; the role of gender in the design and implementation of CHW programmes, financing and resource mobilization, and the contribution of the private sector to CHW programmes.

A member of the LSTM evaluation team conducted a total of 11 KIIs with 11 key informants in Pakistan, between March and June 2020. Due to the severity of the COVID 19 situation in the country at the time of data collection, many of the interviews were conducted remotely.

Participation of key stakeholders and duty bearers

Stakeholders and duty bearers participated in different capacities. UNICEF personnel participated in the selection of key informants. The LSTM evaluation team provided guidance for the UNICEF Cos on a range of potential national level Kis for inclusion in the study, comprising policy makers and programme managers from the Ministry of Health, and other line ministries, including Ministry of Gender, Ministry of Women's Affairs and representatives from professional councils, associations and regulatory bodies, training and academic institutions, international and local NGO; UN agencies, development partners and funders and the private sector. A list of KIs for each country was then drawn up, validated and finalized. Selected persons participated in the key informant interviews.

Three members of the LSTM evaluation team also participated in the UNICEF Regional Management Team (RMT) meeting in Nepal in April 2019. They presented an overview of the evaluation and preliminary findings from the desk review, facilitated a question and answer session, and elicited feedback and inputs from participants on the study. During the UNICEF RMT, the LSTM evaluation team also conducted Key Informant Interviews (KIIs) with UNICEF country office representatives. Another level of participation was the review and validation of country reports. Both UNICEF and the relevant government stakeholders provided feedback on the reports before being finalized.

2. Data analysis

KIIs were digitally recorded with the participants' consent. All interviews were conducted in English and were transcribed verbatim soon after collection and all identifying information removed. The transcribed KIIs material was cleaned and then underwent a framework analysis by the LSTM team using Nvivo Version 11. A data analysis plan, shown below, was formulated with topics for analysis drawn from the WHO Guideline (WHO, 2018), the health system building blocks framework (WHO, 2007), the WHO/UNICEF Operational Framework PHC levers (WHO/UNICEF, 2018), the WHO Gender Responsive Assessment Scale (WHO, 2011), and the Steege et al (2018) conceptual framework. Other topics, such as PHC reforms and the contribution of the private sector to CHW programmes were also included in the analysis.

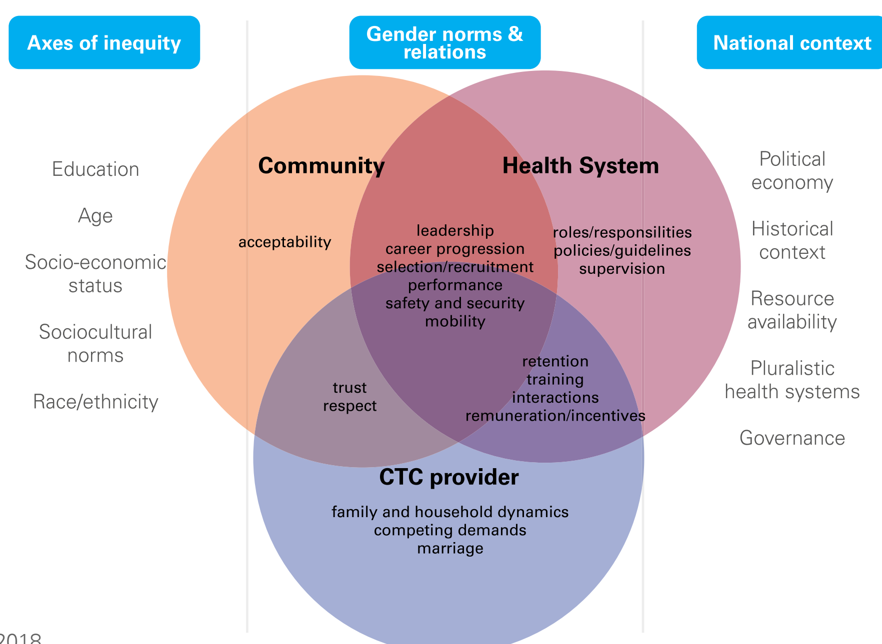
Additional documents identified by Kis during the data collection in Pakistan were reviewed by the LSTM team. (A full list of references is included in Annex 3). The findings and results from the analysis of the eleven (11) KIIs and the additional secondary data are presented in the findings section.

Table 2: Analysis Plan

Topic	HS Building Block	PHC Levers	Gender dimensions	Research questions
CHW programmes and cadres	Health Workforce	PHC workforce	Availability of gender sensitive, responsive and transformative CHW policies and programmes; implementation and evaluation of such policies; maintenance of sex disaggregated CHW workforce data and use for design of CHW programmes	KEQ 1
CHW roles and responsibilities	Health Workforce; Service delivery	PHC workforce; Service delivery	Division of roles/services between male and female CHWs; barriers to delivery of particular services to women, men, adolescents by female and male CHWs; constraints on female CHW mobility; expectation that female CHWs roles will be voluntary/unpaid; other axes of inequity and gender (religion, ethnicity/race, disability, poverty, education, age); provider cultural and gender norms	KEQ 1
Selection, education, certification	Health Workforce	PHC workforce	Requirements for selection for CHW training/education and impact of men and women's competing gendered responsibilities on ability to take up training and/or CHW roles; recognition and certification of knowledge and skills; affirmative action to preferentially select women to empower them and, where culturally relevant, to ensure acceptability of services by the population or target group; adaptation of education/training approaches and materials for illiterate or those with low educational levels;	KEQ 1 & 2
Management and supervision, including remuneration, contracting and career ladders	Information; Health Workforce	PHC workforce; monitoring and evaluation	Family and household dynamics and impact of responsibilities/obligations/demands of male and female CHWs on employment needs and preferences; accommodations in employment contracts and work environments to support needs and preferences of women CHWs, incl. mobility, family responsibilities and relocation after marriage; women's access to supervisory positions; support from supervisor with gender related issues for male and female CHWs; support with maternity leave and during mensuration; fair remuneration and compensation including financial and non-financial incentives; participation in community/health facility leadership roles; cultural and gender barriers to remaining in the CHW role; career progression opportunities; provision of safe and secure workplaces, including gender based violence, and basic amenities and necessities for male and female CHWs; strategies used by CHWs to remain safe; CHW accountability and responsibility for performance and delivery of services/tasks	KEQ 1 & 2
Integration with health system and communities, including target pop size, data collection and use, types of CHWs, community engagement, and availability of supplies	Health Workforce; Medical Products	Engagement of community; Appropriate medicines and products	Acceptance, trust, respect for female and male, married/unmarried CHWs by the community and the formal health system; relationship with facility based providers; access to and take up of RMNCAH services from male and female CHWs by community members; representation of female CHWs on community and health facility leadership/management committees; impact of expanding target population size on ability of females to undertake CHW role	KEQ 1 & 2

Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
RMNCAH focus	Service delivery	PHC workforce	Acceptability of RMNCAH services provided by male and female CHWs; access to and take up of RMNCAH services from male and female CHWs by community members;	KEQ 2
Leadership and Governance	Leadership and governance	Political commitment and leadership; Governance and policy frameworks	Efforts/progress towards gender sensitive, responsive and transformative CHW policies and programmes; gender power relations and access to resources	KEQ 1, 2 & 3
PHC reforms	Service delivery; Health Workforce	PHC workforce; Adequate funding and equitable allocation of resource; Political commitment and leadership; Governance and policy frameworks	Formulation of gender sensitive, responsive and transformative CHW policies, programmes and practices that consider and address gender inequalities; resources and action to transform unequal and harmful gender inequalities; design appropriate indicators to measure impact of reforms on gender equity; participation of CHWs and community members in design, implementation and evaluation of gender policies; and implementation of gender sensitive system support; CHW participation and representation in leadership and decision-making; disaggregated CHW data by factors such as sex, age, location; consider gender composition of the CHW/PHC workforce; conduct assessments with participation of CHWs and community members	KEQ 2
Financing and Resource mobilisation	Financing; Medical products; Service delivery	Adequate funding and equitable allocation of resource	Remuneration/compensation of CHWs; gender sensitive planning and budgeting for CHWs and community health systems in processes; gender sensitive budgeting for PHC and community-based health programmes	KEQ 2 & 3
Private sector	Service delivery; Health Workforce; Medical Products	Engagement with private sector providers	Private sector employers' gender policies and practices	KEQ 2 & 3

Figure 2: Conceptual Framework on gender analysis



Source: Steege et al., 2018

Figure 3: Gender Responsive Assessment Scale

In all cases respondents' comments and insights are quoted verbatim, however some have been shortened and where it is deemed necessary, include explanations, to improve clarity. In discussions with country offices it had been decided that because many of the respondents were policy makers at the national level, they would be proficient in English and would not need a translator.

Gender Analysis Frameworks

The gender analysis draws on the Steege et al. (2018) conceptual framework (see Figure 2), which focuses on gender relations and factors affecting the working lives of community health service providers at the individual level (family and household dynamics, decision-making competing demands), the community level (social and cultural norms, acceptability, trust respect) and the health system level (gender policies and gendered system support, roles and responsibilities, and integration). At the individual level, family influence and household dynamics are important factors affecting CHWs; at the community level, safety and the ability to move around are aspects considered; while at the health systems level, gender relations and norms affecting training and supportive supervision, remuneration and career progression are important factors considered. (Steege et al., 2018).

The analysis also draws on the WHO Gender Responsive Assessment Scale (WHO, 2011) (see Figure 3) to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

The scale includes five stages of GESI responsiveness within policy and programming as follows:

- **Gender Unequal:** perpetuates gender and other forms of inequality by reinforcing unbalanced norms, roles and relations.
- **Gender Blind:** Ignores gender and other forms of inequality.
- **Gender Sensitive:** considers gender and other forms of inequality but takes no remedial action to address it.
- **Gender Specific:** considers gender and other forms of inequality and takes remedial action to address it but does not change underlying power relations.
- **Gender Transformative:** addresses the causes of gender-based and other forms of inequality by transforming harmful norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships.

3. Frameworks used to inform data collection and analysis

The evaluation uses the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the policy and system enablers it identifies, and in particular, the fifteen (15) policy recommendations it presents, as a benchmarking framework to map and assess CHWs policies and system support and identify gaps and areas for optimizing CHW programmes.

The Guideline's 15 policy recommendations are organized around three broad areas as follows:

1. Selection, education and certification (selection, duration of pre-service training, competencies in pre-service training curriculum, pre-service training modalities and competency-based certification)
2. Management and supervision (supportive supervision, remuneration, contracting agreements, and career ladder)
3. Integration into and support by health systems and communities (target population size, collection and use of data, types of CHWs, community engagement, mobilization of community resources, and availability of supplies)

For the purposes of the evaluation **health system support** is defined as the support that the health system provides to optimize CHW programmes, including the education, training, management, supervision, remuneration and compensation of CHWs, the provision of commodities and supplies, clear definition of roles and responsibilities, and expectations, as well as adequate financing and the integrated of such programmes into the health system and community.

The evaluation framework was also informed by the WHO six health system building blocks (WHO, 2007), namely, leadership and governance; health financing; service delivery, the health workforce; medical products, vaccines, and technologies; and health information systems. In addition, the leadership and governance, policy, and finance and operational levers presented in the WHO and UNICEF Operational Framework (WHO/UNICEF 2018) provide useful benchmarks levers for assessing plans and progress on PHC strengthening.

The LSTM team adopted a gender lens in the review of secondary data, the design of the data collection tools, and the analysis of the data. A gender specific topic guide was

designed to target informants with specialist knowledge of, or responsibility for gender and CHWs, to enable a more in-depth exploration of the gender issues and constraints that impact the effectiveness of CHW programmes, and the identification of efforts to address these constraints to improve the functioning of CHW programmes and cadres and strengthen PHC. The gender component of the evaluation drew on the Steege et al (2018) conceptual framework of gender norms and relations across the levels of individual, community and health system.

As mentioned above, the team also assessed CHW programmes and policies using the WHO Gender Responsive Assessment Scale (WHO, 2011) where the data were available, and where possible, presents findings along the five levels of the scale including 1) gender-unequal, 2) gender-blind, 3) gender-sensitive, 4) gender-specific, and 5) gender-transformative.

Application of a Rights-based approach, and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Gender Equality and the Empowerment of Women

As reflected in the frameworks applied, this evaluation uses a gender-responsive evaluation methodology, and data analysis techniques. Moreover, because women comprise a substantial number of CHWs in many SA countries, the evaluation also looks at aspects of inequality, examining how existing policies and systems may unequally affect women in the selection, training and promotion in the different CHW cadres.
At the core of this evaluation is an assessment of Gender Equality and the Empowerment of Women (GEEW). Both the WHO Gender Responsive Assessment Scale and the framework proposed by Steege et al. which are used in this evaluation focus on gender equality and empowerment. The ability of existing systems to reach all persons including those who are marginalized is also explored.

4. Ethical standards

The proposal for the evaluation was submitted to the Institutional Ethics Review Committee of LSTM and full ethical clearance for the study was granted by LSTM (REC 19-037). LSTM has ensured, in line with its internal policies and code of conduct, that the research associated with the evaluation follows the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001). In addition, the UNEG norms and standards were observed.

Written informed consent was obtained from all key informants (Kis) in this evaluation using the LSTM Research Ethics Committee (REC) consent template, adapted for this evaluation. The template consists of an information sheet and certificate of consent. LSTM's stringent procedures for obtaining consent adhered to the Helsinki declaration on the rights of subjects. These rights included autonomy (ability to participate or withdraw from the study at their own free will), beneficence (that the benefits of participation to the respondent outweigh the possible harms) and justice. Written consent included the participants' consent to participate in the interview and for the interview to be digitally recorded to aid in the transcription. The participant information sheet, which explained the purpose of the study and all the possible benefits and harms, was provided to respondents in advance of the interviews and also reviewed with the participant, if required, before the start of the interview. The participant was provided with the opportunity to ask questions and responses were provided to the queries and issues raised. Participation was on a voluntary basis and all participants were assured that they had the right to withdraw from the interview at any stage without needing to offer any explanation. Participants were also encouraged not to disclose any information they are not comfortable with sharing and to decline responding to any statement they considered sensitive.

Every effort was made to ensure that the confidentiality and privacy of participants was protected at all stages of data collection and processing. Confidentiality and anonymity were ensured and assured to the participants explicitly in writing and verbally at all stages of the study to ensure that no data or responses/statements could not be traced to the participant.

All members of the LSTM evaluation team involved in conducting the KIIs received training in good interviewing skills and principles of data confidentiality. Participants were informed about the study in advance (written communication and telephone calls for key informants) and prior to data collection to ensure that participants understand the purpose of the study and their rights to participate (voluntarily) or not and to withdraw from the study at any time without prejudice.

All interviews were conducted in English and were transcribed verbatim soon after collection, anonymised and all identifying information removed. The transcribed KII material was cleaned and then underwent a framework analysis by the LSTM team using Nvivo Version 11. Recordings of interviews were stored on password-protected data devices.

5. Limitations and mitigation measures taken by evaluation team

- Availability and quality of secondary data related to VHWs
  - ◊ **Mitigation measure:** To ensure maximum responsiveness of stakeholders and access to relevant and quality data, the LSTM evaluation team sought the support and guidance from UNICEF country offices in approaching and following up with relevant partners to obtain the necessary information. Processes for the quality assurance of secondary data put in place for the desk review were applied and where possible, triangulation of data collected through KII was used to validate findings.
- Limitations of the qualitative research methods used such as participant and interviewer bias during the key informant interviews (KII)
  - ◊ **Mitigation:** The LSTM evaluation team used topic guides with open-ended questions to minimize interviewer/facilitator bias and probe with follow-up questions to clarify intent and meaning. Independent coding of qualitative data was performed by the LSTM team to minimize the risks of bias.
- Limited generalizability of the evaluation findings due to the limited availability of stakeholders for interviews during the field visit.
  - ◊ **Mitigation:** By using qualitative research methods such as KIIs, the evaluation team sought to get in-depth information to answer evaluation

questions. Generalisability was not the main goal of qualitative research. The LSTM evaluation team used purposive sampling carefully targeting 'information-rich' participants to represent (not statistically) the broad types of informants relevant to our evaluation.

- All interviews conducted in English affecting the ability of participants to fully articulate views and insights
  - ◊ **Mitigation:** Probes were used to ensure that respondents understood the questions. There was careful review of KI guide to ensure that the level of English used was most appropriate for the respondents.

Findings

The following findings are based on a desk review of available secondary data and studies conducted under the auspices of the Government and private sector entities. They include an analysis of qualitative data collected through 11 KIIs with key stakeholders in Pakistan's health system. As decision-makers, CHWs and participants in Pakistan's' health infrastructure, these respondents were able to provide insights and their perspectives on CHW policies, programmes and system support. While the respondents identified two key CHWs – the LHW and the CMW, the majority of informants were more knowledgeable and comfortable discussing the LHW cadre, as a result the analysis yielded more information on this cadre.

