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Final Report

Assessment of Lady Health Workers (LHWs) Program, Sindh

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The Evaluation Team

Acronyms

ADC	Assistant District Coordinator
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BHU	Basic Health Unit
CBO	Community-Based Organization
CEO	Chief Executive Officer
CPR	Contraceptive Prevalence Rate
DG HEALTH	Director General, Health Services
DG PWD	Director General, Population Welfare Department
DHO	District Health Officer
DHPMT	District Health and Population Management Team
DOH	Department of Health
DOTS	Directly Observed Therapy Short-Course
DPWO	District Population Welfare Officer
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FLCF	First Level Care Facility
FP	Family Planning
FWC	Family Welfare Centre
FWW	Family Welfare Worker
GOS	Government of Sindh
HANDS	Health and Nutrition Development Society
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IEC	Information, Education, Communication
JSI	John Snow, Inc.
LHS	Lady Health Supervisor
LHW	Lady Health Worker
MCH	Maternal and Child Health

MMC	Maternal Mortality Conference
MNCH	Maternal, Newborn and Child Health
MNT	Maternal Neonatal Tetanus
MO	Medical Officer
NGO	Non-Governmental Organization
NIDS	National Immunization Days
OPM	Oxford Policy Management
P&D	Planning and Development
PC-1	Planning Commission Document
PHC	Primary Healthcare
PNC	Postnatal Care
PPHI	People's Primary Healthcare Initiative
PPIU	Provincial Program Implementation Unit
PWD	Population Welfare Department
RBM	Roll Back Malaria
RHC	Rural Health Centre
RHS-A	Reproductive Health Service A Center
RMNCH	Reproductive, Maternal, Newborn and Child Health
RSPN	Rural Support Programs Network
SBA	Skilled Birth Attendant
SNE	Statement of New Expenditures
SNIDS	Sub-National Immunization Days
STDS	Sexually Transmitted Diseases
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCI	Technical Committee of Innovation
THQ	Tehsil Headquarter/Taluka Hospital
TPM	Team Planning Meeting
TORS	Terms of Reference
TT	Tetanus Toxoid

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Executive Summary

The Lady Health Workers (LHW) Program was launched by the Ministry of Health, Government of Pakistan in 1994 for local delivery of essential primary healthcare services to women and children, especially in rural communities, by trained female health workers. Major changes have occurred in the program's structure, most significantly its transition from federal to provincial management after the 18th Constitutional amendment as well as LHWs' transition to government employees, in compliance with a Supreme Court declaration ending their original status of paid volunteers. The Government of Sindh's 2012-2020 Health Strategy pledges continued support to LHWs, their supervisors—Lady Health Supervisors (LHSs)—and the staff of their affiliated basic health units (BHUs). A fresh assessment of the current situation of the LHW Program in the province is required to ensure government support is targeted and effective.

This assessment by the Population Council, commissioned by John Snow, Inc. (JSI) and supported by the United States Agency for International Development (USAID), of the strengths, weaknesses, opportunities, and threats (SWOT) facing Sindh's LHW program specifically examined 1) program, managerial, and operational issues inhibiting its more effective implementation; as well as 2) the Sindh government's vision for the program, including increasing operational efficiencies and coordinating expansion in areas currently not covered; and 3) further strengthening of the program's functional integration and coordination with other maternal and child health (MCH) programs, particularly the Maternal, Newborn and Child Health (MNCH) Programme, Nutrition Programme, and Expanded Programme of Immunization (EPI).

The assessment was conducted in two Sindh districts, Sanghar and Larkana. The study design was based on a mixed methods approach to ensure multiple triangulations of data, with in-depth interviews (IDIs), formal and informal interactions, and focus group discussions (FGDs) with all stakeholders engaged with the LHW program, including senior policymakers, provincial and district officials, program managers, development partners, non-governmental organizations (NGOs), health facility staff, LHSs, LHWs, and women of the communities. A desk and literature review of project documents, financial outlays, past evaluations, gray literature, and other relevant papers was also conducted.

Past studies and evaluations of the LHW Program have emphasized its important role in improving reproductive, maternal, neonatal and child health, particularly positively influencing antenatal, delivery and neonatal care-seeking behavior among rural women, as well as increasing tetanus toxoid (TT) vaccination and attended deliveries, controlling major child killers such as pneumonia and diarrhea, increasing complete immunization among children, and significantly improving contraceptive prevalence.

Studies also note that LHWs have been assigned tasks in addition to their original, stipulated functions, particularly polio and immunization support, which are linked with a decrease in number of clients an LHW is able to serve. Moreover, while the program has expanded in rural areas, and a basic supervision structure is in place, it has still not penetrated the most deprived rural communities. Irregular supply and frequent stock outs of medicines and contraceptives hinder LHWs' full achievement; the last evaluation of the program, in 2009, found that lack of medicines is a particularly acute issue in Sindh, with periodic stock outs of over two months. Notably, the 2009 evaluation found Sindh with the worst performance in LHW selection by merit: 11 percent of its recruited LHWs did not meet the key criterion- residency within the communities they serve- and in the prevailing culture of *ad hoc*-ism, or lack of advance planning, and political appointments, the province is struggling to improve performance.

Many of these earlier findings are corroborated by this evaluation. Key strengths, weaknesses, opportunities, and threats for Sindh's LHW program are summarized in the table below, and outlined in the following sections.

SWOT Analysis of the LHW Program in Sindh

Strengths	Weaknesses
• Community-based network of primary healthcare providers serving half of Sindh's population • Full support of policymakers to strengthen the program • Respect and appreciation of communities • Regular monthly meetings • Data on maternal deaths	• Deviation from original mandate • Weak supervision, especially due to vehicles being unserviceable • Issues of payment of salary and lack of funds for operational costs • Lack of new and refresher trainings • Lack of commodities, including medicines and contraceptives • Poorly functioning referral system • Weak Management Information System (MIS) • Ineffective community support group meetings • Frequent managerial changes • Meetings not linked to achieving pre-defined outcomes such as onsite training
Opportunities	**Threats**
• Interest of development partners and the Government of Sindh (GOS)in supporting and strengthening the program • Regularization, revamping, and revitalization of the program • Consensus on enhancing coverage by the Government of Sindh (GOS)	• Politicization and undue political interference • Gender-based victimization and sense of insecurity

Key Strengths of the LHW Program in Sindh

Nearly 46 percent of Sindh's population receives primary healthcare services at home through the LHW program. Communities generally report at least two LHW visits within three months for child immunization and polio drops administration, TT vaccinations for pregnant women, antenatal care (ANC) and counseling, as well as delivery, nutrition and family planning (FP) advice. Most community members appreciate the role of LHWs and consider them trusted health advisers, although they emphasize that LHWs should be provided medicines, contraceptives, and necessary equipment to enhance their usefulness.

The LHW program also generally enjoys the full support of policymakers. Senior officials from the departments of Health, Population Welfare, Planning and Development, the provincial Oversight and Coordination Cell for Public Health, and major health programs all agree the program should be strengthened and expanded.

Notwithstanding serious resource constraints, a basic supervisory structure for LHWs exists. Moreover, the LHW program currently serves as the only functioning system in Sindh for collecting maternal mortality data and its underlying reasons, albeit only in areas served by the program.

Key Program Weaknesses in Sindh

Over the years, new skills and responsibilities have been added to the LHW portfolio, steadily enlarging their scope of work to services beyond their original mandate, including tuberculosis (TB) direct observed therapy (DOT); malaria control; health emergency response activities including floods and earthquakes; disease surveillance; and the most intensive-polio eradication campaigns. At all levels of the health system, there is a growing realization that LHWs and LHSs are preoccupied by their polio-related tasks, which disrupt their schedules, undermine their ability to meet targets, and can lead their clients to feel neglected and become uncooperative. Currently, according to the records of Emergency Operations Centre, Government of Sindh, 81 percent of LHWs are engaged in polio eradication campaigns.[1]

While a basic supervision system is in place, it is weak. One reason is the insufficient number of supervisors—the province currently has 770 LHSs supervising 22,500 LHWs, which means each LHS supervises 29 LHWs on average. Ideally, each LHW should cover no more than 25 LHWs. Serious budget shortfalls for the operational costs of supervision, particularly fuel allowances and vehicle repairs, have resulted in a staggering 782 of 954 vehicles provided to supervisors that are now unused. LHSs are currently forced to make their own self-financed arrangements for their field visits. A third source of weak supervision is over-reliance on checklists, which shifts focus of supervisors from problem solving and supportive, on-the-job training.

Inadequate funding exacerbated by LHWs' regularization and resultant salaries, as well as the program's transfer from federal to provincial management, is a critical issue and includes funding uncertainties. While Punjab and Khyber Pakhtunkhwa (KP) provinces have individual PC-1s for securing funding, this process has only recently begun in Sindh. In January 2015, the Program Provincial Coordinator informed the Secretary of Health, "Since the capping of National Program for Family Planning & Primary Healthcare [the LHW program] from July 2012 at 2,310.528 million Rupees, there is serious and significant shortfall in the funding to execute many activities as per approved scope of program. From this amount, the salaries and a bit operational activities of Provincial Program Implementation Unit PPIU could be hardly met and rest remained standstill."

The funding shortfall in the province has the program in a stranglehold. LHW salaries remain low and are delayed by months, resulting in financial hardship and demotivation, as well as resistance by LHWs' families to support their continued work. Poor forecasting and allocation of operational costs results in delayed and inadequate procurements and travel allowance releases, which translate to inadequate supervision and stockouts of medicine, contraception, and equipment..

While all policymakers acknowledge the value of the LHW program, its coordination with other departments and programs concerned with public health is weak. Potential synergies are unrealized, particularly with the Population Welfare Department, in establishing a formal referral system, joint trainings, and joint supervision. Better coordination mechanisms are needed for the LHW program and People's Primary Healthcare Initiative (PPHI), as the latter owns many of the basic health units (BHUs) with which LHWs are associated but currently do not extend any administrative or training support to these LHWs as there is lack of clarity regarding their contractual obligations.

[1] Data was obtained by email from Emergency Operations Centre, Government of Sindh on March 24, 2015

The growing responsibilities of LHWs would suggest that efforts for building their capacities must also have intensified, but on the contrary, LHWs report that such initiatives have declined, without any training, new or refresher, from the program in the past four years. LHWs' only capacity building efforts during this period were organized by non-governmental organizations (NGOs), and lately they have focused on MCH and the polio eradication campaigns. All LHWs report need for refresher training, especially for measles, MCH, FP including contraceptive side effects, counseling, TT shots, health and nutrition, symptoms of high risk pregnancy, first doses of injectable contraceptives, and additional contraceptive methods.[2]

Stock outs of medicines, contraceptives, and equipment remain an issue, hindering delivery of complete health services, and leading community members to question the utility of being visited by empty-handed LHWs. Some community members even accuse LHWs of secretly selling the medicines.

This assessment found that contraceptive stocks reach district offices but funds are lacking for further distribution to facilities. As a result, some LHSs are unable to bring supplies to facilities, leading to stock outs among LHWs. Health facility staff report delays of up to three years for LHWs' medicine supplies. Even when stocks do arrive, they are often woefully inadequate for populations LHWs are expected to serve. Of the three types of contraceptives LHWs are supposed to provide, they reported stock outs of pills and injectables in four of six FGDs in Sanghar, while all LHWs from Sanghar, as well as Larkana, reported a current condom stock, with durations varying from two months to over three years. Upon seeking further information on stock-out situation from the DELIVER Project, we were informed that there were stock outs at certain locations and the situation is now being rectified..

Key reasons for stock outs include: 1) lack of a formal system for demanding medicines and other supplies for the LHW program—currently, LHWs do not have a standardized form for requisitioning supplies; 2) lack of capacity by LHSs and Assistant District Coordinators (ADCs) for planning and demanding appropriate quantities of medicines and contraceptives; 3) lack of a computerized system for submitting commodity requisitions due to non-availability of information technology (IT) equipment and frequent power failures; 4) lack of a budget for transportation costs for transporting contraceptives and other supplies to BHUs, where they are distributed to LHWs; and 5) lack of storage capacity at a number of BHUs. LHWs are forced to work without weighing scales, thermometers, or blood pressure apparatuses, frustrating their clients and making it impossible to execute many of their stipulated tasks.

Referring clients who require more than basic primary care to appropriate health facilities is a core LHW responsibility, intended to improve utilization of health facilities by communities and increase FP clientel. However, the referral system is not functioning well. Patients referred by LHWs are not afforded priority treatment at health facilities: referral slips from LHWs are often discarded in front of referred patients by facility staff, and they suffer the same poor quality of care as non-referred patients. Moreover, LHWs accompanying their patients are at times criticized openly by the doctor on duty. These experiences reduce client respect for LHWs. In addition, facility staff apparently does not issue referrals to discharged patients for continued care by LHWs—no LHWs surveyed had ever received a case from a facility for follow up or continued management. Meanwhile, higher financial incentives to refer LHWs to private sector facilities supported by NGOS are also disrupting the referral system.

Discrepancies in LHWs' reports indicate weaknesses in the provincial management information system (MIS) as well as supervision gaps. LHWs' and community members' conflicting accounts of community support group meetings, with LHWs reporting their regular conduct of these events and community women's statements that have never heard of such meetings, imply that any meetings that actually are conducted are not effective.

[2] Currently, per policy, the first dose of the injectable contraceptive is given at the health facility with subsequent doses given by LHWs.

Finally, rapid managerial changes in Sindh's LHW program is a serious concern and indicates insufficient time for program leadership development and the implementation of a well-conceived strategy for improved performance. —For example, Provincial Coordinator was replaced four times within two years.

Major Opportunities

Development partners are cognizant of LHWs' immense contributions and their potential role in further cost-effective improvements for access to services by poor, deprived rural women and children, and are committed to strengthening the program. In Sindh, important interventions are being supported by the United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and USAID for targeted training and refresher training of LHWs and LHSs, provision of required equipment, strengthening of monitoring (through vehicle repair, MIS tool printing and dashboard development), and support for PC-I development. With commitment and vision, these relationships can be nurtured and developed further for common aims.

LHWs' regularization provides an excellent opportunity for addressing multiple essential program elements: restoring LHWs' focus to FP service provision; enhancing their motivation; improving their accountability by defining responsibilities; assessing and rewarding good performance by ensuring dedicated workers are placed on a well-defined career pathway; developing a new recruitment policy(that can be applied once the existing program is consolidated and fiscal space is made available in the future ; instituting procedures for official leave; and outlining disciplinary actions and incentives based on performance. All of these measures will help mitigate political interference and incomplete planning, enhancing the efficiency and effectiveness of the LHW program. If LHW recruitment and placements are in accordance with a well-defined policy, arbitrary decisions based on political expediency will be mitigated.

