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Commentary

The lady health worker program in Pakistan—a commentary

Internationally, approximately 4 million neonatal deaths occur each year, the majority within the first few days of birth in communities with inadequately designed health systems.[1] Value is defined as patient health outcomes per dollar spent.[2] Neonatal deaths account for an increasing proportion of child deaths.[1] Newborn survival is related to Millennium Development Goal (MDG) 4 for child survival and is also related to MDG 5 for maternal health as the interventions are closely linked.[3] This often requires health system strengthening.[1,3]

Health-care challenges in developing nations are several:[3,4] there is a lack of basic health-care services and of health-care professionals, insufficient Infrastructure, incompetent health education, lack of understandable association between health service needs and education, and lack of continued medical education leading to out dated treatments. The financial health situation is generally: low per capita incomes (GDP); poor health status indicators; inadequate budgets and lack of reliable funding; ineffective implementation of health-care practices due to inadequate technical skills and capacities; poor knowledge and practice of social health insurance; poor understanding on the link between health, poverty and economic growth.[4] The health status of the people of Pakistan is well below the averages for all low-income countries in key indicators.[4–7] In Pakistan, a typical district health infrastructure comprises basic health units, rural health centres and a referral hospital. However, in many rural settings, staffing levels are inadequate and referral systems function poorly.[4,5,8,9] A significant percentage of births take place at home, usually attended by a *Dai* (Midwife).[5,6] We need to devise a culture sensitive strategy in improving health outcomes. According to the World Bank statistics, Pakistan's under-five mortality remains the highest among the South Asian countries except Afghanistan.[5]

The lady health worker program (LHWP) in Pakistan, created in 1993 is based on lady health workers (LHWs) trained to provide specific, basic primary health-care treatment plus preventive services establishes a milieu of well being, enhance interaction of patients with health-care providers, enable timely treatment, prevention and even screening. Women from local communities, with at least 8 years of formal education, undergo 6 months of training to deliver care in the home,[9] and each LHW is responsible for a population of about 1000 (i.e. approximately 200 families). The curriculum for the LHW's programme includes: promotion of antenatal care, iron and folate use in pregnancy, immediate new born care, cord care and promotion of breast feeding.[7] By the end of 2006, some 93 000 LHWs had been trained and they covered 60–70% of the rural population. LHWs discuss with community issues related with better health, hygiene, nutrition, sanitation and family planning emphasizing their benefits towards improved quality of life. LHWs act as liaison between formal health system and community. To disseminate health education message to their community on hygiene and sanitation. LHWs provide essential drugs for treatment of minor ailments like diarrhea, malaria, acute respiratory tract infection, intestinal worms and contraceptive materials to eligible couples. LHWs brace the expanded programme of immunization programme to advance vaccination status of the women and children. The official stipend for LHWs is 1800 Pakistan rupees per month plus local travel costs. Although LHWs receive no training in delivering babies, they should liaise with *Dais* and medical staff at basic health units (BHU) or rural health centres to examine growth and to provide antenatal care, contraceptive advice and immunization services. An external evaluation of the LHW programme concluded that the programme was effective in delivering family planning services and immunization and in the managing of diarrhea.[9]

The LHWP is implemented through execution units at the three-tier level of governance: federal, provincial and district levels—dividing responsibilities for policy making, operational planning and budgeting, and health management information system at federal level. Then provincial programme implementation units, based in each province, are responsible for district LHW allotment, department operational plan performance and arranging training. Coming to the district level: the district executive officer at the first level care facility in each district is responsible for allocation, supervision and hiring/firing. In 2005/06, the programme has been given more than a quarter of the entire public spending in health. Out of these, the federal government contributed about 20.5% while provinces contributed 79.5%. The programme has managed to stretch since its commencement and now caters to all districts of the country.[4,6,7]

External evaluation in the year 2009 shows that LHWs' clinical knowledge has enhanced since the 3rd Evaluation, however, there is still room for improvement.[9] There have been some alterations in the schedule of pay of salaries to LHWs. Compared with 2000, far fewer waited over 3 months to be paid, although a smaller proportion had been paid in the last month.[9] Medical supplies, equipment and clinical services provided by the health facilities were the areas that manifested problems and are in need of improvement. There has been an enhancement in the management of LHWs—some 78% had had a supervision meeting in the preceding month. A similar proportion of LHWs reported that their supervisors used a checklist in the previous supervision meeting. Lady health supervisors have, on standard, fewer LHWs to supervise than in 2000, making appropriate supervision probable. They have relatively better access to transport, although a significant number still have no access to a programme vehicle. The challenges that surfaced were that LHWs were seriously underprovided with drugs and contraceptives. Services are inadequate in health facilities to which patients are referred.[9,10]

There is significant difference in health status of communities in LHWs' catchment's area as compared with non-LHWs area.[4,7–9] Tetanus toxoid coverage improved from 14% to 31% and attended deliveries increased from 27% to 48% coverage. The percentage of

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children fully immunized has increased from 57% to 68%.There is an improvement in exclusive breastfeeding. The programme has manifested empowerment of women it employs.[9,10]

The LHW's serve as a link between community and health facilities, providing both preventive and curative care.[4,9] In low income settings this is one of the ways of strengthening health-care systems.[8,9] In Pakistan, we face a diverse array of challenges such as LHW's being under paid; and stipend payments need to be timely. There is a lack of continued medical education, lack of sustained motivation.[9] This could be improved by incentivizing: improving not just their salaries; but also a timely contract renewal and promotion, reevaluation of goals. Consider taking LHWs into the main government system in order to provide them with job security; increasing their ambit of services. Good services should be rewarded with monetary recognition; affiliate LHW with the government hospitals—servicing as gate keepers within community, for instance for gynecological services—this would decrease the load in BHUs; provision of health coverage and insurance for LHW's families. There is also a need to boost efficacy of supervision. Also provide transport for supervisors.

LHW's are an vital resource for countries like Pakistan, and maintaining procedural standards and guidelines would facilitate a thriving programme, which requires to be monitored and evaluated.

Conflicts of interest: None declared.

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Sabeena Jalal
Harvard School of Public Health, Harvard University, 677 Huntington Ave, Boston, MA 02446, USA

Correspondence: Sabeena Jalal, MS candidate, Harvard School of Public Health, Harvard University, 677 Huntington Ave, Boston, MA 02446, USA, tel: +0 921 300 227 0187 (Karachi, Pakistan), e-mail: sjalalkhan@yahoo.com; sjkhan@hsph.harvard.edu

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