The findings presented also draw on the findings of the Oxford Policy Management's extensive evaluations of the Lady Health Workers Programme in 2019.

1. Current CHW profiles, roles and responsibilities, policies and system support

This section responds to KEQ 1 and provides an overview of the current profiles, roles and responsibilities of the identified CHW cadres in Pakistan that are involved in the provision of RMNCH services – namely the Lady Health Worker (LHW) and the Community Midwives (CMW). It also reviews and assesses the policies and support these cadres receive from the health system.

- **KEQ 1**: What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?

The public health system in Pakistan is divided broadly into three tiers of governance, federal, provincial and district. Historically, the Federal Government was responsible for public health, working in close concert with Provincial Governments (The Governments of Punjab, Sindh, Balochistan and Khyber Pakhtunkhwa), particularly with regards to policymaking, planning and budgeting. However, following the 18th Constitutional Amendment (2011), the Federal Ministry of Health (FMoH) was dissolved, and its powers and responsibilities were delegated to the provinces. Due to numerous concerns and issues raised by the lack of a FMoH, a Ministry at the Federal level was re-established in 2013, as the Ministry of National Health Services, Regulations and Coordination, (MNHSR&C) responsible for service delivery in the Federal Capital and FATA (including Gilgit-Baltistan and Azad Jammu and Kashmir).

A province in Pakistan is divided into multiple districts, that form the first tier of local Government. At the district level, the health care delivery system includes, Basic Health Units (BHU) and Rural Health Centres (RHC), which function as PHC establishments. Secondary health care, comprising of first/second referral services offering acute, inpatient ambulatory care is provided at tehsil/taluka headquarter hospitals (THQ) and district headquarter hospitals (DHQs), which are assisted by teaching hospitals (tertiary care).

Maternal and child health (MCH) care is also a part of this integrated health system, but the number of such health care units is limited. Such MCH care units are based out of BHUs and RHCs which provide all the basic obstetric care through community outreach programmes delivered by LHWs.

1.1. CHW profiles

CHWs in Pakistan provide a myriad of services, and it is along the lines of their responsibilities that the various cadres are divided. Community based health workers in Pakistan primarily include Lady Health Workers (LHWs) and Lady Health Supervisors, Community Midwives (CMWs), Community Based Vaccinators (CBV), and malaria supervisors, among others (MNHSR&C, 2018). All LHWs and CMWs are women. NGOs and community based organizations (CBOs) also deploy a large number of CHWs for different programmes and purposes, for example for the provision of HIV & AIDS preventive services.

Of these programmes, the most established is the Lady Health Worker Programme (LHWP). The roots of the LHWP in Pakistan can be traced to the Prime Minister's Programme for Family Planning and Primary Health Care established in 1993, which employed CHWs to provide primary health care (PHC) services in their communities. Given the nature of the type care being provided, the programme only employed female CHWs, with the LHWP introduced in 1994.

The stated objective of the LHWP was to reach rural areas and urban slums with a set of 22 essential PHC services, including promotive, preventive, and curative services; to improve patient-provider interactions; to facilitate timely access to services; and to increase contraceptive uptake (Zulliger, 2014).

'The key roles of the Lady Health Worker they were mostly centred around primary health care definitely and family planning also. The basic programme was the national programme for family health planning and family health care, so their main focus was family planning and all the components of primary health care'. (KI, Health Department). In 2000, the programme was renamed the National Programme for Family Planning and Primary Health Care, but it is still commonly known as the Lady Health Worker Programme. Following the 18th Amendment, the management of the LHWP has been devolved to the Provincial Governments.

The women employed by the LHWP are known as Lady Health Workers (LHWs). LHWs play a critical role by bridging the gap between health facilities and the community. The scope of services provided by LHWs has grown from an initial focus on MNCH and routine immunization to include participation in large health campaigns (such as polio immunization), new-born care, and health education (Zhu, et al, 2014).

As the LHWP was originally envisioned, LHWs were not government servants, and instead worked on a contractual basis, however, the ad hoc nature of their position was a cause of concern for the LHWs. This led LHWs to create an association in 2009, the All Pakistan Lady Health Workers Association (APLHWA). They started a national movement for the regularization (the process of converting contractual workers into full time public servants) of their jobs as public servants. In 2012, the Chief Justice of Pakistan ordered the regularization of all staff under the Programme. However, it is worthy of note, that due to a series of administrative delays related to the financial burden of the LHWP, it has taken more than four years for the regularization to be adopted by each province. The process of regularization is mired in ongoing problems to this day (Ali, 2019).

In 2006, the Ministry of Health established a National Maternal Newborn and Child Health Programme (NMNCHP). The programme was funded in part by the Federal Public Sector Development Programme (PSDP), which channeled funds from health and grants from DFID, USAID, UNICEF, UNFPA and other international agencies. One of the changes made by this programme was the introduction, in 2007, of a new cadre of skilled birth attendants (SBA) called Community Midwives (CMW). As with LHWs, these were rural women from the same community as their clients. They were given 18 months of training in antenatal, intra- partum, postnatal and new-born care. At the time, the programme aimed to train and deploy around 12,000 CMWs nationwide to increase coverage of MNCH services by skilled providers (Khan, et al, 2012). There are, however, no data available on how many were actually produced and deployed and are still active today.
There is still some debate as to the success of this programme, with many stating the CMWs are yet to emerge as a significant maternal care provider in rural Pakistan, with one respondent commenting that, '... the major observation on promoting this community midwifery was that institutional deliveries are much more preferable compared to [at home births]... because, in the community, I don't think we can fully have a fool-proof setup which can ensure maternal health and maternal deaths are prevented'. (KI, UN Agency)

1.2. Availability of CHWs

LHWs are deployed across the nation in all four provinces and Federally Administered Territories of Pakistan. Though these workers may also be attached to a local health facility, their role is primarily community based and LHWs often work from their homes.

An evaluation completed in 2000 estimated that to obtain optimal coverage and service delivery, 150,000 LHWs were needed across the country. As a result of this study, a 2003 strategic plan set the goal of achieving 100,000 functioning LHWs by 2005. However, this goal was not achieved; in 2003, there were a total of 75,038 LHWs working or in training, with numbers growing to 83,280 in 2005 and to 90,074 by 2008. It is interesting to note, that though the goal of 100,000 LHWs was not reached, in the same time period coverage rates improved, and by 2006, the LHWP covered 60 per cent to 70 per cent of Pakistanis in rural areas.

The current scenario paints a different picture. A review of the LHW-MIS over the period 2014-2018 reported (Oxford Policy Management (OPM), 2020) a decline in overall numbers of LHWs across Pakistan of four per cent. This was reflected in a decline in absolute numbers of LHWs in all regions of Pakistan with the exception of Khyber Pakhtunkhwa, where LHW numbers increased by 18 per cent due to the recruitment of almost 4,000 contract LHWs.

Balochistan suffered the most severe decline in overall LHW numbers by 21 per cent, a loss of more than 1,000 LHWs as reported by the LHW-MIS. It is worth noting here, that the Balochistan Government estimated that there was a need to recruit 500 LHWs per year until 2022 in order to meet the LHWP coverage targets in that province.

According to the Pakistan Human Resources for Health Vision (2018-2030), in 2017 there were 92,849 LHWs available across the country (see Table 3).

Table 3: Availability and distribution of LHWs

Province	No. of LHWs	Density 1,000/ pop
Punjab	44, 497	0.41
Sindh	21,358	0.45
Khyber Pakhtunkhwa	14,460	0.47
FATA	1370	0.27
Balochistan	6400	0.52
Islamabad	309	0.15
AJK	2990	0.74
GB	1465	0.81
Total	92,849	0.43

Source: Pakistan Human Resources for Health Vision (2018-2030) Ministry of National Health Services, Regulations and Coordination (2018)

At the national level, despite explicit targets to increase coverage (i.e. 100 per cent rural areas and 30 per cent urban areas mainly slums/densely populated areas), there is stagnation in the overall population coverage across Pakistan at just under 60 per cent for the period of 2014-2018. Sindh is closest to its more modest target of 55 per cent population coverage. There are marginal decreases in population coverage in all regions, with the exception of Khyber Pakhtunkhwa and Sindh.

Following regularization, LHWP staff were declared a 'dying cadre' across Pakistan, the implications of this decision was a freeze on recruitment of any new LHWs, thereby directly compromising the ability of the LHWP to expand its coverage. In fact, numbers of LHWs have decreased since regularization was implemented, with attrition resulting from resignations, terminations, and the deaths of LHWs.

Khyber Pakhtunkhwa was the only province that managed to increase the number of LHWs, doing so by using donor funding of the IHP to hire LHWs on a contract basis, under similar terms as all LHWs prior to regularization.

It is worthy of note, that the LHW-MIS in Sindh has not taken into account population growth, which could affect population figures (OPM, 2020).

1.3. Key policies and policy environment for CHW programmes

1.3.1. Health and Primary Health Care Policies

The policies referenced below cover a large variety of issues. In keeping with the theme of this report, the sections that effect CHWs (more specifically, LHWs and CMWs) have been summarized.

As mentioned above, the Federal Government has retained the responsibility for setting national health priorities and strategies and for ensuring that the provincial health strategies remained aligned to Pakistan's international commitments. As such, in 2014 the Federal Government developed a detailed and ambitious Pakistan Vision 2025, in consultation with Provincial Governments and all key stakeholders, for the overall development of the country (Ministry of Planning, Development and Reform, 2014). The Pakistan Vision 2025 highlighted numerous shortfalls, particularly with regards to Human Development in the Health and Population sectors. These included, but were not limited to, the low levels of public expenditure on health, weak management systems and poor governance, low health professionals to population ratios, and a rural population that is particularly deprived in relation to health (Ministry of Planning, Development & Reform, 2018).

In order to address these issues, the FMoH developed a detailed National Health Vision (2016-2025), with the stated objective, 'to improve the health of all Pakistanis, particularly women and children by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities' (MNHSR&C, 2016).

To transform the National Health Vision 'into reality' and to steer the health system towards UHC, the MNHSR&C, in collaboration with the provincial and area departments of health, health academic institutes, private sector, civil society organizations, development partners and other stakeholders has developed the UHC Benefit Package of Pakistan. The Package consists of an Essential Package of Health Services (EPHS) at five platforms, including at Community and Primary Health Care Centre Level with implementation expected to commence in 2020 (Ministry of Health & Population, Provincial/Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020).

The UHC Benefit Package reaffirms the commitment of the Ministers of Health at federal and provincial/area level 'to implement a stronger primary health care and integrated people-centred health'. Through the implementation of the UHC Benefit Package, the Ministry aims to 'fulfil the right to health for all at the highest attainable standard, allocating investment to the right services and implementing reforms on time, with appropriate budget in order to achieve universal health coverage in Pakistan'.

With the support of the DCP3 secretariat based at the London School of Hygiene & Tropical Medicine (LSHTM), global evidence was reviewed and adjusted to the needs of Pakistan to inform the prioritization of health interventions at community and PHC centre level for inclusion in the EPHS. In designing the EPHS, the burden of disease, budget impact, efficiency, feasibility, fairness and socio-economic context were considered

The EPHS has defined four clusters as follows:

1. Reproductive, maternal, new-born, child, adolescent health & nutrition/ Life course related cluster,

2. Infectious diseases cluster,
3. Non-communicable diseases & Injury prevention cluster and
4. Health services cluster.

EPHS at community level

The package of services proposed at the community level are based on the community needs, the burden of disease, cost-effectiveness of interventions and the contextual factors to ensure the delivery of 'efficient, effective and quality services at the doorstep' (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020). The prioritized interventions to be delivered at this level are based on the life-cycle approach and include Reproductive Health/ Birth spacing, Antenatal Care, Delivery care, Post-natal care, New-born care, Nutrition, Childcare, School age childcare, Adolescent health, Infectious diseases, Non-communicable diseases, and Health services access.

Each provincial/area department of health will prioritize a sub-set of essential health services based on their needs, the burden of disease, and fiscal space. Lady Health Workers, Lady Health Visitor, Health-Population-Nutrition (HPN) Counsellor and other providers from community-based organizations are expected to provide these services in the community. A detailed list and description of the proposed interventions to be delivered are outlined in the EPHS document (Ministry of Health & Population, Provincial/Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020, p. 9).

In addition to these policies, the Ministry, in consultation with provinces and other agencies developed a National Vision for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCH) and Nutrition (MNHSR&C, 2016). This document identified ten priority actions to accelerate improvements in new-born, child and maternal survival, with a special focus on reducing morbidity and mortality linked to common preventable causes. For the purposes of the current document, it is important to note that the first of these priorities refers to the role of the LHW in improving the access to and quality of MNCH community based primary care in rural districts and urban slums (MNHSR&C, 2016).

Under the devolved arrangements, the provinces have responsibility for developing province-specific Health Strategies, which include both strategic objectives, as well as implementation plans for the delivery of health care in the provinces. While there is a general expectation that these should be aligned with the National Vision, there is some variation across the provinces.

The health policies for selected provinces, including Sindh and Punjab, and strategies and activities relevant to the CHW cadres under review are outlined below.

Punjab

Punjab's Health Sector Strategy 2018-2030 includes RMNCH & Nutrition as one of its key priority areas. The strategy aims to achieve increased equitable access to and quality of MNCH, Family Planning (FP) and Nutrition across all public and private sector facilities in Punjab. Key objectives highlighted in the Strategy include the timely and free access to quality MNCH services, irrespective of ability to-pay, to all the people in Punjab; the institutionalization of quality of care in MNCH services delivery system; ensuring timely and free access to quality nutrition; and ensuring that FP services provided free of cost, at the appropriate levels (Health Department, Government of Punjab, 2018)

In order to achieve these objectives, the health policy has outlined numerous strategic directions. For the purposes of this document, a few of the relevant points include, establishing a Human Resource Planning and Development Unit to meet gaps in recruitment; ensuring political will and commitment; availability of both basic and comprehensive Emergency Obstetric and Newborn Care (EmONC) facilities; establishing urban MNCH centres; and the institutionalization of a well-defined referral mechanism. It also proposes enhanced coordination and partnership with donors, including but not limited to, INGOs, development partners and local NGOs for resource mobilization and pooling to aid procurement, and similarly, establishing strong links with the private sector and family physicians, as well as the implementation and institutionalization of a structured mechanism for verbal autopsy of maternal and new-born deaths at all levels.

Additionally, the Strategy highlights the need to reposition FP as a core health intervention and the overall enhancing of the availability and accessibility of FP services.

Sindh

Sindh's Health Sector Strategy (2012-2020) outlines a number of RMNCH related policy priorities, including the deployment and training of LHWs and multi-purpose health workers for the implementation of an enhanced and integrated community-based package of services targeting the entire household. It aims to enhance the quality and outreach of community-based workers and implement an aggressive coverage strategy for polio immunization. The Strategy proposes the delivery of MNCH care as part of an essential package of health services (EPHS) and encourages a shift in strategy for contraceptive services through district and urban PHC systems, aimed at birth spacing in younger couples. It also calls for increased investment in the provision of primary care and essential secondary referral care (Health Department, Government of Sindh, 2012).

The Health Sector Strategy includes a monitoring and evaluation (M&E) framework., which envisages sector-wide monitoring of the strategic outcomes mentioned above, based on key performance indicators as provided for under the SDGs and other key international obligations.

Khyber Pakhtunkhwa

The Government of Khyber Pakhtunkhwa's (KP) Health Sector Policy (2018-2025) sets a number of RMNCH policy priorities. The stated implementation process involves the design of detailed activities and project plans to secure the technical, human and financial resources required. A Health Sector Reform Unit (HSRU) will be responsible for the implementation of the policy (Health Department, Government of Khyber Pakhtunkhwa, 2018).

The KP Health Sector Policy gives priority to the execution of a Minimum Health Service Delivery Package at primary and secondary health facilities in the province. Special focus areas include new-born survival; birth spacing and contraceptive supply; communicable and non-communicable diseases; and nutrition. Additionally, it also envisages strengthening of the referral mechanism.

The Department of Health will specifically focus on the provision of family planning services through a health facilities network and community based LHWs and CMWs. Ambulance services will be established for maternal and childcare. Utilization of existing ambulance services will be reviewed and improved. Provision of other transportation options will be explored to make access to health care easy for the disadvantaged. Preventive health care services will focus on child immunization, reproductive health and malnutrition. LHWs will be involved to deliver routine immunization services in their catchment areas.