According to policymakers and other health managers, regularization can be an opportunity to enhance motivation; improve accountability by defining responsibilities; assess and reward good performance by promoting good workers along a well-defined career pathway; and develop a new recruitment policy; institute procedures for availing leaves; and outline disciplinary actions and incentives based on performance. All these steps will help mitigate political interference and partial decision-making

Another related opportunity is the prevailing broad consensus among all key stakeholders that the program should be extended to cover Sindh's remaining unserved populations. While the challenges of regularization and inadequate funding presently preoccupy the Department of Health, with further recruitment banned, the future for the Government of Sindh lies in formalizing the regularization of its LHW program within the health system, recognizing LHWs' new status, and inaugurating procedures facilitating the discharge of their duties according to their new status.

Major Threats to the Program in Sindh

The major threats to the LHW program in Sindh are linked with LHWs' motivation for their job performance.

Following their regularization, LHWs are happy with their anticipated salary increase and status as permanent government employees; they also expect arrears from 2012, based on the judgment of the Supreme Court of Pakistan when their services were regularized. If their expected salaries are not paid and they are not provided revised official job descriptions, there is a possibility they will experience further demotivation.

If allowed to continue, undue political interference exercised in the program's recruitment and operations may severely impair and undermine its effectiveness. Political interference results in inefficiencies, such as appointments of multiple LHWs to the same catchment population, as well as underperformance by LHWs who feel secure of not being dismissed due to their political patronage.

Gender-based victimization is a threat faced by LHWs. Such victimization can begin at home—when an LHW's husband is unsupportive of her work or disgruntled by her lack of pay—or arise in unfriendly communities, especially during the polio campaign, when LHWs are assigned to communities other than their own. Risks in the field can include disparaging or aggressive remarks about their work or characters, other harassment, or even physical assault by men. With rising militancy in Pakistan, terrorists have directly targeted LHWs engaged in polio activities in various parts of the country including Sindh. Currently, LHWs manage these threats on their own, by avoiding visits on their own or asking male relatives or colleagues (from the health facility) to accompany them in the field.

Recommendations

These findings and analyses have identified a number of measures for improving the performance of Sindh's LHW program. These recommendations, outlined below, are stratified into three thematic areas: Policy and program interventions, Management interventions, and Operational measures.

Immediate Policy and Program Interventions

Formalizing and Streamlining:

Operational Interventions

All policymakers unanimously acknowledged LHWs' pivotal role in the health delivery system and describe it as the backbone of the system. All agree that the program needs to be strengthened with enhanced funding, integration with other vertical programs, better monitoring and supervision, and in the long term, plans for expansion to incrementally reduce unserved areas.

LHW Regularization

To fulfill the requirements introduced after the Supreme Court judgment that regularized LHWs, Sindh's Assembly needs to pass a Lady Health Workers Program and Employees (Regularization and Standardization) Act similar to the law passed by KP's assembly in 2014, followed by notification of LHW Program Employees Service Rules. The Act should address:

- Selection criteria for appointment of new LHWs and LHSs, as well as new staff Provincial Program Implementation Unit;
- Functions of the Lady Health Supervisor and Lady Health Workers;
- Length of service of LHSs and LHWs, and their entitlements at retirement;
- Catchment population to be served by a LHW;
- Policy for determining seniority; policy on pension benefits, and the General Provident Fund, Benevolent Fund and Group Insurance; and procedures for availing casual, medical and emergency leaves; and
- Procedures for staff assessment and promotion based on performance.

Referral System and Coordination (Immediate)

- The existing referral system should be made fully functional with a comprehensive referral strategy, in consultation with the Health and Population Welfare departments and private sector organizations. The strategy should be clearly written. Important measures include sensitizing facility staff on the need for prioritizing cases referred by LHWs, improving documentation of referred cases, mechanisms for promoting

communication between facilities on referred cases, and compensating LHWs for their time and transportation costs in accompanying referred cases to facilities. Its implementation will require development and printing of requisite stationery and staff training. A suggested referral system is proposed in Figure 3, in the Recommendations section of this report.

- Utilizing the Provincial Technical Committee, closer coordination should be established between the LHW Program, Health Department, and Population Welfare Department (PWD) by organizing quarterly trainings through PWD for LHWs on the client-centered approach for delivering FP services and for clarifying the working relationship between the LHW program and PPHI and documenting this accordingly.
- The program in consultation with the PWD needs to Identify weighted key performance indicators for FP against which LHWs' performance with respect to FP service delivery can be measured. This will help lower unmet need and increase contraceptive prevalence.

New Trainings (Intermediate)

- New and continuing educational opportunities must be provided to LHWs and other program staff, based on their specific identified needs, and on a regular basis according to an annual training calendar. To meet the requirements of a new job description (after regularization), a new training strategy, training curricula, materials, and methodology are necessary.

Expanding Access to Non-covered Areas (Long Term)

- In the long term, we recommend scaling up the program to rural communities not covered by the program. To overcome the special challenges of resistance and lower education in the most deprived communities, tried and tested models can be adapted for pairing male and female volunteers. Examples that have shown promise are the Falahi Health Workers employed by the USAID-supported Family Advancement for Life and Health (FALAH) project implemented by Population Council and the Marvi Workers of HANDS. In both models, less educated volunteers were identified, who were paid nominal honoraria, and mainly carried out community mobilization activities as well as working as depot holders for certain contraceptive methods prescribed by healthcare providers.
- Current staff positions should be realistically re-examined to eliminate redundant positions. The cost savings can be diverted to expand LHW coverage.

Management Interventions

Improving Governance (Immediate)

To efficiently manage the LHW program's post-regularization transformation, a Program Technical Committee should be constituted with the Chair of the Oversight Committee for Primary Health Care (PHC) as the new committee chair, with members comprised of senior policymakers, researchers, and development partners. The committee should determine LHWs' range of services; identify ways and means for improving their performance and accountability; decide upon integration of all primary healthcare services; explore possible alternatives for improving service access in non-LHW areas where locating literate women is difficult; develop draft legislation for LHW regularization; and determine key performance indicators (which must include FP) that should be weighed.

To improve management out of box approaches such as management outsourcing could be an option that can be considered, once all stakeholders are taken onboard.

Tackling Security Issues (Immediate)

A comprehensive and completely reliable strategy should be developed, led by the communities and supported bypolice and intelligence agencies to ensure that program staff, especially LHWs, are protected against any

security threats. Communities should be involved in providing security for LHWs, with commitments from community leaders, who should depute respected community members to escort LHWs during field visits.

Budgetary Support (Immediate)

Adequate budgetary allocation to the program must be arranged to meet operational costs and ensure timely payment of LHWs' salaries. Greater balance should be established between the salary and operational cost components of the budget. As the Accounts Department of LHW Program of Sindh proposes, at least 40 percent of the total budget should be for operational support. This operational budget will be adequate to cover equipment and supplies, training (both initial and refresher), fuel cost for supervisory visits, procurement of spare parts and repair of vehicles, and printing stationery and IEC materials. At present, salary disbursement is considerably delayed due to late release of funds from the federal government. It is recommended that salary disbursement statuses be reported every month to the Special Secretary of Health to address delays. One option for overcoming delays is bridge financing by the Government of Sindh. To expedite disbursement of salaries, transfer of funds through mobile phone services (Easy Paisa Service for e-payments) may be considered.

Improving Supervisory Support (Immediate)

The monitoring and supervisory system should be improved by adopting a more supportive supervisory model; harnessing mobile technology for data management; streamlining the logistics management system by instituting a formal system for LHSs to requisition medicines and contraceptives; and periodic third party evaluations, as well as surveys and operations research in areas such as assessing the factors that motivate or demotivate them.

Strengthening Management (Intermediate)

- A post for a Deputy or Additional Director General Reproductive, Maternal, Neonatal and Child Health (RMNCH) should be created to ensure integration and better coordination among all vertical programs (Provincial Coordinator).
- A minimum tenure of three years should be ensured for the provincial Head of the program.
- To ensure local ownership of the program, district "oversight committees" headed by the local elected provincial Assembly member should be established to examine all matters related to reproductive health service provision.

Chapter 1: Introduction

The National Program for Family Planning and Primary Health Care, more commonly known as the Lady Health Worker (LHW) Program, was launched by the Ministry of Health, Government of Pakistan in 1994 for home delivery of essential primary healthcare services to women and children, especially in rural communities, by trained female community health workers. The program is widely seen as the backbone of the national health system, particularly in rural areas. With 110,000 LHWs currently employed, it is one of the largest community health worker programs in the world (Zhu et al. 2014).

According to the LHW program officials, in Sindh, there are currently 22,576 LHWs employed. The LHW Program covers almost 46 percent of Sindh's Population. Each LHW provides services to a population of 1000-1200 people

or approximately 150-200 households. The LHWs are supervised by a Lady Health Supervisor (LHS). Each LHS has to supervise nearly 20-25 LHWs.[3]

Since 2000, two national external evaluations of the LHW Program have been conducted by the Oxford Policy Management (OPM), the first in 2002 and the second in 2009.[4] While the evaluations found the program to have had a significant positive effect on several health outcomes in the country, they also identified a number of weaknesses that need to be addressed for optimal gains.

In the six years since the last evaluation, major structural changes in the program have occurred. The 18th Constitutional Amendment devolved responsibilities for health to the provinces, with LHWs regularized into salaried positions. These changes affected the program differently across Pakistan. Now governed within provinces by Provincial Coordinators, and funded by both federal and provincial budgets, the program has to be re-evaluated within the context of each province.

The Government of Sindh's 2012-2020 Health Strategy pledges continued support to LHWs and LHSs (Government of Sindh, Sindh Health Strategy 2012-2020). Given the changes in the program since the last evaluation in 2009, a fresh assessment of the current situation of the LHW program in the province is required to ensure its government support is targeted and effective.

This study, conducted by Population Council in early 2015, assesses Sindh's LHW program. This study was commissioned by JSI Research and Training Institute (JSI), the lead agency of the Health Systems Strengthening (HSS) component of the Maternal and Child Health Program (MCH) funded by the United States Agency for International Development (USAID). (Details are provided in Appendix 1).

1.1: Purpose and Objectives of the Assessment

The purpose of this assessment is to assess the strengths, weaknesses, opportunities, and threats (SWOT) facing the Sindh LHW Program at the beginning of 2015, and to determine how best to ensure access to quality community healthcare services in the province in the coming years.

The assessment was conducted with the following objectives:

- Assessing program, managerial, and operational issues inhibiting more effective program implementation, to identify how barriers to better performance may be removed.
- Determining the Sindh government's vision for the program, including plans for increasing operational efficiencies and coordination or expansion of work in areas not covered by the program.
- Determining the space for further strengthening the functional integration/coordination with other MCH programs (particularly the Maternal, Newborn and Child Health [MNCH] Programme, the Nutrition Programme, and the Expanded Programme on Immunization [EPI]).

1.2: Structure of the Report

Section 2 of the report provides an overview of the LHW program and its performance based on a review of relevant literature, in particular the two external evaluations since 2000.

[3] The information/data provided in this paragraph was obtained from the Provincial LHW Program Office.during in-depth interviews.

[4] The 2002 evaluation was conducted over the period 2000-2002 (Oxford Policy Management, 2002). The most recent evaluation of the program was carried out from December 2007 to November 2009 (Oxford Policy Management, 2009).

Section 3 discusses the scope of the assessment in more detail and then describes the methodology for a SWOT analysis of the LHW program in Sindh.

The findings of the assessment are reported and analyzed in Section 4.

Section 5 presents recommendations for strengthening the LHW program at program, managerial, and operational levels (details provided in Appendix 2).

Chapter 2: Review of LHW Program Literature

The LHW Program was initiated in 1994 as part of a national strategy to reduce poverty and improve health outcomes by providing local health services, especially in rural areas (Oxford Policy Management 2009). The program's main objective was to increase utilization of promotive, preventive, and curative services within communities, particularly for women and children in poor and underserved areas. Over the past two decades, the LHW Program has played a strategic role in the provision of primary healthcare in Pakistan and its efforts to achieve its Millennium Development Goals (MDGs).

A wide array of literature has been published on various aspects of the program. This section discusses key findings of the main studies conducted after 2000.

2.1: LHWs' Roles

To understand the findings, critiques, and recommendations of various studies of the LHW Program, it is useful to be apprised of LHWs' precise roles. The tasks originally stipulated for LHWs and the additional tasks assigned over the years are listed in Table 1.

Table 1: LHW Tasks

Stipulated Tasks of LHWs	Additional Tasks of LHWs
1. To register and educate all eligible couples in a catchment population about FP methods 2. To distribute contraceptives pills, condoms, and injectable contraceptives (second dose) to eligible couples 3. To facilitate IUD and surgery from nearest centers for eligible couples 4. To maintain a register of all pregnant mothers and children under five years old in the catchment population 5. To look after pregnant mothers and issue pregnancy cards 6. To provide iron and folic acid tablets for pregnant mothers and women of reproductive age 7. To encourage and facilitate antenatal, birth, and post-natal care by a skilled birth attendant (SBA) 8. To facilitate an Expanded Program of Immunization 9. To provide basic treatment and appropriate referrals for children with diarrhoea and acute respiratory infections 10. To raise awareness about balanced nutrition 11. To educate women of all ages on common ailments 12. Encourage breastfeeding and complimentary feeding 13. Health education through growth monitoring of children 14. To promote use of iodized salt in the community	• Immunization - NIDs: About 20 million polio doses were administered by LHWs - MNT: LHWs role was recognized in the success of neonatal tetanus elimination campaign and they vaccinated hard to reach groups of women in difficult areas - Measles campaign: In the recent nationwide measles' elimination campaign almost 100% coverage was achieved by involving LHWs. • Emergency relief activities - Earthquake relief 2006 - Flood relief 2007-2008 • TB DOTS: LHWs play a vital role in case detection and case retention to enhance treatment completion and cure rates • Malaria control: RBM program utilizes LHWs in various malaria control activities

15. To provide treatment for common ailments	
16. To provide awareness on prevention from Malaria and TB and participate in DOTS management 17. To provide awareness of HIV/AIDS and STD prevention and control 18. To promote principals of basic hygiene 19. To prepare and submit a monthly report, on structured pro formas, to affiliated health facility (FLCF) 20. To maintain close liaisons with Lady Health Supervisors 21. To provide medicine and supplies provided by the government, to the catchment population 22. To maintain close liaison with the attached health facility for skills training, supplies, and supervision (3 Ss), as well as for referrals	• Innovations: Various innovations have been introduced in the program after pilot testing through LHWs to extend these PHC services to the community

DOTS; Directly Observed Therapy Strategy, STD: Sexually Transmitted Diseases, FLCF: First Level Care Facility, NID: National Immunization Days, MNT: Maternal Neonatal Tetanus, RBM: Roll Back Malaria, PHC: Primary Health Care

Source: Hafeez, Assad et al. 2011. Lady health workers programme in Pakistan: challenges, achievements and the way forward. *Journal of the Pakistani Medical Association* (61) 3: 210-215

Although identified tasks are useful, yet it is a long list and performing multiple tasks not effectively carries the risk of losing overall programmatic impact. Among additional tasks, LHWs have been most extensively involved in immunization support. On National Immunization Days (NIDs), about 20 million polio doses are administered by LHWs. LHWs' role has also been recognized in the success of the maternal neonatal tetanus (MNT) elimination campaign, and they have been instrumental in vaccinating women in difficult areas. Likewise, in the recent national measles elimination campaign, almost 100 percent coverage was achieved by involving LHWs.