The Department of Health will also develop a practical programme with the objective of improving the nutrition status of women of childbearing age and children below three years by improving the coverage of cost-effective nutrition interventions. It also prioritizes enhancing the capacity for education and training of nurses, LHWs, midwives, pharmacists, allied health workers/paramedics. For example, LHWs will be trained to provide counselling on birth spacing and family planning, and their roles and responsibilities will be reviewed with a focus on nutrition interventions, family planning and child health outcomes and on improving coverage in the province, especially in the rural and hard-to-reach areas. This includes a further increase in the number of LHWs in the province.

In order to achieve the set RMNCH priorities in the KPK Health Policy, a Draft Health Sector Strategic Plan (2019-2023) has been developed. The targets include increasing the contraceptive prevalence rate (CPR) to 55 per cent. At least 90 per cent of births should be attended by a skilled birth attendant. A reduction of the maternal mortality rate to 140/100,000 live births. A reduction of the infant mortality rate to 40/1000 live births, with an emphasis on reducing new-born deaths. It proposes a 10 per cent reduction in the prevalence of underweight children under five years old through the implementation of a comprehensive nutrition programme and increased exclusive breastfeeding to 65 per cent. In addition, 90 per cent of children under five should have received appropriate vaccinations according to the EPI schedule, and 90 per cent of children under five should have received appropriately timed Vitamin A supplementation.

In **Balochistan**, the Comprehensive Development Strategy 2013-20 sets out policy priorities and includes a basic section on health. However, there is no complete RMNCH strategy for this province. RMNCH objectives and targets for the Balochistan Development Strategy have been incorporated from the Federal LHWP and guide the Annual Development Plans (Pakistan, Planning and Development Department, Government of Balochistan, 2013).

When questioned about the efficacy of these policies, most respondents in this study were unable to provide information as to their current status, or impact. Additionally, the literature notes that there are very little available data as of September 2020, on the implementation and subsequent impact of these policies (OPM, 2019).

1.3.2. Gender responsive policies

The Pakistan Vision 2025 recognizes that gender equity and women's development is strongly linked to 'a woman's independence to pursue economic growth and exercise her life choices freely' (Ministry of Planning Development and Reform, 2014). It proposes strengthening legislative frameworks to protect women's rights; increasing women's participation in decision-making through affirmative action; protecting women from harassment at work; promoting the economic empowerment of women through ensuring access to education and enterprise and creating gender sensitive enforcement machinery to improve implementation of such initiatives. Further, it highlights the need to discourage practices based on 'gender discriminatory cultural patterns'.

At the time of this study, there were no updated, comprehensive measures or analytical data available to accurately assess the gender responsiveness of Pakistan's health sector policies. It worthy of note here, that the LHWP is perceived to be supportive of the empowerment of both LHSs and LHWs in terms of their improved economic status and greater social status in the communities in which they work (OPM, 2019). However, Pakistan is number 151 on the 2020 Global Gender Gap Index (GGGI), having closed only 56 per cent of the gender gap (World Economic Forum, 2020). While Pakistan has improved in a majority of the categories the Index uses to make an assessment, the gap remains large in terms of economic participation and opportunities.

Pakistan was also among a group of four large countries trailing behind in closing the gender gap with regard to 'health and survival', with women in the country are not yet granted the same access to health as men. While a majority of countries have bridged or nearly bridged the educational gender gap, Pakistan's still stands at almost 20 per cent. Less than half of women are literate, compared with 71 per cent of men, while the share of women enrolled across primary, secondary and tertiary education is systematically lower than the share of men.

Only one-quarter of women participate in the labour force (i.e. working or looking to work), compared with 85 per cent of men, with 18 per cent of Pakistan's labour income going to women, one of the lowest shares among countries studied in the index. Five per cent of senior and leadership roles held by women, twice the Management, and the political gender gap has narrowed over the past two years, with three female ministers out of the 26-member cabinet as of September 2020, compared to none in 2017.

A reported 32 per cent of women have experienced physical violence in Pakistan and 40 per cent of ever-married women have suffered from spousal abuse at some point in their life. However, it is widely accepted that these statistics do not accurately represent the full extent of cases as one in two Pakistani women who have experienced violence never sought help or informed anyone about the violence, they had experienced (National Institute of Population Studies and ICF, 2013).

There are numerous barriers to the prevention of, and response to, Gender Based Violence (GBV) in Pakistan, including misperceptions around GBV, limited or ineffectual legislation, and a lack of support systems and safety nets for those who do attempt to seek support. Insufficient systems

at the state, civil society and community levels are serious obstacles to comprehensively addressing GBV in the country.

The UHC Benefit Package and Essential Package of Health Services (EPHS) is largely silent on gender, with only one of the prioritized interventions for the BPHS at community and PHC Centre level gender related, as follows: 'post gender-based violence care including counselling and referral'" for adolescents (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020, p. 11).

1.3.3. Health workforce policies

Pakistan has one of the lowest densities of health workers in the region and globally, with an essential/skilled health professional (physicians including specialists, nurses, lady health visitors (LHVs) and midwives) density of 1.4 per 1,000 population against the threshold of minimum 4.45 per 1,000 population necessary to achieve universal health coverage (Ministry of National Health Services, Regulations and Coordination, 2018). For sustainable development, it is not only the numbers, which are needed but also an equitably distributed workforce with appropriate skills mix and opportunities to provide quality services. Poor job satisfaction and work environment as well as out-migration are other key challenges identified in the National Human Resources for Health (HRH) Vision 2018-2030.

The National HRH Vision 2018-2030 provides guidance for deploying strategic measures to combat these gaps and challenges and recommends the scope of work for national and provincial health systems. It recommends the creation of linkages and networks, which while allowing all stakeholders to plan their own agendas, ensures that some principles and strategic choices will be common to all and mutually agreed upon.

'To improve health and socio-economic outcomes in Pakistan by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate health system strengthening investments and the implementation of effective HRH policies and strategies at national and provincial levels (Ministry of National Health Services, Regulations & Coordination, 2018).

The Vision document goes on to elaborate that this is to be achieved by a number of measures including: optimizing the performance, quality and impact of the health workforce; investing in the availability and distribution of the health workforce to meet the needs of the population; building the capacity of institutions at all levels for effective and quality pre-service and in-service training and HRH leadership and strengthening HRH data for monitoring and accountability at all levels.

1.3.4. Leadership and governance of CHW programmes

The 2010 18th Amendment abolished the concurrent list of functions between the federal and provincial levels of government. As a result, provinces were given complete administrative authority and fifteen federal ministries were abolished, with their functions devolved to the provinces. In the health sector, when the FMoH was dissolved, the provinces took over the implementation of the government vertical health sector programmes, including the LHWP, along with the delivery and management of all other health sector activities.

When the Federal Ministry of Health was re-established as the MNHSR&C, a Health Planning Unit (HPU) was created as part of the Federal Ministry, to reconnect with the MNCH and LHW programme and other programmes by holding regular meetings with all the provinces/regions. An Inter-Ministerial Forum on health issues was established in 2014 in which provincial Health Ministers, and Secretaries of Health, Population and Planning and Development were invited. It was chaired by Federal Minister for Health. While the Inter-Ministerial Forum at times discussed the LHWP, a dedicated forum for the programme was not established.

The MNHSR&C has established a Federal dashboard to create an integrated Management Information System (MIS) across the provinces and regions. Currently, the MIS for Sindh, Punjab and KP provinces are linked with the federal dashboard as only these regions have online data. However, no reporting or analysis of these consolidated data has taken place.

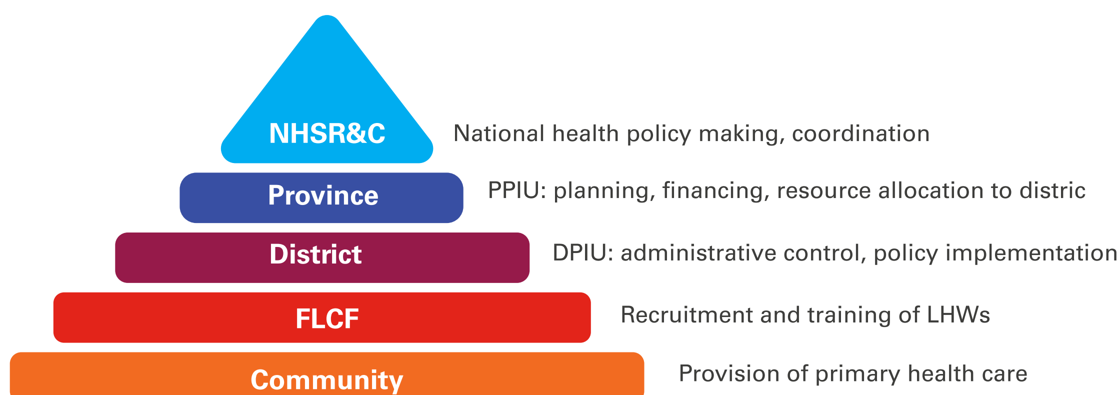
The capacity of the MNHSR&C for data analysis has been strengthened through the establishment of the Health Planning, System Strengthening & Information Analysis Unit (HPSIU), with support from USAID, with a view to supporting the implementation of the National Health Vision.

The overall management model as envisaged for the LHWP in relation to the federal role following devolution may be summarized as follows. MNHSR&C would have responsibility for the delivery of national health sector strategies, the regulatory environment and coordination. The Provincial Project Implementation Unit (PPIU) would maintain responsibility for the delivery of the LHWP strategy and planning, as well as financing and the allocation of resources to the district level. At the district level the District Project Implementation Unit (DPIU) would be responsible for the implementation of the LHWP, with BHUs providing support to the recruitment and training of LHWs, as well as consolidating the monthly reporting of LHWs, and LHWs providing PHC services at the community level.

However, for the health sector, this handover was not structured enough to support a smooth transition, since the provinces lacked the (technical) capacity to support the LHW programme. Respondents highlighted some of the challenges related to the devolution process. Some intimated that 'devolution was a problem for the provinces', that the 'provinces were not ready', they did not have the 'infrastructural capacity to manage their vertical programmes on their own', and that 'the technical capacity was a big gap'. Up to this time, all vertical programmes had been managed by the central government and all 'technical capacity was available at the central federal level', with 'work assigned by the Federal level'.

As one respondent indicated, before devolution, 'there was a strong system, with the "Central Government supporting the provincial Governments"'. The shift of power also meant a loss of central coordination and implementation. This affected the quality control of the LHWP, which was previously regulated by a central committee with interprovincial coordination and consultations. Respondents reported that after devolution the central level quality assurance function performed by the Programme Implementation Unit of the programme across all provinces was 'lost'. One described the devolution process as

Figure 4: Vision of integrated management of LHWP



Source: ZHU, et al, 2014

an *'incomplete process'*, without *'a proper plan for the devolved setups'*. Without central government support and facilitation, the LHWP, reportedly, *'the deterioration started from 2011'.*

Respondents reported that post devolution, there was an agreement that the federal government would continue to provide the salaries at the 2011 rate, but with the regulation of the LHWs, reportedly, provinces are now 'barely able to only provide the salaries of the lady health workers'. The provision of equipment to the provinces, which had been managed by the Central Government, has also been impacted. Along with these issues, interruptions to the provision of refresher trainings as a result of devolution and the regularization of the LHWs, has also (transiently) affected the quality of LHWs services.

However, in practice the high level of autonomy enjoyed by provinces acts against any common management model, to the extent that provinces may decide to develop and employ different approaches.

The MNHSR&C has no authority and few effective incentives to ensure cooperation from the provinces, for instance, with the provision of consistent, quality information, or the development of common curricula or training programmes.

The organizational structure of the LHWP is diverging across provinces both as a result of decisions about the specific roles and tasks of LHWs, the organization of health service provision, including the integration of vertical health programmes. This change has been greatest so far in Punjab and KP. Crucially, in the longer term, this also leaves the LHWP vulnerable to potential changes in the role and structure of local government. Though no such changes have occurred, numerous Provincial governments have stated their intention of doing so, and there is also strong political will.

Implementation of devolution: provinces and territories
With the transfer of responsibility for strategy setting and programme implementation to the provinces, there has been some divergence in the role that the LHWP is seen as playing in achieving RMNCH objectives, its relation to other programmes and activities, and the functions that LHWs are being asked to perform.

In **KP**, the LHWP was merged with the Expanded Programme for Immunisation (EPI), the MNCH programme, and the Nutrition Programme into the Integrated Health Project (IHP), headed by a Project Director, working through the Project Implementation Unit (PIU). At the district level, the IHP is managed by the District Health Officer (DHO), with additional coordination support across districts. The LHWP in FATA is being integrated into this structure . There have been no significant changes to the role of the LHW except that health education responsibilities have been expanded to include non-communicable diseases.

In **Punjab**, maternal, neonatal and child health, family planning and nutrition programming have been consolidated along with the LHWP into the Integrated Reproductive, Maternal, New-born, and Child Health (IRMNCH) programme. District Coordinators are responsible for the management of the integrated programme at district level. LHWs now have an expanded role in disease treatment and referral.

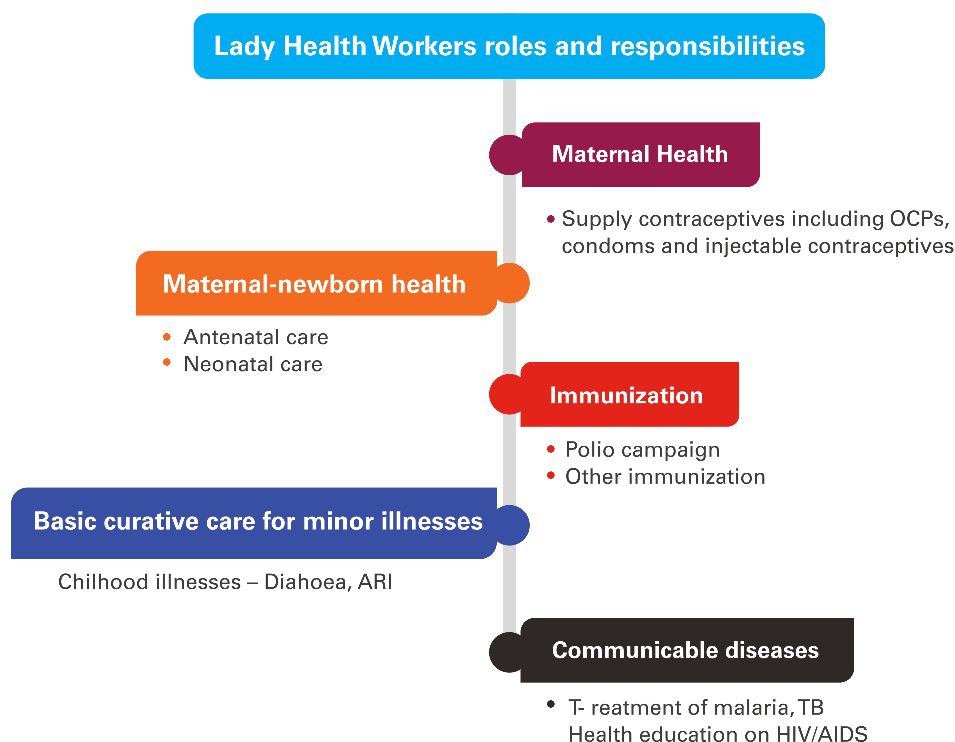
In contrast, in both **Sindh** and **Balochistan**, the LHWP remains as an independent vertical programme under its original name. This is also the case in the **Islamabad Capital Territory, AJK** and **Gilgit Baltistan.** In each of these regions, the management structures are broadly unchanged since devolution, but it is noted that there is a much stronger emphasis on polio eradication in the allocation of time and resources (especially in Balochistan).

1.4. CHW roles and responsibilities and focus on RMNCAH

In Pakistan, at the household level, services are provided through community-based health providers including Lady Health Workers (LHWs) and Lady Health Supervisors, and Community Midwives (CMWs), which are the largest cadres of CHWs in Pakistan. A newly created cadre, a Health-Population-Nutrition (HPN) Counsellor, is expected to provide community level health awareness and education sessions in collaboration with the LHW and also to support facility-based health care providers to organize health education sessions for clients visiting the facility (Ministry of Health & Population, Provincial/Area Departments of Health and Health Planning, & System Strengthening and Information Analysis Unit, 2020).

As mentioned above, the LHWP is the most prominent CHW programme in Pakistan. LHWs are essential in supporting the provision of PHC and preventive services throughout the

Figure 5: Roles and responsibilities of LHW



country. Though their roles have expanded considerably, their primary mandate remains MNCH services, with immunization activities (particularly polio) a core aspect of their work.

1.4.1. Roles and responsibilities of LHWs

An LHW will register approximately 200 households, or 1,000-1,500 clients in her community to whom she will offer a range of preventive and promotive services, including family planning. Every working-day, she is required to visit seven to ten households and will undertake a repeat visit once every month. She should be able to treat simple illnesses and refer cases to the nearest health centres in accordance with provided guidelines. The LHW's services are free at the point of delivery (Hafeez, et, 2011).