LHWs have also been engaged in post-disaster emergency relief activities, particularly after the 2006 earthquake and floods of 2007 and 2008. Moreover, they are playing a vital role in TB DOTS through case detection and case retention to enhance treatment completion and cure rates. The Roll Back Malaria (RBM) program utilizes LHWs in various malaria control activities.

Various innovations have been introduced in the program after pilot testing through LHWs to extend these primary health care (PHC) services to the community (Assad et al. 2011).

2.2: Achievements of the Program

Improved Health Outcomes

The last two evaluations of the LHW program have noted that it has brought about significant improvements in major indicators of reproductive as well as maternal, neonatal, and child health.

The success of the program is attributed to its ability to influence women's healthcare seeking behavior. A 2009 study in Punjab investigated the reasons that determine pregnant women's choices for antenatal care (ANC) and delivery providers (Ahmad, 2009). The results revealed that the women's decisions were heavily influenced by their social network and degree of LHW contact. All women advised by their LHW during their pregnancy started availing ANC services at public facilities in the first trimester and continued until the end of pregnancy. Furthermore, when results were gauged for neonatal mortality impact, women who chose public ANC services had 21 percent lower neonatal mortality than women who chose traditional services by the traditional birth attendants (TBAs)[5] (Zhu, 2013).

The latest evaluation of the LHW program, in 2009, associated it with a significant increase in tetanus toxoid (TT) vaccination coverage (14% to 31%) and attended deliveries (27% to 48%) (OPM, 2009). Incidence of neonatal checkups was also 15 percent higher among households served by the LHW program.

Maternal and child health has improved significantly with LHWs, as they have facilitated access to antenatal services, skilled attendance at birth, and FP services, and played a key role in controlling major child killers, pneumonia and diarrhea (Peers for Progress, n.d.). Research in the rural Sindh district, Matiari, examined whether timely case identification and provision of treatment by oral antibiotic delivered through community health workers has the potential to reduce infant morbidities at home (Soofi et al. 2012). The results of the study show that LHWs have the ability to diagnose and effectively treat pneumonia at home. The LHW program holds great potential for reducing childhood morbidity caused by pneumonia, especially in settings where it is difficult for children to visit a health facility. The last evaluation of the program also found that the proportion of children fully immunized rose from 57 to 68 percent among households served by it (OPM, 2009).

In addition, the LHWP is strongly linked with FP improvements. Douthwaite and Ward (2005) associate the rise in use of modern contraceptives in Pakistan with the increase in contraceptive prevalence in rural areas which, in turn, was mainly achieved through doorstep provision of FP services by LHWs. Their study used data from the third national evaluation of LHWP (Oxford Policy Management, 2002) to see the impact of the LHW program on the use of modern contraceptives with a focus on rural women. Comparisons were drawn between areas served by LHW program and the control population by various techniques, such as interviews with men, women and LHWs, to gauge the difference in use of contraception in currently married couples. The results clearly showed that in areas served by LHWs, use of modern contraceptives was higher than in unserved areas, even after controlling for a number of socioeconomic indicators. This study provides strong proof that the LHW program has fulfilled two of its major goals: providing doorstep FP services and increasing modern contraception in rural areas.

The 2009 evaluation found that although LHW served households were 11 percent more likely to use FP, there had been an increase of only one percent in the contraceptive prevalence rate (CPR) since the previous evaluation in 2002 (OPM, 2009).

[5] TBAs, known locally as *dais*, are unregulated providers who assist childbirth at home. They are often untrained and poorly qualified, and use herbal medicines.

Female Empowerment

Apart from improving health outcomes, the LHW program is also credited with a positive role in women's empowerment. It has been observed that LHWs enjoy a higher degree of empowerment compared to other working women. This may be due to the nature of their job, which involves a high level of mobility. LHWs' salaries often serve important sources of income for their families. Moreover, due to their training and knowledge, and their occasional roles as life savers, LHWs enjoys a higher level of respect in the community.

Khan (2011) explores in detail how various aspects of LHW program contribute to the process of female empowerment. In light of Kabeer's (2001) view of empowerment, that women's enhanced access to resources gives them a say in important decisions in their lives, the author links paid work and the ability for collective action, and how increased mobility of LHWs, in direct contrast to gendered segregation of public and private spheres, has allowed LHWs to reform their society. The largest employer of women in the formal sector, the LHW program is seen as a key instrument for social change. If the program continues to expand to achieve universal coverage, it would mean every community has one LHW—in other words, one potential female leader working for the betterment of other women in her community (Khan, 2011).

LHWs' interaction with one another, for example during training sessions, also puts them in a better position to negotiate for job security. In 2002, LHWs held nationwide protests against the insufficiency and delay in the payment of their stipends.

The LHW program has played an important part in reducing the gender inequity that is a norm in Pakistan's patriarchal society by helping women overcome financial dependence on male family members, making them more independent, and improving their overall image in the community (Peers for Progress, n.d.).

Improvement in Coverage and Supervision

According to the 2009 evaluation, expansion after 2000 has increased the program's reach to more rural and poor areas. In LHW served areas, 85 percent of houses reported a LHW visit at least once within the past three months, which means only a small proportion of households are not maintaining close LHW contact (OPM, 2009). However, the most disadvantaged areas still remain unserved by the program (OPM, 2009).

The 2009 evaluation also found that several management issues identified in the 2002 evaluation had been addressed, although room for improvement remained. In particular, overall supervision has improved, accompanied by a rise in the average level of knowledge among LHWs. Some 78 percent of LHWs reported that they had attended the monthly supervisory meeting the previous month. Similarly, a high proportion of LHWs reported the use of checklists by their supervisor at the previous meeting. Moreover, as compared to 2000, Lady Health Supervisors (LHSs) are now responsible for fewer LHWs, which may be expected to enhance their ability to monitor and guide individual LHWs under their charge.

2.3: Weaknesses

Studies have identified a number of weaknesses limiting the LHW program's performance and achievements.

The third evaluation of the LHW program found, although it had delivered better results and had a significant, greater impact on national health outcomes than other national and international community health worker programs, several issues to be addressed (Oxford Policy Management, 2002). The evaluation highlighted underperformance by a substantial proportion of LHWs. Throughout Pakistan, one third of LHWs reported 10 or fewer clients per week. In Sindh, more than two thirds of LHWs reported working less than 15 hours per week.

Another finding of the evaluation was that, in rural areas, LHWs were placed in socioeconomically better off populations. Moreover, even within these populations, LHWs were not reaching the poorest households on their registers. While the program had penetrated more rural and less advantaged areas, the most disadvantaged communities were still not being reached.

The evaluation failed to find significant evidence of any effect of the program in urban areas.

The latest evaluation of the program noted that LHWs' working hours had increased compared to 2000 while the average number of people served by each LHW had gone down from 980 in 2000 to 918 in 2009. The rise in average working hours could be explained by the fact that LHWs were providing a wider range of services to a higher proportion of clients than before (Oxford Policy Management, 2009).

Regular and adequate supplies of medicines and equipment for LHWs still remain unaddressed. Although LHWs seem to have a wider range of medicines available and face less frequent and comparatively shorter stock outs than in 2000, they continue to remain undersupplied. The 2009 external evaluation found that lack of medicines was a particularly important problem in Sindh. Only one third of LHWs had access to a functional weighing scale (Oxford Policy Management, 2009). Improved supervision, and the necessary support structure, were emphasized as key areas for improved performance. Effective district management was also identified as an important factor contributing to better LHW knowledge and performance.

According to the last evaluation in 2009, Sindh had the poorest performance in merit selection. Eleven percent of LHWs were not residing in the villages they served. Sindh seems to be struggling to make any considerable improvement in this area due to prevailing *ad hoc*-ism and political appointments. The same evaluation reported that Sindh had the greatest problems with stock outs enduring for two months or more. This colossal problem still exists and is eroding the performance of the provincial program.

Moreover, problems with LHWs' referrals of patients to facilities need to be addressed. LHWs report that their patients are not given due attention or proper treatment at referral facilities, corroding their standing with clientele. Worse still, when they accompany a patient to the health facility, they sometimes face degrading remarks about their own competence from the duty doctor in front of their clients. This damages their reputation in the community and makes it more difficult to convince clients to visit the facility when the need arises (Afsar et al. 2005).

The 2009 evaluation notes that the program does not seem to be effective in several areas in its purview, including hygiene and sanitation, breastfeeding, growth monitoring, skilled birth attendance, and diarrhea and respiratory infection. It identified absence of strong governance as the underlying reason for the persistence of issues identified in earlier management reviews, such as integrating with BHUs now headed by NGOs, options for decentralization, and continued expansion in urban areas at the expense of rural development.

Salary delays, low salaries, no or poor referral support by the district health system, and lack of career development opportunities have also been identified as factors hampering the program's performance.

Since the primary healthcare program is the responsibility of the federal government but is operated through provincial and district health facilities, LHWs share responsibilities under the Expanded Immunization Scheme (EMI). In recent years, the polio campaign has led to significant increases in LHW workloads (Khan, 2011).

Mobility issues confronting LHWs, as women, require creative solutions. Mumtaz (2012) studied the impact of gender and social geographical constraints on LHWs' mobility and found that LHWs, as women, suffer the same gender problems their clients or any other woman in Pakistani society faces. Ethnographic research explicitly states that social geography, rather than physical geography, comprises the major barriers in women's mobility

(Mumtaz & Salway, 2005). Specifically, norms pertaining to *biradri*[6] set boundaries on the physical spaces in which women can move freely. For LHWs, as for other rural women, interaction with people, especially men, outside their own *biradari* is highly unacceptable, and as a consequence LHWs should be allotted catchment populations on the basis of social rather than physical geography.

2.4: Recommendations

Several studies have provided recommendations for the program.

Regular and timely payment of LHW salaries would greatly improve their morale (Afsar et al. 2005). Moreover, LHWs who fulfill defined criteria (qualified to a specific level, certain years of experience) should be given incentives in the form of special trainings that may be significant tool in their career development (Ndiwane, 2000). This would also address LHWs' high attrition (Afsar et al. 2005). In addition, in areas where social norms and patriarchal practices create difficulties for LHWs in effectively performing their duties, there is a need to educate communities about LHWs' role and significance (Afsar et al. 2005).

The 2002 evaluators recommended a strategy for LHWs' underperformance prior to further recruitment (Oxford Policy Management, 2002). The 2009 evaluation recommended that underperforming provinces not be allowed to recruit new LHWs until they had resolved issues of underperformance among already employed LHWs (Oxford Policy Management, 2009). This would improve the program's cost effectiveness.

Moreover, to ensure the program penetrates the most disadvantaged communities, it was recommended that LHWs are recruited from more underprivileged areas and only be expanded in rural areas (Oxford Policy Management, 2002). This recommendation was reiterated in the 2009 evaluation, which proposed a "targeted expansion" strategy addressing the issue of bias in program coverage in urban and relatively richer areas (Oxford Policy Management, 2009). This is also likely to improve the program's cost effectiveness, as no empirical evidence suggests the program has had a significant impact in urban areas.

To reduce the problems associated with referrals of cases by LHWs to health facilities, a study conducted in Karachi recommended provision of trainings and knowledge to LHWs regarding simple medical problems in order to minimize the number of referrals (Afsar et al. 2003).

Another approach that yielded positive results in improving LHWs performance and helping them to provide FP services was a training imparted by the Population Council's FALAH project to LHWs on delivering client centered family planning services. The training focused on improving interpersonal communication skills, using a frame work that helped workers to holistically asses client needs and help them choose a solution to meet their needs through a process of mutual negotiations. The training also enhanced the workers knowledge regarding various contraceptive methods and how to deal with side effect. A third party independent evaluation showed that CCA training improved the LHWs performance significantly in terms of providing family planning services and increasing referrals. Home visitation rates in the last three months by the trained workers also increased compared to the control areas. On the whole the contraceptive prevalence rate was significantly higher in the areas where the trained LHWs were deployed compared control area (Shafaat et al. 2011).

The review of literature indicates that the LHW program has undoubtedly shown that female community health workers can play an important role in delivering health services and achieving improved health outcomes, such as higher contraceptive prevalence and lower maternal and child mortality and morbidity. To further improve the program's performance and extend its scope, program, managerial, and operational issues must be addressed.

[6] "*Biradri* is… a group of households related by blood… the basic social, class, economic and political unit in Pakistan…" (Mumtaz, 2012).

With better governance and management, the program can serve as a key resource ensuring universal access to primary healthcare, achieving MDGs, boosting rural women's empowerment, and addressing poverty.

The recommendations made nearly 6 years ago by OPM (2009) regarding irregular payment of salaries, poor supervision and lack of supplies have also been identified by the current assessment, reflecting the persistence of these issues

Chapter 3: Assessment Scope and Methodology

This section outlines the scope of this assessment of the strengths, weaknesses, opportunities and threats facing the LHW program in Sindh, and outlines the methodology adopted for the study.

3.1: Scope

The three objectives of the assessment are to 1) identify program, managerial, and operational barriers to optimal performance of the LHW Program in Sindh; 2) understand plans of the Government of Sindh to improve the program's operational efficiency and extend it; and 3) identify measures to strengthen the program's performance in the province.

Accordingly, this assessment focuses on program features, with less emphasis on household indicators measured in earlier national evaluations by OPM. Table 1 lists the program, managerial, and operational issues covered by the assessment.