The LHW's house is designated as a 'Health House', where the LHW is expected to establish a 'kit corner' to provide counselling and treatment services and to offer vaccinations to women and children. The LHW is also responsible for the establishment of health committees and women's groups in her community and the organization of meetings for these groups on a regular basis (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit 2020).

As mentioned, the scope of services provided by LHWs has grown from an initial focus on MNCH and routine immunization to include participation in large health campaigns, new-born care, and health education on HIV/AIDS. Additionally, respondents reported that currently, LHWs are engaged in activities such as the promotion of the use of contraceptives and provision of other family planning (FP) services (distribution of oral contraceptives and condoms and provision of injectable contraceptives); ANC; treatment of diarrhoea, malaria, acute respiratory tract infection; and referral of community members with more serious illnesses. LHWs are also expected to provide treatment for TB patients, carry out surveillance for cases of polio and assist in other immunization-based activities, and keep comprehensive records for all of their patients.

As the eradication of polio has been declared a national emergency, LHWs have become increasingly involved in supporting polio campaigns. As reported in a recent evaluation of the LHWP, involvement in polio campaigns can take an LHW away from her mandated catchment area for significant periods of time; polio duties in Sindh Province could take up to 50 per cent of a LHW's time (OPM, 2019).

The majority of respondents referenced the dilution of LHWs core mandate, as one of the leading causes of declining quality in their services. In particular, the over-burdening, lack of resources, inadequate training among other issues, arising directly as a result of the expansion of services offered, are mentioned.

Reportedly, the regularization and the change in the employment status of the LHWs to 'government servants' led to an expansion of their scope of work to include non-health tasks. One respondent opinioned LHWs are no longer 'representative of the community'. While the situation varies across district, LHWs are reportedly being 'called for many other jobs' and are often found 'sitting in the district health offices, rather than being in the community and the field'.

1.4.1.1. Sexual and Gender Based Violence (SGBV) Services

The area of GBV and SGBV falls under the ambit of the Ministry of Human Rights (MoHR), who have taken steps to mitigate its effects in Pakistan. A document entitled, 'Brief Review of Implementation of Action Plan for Human Rights (Ministry of Human Rights (MoHR), 2020), gives an idea of the mitigation steps undertaken. The second of the six key thematic areas in the Action Plan, is 'Implementing Key

Human Rights Priorities: Rights of women, children, minorities and vulnerable population'. The 'review of implementation' provides that for the protection of women's rights and the elimination of GBV, the MoHR has formulated National Policy Guidelines on Gender Based Violence, through a consultative meeting with Federal and Provincial stakeholders.

However, this document was not available for review by the team, and there were no publicly available data to enable the team to determine the role of CHWs in countering GBV and SGBV in Pakistan. In fact, data on GBV itself are very limited and do not create a detailed enough picture to enable a meaningful review.

Additionally, a research study has been conducted on men's perception of GBV, to inform the design of a model to engage men in this area, which has now been completed. However, neither of these documents were available for review at the time of this study.

Furthermore, a Domestic Violence (Prevention and Protection) Bill has been prepared at the Federal level. According to the 'review of implementation', the Bill has been finalized by MoHR and has been sent to the Ministry of Law and Justice for vetting. The Bill is not currently available; however, it is worthy of note that the Domestic Violence (Prevention and Protection) Act, 2012 does not make mention of LHWs or any other CHWs.

1.4.1.2. Effectiveness of LHWs

Despite the clear challenges faced by the LHWP, the programme continues to have an impact on the long-term health outcomes of the population it reaches. In a review of the services provided under the LHWP, including family planning, maternal care, and infant and young childcare, the strongest impact was seen in family planning and maternal care. Little impact was seen on infant and young childcare including immunization rates, although the positive impact on polio is an exception, reflecting the massive diversion of resources to this area (Oxford Policy Management (OPM), 2020). The 2019 OPM Evaluation of the LHWP found that for a number of reasons, not least system support gaps, the LHWP missed many marginalized communities, however, the impact of the LHWP was still strongest for the poorer households that it did reach (OPM, 2019).

'[...] to my surprise, those lady health workers, although underfunded, and system support was not available, like supervision, monitoring, availability of medicine, contraceptives, - there were a number of issues which have been identified, and we know why those issues were there - but even then, they are contributing to impact on health outcomes. More specifically, in Pakistan, over the last five or six years, there is a significant improvement on RMNCH indicators, and lady health workers are contributing to those results'. (KI, MNHSR&C)

Currently married women aged 15-49 years on average know more about modern methods of contraception, and are more likely to have ever used contraception, currently be using any form of contraception (Contraceptive Prevalence Rate) and to be using any modern method of contraception.

This suggests that against these areas the LHW both has an impact on women that she visits, but that this outreach is strong enough to also generate an impact at the community level. In terms of the number of modern methods known, the data show that the LHWP has increased the average number of methods known at individual and community levels respectively. In terms of the proportion of women who are using any modern method of contraception, the LHWP increases this probability by five per cent and three per cent at the individual and community level respectively (OPM, 2019).

However, the impact of the regularization on the continued and future roles of the LHW cadre was also highlighted by respondents. Reportedly, the regularization and the change in the employment status of the LHWs to 'government servants' has led to an expansion of their scope of work to include non-health tasks. One respondent opinioned LHWs are no longer 'representative of the community'. While the situation varies across district, LHWs are reportedly being 'called for many other jobs' and are often found 'sitting in the district health offices, rather than being in the community and the field'.

1.4.1.3. Impact on maternal care

Antenatal care is one of the areas of focus of the LHWP, and studies have shown consistently positive results for the impact of the LHWP against two key dimensions of antenatal care, in particular the proportion of women who have had at least two tetanus toxoid (TT) injections and who have bought or given iron tablets to take during pregnancy.

The picture is more mixed with regards to antenatal consultations. At the individual level, i.e. if a woman has actually been visited by an LHW within a 12-month period, there is a positive impact on the proportion of pregnant women who had at least one consultation. However, it is worthy of note that this result is not replicated at the community level, which suggests that whilst there is impact on antenatal care for those women that the LHW reaches, the LHW does not reach sufficient number of women in her catchment area for impact to be observed at this level.

Finally, although the LHWP aims to improve the quality of birth attendance as reflected by the targets set at Provincial levels, the 2019 OPM Evaluation of the LHWP found no significant effect on either trained birth attendance or institutional deliveries (OPM, 2019).

1.4.1.4. Impact on Infant and Young Child Health

This is an area that should be of concern for the LHWP. In observing the immunization of children aged 12-23 months, there is weak evidence to support the claim that the LHWP has a positive impact on this indicator. In fact, the LHWP increases the proportion of children aged 12-23 months who are fully vaccinated only at the individual level of estimation.

Despite this finding and given the importance of polio programming and the increasing role that LHWs play in the delivery of polio vaccination campaigns, the impact of the programme on the proportion of 12-23-month-old children who have been immunized for polio performs much better. However, this may simply be a reflection of the massive resources of the polio immunization programme.

Indeed, when respondents were asked to identify those services most synonymous with the LHWP, the supply of Polio drops was mentioned by most, if not all, as the best practice of an LHW,

particularly in rural communities. A reason for this could be that communities in rural areas appreciated that the LHW had brought the vaccinator to their doorstep and as a familiar woman from the community, she was allowed better access.

Additionally, breastfeeding practices should remain an area of concern for the LHWP. The 2019 OPM Evaluation found that there were no positive or significant results of the LHWP on either the early initiation of breastfeeding nor exclusive breastfeeding at either the individual or community level.

1.4.2. Role and responsibilities of the CMW cadre

To increase the proportion of births attended by a skilled provider, the Government of Pakistan introduced a new cadre of rural midwives, the Community Midwife, in 2006. Rural women with ten years of education were recruited and received 18 months of midwifery training. They were then deployed back to their home villages, where they were expected to establish private practices and provide domiciliary maternity care to a population of 10,000, in geographically defined catchment areas. Out of the planned 12,000, to-date, 8,000 midwives have been trained, most of whom have returned to their home villages (Tabbassam & Menhas, 2014).

Recent evidence suggests, however, that the CMWs have yet to emerge as significant providers. A survey of 1,457 women from Layyah and Jhelum districts in Punjab province showed that only three per cent and 11.7 per cent, respectively, reported their births were attended by a CMW. Another survey of 2,216 women in the three Balochistan districts of Lasbela, Gwadar and Ziarat showed that only zero per cent, 0.4 per cent and 0.7 per cent births, respectively, were attended by a CMW.

Reportedly, a large proportion of CMWs are inactive, particularly in the large, urbanized districts where institutional deliveries are increasing. Although there is no planned expansion of CMW intervention as a result of increasing levels of institutional deliveries, the literature suggests that CMWs may be useful to retain in hard-to-reach districts, especially with the health workforce shortages in these areas. Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit, 2020).

Programme monitoring data from Punjab shows that only 16 per cent of CMWs were conducting four or more deliveries a month—the minimum number required to maintain skills. The survey in Layyah and Jhelum in Punjab province also found that 30 out of 38 CMWs sampled were not working. Respondents identified the recruitment of unsuitable and uninterested candidates, lack of community trust in CMWs' skills, 'the introduction and availability of twenty-four/seven health facilities', perceived unaffordability, gendered mobility limitations, lack of health system support, including financing for stipends, and overall poor programme implementation as key reasons for the CMWs' failure to practice.

As one respondent reflects:
'Community midwives was a programme which had this ethos that once we trained these community midwives, they would go to the community and they would be given a certain base stipend and then they would be helped by the Government to set up birthing stations and they would be able to generate their own income. Having said that, a lot of the community midwives did not practice the way it was intended. The MNCH programme which was supposed to manage their deployment and their services in the community couldn't take off because of various reasons, funding and other issues. So many of them did not, they were not captured by the net. So many of them are lost. Some of them are there but there is no efficient database for measuring impact…'. (KI, MNHSR&C)

1.5. Selection, education and certification

1.5.1. Selection

The LHW must be female, preferably married, and a permanent resident of the area for which she is recruited. She should have a minimum of eight years' schooling, and preferably have matriculated, after which she would have 10 years of education. Further, the LHW should be between 20 and 50 years old, although between 18 and 20 years old is acceptable if she is married. She must be agreeable to her residence being designated as a 'health house'.

The LHWP supplies the LHWs with a basic kit of essential drugs and contraceptives, which is replenished on a monthly basis through the health facility.

Respondents perceived the selection process to be, 'very transparent and competent'. However, the prior learning requirement (i.e., 10 years of education) and the stipulation that the LHW should be from and live in the community that she serves, excludes individuals and communities that have poorer than average access to education services.

Recruitment criteria have not been adapted to changes in LHW roles (with the exception of Balochistan). Increased salary costs following regularization have constrained new recruitment. Regularization is generally reported to have initially improved LHW motivation, but following delays in implementing new service arrangements, and in salary payments, labour militancy has increased. It is reported that increased job security has also made it more difficult for employers to address problems of poor performance (OPM, 2019).

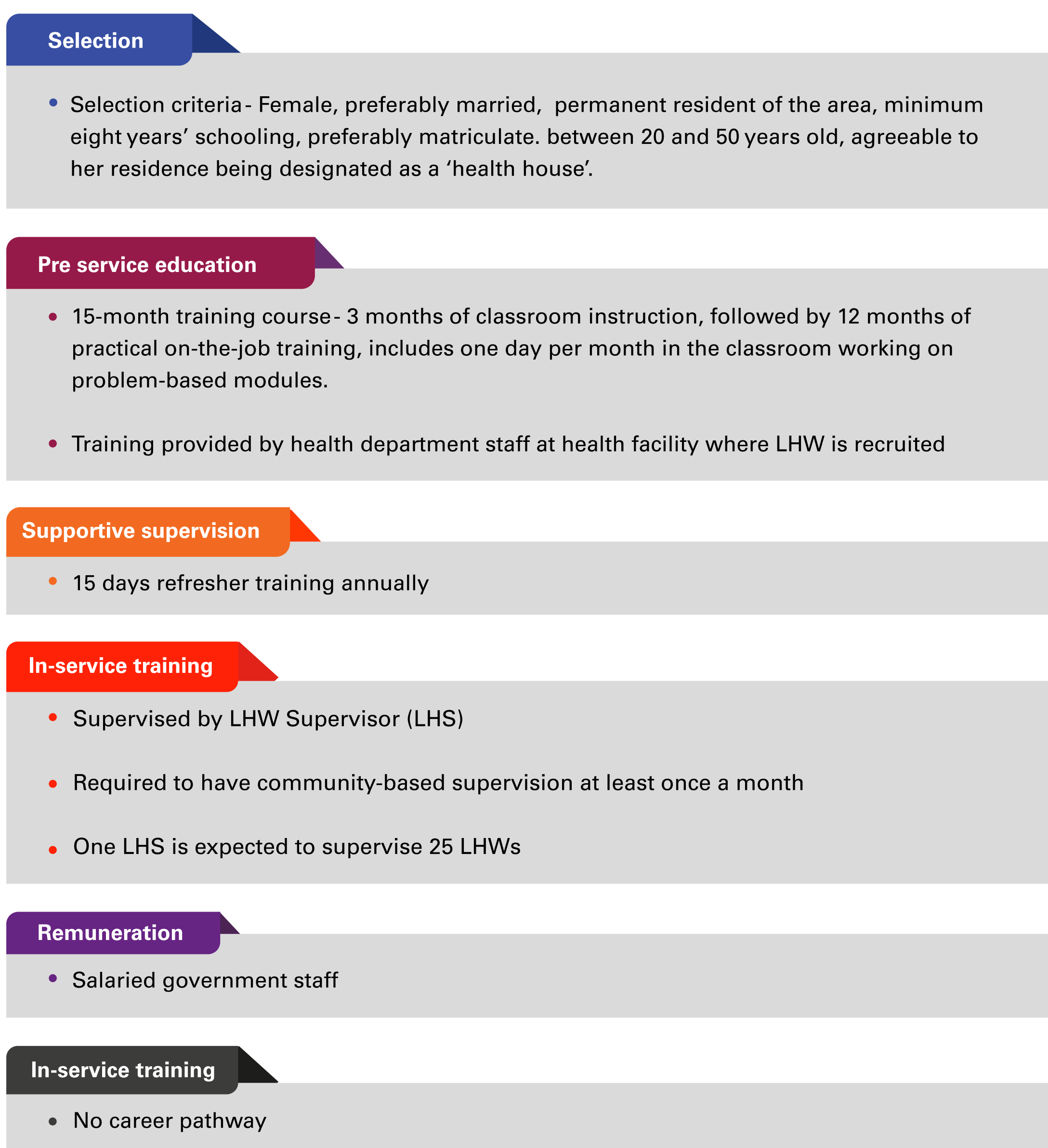
1.5.2. Education and training of CHWs

1.5.2.1. LHWP Pre-Service Education

The training of LHWs is provided by health department staff working at the health facility where they are recruited. A 15-month training course is provided, consisting of three months 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.

Following her 15 months training period, a LHW is expected to be capable of delivering PHC services and carrying out MNCH services, such as ANC, advice on natal and post-natal services, increased coverage of immunization, promotion of health education, promotion of nutrition and basic sanitation, and the treatment of common diseases and injuries.
Prior to devolution, it was found that training had been carried out reliably for most LHWs, with all LHWs having completed the full-time three-month basic training course. However, since devolution, not all provinces, with the exception of Punjab, Sindh,

Figure 6: Selection, training and management of LHWs



and KP, have updated the core curriculum of the LHWs and as a result, the LHW curriculum now differs between provinces.

Regular review and revision of the curriculum is a necessary measure as the mandate of the LHW has expanded since devolution, and in particular there is increased engagement between the LHW and other programmes (such as polio campaigns). There is a risk that the current LHW curriculum being used in some regions will not provide accurate information or cover the full set of roles and responsibilities that an LHW is now expected to undertake. Further, it will not reflect current best practice in the delivery of community-based family planning and RMNCAH interventions, undermining the quality of care that an LHW can provide.

1.5.2.2. Refresher Training

LHWs are required to attend 15 days of refresher training annually. Prior to devolution, it was found that 96 per cent of LHWs had received at least one refresher training course in the previous year. However, since devolution, there have been significant constraints, mainly financial, on the ability of the provinces and regions to deliver refresher training, and in many provinces, notably, Sindh, Balochistan, Gilgit-Baltistan, and AJK, it has ceased altogether. The 2019 OPM Evaluation indicates gaps in refresher training across all provinces.