Table 2: Issues Covered by the Assessment

Policy Issues	Managerial Issues	Operational Issues in Districts
Vision and direction for the next 3 to 5 years	Supervision and monitoring challenges	Availability of equipment and supplies
Strengths and weaknesses of the program	Hiring and firing policies	Trainings, new and refresher
Coverage increase by hiring and training new LHWs or volunteer health workers	Accountability and performance monitoring	Availability of information, education and communication (IEC) materials
Coordination with Population Welfare Department	Functionality of the referral system	Capacity for data collection and analysis and utilization of existing data
Procedure for hiring male health workers	Regular salary disbursement, financial and logistics challenges	Availability of vehicles for transportation
Future funding and PC-I development	Incentives and motivation	Impact of operationalizing the regularization of LHWs
Program restructuring and new job description		Maternal Mortality Conferences
Implications of LHWs' regularization on program performance		
Program expansion by absorbing other workers		
Policies for leaves, medical benefits, retirement, etc.		

To explore these issues, the key questions listed in Table 2 were asked of different categories of stakeholders for the evaluation.

Table 3: Key Questions Posed

POLICY	1. Given concerns regarding the effectiveness of the LHW Program as per its original objectives and the scope and scale of issues related to maternal, newborn and child health in Pakistan, what is the Department of Health's vision for the LHW Program in the next 3 to 5 years? What can be realistically expected from the program? 2. What are specific strengths of the program according to the Department of Health (DOH)/Population Welfare Department (PWD)? 3. Is the Government planning to establish some functional/programmatic integration between PWD and LHW program? 4. What specific weaknesses of the program is the DOH/PWD planning to address in the next 3 years? How is the DOH/PWD planning to do this? What sources of funding are available for this? 5. How does the DOH/PWD expect the program will change now the LHWs are regularized, if at all? 6. How is the DOH/PWD planning to provide outreach in areas not covered by the LHW Program? 7. What are the DOH's thoughts regarding coordination with (or absorption of) community health workers outside of the LHW Program?
PROVINCE	1. Which areas of LHW/PWD performance are currently strong and which are weak? What are the reasons for the current performance of the LHW Program? 2. What are current human resource constraints? What is the long-term plan, particularly in a devolution environment? 3. What aspects of the program keep LHWs motivated? 4. What approaches is the DOH using to address financial and logistical challenges for keeping the LHW Program going? 5. Are there challenges in effectively monitoring LHWs' performance? 6. What would be required to overcome these challenges?
DISTRICT	1. How are human resource issues (e.g., recruitment, deployment and retention of LHWs and LHSs) being handled? 2. How is the quality of LHW outreach/capacity of LHWs ensured? What changes if any are needed to improve capacity and quality of services? 3. Which are the issues most commonly found in the LHW Program with regards to supply chain of medicines/supplies? How are they addressed? 4. How are LHSs supported in monitoring and supervision of LHWs? 5. What approaches is the DOH using to strengthen and enhance LHS capacities? 6. What impact has the regularization of LHWs had on performance/motivation? 7. What is the frequency, regularity and effectiveness of Maternal Mortality Conferences (MMCs) at district level?
FACILITY	1. How has the role of the LHW changed in the past ten years? 2. How well is the referral mechanism working? 3. On average how many referrals are generated by an LHW in a month? 4. What are the strengths and weaknesses of the LHW Program?
SUPERVISOR	5. How frequently do they meet with LHWs? 6. How do LHS go about conducting their supervisory activities? 7. What are their priorities in supervision? 8. What mechanism of providing feedback to LHWs do they employ? (Evidence of LHS feedback to LHWs should be reviewed.) 9. How do they assess the quality of LHWs work? 10. Do they conduct any real time monitoring of LHWs work by making surprise visits/spot checks? 11. How do they help LHWs set their priorities and review performance against priorities? 12. Is there any variation in the performance of LHWs and, if so, what are the reasons for such variation? 13. LHW records should be reviewed with LHSs to determine how updated the records are and to collect information on the average number of LHW household visits per month, provision of contraceptives, participation in campaigns, etc. 14. How is this information shared with the district and what type of forum is used to highlight weaknesses in the program with district and provincial management staff? 15. What is the regularity of monthly meetings at health facility level and how do they address the issues highlighted/discussed during these meetings?

LHW	1. Profile of LHWs in terms of age, marital status, dependents, and education. Are they the sole breadwinners in their families? 2. What is their monthly income? 3. What are their financial responsibilities? 4. Some LHWs have dual employment. Are they doing so only for financial reasons? 5. How much distance do they have to travel to reach their clients? 6. What are their key responsibilities? 7. Average hours per week spent on LHW responsibilities. 8. How much time is spent in the community versus the facility? 9. On average, how many referrals per month do they generate for their first level care facility? 10. How are their referrals received at the facility? 11. What mechanism do they have for following up on their referrals? 12. What are the biggest challenges in their work? 13. How do they manage competing work priorities? 14. Do they consider certain types of outreach/ service provision more important? 15. Are they confident about their level of training? 16. How often and in what areas do they receive training? 17. What support do they get from their supervisor/the LHS? 18. How frequently do they meet with their supervisor? What occurs during these meetings? 19. Do they use their own transport to visit the households registered with them or get some transport facility? 20. How big a problem is their personal security? 21. What precautions do they take to protect themselves? 22. Do they expect that their financial and work situation will improve now that they are regularized? 23. What might enable them to complete their work responsibilities with greater effectiveness? 24. Are they comfortable with the additional assignments they are given besides their assigned TORs? 25. How far do those additional assignments (polio campaign, etc.) hamper their regular activities and quality of work? 26. How far are the village health committees and women support groups functional in their areas, and how frequent are their
COMMUNITY	1. What is their perception of LHWs? Has this perception changed over time? 2. Did an LHW visit their house in the last 3 months? 3. What services have they received in the last 3 months from an LHW? 4. Did an LHW refer them to a health facility for ANC, delivery, postnatal or newborn care? 5. Did they visit the health facility as a result of the referral? 6. Were they satisfied with the care they received at the facility? 7. Do they value LHWs' advice and guidance? 8. What is LHWs' role in the community? 9. Do they know that LHWs have group meeting (support groups) to educate women in the community on health issues?

3.2: Methodology

The evaluation design was based on a mixed methods approach. To ensure multiple triangulations, in-depth interviews, formal and informal interactions, and focus group discussions (FGDs) were conducted with all LHW program stakeholders.

The methodology included, but was not limited to:

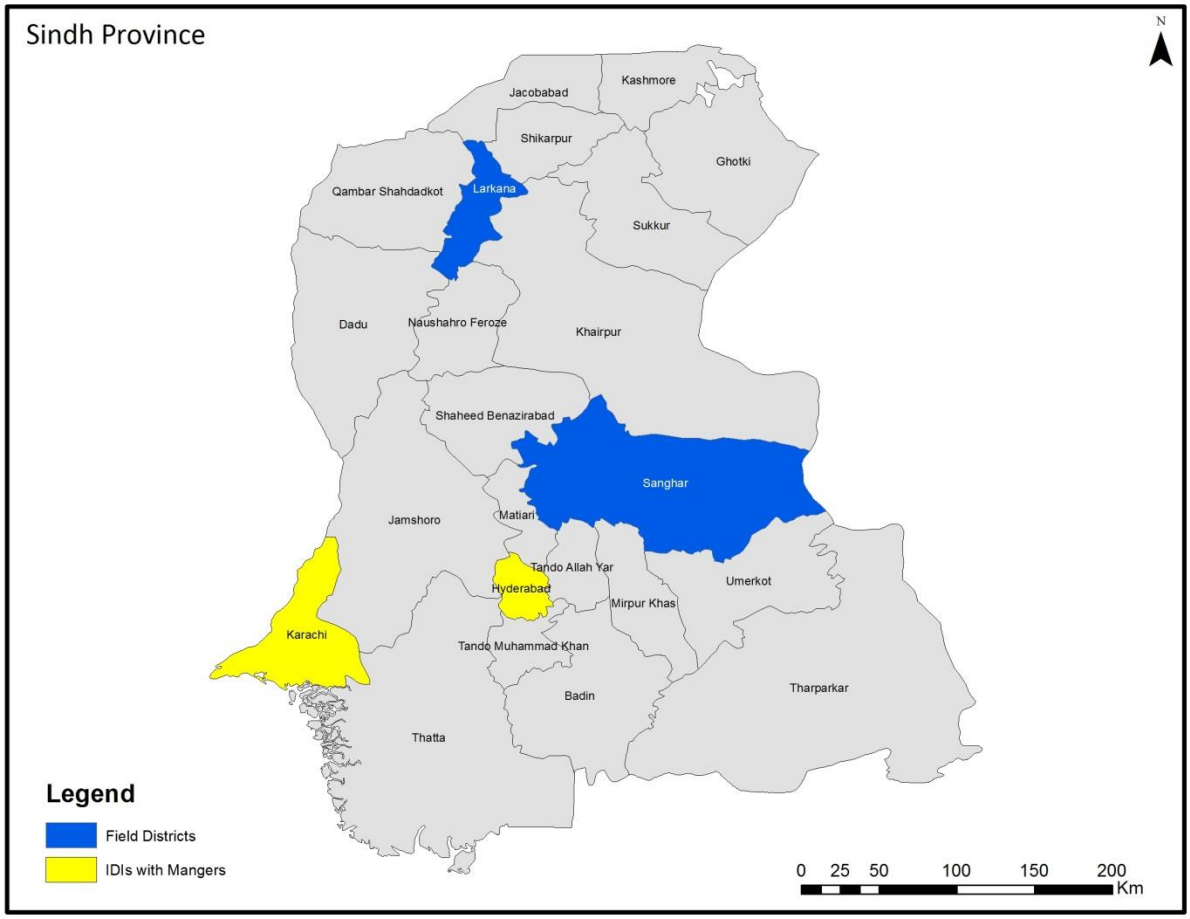
- A desk and literature review of project documents, financial outlay, various past evaluations, grey literature, and other relevant papers;
- In-depth interviews (IDIs) and formal and informal interactions with policymakers, program managers, development partner representatives, non-governmental organizations (NGOs), and academicians; and

- Focus group discussions (FGDs) with health providers (LHWs and LHSs) and community women served by LHWs.

3.3: Study Districts and Data Sources

From discussions with the JSI and USAID teams, fieldwork for the assessment was carried out in districts Sanghar and Larkana of Sindh. The team coordinated with USAID Pakistan to prepare and conduct site visits and interviews.

Figure 1: Map of Sindh showing Study Districts



At the provincial level, key informant interviews were conducted with the following stakeholders associated with the LHW program. (The list of stakeholders is provided in Appendix 6.)

- Policymakers: In total, 42 interviews were conducted with Provincial Secretaries of the departments of Health, Population Welfare, and Planning and Development
- Provincial Level: Managers of the People's Primary Healthcare Initiative (PPHI), LHW Program, Nutrition Program, and EPI
- Representatives of NGOs: HANDS, Pathfinder
- Representatives of Development Partners: USAID, United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA)

- Representatives of Donor Assisted Projects: Maternal and Child Health Integrated Program (MCHIP), JSI; and Deliver, JSI.

At the district level, a total of 23 in-depth interviews (IDIs) and 22 FGDs were conducted in Sanghar and Larkana. Details are presented in Tables 4, 5 and 6. Profiles of LHWs who participated in FGDs are provided in Appendix 12.

Table 4: IDIs at the District Level

Respondent	Sanghar	Larkana
District Health Officer (DHO)	-	1
District Population Welfare Officer (DPWO)	1	1
District Coordinator of LHW Program	1	1
District Manager, Maternal, Newborn and Child Health (MNCH) Program	1	1
District Support Manager, PPHI	1	1
Representative of HANDS (NGO)	1	1
Total	**11**	

Table 5: IDIs at Facilities

Respondent	Sanghar	Larkana
In-charge of Basic Health Unit (BHU)	1	1
In-charge of Rural Health Center (RHC)	1	1
In-charge of Tehsil Headquarters Hospital (THQ)	1	1
In-charge of Reproductive Health Services A (RHS-A) Centre	1	1
In-charge of Family Welfare Center (FWC)	1	1
Lady Health Supervisor (LHS)	1	1
Total	**12**	

Table 6: Focus Group Discussions

Group	Sanghar	Larkana
Lady Health Workers	6	6
Lady Health Supervisors	1	1
Community Women	4	4
District Total	*11*	*11*
Total	**22**	

3.4: Evaluation Process

The evaluation process consisted of five main stages:

1. Preparation and planning by evaluation team;
2. Initial review of priority documents;
3. Two day team planning meeting (TPM);
4. Field work; and
5. Data analysis and report writing.

Initial Review of Priority Documents

The Council's evaluation team reviewed all project background documents, including:

- Program PC-I;
- LHW reports;
- Project-generated evaluations;
- Relevant external evaluations from other sources (other donors); and
- Review of research articles.

Team Planning Meeting

The evaluation team conducted a two day planning meeting prior to the key stakeholder meetings and field work. The meeting clarified team roles and responsibilities, finalized the work plan and methodology, and created a timeline and action plan for completing deliverables.

A briefing with USAID Pakistan at JSI's office in Karachi discussed the draft work plan, expectations of the evaluation, and approval of final methodology and work plan. To review the scope of the evaluation, the proposed schedule, and overall assignment, the initial briefing also included a review and final agreement on the evaluation questions.

Field Work

Having completed preparatory and planning work in Islamabad, the evaluation team began fieldwork. Team members conducted key informant interviews (IDIs), facility evaluations, and on-the-spot document reviews in Karachi, Hyderabad, Sanghar, and Larkana. The field plan for IDIs with Managers is provided in Appendix 7.

Guidelines for the interviews and FGDs were developed, then discussed with JSI in an initial meeting, and finalized after incorporating their suggestions. The interviews and group discussions used these pre-defined guidelines to assess the strengths, weaknesses, opportunities, and threats (SWOT) facing the Sindh program. The key questions posed to each category of stakeholders are indicated in Table 2. (FGDs and key informant interview guidelines and protocols provided as Appendix 11 and Summaries of IDIs as Appendix 12)

Field Team Composition and Quality Assurance. Implementation of IDIs and FGDs was initiated simultaneously. Interviews with stakeholders at policy, provincial, district and facility level were conducted by the study director; while FGDs with providers and communities were conducted by two separate teams, with one team holding discussions with facility staff and the other team interacting with communities. Both teams were supervised by the study manager and guided by experienced Council research staff.

A detailed plan for field work was developed after obtaining appointments for interviews from all stakeholders. (Field plan for FGDs and district IDIs is provided as Appendix 8.) The teams were closely supervised to ensure that high quality information was collected. (The detailed structure of the evaluation team is in Appendix 5.)