'I personally feel that we have to prioritize training; repeated trainings and refresher trainings to update her knowledge and capacities and skills'. (KI, Provincial Health)

Conversely, in Punjab and Khyber Pakhtunkhwa refresher training has recently restarted in 2017 and 2018 respectively, with training curricula updated in each province

In **Punjab** Province, the refresher training programme was revitalized in 2017 under the Chief Ministers Skill Enhancement Programme for LHWs across all 36 districts of Punjab. Under the training programme, designed by BRAC and funded by the Punjab Skills Development Fund, 700 master trainers were trained and a Work Book for LHWs was developed to streamline the refresher training process. Respondents

in Punjab indicated that they planned to conduct refresher training every two years, complemented by additional training, targeting specific programme components.

In **Khyber Pakhtunkhwa Province**, the process of updating the curriculum began in 2014 but was only completed in 2018. This was followed by the launch of refresher trainings for all programme staff, the first time that such training had occurred since devolution.

In all other provinces financial constraints have meant that capacity building sponsored by the LHWP has halted, placing a core component of the programme, the skills of its frontline workers, at risk despite annual refresher trainings being articulated as a core and vital aspect in programme documents. Financial constraints not only affect the provision of the refresher trainings themselves, but also the revision and updating of the LHW curriculum to respond to the additional tasks the LHWs are expected to perform.

In Sindh, Balochistan, Khyber Pakhtunkhwa, Gilgit-Baltistan, and AJK, where refresher training was not being provided by the LHWP, donors, including UNICEF and the World Health Organization (WHO) stepped into the gap and have supported training sessions for LHWs. However, respondents indicated that while this support is greatly appreciated, not all the topics in the LHW curriculum or all the LHWs core functions are covered, and this type of training tends to focus on the specific needs of these donors. In addition, given that this training is project specific, it tends to be sporadic in nature, and is not perceived to be a substitute for the refresher training articulated in programme documents. These finding were verified by the respondents, who confirmed that training sessions had become increasingly sporadic, and when they did occur, they tended to focus on the needs of specific campaigns.

1.5.3. Education and Training for Community Midwives

CMWs receive 18 months of training. During the first three months, CMWs undergo classroom based study in the training school, after which they sit an exam. After successfully passing the exam, the CMW undertakes 12 months training in the hospital allied with the training school where they did their first three months of training. As a part of these 12 months, students spend three months in each of the following areas/wards: 1) gynecology and obstetrics, 2) gynecology and obstetrics operating and delivery rooms, 3) new-born nursery ward, and 4) labour room, supervised by the head nurse of each department.

After completing the 12 months hospital training, CMWs are sent to their respective communities where they are linked to the local health facility for the final three months of their training, to gain experience working in cooperation with the LHWs and Lady Health Supervisor (LHS), before they begin to fully function on their own conducting home deliveries (or CMW health home deliveries). During this period, CMWs are supervised by the Lady Health Visitor (LHV) or woman medical officer (WMO) present in the attached health facility. One of the main purposes for this community practice is to help the CMWs transition into their communities and to establish linkages with LHWs, so that their work and relationships within their community, especially in regard to the referral mechanisms, are strong from the outset. Once the CMW has completed the community component of the training, she sits for the nursing examination board and **is examined on midwifery and obstetrics skills and knowledge** (Pakistan Nursing Council, 2012).

1.5.4. Supportive Supervision for LHWs

LHWs are attached to a public health clinic (such as a BHU) and are supervised by an LHW Supervisor (LHS). In theory, LHWs are required to have community-based supervision at least once a month in which her LHSs meets with both clients and the LHWs, reviews the LHWs' work, and makes a work plan for the next month. However, in practice, these supervisory meetings do not occur with the consistent regularity that they should.

One LHS is expected to supervise 25 LHWs. An LHS is provided with a vehicle and driver, and it is expected to visit each LHW under her supervision at least twice a month. The LHW and LHS are supervised by Field Programme Officers (FPO) and the management staff of the Programme Implementation Units (PIU) at district and provincial levels.

On average across Pakistan there are sufficient numbers of LHS to cover the current workforce of LHWs. Pakistan as a whole, has a ratio of 1 LHS to 25 LHWs; Punjab 1:24; KPK 1:26; Balochistan 1:24; AJK 1:21 and GB 1:23. This result holds across the provinces with the exception of Khyber Pakhtunkhwa and Sindh. Sindh in particular appears to have a shortage of LHSs, with an average LHS:LHW ratio of 1:29, with the Provincial Report indicating that some LHSs are supervising up to 50 LHWs.

However, most respondents perceived supportive supervision to be a key priority, 'if we guide her, if we support her in her working and in addressing her weaknesses that is number one'. Most were of the view that LHWs required more supervision to enable them to achieve better results. Despite, adequate availability of LHSs, there has been a significant reduction in the capacity of LHSs to perform their supervisory tasks. Respondents acknowledged that a lack of funding, particularly for transport is a major barrier to the effective supervision of LHWs by LHSs, with the exception of the provinces that have a smaller geographic area to cover (for example, ICT and Gilgit-Baltistan). There are significant funding gaps for the maintenance of vehicles experienced in almost all provinces, with the lack of functioning vehicles creating significant challenge for LHSs in conducting their work and many often having to rely on their own or public transport to get around (OPM, 2019).

1.5.5. Remuneration

Following devolution, the Federal Government ceased funding non-salary expenditure for the LHWP in 2011 but continued to fund the salaries of LHWP staff in provinces until the Fiscal Year (FY) 2017-2018. Thereafter, the provinces were given complete responsibility for funding the LHWP from their own budgets, with the Federal Government retaining responsibilities for funding the LHWP in the regions of AJK, Gilgit-Baltistan, and ICT through the Public Sector Development Programme (PSDP) within the MNHSR&C budget.

However, this process has come upon several obstacles, as noted by respondents, including the financial burden on the provinces as a result of the doubling of LHWs' salaries.

'...I think when this decision by the Supreme Court was taken in which their salary was doubled from, I think it was around 3,000 (PKR) to almost 7,000, it had a really huge financial implication for the Government of Pakistan, this doubling of the salary for the lady health workers and of course for supervisors as well as other cadres. What happened was it compromised on the budget or the allocation which was supposed to be there for the operational expense, which included the supplies as well. So, things had started, and then of course, came devolution. They were regularized, the salary was increased so much. All these things really compromised the government, both at the federal and the provincial level, who were really struggling to coordinate, to implement things in the new reality of the devolved system'. (KI, Provincial Health)

While regularization has improved the status and pay of LHWP staff, the slow implementation of the process resulted in the accrual of salary arrears over several years, which, along with the lack of pension provision, and a defined service structure, led to staff grievances.

In the initial period after regularization motivation levels for LHWs had increased across all regions of Pakistan, mainly as a result of a perceived sense of job security. However, due to the poorly planned process of regularization, this initial boost to motivation has been undermined by the lack of a career advancement structure which would allow for the job mobility of LHWs. LHWs were also dissatisfied with their lack of access to the full benefit package (including pensions or medical allowance) enjoyed by other government civil servants and aggrieved by the considerable delays experienced in the payment of salaries across all regions.

'One of the decisions was that even after devolution, up till 2015, the Federal Government would fund the programme. They would send the salaries on quarterly basis or bi-annual basis and then we used to just disburse. But there were many delays in salary from Federal Government to provincial level and then our processing down to the Lady Health Workers was really a problem. This was a constant headache'. (KI, Provincial Health)

Furthermore, there is a perception among many LHSs and LHWs that the level of monetary incentives provided to them through the basic pay scale is not commensurate with the level of effort expected from them, under their expanded scope of responsibilities.

1.5.6. Career progression

According to the respondents, LHWs do not have access to a structured system of career progression. This is because they were initially inducted as voluntary workers with some compensation and there was no thought at that time of establishing them as a regular Government cadre. Following regularization of the LHW cadre, as described above, a process for career progression should have been established, however, there is no clear indication of how or when this might happen. If, for example, an LHW wants to become an LHS, which is a hierarchically senior position, they may in theory gain additional educational qualifications to do so. However, as one respondent pointed out, there can only be one LHW in a catchment area, from that same community, so, in practice, this is not feasible.

1.6. Integration into and support by health systems and communities

1.6.1. Integration into and support by the health system

In Punjab, the integration of the LHWP into the IRMNCH & NP has led to improved coordination between related health departments and encouraged the practice of regular intra-departmental meetings, which involves the regular gathering of district coordinators from all 36 districts in the province to share issues and discuss progress. However, all respondents stated in some form, that there was a lack of clarity on the division of roles between front line staff and identified a need to strengthen functional integration at that level.

In particular, it was perceived that there is a lack of coordination, and indeed active competition, between LHWs and CMWs, which appeared to be related to the facility-based targets for referrals that are part of the LHW's performance management process. This has led to LHWs referring their cases to FLCFs, rather than referring them to CMWs. This situation is further compounded by the fact that the local health facilities often recommend institutional delivery as a superior option to a CMW assisted delivery.

Similarly, in Khyber Pakhtunkhwa, the LHWP has been integrated into the IHP. This has provided administrative integration between the LHWP, the EPI, and MNCH. Planning documents for the IHP also defined a model for horizontal linkages between LHWs and CMWs. However, evidence from the interviews can lead us to conclude that this has not in fact resulted in improved coordination between LHWs and CMWs for similar reasons as in Punjab.

In other regions where the LHWP has remained as a standalone programme and had not been integrated, respondents, particularly those currently or previously engaged with the government, consistently state that there are a lack of mechanisms for coordination between key stakeholders, in particular the Health Department, the Population Welfare Department and the PPHI.

AJK was the exception, where a wide range of government stakeholders reported there were strong inter-departmental linkages. These appear to have been facilitated by regular inter-departmental meetings. As a result of this coordination, it is now envisaged that LHWs will play a central role in the MNCH Action Plan managed by the Population Welfare Department. This has led to further consideration of the full integration of vertical health programmes related to Family Planning and RMNCAH (OPM, 2019).

1.6.2. Target population

The expansion of the LHW caseload from a maximum of 1,000 residents to 1,500 residents was undertaken without a careful assessment of the capacity and capabilities of the LHW, in

particular, the ability of an LHW to maintain the same level and quality of service to a larger population. The expansion of the LHW's role to include participation in other activities, such a polio programming, did not consider the implications of taking an LHW out of her community and diversifying her efforts away from her core RMNCAH functions. Indeed, a higher number of tasks and larger catchment areas negatively affects a CHWs' performance and the quality of the services that they deliver.

1.6.3. Availability of medicines and supplies

The logistics system of the LHWP must ensure that there is a timely supply of drugs and non-equipment supplies for the LHW. Failure to do so risks the quality of service that she can provide and can damage her professional reputation in the community. Prior to devolution the procurement of supplies was managed centrally through the Ministry of Health, using competitive bidding procedures. Post-devolution procurement is undertaken at the Provincial level with the PIU, or its equivalent in the integrated programmes in Punjab and Khyber Pakhtunkhwa.

Continuing issues with the LHWP logistics management system have resulted in significant gaps in the provision of basic supplies and equipment. Respondents noted that this has led to significant stock outs of supplies, including contraceptives and basic medicines. There were also challenges with the provision of the core LHW kit, which includes basic medical equipment essential for the LHW in the performance of her core functions, such as, weighing scales, blood pressure apparatus, thermometers, and pregnancy kits. Such stock outs hinder the ability of an LHW to perform her core duties and limit the extent to which the LHWP can be expected to meet its health outcome targets.

1.6.4. Collection and use of data

The core purpose of the LHWP Management Information System (LHW-MIS) is in the measurement of results against key performance indicators defined in project documents. Progress has been made in upgrading the LHW-MIS to a web-based system (in KP, Punjab, and Sindh) but in AJK, Balochistan, GB, and ICT the LHW-MIS is still manual. However, effective quality control mechanisms and enforcement of reporting on all indicators are lacking across most regions.

Consequently, the data produced is of limited reliability. MIS data does not appear to be used systematically (e.g. through regular review meetings) to inform programme strategies in any region. Further, updates to the monitoring system, and in particular reporting formats for LHSs and LHWs, have not been accompanied by adequate training. This means that rather than facilitating supportive feedback, the current supervision mechanisms appear to be adding to the burden of LHWs.

The lack of a harmonized Logistics Management Information System (LMIS) for all LHWP supplies, and the lack of capacity to fully implement the LMIS where it is available, severely limits the ability of the LHWP to adequately plan the distribution of supplies. All regions suffered severe disruptions to supplies and equipment in the initial period following devolution of the LHWP relating to shortages of funds for non-salary purposes. In addition, only partial progress has been made in replacing the centralized procurement system that was in place before devolution. As provinces have taken full budget responsibility for the LHWP, the supply situation has improved though significant capacity constraints remain throughout the system.

1.6.5. Community integration and engagement

Client engagement for the LHWP was defined as 'LHWs feel free to operate within, are accepted and trusted by, and are accountable to, the communities that they serve'.
Studies indicate that LHWs and LHSs consistently report that the main driver of their empowerment is the sense that they have made a real contribution to improving health outcomes in the communities that they serve. Community response to their work is positive and they enjoy an elevated status within the community as a result. Each LHW is expected to organize health committee and women's group meetings on monthly basis to discuss health related issues.

In this regard the LHWP is for the most part functioning well. The recruitment criteria that requires LHWs to be recruited from the communities in which they live, means that they are known, and more likely to be trusted, by the communities in which they work. However, LHWs are being asked to engage in programme activities that force them to work outside of their communities. This undermines the functioning of the client engagement mechanism, suggesting that LHWs may struggle to be accepted by communities where they are not known.

All respondents indicated that integration with the wider health system is crucial for the effective delivery of a community health worker programme. The coordination with other health professionals in the health system improves the credibility of community health workers thereby improving their ability to engage with their community (OPM, 2019).

1.7. Financing

Health financing is the strategic approach to generating, pooling, allocating and using financial resources in a country's health system.

According to the last round of National Health Account (2015-2016), the total annual health expenditure in Pakistan was Rs. 907.5 billion, with out-of-pocket expenditure constituting 57.6 per cent, followed by the share of provincial government of 20.6 per cent. The share of district government and federal government (civil) was only 4.3 per cent, while the share of Official Donor Agencies was only 1.7 per cent (Pakistan Bureau of Statistics, 2018).

During the financial year 2018-2019, the cumulative health expenditure by federal and provincial governments increased to Rs 421.7 billion from Rs 416.4 billion of the previous financial year, recording an increase of 1.99 per cent only. The current expenditure increased by 10.3 per cent from Rs 329 billion to Rs. 363 billion while the development expenditure decreased by 32.9 per cent from Rs 87 billion to Rs 58 billion. The Government has also launched a health insurance initiative, the Sehat Sahulat Programme for families living below the poverty line of US$2 per day. Through this health insurance the family of each member is able to access health care services from empanelled hospitals up to PKR720,000 per annum.

Prior to devolution, the LHWP, like all vertical health programmes, had been funded federally through the Public

Sector Development Programme (PSDP), and had been, to a large degree, fully funded, with relatively minimal delays in the release of funds. Since devolution, however, the LHWP across all regions has faced considerable financial challenges in large part due to the regularization of LHWs, with the per LHW cost more than doubling, with an associated and significant decline in funds allocated to non-salary expenditure.

Across Pakistan, traditionally well performing systems, such as monitoring and supervision, training and capacity building, and logistics and supplies have been underfunded and have suffered since regularization.

In the transitionary years following devolution, a decision of the Council of Common Interest (CCI), a constitutional body in the Government of Pakistan, established to resolve disputes of power sharing between the federation and provinces, led to expectations that the LHWP would be funded from the PSDP up to 2017. However, with regularization there were significant funding gaps in the years that followed, which led to long periods of non-payments of LHWs. This was exacerbated by long delays in the release of PSDP funds experienced in the majority of regions, but particularly in Khyber Pakhtunkhwa, Gilgit-Baltistan, and AJK, where PSDP funds were often released only in the last quarter of the financial year. Significant salary arrears had accrued over the period 2012-2016. This amounted to PKR 4,213 million in Punjab, PKR 5,194 million in Sindh, and PKR 1,000 million in Balochistan.

There have been various responses to the accrual of salary arrears across the regions. Punjab, Sindh, and Balochistan provided bridge financing sponsored by provincial Finance Departments. In Khyber Pakhtunkhwa the salaries component of the LHWP was shifted to the recurrent budget in 2016, and salary arrears of PKR 2,000 million were paid in the 2017-2018 financial year

Risks to funding and the financial sustainability of the programme vary across the regions. **Sindh** shifted both salary and operational costs in their entirety to the recurrent budget, offering greater security in funding for the programme, with no expectations of receiving further funding through the PSDP. A similar situation is found in **Balochistan**, where all expenditure has been shifted to the ADP.

In **Punjab**, funding of the LHWP remains heavily reliant on PSDP funding. However, the creation of a Schedule for New Expenditure (SNE) has been signed, to shift all salary expenditure to the recurrent budget from the 2018-2019 financial year.
In **Khyber Pakhtunkhwa**, salary expenditure was also shifted to the recurrent budget from 2016. However, Khyber Pakhtunkhwa remains heavily dependent on both donor and PSDP funding, placing risks on the financial sustainability of the programme in that province.

The situation is less clear elsewhere. In AJK salary costs have been shifted to the recurrent budget but remains dependent on the PSDP to fund operational costs, which have decreased significantly over the period 2015-2018. Gilgit-Baltistan remains entirely dependent on the PSDP to fund the entire programme. In both AJK and Gilgit-Baltistan, there is an expectation that the Federal Government will continue to fund the programme from the financial year 2019-2020 and onwards.

In summary, in the majority of regions across Pakistan, the LHWP is appropriately funded in terms of budgeted cost. However, this funding is heavily skewed towards salary expenditure, which means that despite there being sufficient funds for planned expenditure, there remains a significant risk to the ability of the LHWP to effectively deliver. The recent 2019 evaluation of the LHWP programme by Oxford Policy Management reported the actual annual unit cost of a LHW was PKR 280,508 (US$1,810), however it also reported 'serious gaps in capacity building/training; supervision & MIS; governance & planning; and procurement of supplies/equipment'.

For regions where information is available, the proportion of total costs that are devoted to salaries expenditure has dramatically increased, from 57 per cent in 2008-2009 to between 85 per cent and 97 per cent depending on the region in 2017-2018. This shift in the allocation of expenditure greatly inhibits the programme's ability to deliver the wide range of activities that are necessary to enable an LHW to effectively perform her core functions (OPM, 2019).

1.8. Private sector involvement in CHW programmes

Low levels of public expenditure on health care in Pakistan has meant that the private sector plays a large role in the delivery of health services, with individuals making out-of-pocket payments for health services (including private insurance schemes). According to the National Health Accounts (2015/16), 64 per cent of all current health expenditure in Pakistan comes from private funding, of which the vast majority (90 per cent) is derived from out-of-pocket expenditure. These high rates of out-of-pocket expenditure puts Pakistan in the top decile in relation to countries in South Asia and Sub-Saharan Africa.

Studies have shown that a key factor in pregnant women not seeking seek ANC is its high-cost, especially in the private sector. Thus, LHWs advise their pregnant clients to seek ANC services in the public sector, even though care in the private sector is considered to be higher quality (Majrooh, et al, 2014; Ashraf, et al, 2017; Nisar, et al, 2016).

One respondent highlighted the significant the role the private sector plays in the delivery of health services, 'private health care is a big reality in Pakistan; 70 per cent of the care is in the private sector'.

While the LHWs might refer someone to a government health facility, often 'they do not have the service delivery they are looking for', and "the community is going to the private setups'. Respondent indicated that 'there is no formal mechanism of engaging with the private sector in Pakistan', which they felt was 'big gap in Pakistan'.

Private sector providers were perceived to be 'working totally unregulated'. One respondent pointed out that despite the establishment of 'health care commissions' that are 'supposed to register the private sector and have a sort of a monitoring and supervision goal' many of the systems in the provinces were not working efficiently, with the exception of Punjab, and to some degree in KP.

Some suggested that if there were 'a very serious discussion around at least engaging the private sector in providing this referral backup', this could 'improve and bring this private sector into the loop of the working'. It was felt that this could

help 'form a sort of a link between the lady health workers and the private care'.

2. Policy and system support improvements to optimize CHW programmes

- **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or Primary Health Care (PHC) reforms and strengthening.

The section responds to KEQ 2, which seeks to identify and assess actual or prospective country level Astana commitments or PHC reforms, and what improvements are needed in existing CHWs policies and system support to achieve these, and to improve the provision of RMNCAH services.

2.1. Policy improvements to optimize CHW programmes to respond to post-Astana requirements and PHC strengthening

This section provides an overview of the PHC reforms and the polices frameworks supporting these, and then discusses the policy improvements identified to optimize CHW programmes in Pakistan to better serve maternal and newborn health, and to respond to post Astana and/or PHC reforms.

2.1.1. PHC policies and reforms

The Astana Declaration recognizes PHC as a cornerstone of a sustainable health system for Universal Health Care (UHC) and health-related SDGs and that strengthening PHC is the most inclusive, effective and efficient approach to enhancing people's physical and mental health, as well as their social well-being (WHO/UNICEF, 2018). CHW programmes as a sub-system of PHC, have a vital role to play in strengthening PHC, in expanding the provision and reach of a range of preventive, promotive and curative services, and in achieving universal coverage.

The second of the three resolutions on UHC of the 2019 World Health Assembly recognized the contribution of CHWs and urged countries and partners to allocate adequate resources to optimize CHW programmes. It also emphasized the need for CHWs to be well trained, effectively supervised, and properly recognized for the work they do, as part of multi-disciplinary teams. Further, it recognized that investing in CHWs generates important employment opportunities, especially for women (WHO, 2019). Pakistan's 11th Five Year Plan (health chapter), the National Health Vision and National Action Plan (2019-2023) are underpinned by the principles of ensuring the provision of good quality essential health care services to all people of Pakistan, through a resilient and equitable health care system (Ministry of Planning and Development, 2013). The National Health Vision for Pakistan provides a well thought out strategic framework for implementation of good governance parameters that can positively influence the achievement of health-related Sustainable Development Goals (SDGs) and UHC targets within Pakistan.

The UHC Benefit Package for Pakistan, informed by the global review of evidence by Disease Control Priorities (DCP3) has been developed to transform the National Health Vision into reality (Jamison, et al, 2018). Reportedly, over 100 stakeholders were involved in defining the goals of the EPHS and the prioritization criteria for the interventions. It is expected that the EPHS will enable each provincial/area department of health to prioritize a sub-set of essential health services based on their needs, the burden of disease, and fiscal space.

Sustained political commitment and robust and transparent leadership that promotes multisectoral stakeholder participation and engagement at all levels will be vital for operationalising and institutionalizing the UHC Benefit Package and the effective delivery of the EPHS at all levels, including at the community level, to realize the national health vision of the 'provision of good quality essential health care services to all people of Pakistan through a resilient and equitable health care system'. (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit, 2020).

The Astana Declaration encourages stakeholder alignment in supporting national policies, strategies and plans. The Ministers of Health at federal and provincial/area level aim to implement the UHC Benefit Package with the private health sector, civil society organizations and academia 'to ensure provision of essential health services to ALL'. The involvement of all health sector stakeholders at all levels, including policy makers, managers, facility and community-based health care providers, as well as professional associations will enhance stakeholder ownership and buy-in, and the achievement of UHC. Inter-sectoral linkages and collaboration will also enhance collaboration and promote team working across the PHC workforce.

Some of the concerns expressed by participants in this study reflect a degree of misapprehension about the current reforms and PHC reorganization. A general lack of faith in the ability of the Government, both Federal and Provincial to achieve their goals, evidenced by the ongoing issues relating to the now nearly decade-old devolution process, as well as a chequered history of setting lofty goals, which later prove unattainable for a variety of reasons, are the primary cause of this. However, though somewhat hindered by the COVID-19 Pandemic, the National Action Committee continues to meet (as of September 2020).

There is a need to establish effective coordination and communication mechanisms and monitoring standards and systems, which will promote transparency and provide quality and reliable information to help allay stakeholders' fears and concerns about the effects of the UHC benefit package.

One respondent opinioned that the federal government should take the lead 'to synergize coordination and effort' and that there should be 'some policy mechanism to enhance the integration of all programmes'.
Community engagement, education and empowerment are necessary conditions for effective use of PHC services. Meaningful community engagement and participation will require community outreach, engaging formal and informal community leaders, community groups and societies, and other key actors in the planning, delivery, review, and monitoring of PHC programmes and services. Harnessing the potential of CHWs such as the LHWs, who, through their work with families and households, have established trusting relationships, accumulated significant social capital

and achieved the status of influential social actors and change agents, will enhance such engagement as well as improve the coverage, and reach and equity of PHC programmes.
One respondent emphasized that as well as having 'capable and skillful health care providers in the system' serving the community, there is a need to have 'honest leaders' at the provincial level and the district level 'to support those health care providers'. It was felt that this combination of 'honest leaders' and 'capable and honest staff', would contribute to health systems strengthening.

2.1.2. Health workforce policies

The Astana Declaration identifies human resources for health (HRH) as a key driver for PHC success. Adequate financing and sustained investment in the production, management and retention of the LHW workforce and other PHC health care providers, especially for staffing hard-to-reach and remote areas, will be vital to achieve the expected RMNCAH service coverage and equity goals.

The Human Resources for Health Vision 2018-2030, states the following as its primary goal:
*'To improve health and socio-economic outcomes in Pakistan by ensuring **universal** availability, accessibility, acceptability, coverage and quality of the health workforce through adequate health system strengthening investments and the implementation of effective HRH policies and strategies at national and provincial levels (MNHSR&C, 2018).*

As highlighted previously one of the major challenges for the health sector in Pakistan is the severe shortage of health workers, especially nurses, midwives and LHWs. Other challenges include inequitable distribution between urban and rural areas; inadequate skills; poor job satisfaction and work environment; and out-migration. Adding to these challenges is the lack of reliable information on the numbers and distribution of health workers deployed across the country.

In the face of these health workforce challenges the role of the LHW and CMW cadres becomes significantly important, especially to ensure service coverage in rural, hard-to-reach areas and urban slums. The LHWP is also an effective approach to address the equity and gender challenges in the health sector while ensuring the availability of primary, preventive, promotive and selected curative care services at the doorstep of the community. Currently, the number of LHWs is on the decline, while less than 60 per cent of the targeted population covered by their services.
The HRH Vision aims to scale up the health workforce with a medium and long term, uniform strategy in advancing towards UHC and the SDGs. The federal, provincial/area, district governments, public agencies and autonomous bodies, in accordance with the National HRH Vision, will implement the strategies in partnership with the private sector, NGOs, CSOs and communities. The HRH Vision will provide guidance for provincial strategies to enable them implement health workforce interventions and allow for a rapid scale up. It should also be noted that scaling up will go beyond the quantity aspect, addressing quality, accessibility and performance concerns.

The process will be overlooked by the Pakistan Health and Population Strategic Forum, under the leadership of MNHSR&C, established to facilitate policy and strategic discussions to reach consensus on measures to strengthen Pakistan's health and population sector, to achieve Vision 2025 and other international commitments. This high-level advisory forum will guide and inform the HRH development process and consider strategic issues raised by the national HRH task force.

The review of available data on the health workforce in Pakistan and setting strategic directions will be the responsibility of a high level National Human Resources for Health Task Force- a broad-based committee of stakeholders, including ministry, departments, regulatory bodies, international partners, private sector, academia and civil society.

Additionally, the MNHSR&C has formed a National HRH Working Group consisting of Director Programme, HPSIU, focal points from all provinces/ areas, PMDC, PNC, HSA, WHO, donor constituency and other co-opted members to collate and analyse the available HRH related data.
The same group will continue to function to monitor the implementation of the HRH Vision and provide technical support to provinces to translate this into provincial strategic plans. Similar implementation arrangements will be ensured at provincial level to produce, implement and monitor provincial HRH Strategies.

Though there is no explicit mention of steps taken to strengthen PHC, the commitment to UHC is obvious, of which PHC is an integral component. Within the HRH Vision 2018-2030, a number of steps are outlined that target the development, expansion and support of CHWs.

Despite the recommendations of the HRH Vision, no training or recruitment plans have yet been developed to address the identified workforce challenges, and there is little evidence available which concretely displays that the aforementioned vision has started implementation in earnest.

2.1.3. Financing

After the 2011 devolution of the health sector, a gradual and enhanced increase in spending on health care was witnessed due to the increased fiscal space available to the provinces. However, it is important to note that a large portion of this spending was consumed in salaries and administrative costs varying across provinces.

The major challenges of health financing in Pakistan include inefficiencies in public health spending: duplication of activities; and limited coverage of the health insurance programme, which is currently only available to particular disadvantaged groups. Alternate modes of health financing have not been explored in the country, with low Official Development Assistance (ODA). There is a lack of effective private sector engagement in the provision of essential health services through different financing modalities.

The Government health insurance initiative, the Sehat Sahulat Programme increases the ability of people to access health care at all levels. However, its scope needs to be expanded both in terms of services and the inclusion of other groups, through pooling of risk (Pmhealthprogram.gov.pk., 2020).

Pakistan needs to invest more in the health sector to improve social protection and the health of the population. Policy

makers should encourage more stable and flexible financial plans, along with an increased budget allocation, taking into account the priorities of the health sector. In order to progress towards the goal of UHC and to support a reformed PHC tier, Pakistan needs to reduce fragmentation and inequity, and maximize purchasing power.

2.1.4. Gender responsive polices

As described previously, Pakistan has significant gender disparities that serve as a major impediment to economic and social development, with the country falling to third-to-last place on the 2020 (GGGI). The economic opportunities for women in Pakistan remain limited, with weak efforts made to bridge the gap (32.7 per cent) between men and women in the formal work sector. Less women than men participate in the labour force, they receive less labour income and hold fewer senior and leadership roles (World Economic Forum, 2020). Less women are literate, with more boys attending school than girls and more girls dropping out at the middle/secondary school level (National Institute of Population Studies, 2018).

With regard to health, women in the country do not have the same access to health care as men. To bridge the gap in access to health care, the issue of gender disparity needs to be tackled to ensure equitable health services provision.

Although the LHWP hires primarily women to serve women in the community, the programme was not designed or conceived with an explicit human rights and gender equality approach. However, it does seek to support the goal of achieving UHC through the delivery of doorstep PHC, as well as addressing the specific health needs of women and children. Moreover, it can be concluded from the literature that the LHWP is supportive of the empowerment of LHWs and LHS.

In fact, by design the programme is supportive of human rights and gender equality in a number of dimensions. Whilst access to PHC is not an obligation of the LHWP, in the areas that it currently serves, it acts as a bridge for communities with no access to first level care facilities and is supportive of a continuum care in the RMNCAH domain. In the context of the limited mobility of women this is a crucial aspect of the programme that is supportive of reducing gender inequalities in access to health.

Further design aspects that are supportive of gender equality include the recruitment criteria of the LHWP, which ensures that the LHW is recruited from within the community that she serves, and crucially that all LHWs are women. This both increases the likelihood that an LHW will be accepted by her community, and the acceptability of the LHW visiting clients, including at times when their husbands are not in the household.

Significant gender inequalities also exist in the realization of sexual and reproductive rights in Pakistan (UNFPA, 2019). In this regard, with its focus on family planning, the LHWP is well placed to make gains towards the realization of gender equality. There is evidence that the LHWP has been instrumental in changing the attitudes of both men and women towards family planning, as well as providing evidence that the LHWP is continuing to have an impact on the contraceptive prevalence rate.

2.2. System support improvements to optimize CHW cadres to respond to post-Astana requirements and PHC strengthening

The section outlines the identified system support improvements needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening. Improvements in the education, management and supervision of the LHW and CMW cadres in Pakistan and their integration into and support by health systems and communities are discussed.

Overall, study participants expressed a degree of remorse when discussing the current state of affairs of the LHWP and CMWs. The well-established network of LHW cadres across the country was said to have contributed to the achievement of positive RMNCAH outcomes in a cost-effective manner and strengthened health promotion and prevention in communities. However, of late, a decline in the quality of services offered by the LHWP has been noted. This is a due to a variety of factors, chief among which is ongoing issues stemming from the devolution of health care services to the provinces. This includes but is not limited to the problems that persist following the regularization of LHWs. CMWs have yet to emerge as a significant addition to the skilled birth attendant workforce in Pakistan.

2.2.1. Optimizing CHW roles and responsibilities

All of the respondents felt strongly that the LHWP should continue. Some suggested that male CHWs could be included in the programme but had concerns that for cultural reasons their interaction with women would be limited: they would not be able to enter houses and communicate with women. The roles and responsibilities of male CHWs should therefore be well defined and agreed in a consultative manner, and their work in the community and with households should be well coordinated with that of the LHW and other community based cadres.

Respondents had mixed views on the ongoing and future roles and responsibilities of these cadres. Most suggested refocusing the attention of the programmes towards RMNCAH and emphasized the need to safeguard the role of the LHW in the provision of these services, where they have had such considerable success. One suggestion was to create space within their current scope of work to spend more time with the women, children and adolescents under their care. Maintaining a focus on improving the quality RMNCAH services was emphasized as a key consideration for future PHC planning, budgeting and programming. Improving the uptake of services at the PHC level, would also reduce the burden on secondary and tertiary facilities and staff, and the financial burden of delivering such care at these levels. Given the health workforce constraints in the country these CHW cadres are an important asset: optimizing their role and responsibility would be a key strategy in addressing the shortage and inequitable distribution of the health workforce.