Data Analysis

Proceedings of the interviews and FGDs were documented using structured guidelines. The contents of these documents were checked by supervisors in the field and accurate transcription ensured. Summaries of the IDIs and FGDs were developed immediately after data collection and checked for accuracy and analysis in matrices. A more detailed analysis was undertaken at the Population Council office in Islamabad.

Data collected concerns stakeholders' views of program accomplishments, weaknesses, lessons, and recommendations for improvements for increased effectiveness and sustainability in Sindh. In addition to using the interview guide, all transcripts were reviewed repeatedly to identify emerging themes from the point of view of the aims and objectives of the study as well as key issues identified for the evaluation's scope.

For analysis of the qualitative data, matrices using Microsoft Excel were created to help identify patterns. The matrices were organized at the in-depth interview and FGD level. Each row in each matrix represented one interview or FGD and the relevant data from the discussion were placed in the cell under the relevant column. The matrices were useful in grouping the different notes within each theme, discerning differences and similarities between interviewees within themes, and making broader connections.

All IDIs and FGDs with different stakeholders were first analyzed separately and then triangulated to identify convergences and divergences in opinion on the same topics, including policy, managerial, and operational issues.

3.5: Methodological Strengths and Limitations

The major strength of the evaluation was that data was collected from a wide range of stakeholders and the results obtained shed light on a range of perspectives about the intended outcome and achievements of the LHW program in Sindh. Information obtained through the interviews was triangulated with secondary data.

Limitations of the evaluation included:

- Limited time was available for the study and a quantitative component is therefore missing;
- The evaluation was conducted in only two districts of Sindh, which cannot adequately reflect the entire situation of the province;
- At some instances, it was difficult to find key informants since the turnover and transfer rate in both the government and private sectors in Pakistan is high;
- Non-availability of program records.

3.6: Ethical Considerations

Ethical approval for this study was obtained from the Institutional Review Board (IRB) of the Population Council's New York office.

A number of measures were instituted to ensure that the study maintained the highest quality and ethical standards at all stages, including both data collection and analysis. These are outlined below.

Determination of roles and responsibilities

The roles and responsibilities of team members and field coordinators were clearly identified and each team member was provided written instructions that he/she was required to follow. (Details provided in Appendix 3.)

Confidentiality

All participants were informed that information obtained in the study was transmitted only in a form that could not be associated with the subject. All the questionnaires were filled in private, maintaining auditory privacy. All data collected for the study was kept confidential.

Informed consent

Informed consent was obtained from the participants prior to interview. Sufficient information was presented (in understandable language) so the potential subject could make an informed judgment about participation. Prospective participants in the research study were briefed on the purpose, procedures, and potential risks and benefits of their involvement. (Details provided in Appendix 4.)

Chapter 4: Findings

This section presents this assessment's primary findings. The findings are divided into four sections describing the program's strengths and weaknesses as well as the opportunities and threats potentially affecting its performance. Table 7 presents a summary of the findings, reflecting the current status of the program.

Table 7: SWOT Analysis of the LHW Program

Strengths	Weaknesses
• Community-based network of PHC providers serving half the population of Sindh • Full support of policymakers to strengthen the program • Respect and appreciation of communities • Monthly meetings being held regularly • Data on maternal deaths being collected	• Deviation from original mandate • Weak supervision • Issues of payment of salary and lack of funds to meet operational costs • Lack of new and refresher trainings • Lack of commodities, including medicines and contraceptives • Vehicles unserviceable and in a state of disrepair • Poorly functioning referral system • Weak Management Information System (MIS) • Ineffective Community Support Group Meetings • Frequent Managerial Turnover • Meetings not linked to achieving pre-defined outcomes such as onsite trainings
Opportunities	**Threats**
• Interest of Government of Sindh (GOS) and development partners in supporting and strengthening the program • Regularization, revamping and revitalization of the program • Consensus on enhancing coverage by Government of Sindh (GOS)	• Politicization and undue political interference • Gender-based victimization and sense of insecurity

4.1: Major Strengths

Provision of Primary Healthcare Services to Half the Population of Sindh

At present, nearly 46 percent of Sindh's population is covered by the LHW program. These workers are the only source of primary healthcare to homebound rural woman who are being provided advice, information, preventive, and minor curative services at their door.

> *"The services of LHW are very useful to the village people. She provides door-to-door health facilities such as providing vaccination to children, giving TT shots to pregnant women and discussing family planning (FP) issues. Since, all of us work in agricultural fields, we do not have time to visit the hospital; therefore, it is really useful and timesaving for us when LHWs provide us all the general medicines and treat us for common cold and flu."* FGD, Community Woman, Sanghar

"The things that we can't share with our mother or mother-in-law, we can easily talk about them with the LHW because, apart from being friendly, she also provides great advice. We give a call to the LHW if we are facing any health-related problems. No matter what time of the day it is, she visits us right then, does the check up, and if there is a need, takes us to the doctor as well." FGD, Community Woman, Sanghar

According to feedback from community members who are beneficiaries of the program, LHWs are visiting their homes at least twice within three months. Their primary advice concerns FP, nutrition, and the importance of ANC and delivering at a health facility. They also immunize children, administer polio drops, and conduct TT vaccinations of pregnant women.

"Our LHW is really useful to us. She answers all our queries and also asks us to get our children vaccinated. However, the problem is this that she herself does not receive the supply of medicine. Whenever she gets it, she gives it to us." FGD, Community Woman, Larkana

"She gives polio drops and various other vaccinations to our children, emphasizes the importance of breastfeeding, (and) provides iron supplements and other general medicines. The LHW was providing a good service before as well as now. Her responsibilities and number of visits to our homes have increased." FGD, Community Woman, Larkana

"She gives polio drops to children, provides medicines, gives information about family planning issues, gives TT shots to pregnant women, and helps solve their other health issues as well, and accompanies clients to the hospital." FGD, Community Woman, Larkana

Support of Policymakers and Future Vision

All policymakers unanimously acknowledged LHWs' pivotal role in the health delivery system and describe it as the backbone of the system. All agree that the program needs to be strengthened with enhanced funding, integration with other vertical programs, better monitoring and supervision, and in the long term, plans for expansion to incrementally reduce unserved areas. They mentioned that a PC 1 is to be developed with USAID support that would take into account these considerations.

"No doubt, health indicators have improved through LHWs' efforts, especially in terms of immunization coverage." Policymaker, Sindh

"The specific strength of this program is that the Health Department has a large community-based workforce in the shape of LHWs. However, we need to utilize their services and expertise more effectively and efficiently through improved supervision and better accountability." Policymaker, Sindh

"The Health Department has 23,000 LHWs, which is a big health force." Policymaker, Sindh

"We cannot deny the important role of LHWs in immunization. We are contemplating introducing financial incentives for improving immunization coverage. In Bangladesh, they are offering 50 cents per immunized family." Policymaker, Sindh

"The LHW cadre is a good human resource of the Health Department." Provincial Manager, Sindh.

"The LHW Program is one of the topmost priority programs for the Department of Health as it is the only program that is ensuring that preventive services are offered at the community level." Policymaker, Sindh

"The huge workforce of 23,000 can be a game changer as it has the potential to improve the health indicators of the province by influencing health behaviors. I am a firm believer that this program should be strengthened because this is the backbone of our health system." Policymaker, Sindh

"The plan is to increase the catchment area of each LHW from a population of 1,000 to 1,200. It is also proposed in the PC-1 that new recruitments will be conducted to extend programme coverage, with one new LHW being appointed for every additional population of 1,200. In this way, non-covered area will decrease." District Manager, Sanghar

"I salute the cadre of LHWs who are working at a very low salary and for their efforts for polio eradication. LHWs are the backbone of the health system. The major motivating factor that is enabling them to work even in adverse circumstances is that they belong to the communities where they are working and, hence, they feel a sense of responsibility and obligation to serve their communities." Provincial Manager, Sindh

Policymakers are now in the process of developing a PC-1 to cover the program's operational costs and help strengthen it.

Respect and Appreciation Among Communities

All program managers as well as the beneficiaries who participated in IDIs and group discussions appreciate the services LHWs provide. Community women respect, value, and follow LHWs' advice for all health-related matters. LHWs visit homes at least twice within three months, and at times, they may visit twice in the same period due to polio vaccination days.

"The LHW is doing a great service to our community. She provides us health-related information; gives polio drops to children; educates us about family planning, [and] mother and child health, and provides contraceptives." FGD, Women, Larkana

"The LHW is providing great services and is friendly towards us. She provides us various medicines for fever, flu, weakness and children related [ailments] at our doorstep. She also administers [immunization] injections to children and TT vaccinations to women during pregnancy. She provides us information about family planning, mother and children health and vaccinations. We are really satisfied with her services and hope that she will continue to provide them in the future as well. She has made things a lot easier for us by providing all the health services at our doorstep. Moreover, we can easily discuss any health-related issues if the need arises." FGD, Women, Sanghar

"LHWs are very helpful and useful for us. Since they are women of our community, it becomes really easy and feasible for us to visit them. Moreover, they also keep coming to our houses. Not only does [the LHW] answer our health-related queries but also gives additional information on usefulness of providing vaccination to pregnant women and children, spacing, and other family planning techniques. She also recommends that we visit the doctor if the need arises. [LHWs] should be provided with stocks of general medicines and contraceptives as well as blood pressure apparatus." FGD, Women, Sanghar

Monthly Health Facility Meetings

According to the LHWs and LHSs, despite challenges related to frequent polio campaigns and financial constraints, the LHWs are managing to regularly attend the monthly meetings held at health facilities mainly so they can interact with their supervisors.

In both districts, LHWs attend regular monthly meetings at the start of the month. In this meeting, LHWs visit the attached health facilities to submit their monthly performance reports to their LHSs. The reports are checked by the LHS and feedback given to LHWs.

"Every month, the meeting is conducted regularly at the center. We also check their reports and discuss any issues. For instance, one woman was not agreeing to undergo tubal ligation, but when I visited her and explained everything, she agreed." FGD, LHS, Larkana

"The main purpose of the monthly meeting is to submit the report and to provide an opportunity to LHWs to discuss any issues they might encounter during their field visits with the LHS." In-charge, Secondary healthcare facility, Sanghar

However, there is variation in the frequency of meetings between the two districts. In-charges of facilities visited, LHSs and LHWs from Larkana stated that only one monthly meeting is conducted for report submission. However, in Sanghar, the interviewed health facility managers and LHSs said they conduct two meetings a month. The first meeting is focused on report submission whereas the second is held in the middle of the month to assess the knowledge of LHWs on different health-related topics. Through these tests, gaps in LHWs' knowledge are identified and then the LHS and facility in-charge conduct sessions to fill the gaps. Although LHWs in Sanghar also mentioned that they attend two meetings every month, the first for report submission and the second for discussion on field issues, they did not mention any knowledge test.

"LHWs gather at the facility at least twice for the monthly meetings. The first meeting is conducted on the first day of the month while the second one is conducted on the fifteenth day. The first meeting deals with the issue of reporting while the second one includes a monthly test. There was a DCO, Mr. Hali, who recommended that we organize a meeting on the 15th of every month in order to inform LHWs about any recent development, discuss their problems, and to conduct a monthly test. The monthly test usually covers the topics such as EPI, polio, family planning, mother and child health, et cetera. These tests are conducted in order to check the knowledge level of LHWs. When we grade these tests, we are able to identify the areas of knowledge gaps and discuss them in subsequent meetings." In-charge, Primary healthcare facility, Sanghar

"We meet with our LHWs twice a month at the facility and in the field. LHWs come to the facility in the starting days of the month… and we also visit our LHWs twice a month, which is our target. LHWs also come on the 15th or 16th of each month to appear in a test that we conduct for them. We also meet with them on each Monday at our facility, when LHWs come to collect EPI vaccine. During the polio campaign we meet with them too." FGD, LHS, Sanghar

Working Hours

Time in Community

According to LHWs who participated in group discussions, they spend 60 to 80 hours per month within communities and 20 to 40 hours at facilities. This implies that they are working 80-120 hours per month which does not include time spent on polio related work. At facilities their time is spent in meetings, polio trainings, or with clients they have accompanied for further management. While the program has not prescribed how many hours an LHW should work, it has suggested a working week should comprise around five hours per day, six days per week (Oxford Policy Management, 2002). According to these criteria, LHW's are spending adequate time in the field. After regularization, however, this should be redefined.

"We spend almost two to three hours in field every day because there are few clients whom we have to convince about family planning methods or do their overall counseling which requires time. Therefore, if we add these hours, in total, we spend at least 60 to 80 hours in community in a month." FGD, LHW, Sanghar

"We spend three to four hours in field every day and then take a day off in a week. If there are many pregnant women in the community we measure their weight. LHWs have to spend more time in the field. If husband of any woman is not in favor of spacing, then we also talk to him and convince him about the advantages of spacing. We spend about 80 to 90 hours in our community per month." FGD, LHW, Larkana

"We visit five houses every day. Duties of our home to home visits include meeting pregnant women and giving them advice about family planning issues, discussing other health-related problems, answering their queries… All this takes about three to four hours per day. Therefore, we spend

almost 60 to 80 hours in a community. However, this estimate does not include the time spent during polio campaign, where we work extra hours." FGD, LHW, Sanghar

Time at Facility

"We have to go to the facility at least three times in a month where we have to spend four to six hours on each visit. Overall, we spend 15 to 16 hours in a month as we have to attend the meetings, accompany the pregnant women and collect stock. Sometimes we have to spend even more time if facility is overburdened with patients." FGD, LHW, Larkana

"We necessarily have to attend at least two monthly meetings conducted at the facility. We have to come to the facility to collect the stock of vaccine and to submit monthly report. Moreover, we also accompany a client to facility for her checkup or follow up visits. Therefore, 35 to 40 hours are being spent at the health facility, every month." FGD, LHW, Sanghar

"We go to health center to take any TB or other referral cases, to collect stock, attend monthly meeting for polio training. These activities take up to 30 to 35 hours in a month." FGD, LHW, Sanghar

Maternal Mortality Conferences

In the absence of a functional vital registration system, at present LHWs are the only sources of data on maternal mortality, which are only collected in LHW areas.

A Maternal Mortality Conference is conducted every month under the chairmanship of the DHO at the office of the DHO or the District Coordinator, LHW Program. At these meetings, the Lady Health Supervisors submit the consolidated monthly reports of LHWs working under their supervision. They discuss issues and problems faced by the LHWs during field work. They also report any maternal death occurring in the community. This is also the forum where the LHSs receive feedback from the managers (DHO and District Coordinator) on their own performance as well as that of LHWs.