On the other hand, some suggested expanding the scope of work of the LHWs particularly in the areas of communicable and non-communicable diseases, "to get the maximum

benefit out of these cadres". Alongside their core functions, they could also be utilized to support NCD health promotion, and prevention and control activities, which, it was felt, would also promote greater synergies between PHC curative and preventive services.

If LHWs, and to a lesser extent the CMW cadre, are to play a role in NCD prevention and control efforts, within the scope of their current roles and responsibilities, appropriate systems support, including training, supervision, remuneration, and an enabling environment to address areas where respondents have identified deficiencies, will be required. Such support would enable them to optimally deliver services such as healthy nutrition counselling, early detection, referral for priority chronic diseases, and medication compliance management and other family and people centred care as part of their core functions.

Along with the concerns expressed above about the expansion of the LHWs scope of practice to include non-health tasks as a result of regularization, respondents also highlighted the heavy workload many LHWs now have. Several respondents were of the view that many LHWs already have multiple tasks and responsibilities, including acting as Community Based Vaccinators (CBVs) for polio, which has led to many feeling overburdened. It was suggested that any additional tasks and expectations related to NCD health promotion and education or other services, should be clearly defined and should not interfere with or undermine their ability to undertake their core RMNCAH and other functions. It was further emphasized that activities related to other areas should not add to the LHWs already heavy workloads or crowd out or dilute the care she provides to women and children.

2.2.2. Selection criteria and availability and distribution of CHWs

The requirement that a certain level of prior learning is required for selection as an LHW, by definition excludes communities that have poorer than average access to education services. It was also noted that across the majority of provinces, politically driven recruitment had influenced the allocation of LHWs to certain districts over others, which may in part explain the high variations in coverage.

To encourage improvements within the LHW programme, it was suggested that a key priority of the LHWP should be to ensure that the selection, deployment and transfer of LHWs, as well LHS, is based on merit. One respondent went on to suggest that a merit-based system should also be applied to the selection and deployment of those involved in "programme implementation at district level and the management at provincial level'.

Additionally, it has been reported that the expansion of the LHWP in the past has not always been based on an adequate mapping of need. Any further expansion of the LHWP should be informed by reliable information on the areas with the poorest health outcomes, lack of access to health care facilities, and high rates of poverty. This would ensure the LHWP expands into areas that have the greatest need, potentially, where the programme could have the greatest impact, and which, therefore, should be given priority when recruiting and deploying LHWs. However, in many provinces the expansion of the LHWP has not been prioritized due to the general freeze on new recruitment that followed the regularization of LHWs.

It is important that the LHW cadre be viewed as an asset to the health system, rather than a liability. LHW interventions are cost effective and critical to make progress on UHC. A priority should be renewed strategic thinking on improving the availability and distribution of LHWs across the country, especially in rural and hard-to-reach areas.

Lastly, while regularization has improved the status and pay of LHWP staff, the implementation of this involved the accrual of salary arrears over several years, which, along with the lack of provision of pensions, and a defined service structure, are major sources of grievances for staff.

2.2.3. Education and training

Multiple respondents identified skills development, capacity building and supportive supervision as key priorities for ensuring LHW have the latest knowledge and skills to provide quality services and for strengthening the overall LHWP. Respondents highlighted the importance of continuous and regular refresher training, coupled with supportive supervision, to update LHWs' knowledge and skills and guide her work.

'…if we support her in her working and in addressing her weaknesses that is number one; supportive supervision and supervisory support is one. Second is trainings; repeated trainings and refresher trainings to update her knowledge and capacities and skills'. (KI, Health Official)

While some provinces have supported curriculum review and revision and the training of LHWs, the delivery of training and the updating of the curriculum and training materials for the LHWP was perceived to be erratic and patchy. This was largely due to domestic financial constraints and a heavy reliance on donor funding which tends to focus on specific programmes or areas.

Regular curriculum review and revision, and systematic and regular refresher and in-service training and mentoring are necessary to ensure LHWs have access to new knowledge and have opportunities to maintain and upgrade their skills and competencies, enabling them to effectively deliver quality services and achieve the expected health outcomes and targets. A strong recommendation put forward by government stakeholders in Sindh, Khyber Pakhtunkhwa, and Balochistan is for a Federal role in the development of a uniform curriculum for LHWs.

2.2.4. Remuneration and allowances

The regularization of LHWs has also created significant human resource management challenges as it was not accompanied by the definition of an adequate service structure nor a careful assessment of the workload of an LHS or LHW relative to the remuneration offered. While regularization had improved job security, these gaps, and the differential in benefits between these cadres and other government employees, is impacting on their continued motivation. With LHWs now unionized, the failure to effectively manage and resolve these issues, may result in an increased risk of wider strike action, which is reportedly already an issue in Punjab (OPM, 2019).

2.2.5. Career progression

While an increased sense of job security in the initial period after regularization was said to have led to improved LHW motivation, this has been undermined by the lack of an articulated career pathway for the LHW. Career development is a key factor in CHWs motivation (Glenton, et al, 2013). and career mobility opportunities need to be built into CHW programming to encourage and enable LHW and other CHW cadres to advance to higher levels of the health system, as well as leadership positions, if they so desire. Providing these cadres with the opportunity to progress in their careers, would not only motivate them, but as role models within the community, they could also encourage and attract others to this career.

2.2.6. Supportive Supervision

When performed well, and when used to support performance improvement, 'supportive supervision' can have a positive effect on health worker's performance, job satisfaction and motivation and the quality of services they provide, when compared with traditional or no supervision. (WHO, 2017; Kok et al, 2018).

However, there is evidence to suggest that all provinces are falling dramatically behind their supervision targets (OPM, 2019). One respondent mentioned in particular the need for the 'capacity building of the supervisors' and to support these LHS to ensure that they have the capacity to provide 'on-the-job coaching and on-the-job training' of LHWs.

In addition, as described previously, many LHS lack the transport necessary to move around their catchment area to provide effective and regular supportive supervision. These challenges have significantly reduced the number of visits to LHWs, below the expected two monthly visits. In Punjab, this has been exacerbated by an increase in the supervisory responsibility of an LHS who, since the integration of the LHWP into the IRNCH & NP, had taken on additional tasks related to the EPI, TB dots and nutrition screening programmes.

One respondent from Sindh offered a novel solution to this problem, suggesting that the LHS cadre should be provided with a field travel allowance that would enable them to manage their own transportation and conduct supervision visits as scheduled.

'I have recommended at this stage to provide them a field travel allowance (FTA). This allowance will be given to supervisors, and they can manage transport, because now the condition of these vehicle which were provided in 1995 and 2006, I can't say they are usable, we cannot properly maintain them for the transportation. I have recommended now if there is an allowance paid to the lady health supervisors, they must manage themselves their transportation and supervise and monitor them'. (KI, Provincial Health)

Punjab Province is reportedly funding FTAs for the 50 per cent of LHSs who did not have access to vehicles (OPM, 2019).

2.2.7. CHW integration into the health system and community

In Punjab the integration of the LHWP into the IRMNCH & NP and regular intra-departmental meetings has led to improved coordination between related health departments. However, there is still a lack of clarity on the division of roles between frontline staff, and a need to strengthen the functional integration at that level to encourage greater collaboration and cooperation between the different cadres, especially the LHW and CMWs. Strengthening the integration of the LHWP and improving coordination mechanisms across all provinces will help to ensure the LHWs can continue to play a central role in the provision of Family Planning and RMNCAH services.

All respondents indicated that integration with the wider health system is crucial for the effective delivery of the LHWP. The coordination with other health professionals in the health system will improve the credibility of LHWs, thereby improving their ability to engage with their community.

LHWs enjoy high acceptance and an elevated status within their communities, as one respondent observed, 'lady health workers are the oldest cadre, so they are well accepted'. However, engaging LHWs in programme activities outside their communities where they are not known may be challenging for this cadre and should be well managed. Further, as one respondent warned, expanding their target population, and 'the distances, the spread of households which they have to cover', may be difficult for the LHW, firstly, given the gender related constraints on her mobility, and secondly, will reduce the number of visits she can make as well as the time she can spend with clients, which may in time affect her relationship with the community.

2.2.8. Data collection

The role of health information systems (HIS) is widely acknowledged as contributing to the generation of health information data for programme and performance monitoring, quality of care, planning and policymaking. HIS provide decision-makers with regular and continuous information on the coverage and utilization of health services and mortality statistics, including causes of death. At the subnational level, HIS data enables countries to assess equity in the provision of health services. Routine health statistics are collected at the district and the provincial levels through the district health information system (DHIS) and programme management information systems.

The implementation and consistent use of the DHIS as the main system across all the provincial departments of health is key to ensuring that health-related data are generated for policy and planning at the facility, district, provincial and national levels. As one respondent pointed out, having information on the distribution and location of LHWs is particularly useful in managing services during disasters or health emergencies, for example during the 2010 floods, the government knew 'where the lady health workers were and with which community they have moved to where'.

However, the fragmented structure of the HIS in Pakistan needs to be addressed and the multiple vertical health information systems at the subdistrict, district, provincial and national levels should be integrated. The LHW MIS specifically, needs to be strengthened, with timely, reliable and quality data generated and utilized for decision-making and planning.

Reportedly, the government is considering the option of a (paperless) digital health information system at all levels

(Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit, 2020). The DHIS is undergoing digitization at the reporting and management levels in several provinces across the country. Pakistan is also currently working towards the integration of an AIDS/tuberculosis (TB)/ malaria specific management information system into a single platform and linking it with the Pakistan HIS. In the next phase, a gradual shift to DHIS-2 is being planned across the country, which will build coherence across health and management information systems and support the implementation of an integrated disease surveillance and response system across the country (JICA, 2009; dhis2community, 2020).

3. Prioritized measures to strengthen health policy and system support to optimize the contribution of CHW cadres to PHC

The findings in this section respond to KEQ 3 and provide a synthesis of the key findings from KEQ 1 and KEQ2 and identify prioritised measures to strengthen health policy and system support and enhance the contribution of CHW programmes to PHC.

3.1. PHC strengthening

The Prime Minister's vision for UHC in Pakistan has three major components. Every citizen must have access to health services; the Government should pay the expenses on behalf of those who are unable to pay; and the quality of services should be enhanced (Government of Pakistan, 2019). In Pakistan, a renaissance in PHC is essential to provide health for all, including the most vulnerable. The provision of universal PHC is likely to be the only route to improve the country's health indicators.

In implementing the Prime Minister's UHC vision and attaining the overall goal of UHC, many factors need to be considered, particularly from a CHW perspective. Respondents had the following recommendations for PHC strengthening through a community health lens. Before considering any other element, the basic PHC system in Pakistan needs to be strengthened, which will require expanding the existing infrastructure.

There has been no overarching policy shift, however some provinces have begun testing updated frameworks. For example, Sindh has developed a public private partnership model, called the People's Primary Health Care Initiative (PPHI), where the running of their PHC facilities has been contracted out to Indus Hospital and Integrated Health Services (an NGO). There has been no evaluation conducted as yet, but as one respondent observes, 'the performance is improved, we cannot say 100 per cent but a little improvement is seen'. Additionally, in ICT, a model health care reform package is currently being implemented, which entails the development of an essential services package to be delivered at all PHC facilities; strong referral linkages between primary, secondary and tertiary institutions, and a larger role for the private sector in PHC. In Punjab, the Health Ministry has been divided into distinct curative and primary departments, which has streamlined processes and redefined roles, to ensure more effective decision-making and smooth running of operations. If successful in the long-term, any of these models could be utilized across Pakistan to revitalize PHC systems. Beyond these more expansive systems levels reforms, respondents also made further recommendations. All respondents highlighted the need for increasing coverage and access to achieve UHC and indicated that the 'government option is very much inclined towards expanding coverage at the community health level', as evidenced in the UHC Benefit Package. One suggested that in Punjab particularly, there would be a need 'to increase the number of Lady Health Workers to 100 per cent coverage, to achieve UHC and universal health access'. Additionally, addressing the serious health workforce shortages, filling vacant posts and reducing the high turnover of programme managers, was a key recommendation.

Respondents emphasized the importance of a strong and effective PHC system to reduce the burden on the tertiary level, 'because one gap which burdens the tertiary care system is that your primary health care system is not working very well'. As this respondent observed, 'if the PHC system is working well, then many things need not be taken up or addressed at the referral level'.

Several respondents in this study highlighted the need to strengthen inter-sectoral linkages. They drew attention to the fact that such reform cannot be conducted in isolation. While some progress has been made in working with the private sector to deliver PHC services, strengthening partnership with actors from other government sectors (the Ministries of Interior, Finance, Education, Planning and Development, Ehsaas, Human Rights, Law and Justice, Inter-Provincial Coordination, among others), the private sector and development partners will enhance efforts to mobilize the necessary human, financial and technological resources for effective PHC strengthening. Invariably the development sector is constantly involved, albeit not directly, but through the provision of training and other resources. The strengthening of PHC to the extent required will necessitate public-private partnerships across all levels. The stark reality is, not only financially, but also in quality service, the Government does not have the resources or capacity at this stage to mount such a large-scale operation (Qidwai, 2016).

Given the ongoing challenges with some aspects of devolution and decentralization, building robust leadership and management capacity of sub-national leaders, managers and supervisors at provincial, division and district levels will be critical for ensuring a smooth transition to effective local governance. These groups will also need the support, resources and in some cases, the authority to make decisions, to ensure PHC reforms, associated workforce polices, and CHW programmes respond to local realities and the needs of the population.
There was general sense among respondents that there was a need to organize health financing and create strong supply chains. Importantly, there was unanimous agreement on the need for a strong monitoring and evaluation system and supervisory mechanisms. It was felt that 'serious gaps' in supervision needed to be addressed' and that 'supervisors needed to get proper support, in the form of provision of vehicles for supervisory visits or the provision of a per diem'. Another recommended that supervisors should be attached to 'a very robust network of primary health care facilities'.

3.2. Financing for CHW programmes

A recent presentation entitled 'The UHC BP Investment Case in Pakistan' recommends a number of financial reforms. These include 'increasing and diversifying domestic financing for UHC' and 'financial protection of vulnerable families' (Ngongo, et al. 2020).

MNHSRC is perceived to be playing an effective coordination role with the international community and provincial departments of health to facilitate the introduction of global best practices in the health sector of Pakistan, in order to achieve UHC and health related SDGs and thus lower poverty through improved health outcomes.

As described previously, the costed UHC Benefit Package of Pakistan, which includes an EPHS for Community and PHC Centre level, is expected to enable detailed budgetary planning for advocacy purposes and for government, donors, districts and communities to plan ways to increase their contributions (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit, 2020).

The Essential Package of Health Services at Community and Primary Health Care Centre Level estimates the unit cost of LHW to be PKR 375,948 (US$2,425) compared to the unit cost of PKR 280,508 (US$1,810), reported in the OPM 2019 Evaluation (Ministry of Health & Population, Provincial/ Area Departments of Health and Health Planning, System Strengthening and Information Analysis Unit, 2020).

3.3. CHWs and the PHC workforce

A comprehensive PHC reform initiative would be incomplete without the CHWs. As described earlier, LHWs are perceived to be effective and their contribution to improved health outcomes, in particular within RMNCAH, is recognized. The overall perception among respondents is that the LWP should continue. They have a key role to play in increasing the utilization of services at PHC level. Their utilization and retention will also ensure that the investments and reform efforts achieve the expected health outcomes. As this study has shown, CHWs promote healthy behaviours, extend the reach of health systems, help address health workforce shortages and reduce disparities and inequities in access to health care.

As evidenced throughout this study, a key factor in the recruitment and retention of CHWs is the attractiveness of CHW jobs and careers. Fostering collaborative and cooperative relations across the PHC workforce, including between the LHW and other community based cadres, who are vital members of this workforce, will help realise the ambition of quality integrated PHC services. Improved availability and skills mix of the PHC workforce could also provide opportunities to explore options for the creation of specialist roles and pathways for LHWs and CMWs.

The presentation referred to earlier, entitled 'The UHC BP Investment Case in Pakistan' also recommends a number of health workforce reforms. These include reforming the LHW programme and increasing the coverage of LHWs and CMWs prioritizing hard-to-reach areas, as well as the introduction of a new cadre of multi-purpose male workers (vaccination, school & adolescent health, NCDs) (Ngongo, et al. 2020).
The introduction of additional CHW cadres such as the proposed multi-purpose male health worker, and the new HPN Counsellor, will help relieve the pressure on the LHW and reduce her workload, enabling her to renew her focus on RMNCH. However, this should not come at a cost to the LHWP and further constrain the resources available for the programme and the RMNCH the LHW provides.

The roles and responsibilities of such male CHWs should be clearly defined and agreed to mitigate any unintended consequences, such as these men receiving preferential or better conditions of employment than the LHWs, reinforcing and perpetuation gender power relations.

Clearly defined and documented (i.e. job descriptions) provider and supervisory roles within the PHC structure, will provide increased career mobility for these CHW cadres and promote enthusiastic participation and motivated, collaborative efforts. Robust and effective leadership, stewardship, and human resource management capacity at sub-national levels will be crucial to coordinate and manage the PHC workforce, including the LHW, CMW and other community based cadres.

An inclusive health workforce policy should consider how women's competing gendered responsibilities affect their ability to take up training or opportunities provided to retrain for new positions or to advance professionally in their careers. HR policies should also consider the gendered-specific needs of women and men, especially the different family roles and obligations of female versus male workers and how these may impact employment preferences and needs.

Given the powerful impact that gender has on the health of women and men, it is imperative that health managers and health care providers are equipped with the knowledge and skills to address gender-based health inequities in their work.

3.4. RMNCH service provision

A focus on training, supervision and proper resource allocation, coupled with a comprehensive package of essential health services at the PHC level could provide opportunities for LHWs to maintain their focus on RMNCAH and their core functions, and consequently to give greater emphasis to improving quality and equity.

3.5. CHWs roles in emergency preparedness

Health security and emergency preparedness should be considered in PHC systems strengthening and CHW planning and programming. The COVID pandemic has highlighted the need for strong and responsive PHC and community health systems and workforces. CHWs have critical communication skills and community connections that can be leveraged to boost public health. Not only have CHWs a key role to play in health education and helping to reduce the population's susceptibility to infection, with the trusting and established relationships they have established with the community they are well positioned to explain and help implement and monitor preventive measures in managing current and future public health crises and outbreaks. As the focus of facility-based staff shifts to the management of pandemic and emergencies, such as COVID, it will be vital that CHWs are supported to prevent interruptions to routine health services – immunization, maternal and childcare services – and increased morbidity and mortality due to non-COVID causes.

Conclusions

CHWs have a key role to play in delivering cost-effective PHC services; they promote healthy behaviours, extend the reach of health systems, help address health workforce shortages, and reduce health disparities. They also provide promising benefits in promoting immunization uptake and breastfeeding and reducing child morbidity and mortality when compared to usual care. Their positive impact on CPR cannot be understated.

For the most part, the LHW cadre in Pakistan is acknowledged as a famous PHC policy success. Their contribution to the achievement of positive RMNCAH outcomes, as well as strengthening health promotion and prevention in communities is well recognized. LHWs are well accepted and enjoy a high status within the communities they serve, and in most cases the communities they serve are well covered by their services.

However, a number of policy and health system support areas need to be strengthened to optimize CHW programmes in Pakistan and ensure the continued availability and retention of these cadres to reach and address the health needs of all population groups, especially those that are underserved, marginalized and vulnerable. Robust supervision and monitoring and evaluation systems must be designed and implemented to allow for the routine coordination of the services they provide and the necessary performance improvements.

Preserving the valued status of these CHWs in the community, and supporting, recognizing and rewarding their performance and contribution through improved financial, logistical, academic, policy and system support will ensure that they are retained and supported to provide accessible and quality PHC services, contributing to the attainment of the National Health Vision and the Prime Minister's vision for UHC.

It is recognized that such policy and system support to realize the full potential of CHW programmes and their contribution to PHC strengthening and UHC in Pakistan is still remote. It will require an all-of-government approach, sustained political commitment, predictable financing, robust leadership and governance strong partnerships and multisectoral stakeholder collaboration at all levels.

Recommendations

Recommendations were derived by the evaluation team basedon all findings including responses from respondents on evaluation question three. This question solicited information on prioritized measures that could be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre can make to PHC. Respondents' responses on this question were interpreted considering the other information from all data sources including the desk review. Moreover, the report including recommendations was reviewed by the relevant stakeholders, including the UNICEF staff in the country and region.

Given the system-building nature of the recommendations, all recommendations must be spearheaded by the Government of Pakistan. Relevant development partners in the country should advocate as well as provide the technical support for implementing the recommendations according to their capacity. The evaluation team presents below a key list of recommendations that have already been narrowed based on the findings. Prioritizing the recommendations further is difficult given that most of the recommendations are required to improve and enhance the policies and system to address the needs of the PHC and CHWs in the country.

Recommendation 1: **LHW programme should continue.** They have a key role to play in increasing the utilization of services at PHC level. Their utilization and retention will also ensure that the investments and reform efforts achieve the expected health outcomes. As this evaluation has shown, CHWs promote healthy behaviours, extend the reach of health systems, help address health workforce shortages and reduce disparities and inequities in access to health care. (Actor: Government of Pakistan)

Recommendation 2: Efforts should be made to **strengthen inter-sectoral linkages to mobilize the necessary human, financial and technological resources** for effective PHC strengthening and UHC. For this, sustained political commitment and transparent leadership is required at all levels. While some progress has been made in working with the private sector to deliver PHC services, **strengthening partnership with actors from other government sectors** (the Ministries of Interior, Finance, Education, Planning and Development, Ehsaas, Human Rights, Law and Justice, Inter-Provincial Coordination, among others), the private sector and development partners will also potentially enhance collaboration, and promote team working across the PHC workforce. (Actor: Government of Pakistan)

Recommendation 3: The Government of Pakistan **should invest more in the health sector, organize health financing and create strong supply chains** to improve social protection and the health of the population. Policy makers should encourage more stable and flexible financial plans, along with an increased budget allocation, taking into account the priorities of the health sector in order to progress towards the goal of UHC and to support a reformed PHC tier. (Actor: Government of Pakistan)

Recommendation 4: Given the devolution of authority to subnational level, **building robust leadership and management capacity of sub-national leaders, managers and supervisors at provincial, division and district levels should be done** for ensuring a smooth transition to effective local governance. These groups will also need the support, resources and in some cases, the authority to make decisions, to ensure PHC reforms, associated workforce polices, and CHW programmes respond to local realities and the needs of the population. (Actors: Government of Pakistan, development partners)

Recommendation 5: The evaluation recommends **strong monitoring and evaluation system, supervisory mechanisms, skills development and capacity building** for ensuring LHWs have the latest knowledge and skills to provide quality services and for strengthening the overall LHWP. Capacity building of LHS supervisors and adequate support to enable them to provide effective and regular supportive supervision, on-the-job training and mentoring of LHWs is urgently needed. Recommended interventions of HRH vision including the development of training and recruitment plans should be acted on to address the identified workforce challenges. (Actors: Government of Pakistan, development partners)

Recommendation 6: In order to increase attractiveness of CHW jobs and **careers, career mobility opportunities should be built into CHW programming to encourage and enable LHW and other CHW cadres to advance to higher levels** of the health system, as well as leadership positions, if they so desire. Improved availability and skills mix of the PHC workforce could also provide opportunities to explore options for the creation of specialist roles and pathways for LHWs and CMWs. (Actor: Government of Pakistan)

Recommendation 7: Efforts should be made **to foster collaborative and cooperative relations across the PHC workforce,** including between the LHW and other community-based cadres, who are vital members of this workforce. (Actor: Government of Pakistan)

Recommendation 8: An inclusive **health workforce policy should consider how women's competing gendered responsibilities affect their ability to take up training or opportunities** provided to retrain for new positions or to advance professionally in their careers. HR policies should also consider the gendered-specific needs of women and men, especially the different family roles and obligations of female versus male workers and how these may impact employment preferences and needs. (Actor: Government of Pakistan)

Recommendation 9: The LHW programme should **refocus the attention of LHWs towards RMNCAH** and safeguard the role of the LHW in the provision of these critical services in order to improve the quality of RMNCAH services.

If LHWs are to play a role in NCD prevention and control efforts, within the scope of their current roles and responsibilities, **appropriate systems support, including training, supervision, remuneration, and an enabling environment to address areas where respondents have identified deficiencies, will be required.** Such support would enable them to optimally deliver services such as healthy nutrition counselling, early detection, referral for priority chronic diseases, and medication compliance management and other family and people centred care as part of their core functions. However, **activities related to other areas should not add to the LHWs already heavy workloads** or crowd out or dilute the care she provides to women and children. (Actor: Government of Pakistan)

Recommendation 10: A priority should be **renewed strategic thinking on improving the availability and distribution of LHWs across the country,** especially in rural and hard-to-reach areas. This should **ensure that the selection, deployment and transfer of LHWs, as well LHS, is based on merit.** Any further expansion of the LHWP should be informed by reliable information on the areas with the poorest health outcomes, lack of access to health care facilities, and high rates of poverty. This would ensure the LHWP expands into areas that have the greatest need, potentially, where the programme could have the greatest impact. (Actor: Government of Pakistan)

Annex 1 Key informant interview guide for national level informants (Generic)

Potential informants: policy makers and national opinion leaders; officials from Ministry of Health and from other relevant community health, gender, women's' affairs line ministry officials; representatives from local government and civil service; professional association and regulatory bodies; development partners and donors/funders; representatives from international and local NGOs, private sector, and training providers.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders of policies and systems support for CHW programmes in the country in order to enhance the effectiveness of the health care system and strengthen health outcomes in the country.
- Ensure each participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheets, consent forms, country specific CHW map, CHW definition; definition of support system; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration; figure of WHO HS Framework; and country-specific desk review findings.

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is a key informant interview in the Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

A. National CHW programmes and cadres

1. What is your role in CHW programmes in this country?

2. Are the following key CHWs, (*name cadre(s)*) identified for (name the country), correct? (*Provide agreed study CHW definition, if required)*
   a. If not, which cadres should be omitted or added? (For those added, probe for their roles in Q3 below)

3. Which of these CHW cadres or programmes are you most involved with or knowledgeable about and would be comfortable discussing today?

4. Could you please describe the key roles and responsi bilities of these cadres with respect to the provision of maternal, newborn, reproductive, and child health services?
   a. How would you describe the effectiveness of these CHWs currently in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. any other roles and responsibilities these RMNCAH CHWs might have: immunization/ polio, nutrition &/ECD, disease surveillance, WASH and/or disaster response, etc.
   ii. to determine if RMNCAH roles and responsi-bilities are spread across a number of cadres and how these cadres are coordinated.

   b. What factors facilitate and what factors constrain
   their effectiveness in fulfilling their RMNCAH roles and responsibilities?

   Probe for:
   i. What facilitating factors should be retained
   ii. Factors related to the individual CHW, the community and the health systems
   iii. Any gender related constraints to CHW effectiveness
   iv. Any other equity related constraints such as caste
   v. Any constraints related to competences and availability of supervisors
   vi. Recommendations to overcome these constraints.

Thoughts on how the RMNCAH roles and responsibilities of these CHWs might change in the next 10 years.

During our desk review we identified the following key findings related to health system support (explain/provide definition) for these CHW cadres. Do you agree with these?

and disaster response
iii. Community acceptability
iv. Effectiveness of CHWs in carrying out their roles and responsibilities
v. Access to training
vi. Discrepancies between prescribed coverage area/target population and what happens in practice due to HR/CHW shortages
vii. Work environment and safety
viii. Remuneration
ix. Senior/leadership roles
x. Career progression opportunities/criteria and constraints
xi. Overcoming potentially prohibitive cultural norms
xii. How other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs

2. Of the gender issues related to these CHWs that you have identified, how are these being addressed?

Probe for policies and specific system support

D. Financing and resource mobilisation

1. How are programmes related to these CHWs currently financed and/or resourced?

Probe for information on the following funding streams and proportion of funding from each:
i. Government financing
ii. Donor projects/programmes (off budget)
iii. Direct budget support from donors
iv. Community resources
v. Support from NGO and private not-for profit organisations
vi. Support from private-for-profit organisations

Request any documentation to support responses

2. Are there any changes planned to financing strategies for programmes related to these CHWs and/or to improve system support?

Probe for the following:
i. increased domestic or external funding;
ii. private sector support/involvement
iii. new mechanisms for health financing (user fees, health insurance,...),

Probe for availability of financing for CHW system support including:
i. drugs and medical supplies,
ii. remuneration
iii. job aids
iv. transport and logistics support
v. IT equipment for data collection
vi. supervision and mentoring
vii. refresher training

E. Private Sector Contribution to CHWs

1. What is the private sector's contribution to the production, use and management of these CHWs in this country?

Probe for:
i. Participation of contribution of not-for-profit and for-profit private sector organisations
ii. participation of private training institutions in training these CHWs
iii. participation of health professional societies in training these CHWs

2. How could the contribution from the private sector be enhanced?

Additional information:

- Which key stakeholders would you recommend we meet while we are in the country?
- Are there any key documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

Annex 2 Key informant interview guide on GENDER for national level stakeholders

Potential informants: Informants with a special knowledge/work area of gender and CHWs – including UNICEF CO gender focal person, any gender focal persons with different ministries involved with CHWs, gender focal persons from development partners, representatives from NGOs working on gender and health.

Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders on gender issues in policies and programmes related to CHWs.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form, note on country-specific gender issues identified from desk review; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration

Please include the following details and participant profiles as part of the recording:

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organisation
- Number of months/years working in this position

For example: 'This is an key informant interview in Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.

1. Please describe briefly your current position and your work, current and previous, related to gender and CHWs.

2. In your experience, in this country (name the country), how do you think gender impacts on the work of the CHW cadres we have identified in this country (name the cadres or provide list of the cadres we are referring to)?

   Probe for:
   - I. Gender issues faced by these CHWs
     - i. at family/household level
     - ii. in the community
     - iii. within the health system
   - II. Challenges faced by these CHWs in their work due to these issues

3. You spoke about how gender impacts the work of CHWs. How do other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs?

4. At the policy level how does gender play a role in policies related to these CHWs in this country (name the country)?

   Probe for:
   - I. Selection of CHWs for training
   - II. Division of roles/services between male and female CHWs
   - III. Remuneration
   - IV. Career progression
   - V. Work environment and safety
   - VI. any focus in CHW/PHC policy on gender issues related to other genders (apart from male/female, eg. transgender) and any suggestions on how these can be included

5. At the programme level how does gender play a role in in the design and implementation of programmes related to these CHW cadres in this country (name the country)?

   Probe for:
   - I. Female and male CHW roles in the provision of RMNCHAH services by the health system and take up of services by communities
   - II. CHW selection criteria
   - III. Access to training
   - IV. Work environment and safety
   - V. Mobility
   - VI. Remuneration
   - VII. Senior/leadership/supervisory roles
   - VIII. Career progression
   - IX. Overcoming potentially prohibitive cultural norms

6. Have any specific policy measures been put in place to ensure that policies and programmes related to these CHWs are gender responsive/address issues related to gender?

If necessary, explain that gender responsiveness involves
considering gender norms, roles and inequalities, and measures to actively address them.

Refer back to issues raised as part of previous questions. Probe for answers from Q2 i, ii, iii, and Q3 if any solutions were given).

Probe for:

I. What are the key successes of these measures in addressing gender concerns in the CHW policies/programmes?
II. What are the key challenges of these measures in addressing gender concerns in the CHW policies/programmes?
III. Can you cite any specific examples of CHW programmes in the country where policies or programmes have been/have made efforts to be gender transformative?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

7. If programmes related to these CHW in this country (name the country) were to be made truly gender transformative, what would you suggest should happen to achieve this?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

Probe for:

I. Anticipated barriers, challenges and suggested solutions in implementing these suggestions
II. Equal pay
III. Equal access to training
IV. Equal access to promotion opportunities
V. Overcoming cultural norms/barriers

8. With regards to community health and/or PHC reforms being planned in this country (name the country), what are the measures being put in place to make programmes related to these CHWs responsive to gender concerns?

I. What would be your suggestions to make them more gender responsive?
II. Anticipated barriers, challenges and suggested solutions in implementing these suggestions

Additional information:

- Which key gender informed stakeholders would you recommend we meet while we are in the country (name the country)?
- Are there any key gender related documents that we should review for this study?

Closure

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

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Annex 4: Ethics Approval letter

Margaret Caffrey
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Friday, 30 August 2019

Dear Ms Caffrey,

Re. Research Protocol (19-037) ***Evaluation of South Asia's current Community Health Workers policies and system supports, and their readiness for Community Health Workers' expanding roles and responsibilities within Post-Astana national health care strengthening Plans***

Thank you for your letter providing the necessary in-country approvals for this project. I can confirm that the protocol now has formal ethical approval from the LSTM Research Ethics Committee.

The approval is for a fixed period of three years and will therefore expire on 30th August 2022. The Committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

- Continued adherence to all in-country ethical requirements.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee.
  Failure to do so could result in suspension of the study without further notice.
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements is a breach of the LSTM Research Code of Conduct and will result in withdrawal of approval and may lead to disciplinary action. The Committee would also like to receive copies of the final report once the study is completed. Please quote your Ethics Reference number with all correspondence.

Yours sincerely

Dr Jamie Rylance
Co Chair
LSTM Research Ethics Committee

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Country Report for Pakistan

**UNICEF Regional Office
for South Asia (ROSA)**