Lady Health Supervisors have pointed out LHSs that they have to pay to attend these conferences, with reimbursements after long delays.

"We give feedback through the Maternal Mortality Conference and monthly meetings." FGD, LHS, Larkana

"We provide feedback to LHSs on the reports of LHWs during the Maternal Mortality Conference. The District Coordinator decides when it will happen and where. LHSs come to this meeting with full preparation and records. The DHO is the chairman of the Maternal Mortality Conference." District Manager, Sanghar

"A Maternal Mortality Conference is conducted in the second week of every month. If its date coincides with the polio campaign, we organize it on some other day but it is conducted every month, without fail." District Manager, Larkana

"LHSs provide their performance report to the DHO in the Maternal Mortality Conference and explain the issues faced during the field." District Manager, Larkana

"The DHO asks about the maternal death record from the LHSs and we also verify the deaths from the community." District Manager, Larkana

"Any reported maternal death is analyzed in detail. If any maternal mortality occurs in the community, the Assistant District Coordinator and LHS conduct a verbal autopsy in order to investigate the main cause of death." District Manager, Larkana

"The Maternal Mortality Conference is attended by the ADC. If a maternal death occurs, the ADC goes to the field for its verification." District Manager, Larkana

"We are conducting verbal autopsies of maternal deaths, monitoring visits and Maternal Mortality Conference meetings from our own pocket as we are not getting any funds for operational costs regularly from the provincial department. Although reimbursement of the cost is received from the department after three to six months, initially, we spend this amount from our own pocket." District Manager, Sanghar

4.2: Major Weaknesses

Deviation from Original Mandate

Over the years, new skills and responsibilities have been added in the portfolio of activities of the LHWs. This has contributed in steadily enlarging their scope of work to include services for which they were not originally mandated. New activities in which they have become involved include the polio eradication initiative; TB Direct Observed Therapy; malaria control; health emergency response activities, such as floods and earthquakes; and disease surveillance. However, in recent years, they have become increasingly occupied with polio eradication, which has caused them to deviate even more from their original stipulated tasks.

Interruption by Polio Activities

The polio eradication Emergency Action Plan (2013, Government of Pakistan) mandated that each of the approximately 80,000 mobile teams deployed in polio campaigns include a female worker. As there were few other women in the government health systems, LHWs were included as an essential part of the polio workforce. Currently, about 81 percent of all LHWs are engaged in each campaign. They contribute through health education and door-to-door delivery of polio vaccine. More importantly, as most LHWs are locals and known to the communities, their presence mitigates the chances of refusal.

"The original mandate of the LHW Program was to provide family planning services at community level, which is also the mandate of PWD. Family planning is the lowest priority of the Health Department. That is why they are not focusing on family planning and involving LHWs in polio, EPI and TB programs." Policymaker, Sindh

"The LHWs are overburdened due to all the responsibilities of vertical programs like polio, EPI, TB DOTS, nutrition, measles, and family planning." Policymaker, Sindh

"The role of LHWs has been modified from their original mandate. They have become just polio workers and vaccinators. LHWs are not responsible for this; they are performing as their seniors are asking them to." Policymaker, Sindh

"They were originally identified for provision of family planning and primary healthcare services but they are now overburdened and, [especially with] the extra activities of polio immunization, they have been sidetracked." Policymaker, Sindh

"A major programmatic concern has been refocusing of LHWs' priorities, and their work is mainly directed towards polio eradication activities, leaving no time for the other primary healthcare activities described in their original mandate." Provincial Manager, Sindh

"The primary mandate was to provide family planning and primary healthcare services at the community level. We have deviated from our original mandate." Provincial Manager, Sindh

There is now a growing realization at all levels of the health system that LHWs have been overburdened by polio tasks, which need to be rationalized so that they can return to their original tasks. According to the LHWs, their participation in polio activities is adversely impacting upon their routine work in several ways. First, their scheduled activities are being disrupted and they cannot carry out home visits according to their monthly plan.

Second, they cannot accompany clients to the referral facilities, which results in lowering their credibility. Engagement of the LHSs in polio activities also prevents them from following their routine supervisory visits.

> *"Polio interrupts our routine work because we have to do it anyhow. During polio days, we cannot maintain our registers, perform our daily visits and even we cannot have our monthly meetings in these days. No other work or duty can be done during polio days."* FGD, LHW, Larkana

> *"The polio campaign has seriously affected our core work. Initially, it was conducted only three to four times in a year, however, now we spend a considerable amount of time in polio campaign every month."* FGD, LHW, Sanghar

> *"The involvement in polio campaign does not allow us to perform our core duties. During polio campaign, we are unable to treat our family planning clients who might miss the date of their contraceptive injectables; also we are unable to update the record of any new children born in those dates and cannot do the follow up. Moreover, even after all this we miss on any polio case, it is really disheartening."* FGD, LHW, Sanghar

> *"During polio days our routine duties get neglected especially there is problem for delivery cases. Our routine schedule gets disturbed. We are not interested in doing polio as it increases our work load a lot and do not pay us enough but we have to do it forcefully." FGD, LHW, Larkana*

> *"The polio campaign is carried out twice a month. This has, in turn, increased the workload for LHWs. On average, four to five days of every month are spent in polio-related activities. As a result of this, LHWs are not able to perform their own duties effectively and efficiently."* IDI, In-charge, Primary Healthcare Facility, Sanghar

> *"We are unable to perform our routine work efficiently due to the polio campaign. Sometimes, the polio days conflict with the clients' appointments for TT shots, regular check-ups and vaccination of their children. When we are forced to postpone visits to clients, they do not welcome us cordially [when we visit] at later dates and, in some instances, they refuse to avail our services any longer."* FGD, LHW, Sanghar

Weak Supervision

A key managerial weakness identified related to program effectiveness was weak supervision, due mainly to two reasons: an inadequate number of supervisors and lack of logistic support for supervisory visits. According to the original mandate of the program, there should be one LHS over every 20 to 25 LHWs. Currently, in Sindh, 770 LHSs are supervising 22,576 LHWs, which means each LHS has to supervise 29 LHWs on average. Ideally, based on our calculations , there should be at least 900 supervisors available.

Similarly, provincial supervisors such as Field Program Officers (FPOs) are also unable to frequently visit and supervise the work of the district supervisory staff due to lack of resources to cover operational costs.

The lack of logistic support can be gauged by the fact that most of the program's vehicles have had to be taken off the road due to lack of funds for repairs and maintenance. Currently, only 172 out of 954 vehicles are functional. Furthermore, there are insufficient funds for provision of adequate amounts of POL to LHSs. Due to lack of logistic support, the frequency of supervisory visits has been reduced. Therefore, real-time monitoring is not taking place. In most instances, supervisors have to pay from their own pockets to travel to facilities where LHWs are attached and also to the health houses of the LHWs.

> *"We have vehicles provided by National Program, but they are out of order. Since 2010, they have not given POL or maintenance cost for our vehicles. Without POL and repair and maintenance cost, it is difficult to visit as per plan. We used to arrange our personal vehicle for field visits. Most of the time we borrow money to cover field expenses because salary always released late. Since last five months we have not received our salary."* FGD, LHS, Sanghar

"LHSs are facing serious transport issues. For last four to five years, their vehicles have not been repaired. Due to non-availability of transport, they are unable to make visits to LHWs to monitor their performance." IDI, In-charge, Secondary Healthcare Facility, Sanghar

"Vehicles are out of order and due to this LHSs are not able to do monitoring. We don't have [a budget to meet] operational cost or POL for monitoring visits. When we don't have a budget, we cannot repair the vehicles." District Manager, Larkana

"We usually make the plan at least a week in advance for the following month and then we discuss it with LHWs during the meeting. However, sometimes we are unable to visit the LHWs in far off areas because of lack of POL." FGD, LHS, Larkana

However, despite the difficulties mentioned above, the supervisors are trying their best to carry out their duties as effectively as possible. They try to visit each LHW under their supervision at least once a month. Confronted with lack of petrol for their vehicles, they make their own arrangements, such as travelling with husbands on their motorbikes. Furthermore, according to the existing rules, all supervisors are allocated a fixed amount for POL of 70 liters despite the distances they have to cover.

"If I go by bus to visit a LHW, it would drop me at the stop, and again I have to cover the distance of one to two kilometers on foot. Therefore, I ask my husband to drop me in the field on his motorcycle. However, I am not even entitled to Fixed Travel Allowance because they say I already have vehicle and whether it is working or not, government has no responsibility. "I try to visit every LHW at least once a month, however, my field visits are affected due to non-availability of vehicle." IDI, LHS, Sanghar

"The main challenge in our work is non-functional vehicles." IDI, LHS, Sanghar

"I visit LHWs, making my own transport arrangements, as there is no POL available for the official vehicle. Often, I travel in a rickshaw. I do not get compensated for… traveling and doing my work, as I am not entitled to a fixed travel allowance." IDI, LHS, Larkana

A third problem is the supervisory process's over-reliance on checklists, which shifts focus from problem solving and limits the extent to which LHSs are able to help LHWs with technical issues. In Sanghar, for instance, the evaluation team observed an LHS as she visited the health house of an LHW. The LHS meticulously went through all records, including the household register, the LHW's daily diary, treatment register, growth monitoring chart, and previous monthly reports. All reports were reviewed and cross-checked, with suggestions provided. The LHS checked that the statuses of pregnant women and FP users were updated regularly, and then instructed the LHW to update some of her records, which had not been done because of polio activities. It was observed, though, that LHSs typically do not ask LHWs if they face any problems in the field, or attempt to explore with them ways of resolving them through on-the-job training.

Salary Payments and Lack of Funds for Operational Costs

In the pre-regularization period, the salary of an LHW was 7,000 Rupees. Salary support was provided by the Federal Government until 2015, and later assurance was given that federal funding support would be extended to 2017. (No written assurance has been received, however.) While the provinces of Punjab and Khyber Pakhtunkhwa (KP) have developed their separate PC-1s to secure provincial government funding, this process has only recently begun in Sindh. After regularization LHWs were placed in Grade V and are eligible for the salary for that grade, about 15,000 Rupees, effective from the date of their regularization, in 2012. This additional amount has yet to be raised by the Government of Sindh.

In the meantime, the release of funds by the federal government is also delayed and, as a result, most of the LHWs do not receive their salaries on time. Most LHWs interviewed had not received their salaries for the past four to six months and, as a result, arrears are accumulating.

In a January 27, 2015 letter, the Provincial Coordinator for the National Program for Family Planning and Primary Healthcare of the Provincial Program Implementation Unit (PPIU), Sindh, Hyderabad, informed the Secretary of Health that "Since the capping of National Program for Family Planning and Primary Healthcare from July 2012 at Rs. 2,310.528 million, there is serious and significant shortfall in the funding to execute many activities as per approved scope of program. From this amount, hardly the salaries and a bit operational activities of PPIU could be met and rest remained standstill." The estimated requirement for the next financial year, 2015-2016, is 5,671.77 million Rupees, and it was requested that the scheme may be included in 2015-2016 Annual Development Plan (ADP). The letter further pointed out that over the last few years insufficient funding has had a negative bearing on program activities and outcomes. The regularization of program staff entails an additional requirement of approximately 1,500 million Rupees per year, still awaited from the Federal Government. (A copy of the letter (Ref. NP/Estt-Sec1'/-1316/21) is provided in Appendix 9.)

The Provincial Coordinator, in a letter to the Secretary of Health dated March 19, 2015, requested the Secretary to approach the Finance Department for allocation of funds in compliance with the orders of the Supreme Court of Pakistan. The Provincial Coordinator of the LHW Program also developed a Statement of New Expenditures (SNE) to shift the salary component to non-development, regular budget. (A copy of the letter [Ref: NP (A/c - File)/Budget/2014-15 (3385/92)] is provided in Appendix 10.)

Delays in salary payments create problems for LHWs. Unable to meet household expenditures, they face criticism from family members. Because they do not receive salaries on time, and need to further enhance their household income, nine LHWs of the 118 who participated in FGDs were engaged in additional work.

> *"My husband said, 'You do not receive salary and still you spend the whole time outside home. It seems as if you really enjoy being outside.'"* FGD, LHW, Sanghar

> *"My husband said, 'I will throw you outside the home, if you do not receive your salary this time and if you still insist on working, I will divorce you.'"* IDI, Medical Officer, Primary Healthcare Facility, Sanghar

> *"There has not been any change even after the LHWs have been made regular. We do not receive regular salary; there are delays up to four months due to which we usually have to take a loan to run the household. Then, eventually, when we receive the salary after a delay of many months, it is spent in repaying the loan."* FGD, LHW, Sanghar

> *"Things don't change by making us permanent employees. We don't get paid regularly. Our economic position will only get better if we get our salary on a regular basis. We end up taking loans from people… We get demotivated."* FGD, LHW, Sanghar

> *"We do not receive the salary regularly. If we receive it without delay for two months, then after that, again, there are long delays."* FGD, LHW, Sanghar

> *"Although we have been made permanent [employees], however, we still do not receive our salary on time. Due to continuous inflation, it has now become really difficult to run our homes in such a limited salary."* FGD, LHW, Larkana

> *"We don't receive salary on time. Moreover, the bank deducts a handsome chunk of our salary on account of various charges. The salary should be transferred through some other method."* FGD, LHW, Larkana

> *"We do not receive our salary on time. We receive our salary after four months and even then we only get half of the total amount; and we are told that the rest of the amount will be sent after two months."* FGD, LHW, Larkana

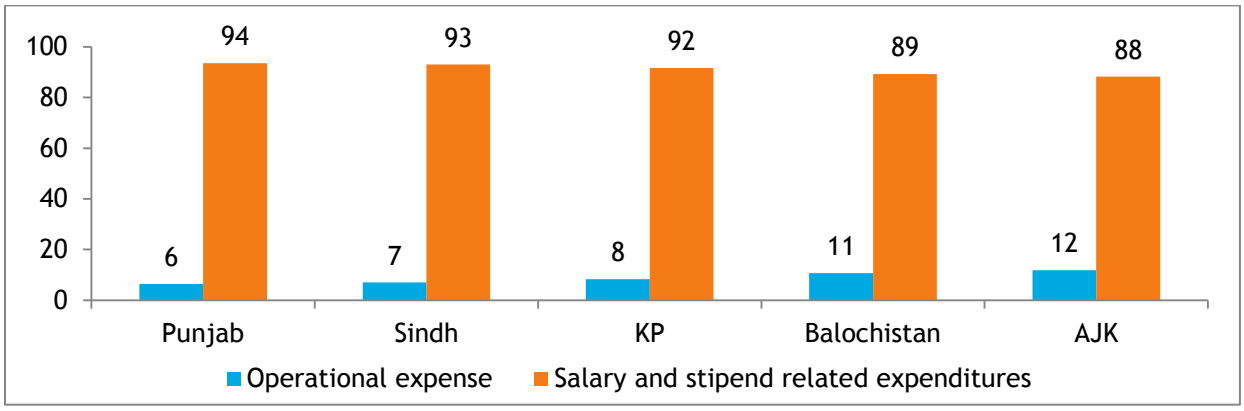
There are two options available to the Department of Health:

a) To develop a new PC-1 and receive funding from the development head for covering operational costs or draw up an SNE and request allocation of funds by inclusion in the Annual Development Plan currently being developed for funding the LHWs salary through non-development expenditures; or

b) To request the provincial government to provide bridge financing as an interim stopgap arrangement.

As Figure 2 shows, there is a great imbalance in the distribution of funds for salaries and for operational costs in all provinces. Current expenditures are disproportionately for salaries while operational costs are undervalued, resulting in lack of funds for procurement of supplies, POL for vehicles, and reimbursement of LHWs' travel costs for meetings. This has an adverse impact on program effectiveness.

Figure 2: Distribution of salary and operational expenditures for 2014-2015, by percent



Source: PC-1 - The Lady Health Workers Programme January 2010 - June 2015. National Programme for Family Planning and Primary Health Care. Islamabad: Ministry of Health, Government of Pakistan

Weak Coordination Between Health and Population Welfare Departments, PPHI, and MNCH Program

Secretaries of both the Health and the Population Welfare Departments acknowledged that there was very little coordination between the two departments at the provincial level. Although there are a number of coordination mechanisms at this level, such as the Provincial Technical Committee, Provincial Coordination Committee, and Commodities Security Committee, these forums are not meeting regularly. According to the Secretary, Population Welfare, at the district level, the forum of the District Technical Committee (DTC) is available at district level, yet collaboration between the two departments is highly dependent upon the interest of individuals. He gave the example of Sanghar where the District Coordination Officer (DCO), National Program and DPWO had a good working relationship and, consequently, LHWs were referring clients to FWCs (which are under the jurisdiction of the Population Welfare Department). Weak coordination was in the areas of referral, joint trainings, joint monitoring, and supervision.

> *"Provincial level coordination can be improved if the PTC is headed by the Chief Secretary of the province."* Policymaker, Sindh

> *"There was no formal institutional coordination mechanism at the provincial level that could ensure that both the departments work collaboratively."* Policymaker, Sindh

> *"While there are many forums for coordination such as Provincial Coordination Committee, Commodities Security Committee, Provincial Population Council, these forums have not met for a long time and coordination is therefore weak. Currently there are no plans at any level to integrate the services of the LHWs with the Population Welfare Department."* Policymaker, Sindh

"There is a complete lack of coordination between the PPHI and the LHW Program. Facility in-charges are under no obligation to support the LHWs as there is no well-defined working relationship between the programs." Provincial Manager, Sindh

"LHWs are reporting at BHU level to their LHSs. We have given them space but they have their own management system. The LHW Program is a separate entity from PPHI. The MOs at the facilities only interfere when they find missing or wrong data entries. Since they are not directly linked with LHWs, they discuss these issues with LHSs. LHSs submit the field plans of their LHWs and also their own to our MOs." District Manager, Sanghar

A major anomaly in coordination is the lack of support being offered by PPHI to the LHW program. In the past, before the takeover of the BHUs by PPHI, the medical officers of the health facilities were actively involved in supervising and training of LHWs. However, PPHI does not consider providing support to the LHW program as part of its mandate. The provincial heads of both the programs admitted that there is a lack of clarity regarding the administrative control of the LHWs at the facility level. A review of the agreement between the Health Department of Sindh Government and the People's Primary Healthcare Initiative (PPHI) Sindh mentions wide clause (6) that "The PPHI Sindh shall arrange due participation of the Rural Health Facilitiess and discharge of such functions by the Rural Health Facilities as are required by the national and/or provincial curative and preventive programme in the primary healthcare sector"

At present vertical programs are working independently. However, according to the Secretary Health Sindh, there are plans in the future to establish an umbrella directorate that functionally integrates the various programs. At the district level through efforts of JSI, DHPMTs are becoming functional in their program districts. This can be an effective forum for district level integration of activities.

Lack of New and Refresher Training

For the past four years, LHWs have not received any new training organized through departmental funding. However, some training events have been organized by UNICEF; USAID, through its MCHIP Project; HANDS. UNICEF has been involved in the following:

- Organization of Mother and Child Health Week twice a year in April and June;
- Printing of Management Information System (MIS) tools for three years (2015–2018);
- Capacity building of LHWs in child care, infection prevention and other MNCH-related tasks;

USAID has been involved in the provision of refresher trainings to LHSs in nutrition.

Program Managers' Perspectives

The need for training of LHWs was acknowledged by program managers.

"LHWs should be provided trainings on new methods of family planning." Policymaker, Sindh

"They have not received any new training for several years, except for trainings imparted by FALAH [Family Advancement for Life and Health project] in some districts some time ago." Provincial Manager, Sindh

"The underlying philosophy of the LHW Program promotes the principles of primary healthcare and FP but the LHW Program has deviated from its original mandate. It should revert to its original mandate and, for this, LHWs should be provided refresher trainings." Provincial Manager, Sindh

"There is a lack of trainings. LHWs should be given regular trainings to improve their knowledge and skills." District Manager, Larkana

Perspectives of Health Facility Managers and Supervision

In-depth interviews with in-charges of health facilities also revealed that LHWs are in dire need of refresher and new trainings. They have recommended that they should be given refresher trainings from time to time in order to ensure that they have all the necessary skills for treating minor ailments, providing nutritional advice and treating micronutrient deficiencies, counseling, and offering contraceptive choices. The managers have also suggested training LHWs in intrauterine contraceptive device (IUCD) and implant insertion. According to the managers, trainings could improve their work and capacity. Most of the in-charges of health facilities said there was a need to review the basic manual of LHWs and to revise it to reflect new ground realities and changing disease patterns. Moreover, LHWs should be informed about the importance of the referral system.

With regard to coordination with the MNCH program, the LHSs were supposed to provide supervisory support to the LHWs but, according to the Provincial MNCH Director, this support is no longer available as the LHSs do not have POL or vehicles, and so they cannot undertake supervisory visits.

> *"Work-related trainings and refresher sessions should be organized for LHWs. LHSs should also be provided refresher trainings for any new methods introduced so their knowledge remains up-to-date and they are therefore better able to explain to LHWs."* IDI, LHS, Sanghar

> *"If we cannot have monthly sessions with LHWs, then we should at least conduct quarterly sessions where we can equip them with the necessary information. Although LHWs are given a number of trainings, their basic training is not very strong, which is reflected by the poor quality of the ANC services they provide to their clients. As our basic training is in ANC, so in these sessions, we can improve their knowledge in this regard."* IDI, Woman Medical Officer, PWD facility, Larkana

LHWs' Perspectives

All LHWs also reported that trainings are highly beneficial and enhance their capabilities. They mentioned that they used to receive a number of trainings but, for a long time, have not received any. In the past, they have attended trainings on mother and child health, AIDS, malaria, TB, behavior change, oral rehydration solutions (ORS), FP, etc. Now they only receive trainings on MCH and polio during their respective campaign days.

> *"The MCH training is organized twice a year. Trainings on all other issues were held three to four years ago. We have not received trainings on these topics since then."* FGD, LHW, Sanghar

> *"Initially we used to receive training on the topic of MCH. Then, we received training about eye hygiene, EPI vaccination and TT, breastfeeding, hepatitis… Now, only training in MCH is being held after every six months."* FGD, LHW, Sanghar

> *"We used to get trainings about mother and child health, how to prepare ORS to cure diarrhea, how to take effective care of eyes. Behavioral trainings were conducted by FALAH. During these trainings, we were taught how to communicate effectively in the community and the importance of punctuality was emphasized apart from discussing MCH and family planning issues. The trainers answered all of our questions very patiently and we enjoyed being part of those trainings."* FGD, LHW, Sanghar

> *"If we are given proper training then we can also give the first dose of injectable contraceptive to the women. We have been working in the field for 10 to 12 years and know all the questions that women usually ask. Therefore, we are fully capable of [giving the injection]; it is just that we need the basic training."* FGD, LHW, Sanghar

LHWs commented on the quality of the various trainings they have received in the past. Although they attended some of the trainings a long time ago, they remembered their experiences. They reported that they learned a lot from the events where trainers were competent and their manner was friendly, respectful and encouraging. They did not like the way the current trainings were being imparted and therefore did not find them interesting.

"The quality and content of trainings four years ago was very satisfactory and they were held very regularly. However, we have not received any training for the past few years, nor have we been informed about any new illness." FGD, LHW, Sanghar

"Also, FALAH training was quite useful as it told us how to convince our patients to opt for family planning methods." FGD, LHW, Larkana

"We really want to have refresher training to increase our level of knowledge. It should be provided concerning measles, family planning, and mother and child health. Through the training of pregnancy related issues, we realized the importance of regular check ups. Moreover, training in mother and child health has played a crucial role in lowering maternal and infant mortality." FGD, LHW, Larkana

In addition, all LHWs reported needing refresher trainings. They believe refresher trainings would enhance their knowledge and skills, and also enable them to address community questions on different health issues. They would like refresher trainings on measles; MCH; FP including dealing with contraceptives side effects; counseling; TT shots; health and nutrition; symptoms of high risk pregnancy; and giving the first dose of injectable contraceptives. Almost all LHWs also said that they were keen to learn about new FP methods as many of their clients wanted newer options.

"There is a strong need for us to undergo refresher trainings to review and increase our knowledge, especially with regard to key health issues like measles, family planning, and maternal and child health." FGD, LHW, Larkana

"We have a strong desire to attend refresher trainings on a regular basis to help us perform our duties more effectively. Trainings should include the topics that are especially vital for us nowadays, which include vaccination for children and women, family planning techniques, cleanliness, and administering the first dose of injectable contraceptives." FGD, LHW, Larkana

"All of us want to receive refresher training at least three to four times a year as it helps us to revise what we have previously learnt. Sometimes, we are not able to answer the questions raised by members of the community. These refresher trainings would, therefore, prove to be quite useful for both LHWs as well as the communities." FGD, LHW, Sanghar

"We need refresher training because a lot of time has passed since we received our basic training. Therefore, there are a number of things that we have forgotten about. If any woman during our community visit asks us about the side effects of oral pills, or why her weight is increasing due to contraceptive injectables, we do not have any information and usually consult our LHS. We should be given refresher courses on the topics of mother and child health, family planning, TT shots, health and nutrition, what are the symptoms of high risk pregnancy and how should it be managed, how to take care of an infant, and on issues of general health." FGD, LHW, Sanghar

Stock Outs of Medicines, Equipment, Contraceptives

The study teams inquired from key stakeholders about the supply of medicines, contraceptives and equipment to LHWs, all of which are critical for the program to effectively deliver doorstep services to communities. The 2009 evaluation of the LHW program by OPM had found that supply of all three sets of commodities was compromised in all four provinces in the country, resulting in frequent and protracted stock-outs due to which LHWs were left empty-handed and unable to provide their clients the medicines, FP methods and treatment they required. This problem was found by the 2009 evaluation to be most acute in Sindh.

The current assessment shows that the problem persists, and there are substantial weaknesses in the three areas that include medicines, contraceptives, and equipment, requiring a renewed focus by the program.

General Medicines

Staff at health facilities acknowledged that LHWs do not have sufficient supplies of general medicine:

> *"LHWs usually do not have general medicines available. After a period of three years, only two months ago, the LHWs were provided with the stock of general medicines. When they do not have the stock, they are reluctant to go to the field. No budget has been allocated for general medicine, nor can they buy it directly from the shop."* IDI, Medical Officer, Primary Healthcare Facility, Larkana

> *"The stock that LHWs get is very low. In a population of 1,000, there is hardly enough medicine for 20 households."* IDI, LHS, Larkana

Apart from the adverse health impact, lack of medicines is negatively affecting the credibility of LHWs in the communities.

> *"Currently, none of the LHWs have any stock of medicines. In the past, they used to supply medicines frequently. For the past five years, there has been no supply of general medicine."* FGD, LHW, Sanghar

> *"We have not received any stock of general medicines for the last two years. People say that we sell those medicines."* FGD, LHW, Larkana

> *"People get angry with us, saying that you keep the stock for yourself and then sell it in the market. We face this situation by giving smaller quantities of medicines to clients, telling them that the rest will be given to them at the delivery of new stock."* FGD, LHW, Larkana

> *"When we are unable to give medicines to the clients, they accuse us of corruption and say 'You sell the stock in the market!' In such cases, we explain to the clients that we have not received any supply from higher authorities."* FGD, LHW, Larkana

Almost all of the community members who participated in the FGDs also complained of not receiving any medicine from the LHWs.

> *"Initially, LHWs used to provide us medicines, but not anymore. They do not complete the immunization course for pregnant women or for children. They are always short of medicines and contraceptives."* FGD, Community Woman, Sanghar

> *"Previously, LHWs used to provide us medicines but not anymore. Now they don't complete the immunization course for pregnant women or children. They don't have medicines. Their services are no longer useful."* FGD, Community Woman, Sanghar

> *"Before, they used to get stocks of medicines and family planning methods but not anymore. Due to this, she does not even visit our houses as often as before, and what is the point of just visiting when she does not have any medicine to give to us?"* FGD, Community Woman, Larkana

Contraceptives

Without contraceptives, an important component of LHWs' work remains unfulfilled and high unmet need for FP persists in communities. In almost all FGDs, LHWs reported that they receive pills and injectables but not on a regular basis. LHWs reported stock-outs of pills and injectables in four of the six FGDs held in Sanghar. Moreover, all LHWs who participated in FGDs, both from Sanghar and Larkana, said they had not received any condoms. Some had not received them in the past two months, while others had not received them for more than three years.

> *"We receive stocks of family planning methods, including pills and injectables. We give oral pills to all clients. We haven't received the stock of condoms for the last one year so condom clients have also started using oral pills."* FGD, LHW, Larkana

"The contraceptive stock has not been available for the last two months. The doctor at the facility asks us to provide them the client's name, only then they give them the first Depo [contraceptive] injection. Those who want the injectable, buy it from the market as it is easily available for 60 Rupees. A few women got pregnant as we were not able to provide them contraceptives since we were in the field doing polio [campaign-related work]." FGD, LHW, Sanghar

"I have a client whose husband uses condoms. Whenever I receive the stock of condoms, I give a few to them. Last time, when I visited her, she told me she was pregnant since she had run out of the stock of condoms and I had not provided her any for the last two months. She said, 'My husband is a maulvi *[religious figure]. He says, if you have any condoms, then I will use them. Otherwise, I will not buy them from the market. I give religious teachings to people; they will make fun of me if I buy such things from the shop. It will ruin my image.'"* FGD, LHW, Sanghar

"Currently, none of the LHWs have any stock of contraceptives or medicine. In the past, they used to give the stock frequently. For the past five years, there has been no supply of general medicine and we have not been given any condoms or injectables for the past four months. When we don't get any stocks of contraceptives, we ask the clients to buy the injectable with their own money but those who can't afford it end up getting pregnant." FGD, LHW, Sanghar

When the evaluation team asked district managers why contraceptives were not reaching the LHWs, they admitted that it was lack of funds that prevented the facility in-charges from transporting contraceptives to the facilities from where they could be distributed to LHWs.

"We have a major issue of supply of contraceptives due to lack funds; the LHSs who have functional vehicles take the stock with them whereas other LHSs sometimes take the stock on ambulances, paying for POL on their own. USAID asks us to supply the stock to LHWs but how can we do it as we do not have funds for POL to transport the stock." IDI, District Manager, Larkana

Reviewing the stock position reported through LMIS and the district monthly report of the DHIS for the period February and March 2015, we found a disconnect between reported figures regarding stock outs. According to the officials of the Deliver Project, such anomalies are resulting from lack of training of related staff which is now being corrected and the process streamlined.

Equipment

Most LHWs who were interviewed did not have Salter weighing scales or blood pressure apparatus. Some LHWs also mentioned not being provided ice for maintaining coolness for polio vaccines. The inadequate supply of medicines and equipment was directly attributed to lack of funds. Shortage of these supplies was also mentioned by women in communities.

"Department has not provided a cooler for keeping vaccines during polio days. I use my own cooler. I asked for ice to put in the cooler but they said that I should buy ice from my own pocket. So, in this situation, how can polio finish?" FGD, LHW, Larkana

"We received a thermometer, weighing scale and kit at the beginning of the program. Now, these items are not in working condition. The thermometers broke." FGD, LHW, Larkana

"BP apparatus and weighing machine should also be available [with the LHW], as the doctor charges us 60 Rupees to check blood pressure. If the LHW has these things, it is useful for us. We cannot go to the hospital again and again for minor ailments." FGD, Community Woman, Sanghar

IEC Materials and Stationery

Moreover, according to LHWs and program managers, no new IEC materials have been provided to LHWs for use in communities. There is also a shortage of printed stationery and, in some cases, LHWs have to make photocopies of official documents to maintain their records. Health house signboards are also missing.

> *"We do not have any type of stationery for our work. We don't have registers or monthly report forms available. We make photocopies at our own expense to submit our monthly report."* FGD, LHW, Larkana

> *"At the beginning of the LHW Program, each LHW had a signboard outside her home which declared it a health house. But since they became involved in polio, EPI and nutrition activities, those boards have been removed. Some LHWs have even removed their health house signboards as they have no medicines to give."* Provincial Manager, Sindh

> *"We don't have health house boards and do not get posters. At the beginning of our job, we had these things but now, over time, the posters are damaged and we need new posters for the health house."* FGD, LHW, Larkana

Reasons for Stock Outs

The most important reason is the lack of a formal system for demanding medicines and other supplies for the LHW program. Currently, the LHWs do not have any standardized form on the pattern of the CLR-6 for requisitioning supplies. A closer analysis of the issues contributing to stock outs and lack of equipment and supplies, apart from availability of funds, reveals underlying reasons:

- Lack of capacity of LHSs and ADCs to plan and demand appropriate quantities of medicines and contraceptives;
- Lack of a computerized system for submitting requisitions for commodities due to non-availability of functional information technology (IT) equipment and frequent power failures;
- Lack of storage capacity at BHUs for supplies for LHWs; and
- Lack of budget for transportation costs entailed in conveying contraceptives and other supplies to beneficiaries.

> *"Demand is not based on actual need and consumption. The district coordinator fills in the CLR-6 forms and sends them to the DG Health and Provincial LHW Program office. However, this is based on a fixed demand every quarter, and thus, it does not reflect the actual needs."* District Manager, Larkana

Poorly Functioning Referral System

For many communities, LHWs serve as the only link with the healthcare system. To ensure that these communities are able to access required services that lie beyond the capabilities of LHWs, a smoothly functioning system must be in place whereby LHWs can refer clients to appropriate health facilities and clients can receive adequate. This would also enhance utilization of health services and increase FP clientele.

> *"Although the LHW is not working with us, we find her quite useful as she brings a lot of cases for us. In this way, we are able to get quite a few family planning cases. She sends us the clients of tubal ligation and we take them to the RHS-A where these clients can get registered on the name of the LHW. There may be instances when the LHW is not available, however, for any such situation, she has already told her clients that they may go to the FWC directly to get the required family planning measures."* IDI, In-charge, PWD facility, Larkana

"If each LHW starts referring one client for implants, IUCD and contraceptive surgery every month, in one year, there will be 6,900 new cases and CPR could rise to 47 percent. There should be a formal working relationship between the PWD and the LHW Program." Policymaker, Sindh

"The LHWs refer very few patients to the facility. Usually, they just ask the client to visit the facility but do not provide any referral slip. During the meeting, when the supervisor asked the LHWs why they do not they give their clients the referral slip, they replied that if they give a referral slip to the client but she does not receive any priority at the facility, then, on the next visit of the LHW, they complain to her, saying that there is no importance of the slip." In-charge, Primary Healthcare Facility, Larkana

Lack of Prioritization of Referred Clients

Most LHWs reported that they referred, on average, eight to 10 clients per month to health facilities, mainly for ANC and delivery care. However, their referred clients were not given any respect or preferential treatment. In many instances, it was reported that the facility providers behaved rudely with clients and tore up and threw away their referral slips. Moreover, the presence of the LHW with clients does not make any difference as the client still has to wait in long lines with other patients. Both community members and LHWs complained about this state of affairs.

"Initially, whenever LHWs used to refer us to the hospital, we always used to go, but a number of factors, such as non-availability of doctor, lack of medicines, and poor quality of service, keep us from going there anymore. Most of the time, the LHW accompanies us to the hospital. However, even her presence does not make any difference; the doctor still behaves very rudely with us." FGD, Community Woman, Sanghar

"[Doctors'] behavior varies. Usually, our referral slip is not given any importance; the doctor throws it in the dustbin. Moreover, clients have to bear other expenses such as travel costs, et cetera, so they do not want to go to the health facility." FGD, LHW, Larkana

It was commonly reported that clients referred by LHWs are not received very well at health facilities, which is why LHWs also avoid referring their clients. They feel embarrassed in front of their clients when they are not received well. This also reduces their value in the community, and clients prefer going to private clinics.

"We usually refer very few cases to the district hospital. This is mainly because no one treats us or our referred patients with respect. The doctor on duty does not give any importance to the referral slip. If we go with our patient to the health facility ourselves, even then we are made to stand in long queues until our turn comes. The way we are treated really embarrasses us in front of our clients because people give us great respect when we visit the field, but after witnessing such treatment with their own eyes, they realize that nobody gives us any importance." FGD, LHW, Sanghar

"We have a lot of respect in the community but when we refer a client to a health facility where she is not given any importance and not treated well, we feel embarrassed and lose our respect." FGD, LHW, Sanghar

"There are also problems related to referral cases. For instance, if an LHW refers a case to a facility where the client is not treated well, she will visit the private facility instead and from then onwards would never follow the advice of LHW." IDI, LHS, Sanghar

Disruption of Referral System by NGOs

The referral system is also being damaged by certain unregulated private sector practices. Some NGOs offer higher financial incentives to both clients and LHWs who refer them for selecting the FP method they offer (such as tubal ligation). These incentives attract LHWs and restrict clients' freedom to choose their preferred FP method.

"LHWs refer quite a few cases to the FWC. The FWC is constantly under pressure from higher authorities to get more cases. For the last three months, since the appointment of the new DHO, LHWs are not referring a lot of cases. Nowadays, LHWs refer more cases to an NGO working in the area as it pays them a higher referral rate. Moreover, Marie Stopes makes on-the-spot payment for any referral case. The LHW receives 800 Rupees per referral case from the NGO, out of which 500 Rupees is given to the client while the remaining 300 Rupees is kept by the LHW herself." IDI, In-charge, PWD facility, Sanghar

"We prefer to refer tubal ligation clients to an international NGO, rather than the Population Welfare Department, as the NGO offers more incentives. They also conduct a proper follow up of all tubal ligation clients to check that they are not having any problems after the surgery. They visit them three to four days after the operation." FGD, LHW, Sanghar

"We prefer to refer clients of tubal ligation to an international NGO rather than the Population Welfare Department facilities due to better incentives and quality of services." FGD, LHW, Sanghar

"We also ask LHWs to send [tubal ligation] cases to our facility. They hardly cooperate because they prefer to take [them] to an NGO where they get 800 to 1,000 Rupees against one... case (maybe a LHW gets 300 Rupees out of it), whereas PWD only gives 400 Rupees (out of which LHW share is only 150 Rupees)." IDI, In-charge, PWD facility, Sanghar

Referral from Higher Facilities to LHWs

LHWs reported that none of them had ever received any clients referred from higher level facilities for follow up or continued management. This is extremely important in case of following up of FP clients who need to be monitored and advised regarding how to deal with side effects and for replenishing supplies.

Weak Data Management

The assessment found that while LHWs are sending in their monthly MIS reports, the data is not regularly being collated at the provincial level. Except for 2014, the reports for the years 2012 and 2013 were not available according to them. Currently, with the assistance of JSI, the MIS is being streamlined at the district level in consultation with the district coordinators of the LHW program, which is expected to address data management issues.

Another weakness is that the analysis and use of data in providing feedback is erratic. In the past, staff of PPIU including the FPOs used to visit the districts to validate the data that was being sent. However, currently, this practice has been suspended due to lack of budgets for operational costs.

"Previously, after every fifteen days, a provincial level official used to visit the area in order to monitor the performance of LHWs. At that time, the program was running quite effectively. However, now there is no such supervision." In-charge, Primary Healthcare Facility, Sanghar

Discrepancies were also seen in the filling in of the monthly LHW reports. For example, while an LHW had noted that no contraceptives were available, the records showed that she was distributing contraceptives. This shows that the forms are not being filled or scrutinized properly at the district level.

Ineffective Community Support Group Meetings

The LHWs reported that they were organizing and holding community support group meetings.

"All of us have formulated a health committee in our community. We gather women in the form of groups for this meeting and provide them information about various issues. This meeting is conducted at least once every month." FGD, LHW, Sanghar

"We conduct a Health Committee meeting every month in which we talk about the importance of vaccination for women and children, cleanliness, maternal and child health, and diet of pregnant women." FGD, LHW, Larkana

When the assessment team asked community members about their female group meetings, their frequency and topics covered, all respondents said they had never attended any such meeting. This leads us to conclude that these meetings are either not being held frequently or are largely unattended.

"We are completely unaware about whether the LHW conducts any such meeting or not. Since no such meeting has ever been conducted, therefore, we have never taken part in it." FGD, Community Woman, Larkana

"The LHW has not conducted any such meeting 'til now. They only provide such information through home visits. A group meeting should be conducted every month so she can give us information about various issues and answer our queries." FGD, Community Woman, Larkana

"Usually, the LHW visits us at our home as we cannot get together at some place for a meeting with her. We all work in the fields and have household responsibilities; therefore, we do not have time to attend such meetings." FGD, Community Woman, Sanghar

Frequent Managerial Change

In the two years preceding the assessment, the Provincial Coordinator of the LHW program had been replaced four times. Such a high rate of turnover leads to adhocism and instability. It also impedes program performance and provides insufficient time to the program heads to strategically deal with program issues, provide a vision, and work towards achieving it.

"The provincial program coordinators of the national program are being frequently transferred and this is having a negative impact on the overall program." Provincial Manager, Sindh

4.3: Opportunities

Development Partners' Interest in Supporting and Strengthening the Program

Pakistan is fortunate in having one of the largest cohorts of community-based female health workers who are performing exceptionally well under the most trying circumstances. Despite chronic delays in salaries and an irregular and inadequate supply of general medicines, they remain committed and motivated. The contribution they have made to the polio eradication program is now globally recognized and acknowledged.

Pakistan's development partners are cognizant of these workers' immense contribution and potential to play a further role in cost-effectively improving access to services among poor deprived rural women. They too acknowledge that, without LHWs' support, Pakistan cannot achieve its polio eradication target and are therefore committed to strengthening the program. Both UNICEF and UNFPA have provided support to the LHW Program likely to continue. UNFPA has developed an ambitious plan to train all Sindh LHWs in the next year and a half in the healthy timing and spacing of pregnancies (HTSP).

UNICEF has been involved in the following:

- Organization of Mother and Child Health Week twice a year in April and June;
- Printing of Management Information System (MIS) tools for three years (2015–2018);
- Capacity building of LHWs in child care, infection prevention and other MNCH-related tasks;
- Strengthening of monitoring and supervision of the LHW Program in districts Kashmore and Kamber Shahdad Kot, with 25 vehicles repaired and functional.

"There should be integration between the different vertical programs [LHW, MNCH, EPI, polio] because they all have the same aim. They should come under one umbrella and the DHO should be responsible for all of them." Representative, UNICEF

USAID is supporting the development of a new PC-1 for the province of Sindh. While MCHIP is operating in all districts of Sindh, its work with LHWs is focused in five districts, including Tharparkar, Dadu, Khairpur, Thatta and Tandoallayar. In these districts, MCHIP is providing the following support to the LHW Program:

- Refresher training to LHSs in nutrition;
- Refresher training to LHWs in support group methodology and family planning;
- Provision of weighing scales;
- Training in use of Misoprostol and Chlorhexidine; and
- Development of a dashboard to monitor activities of LHWs.

Both the governments of Sindh and Balochistan can follow the example of Punjab and KP and develop their own PC-1 and service guidelines for their provincial LHW programs.

Regularization as an Opportunity for Revamping and Revitalizing the Program

It has been nearly two decades since the inception of the LHW program, and its recent regularization provides a serendipitous opportunity for its restructure and redesign, taking into consideration the new realities.

Managers' Perspectives

According to policymakers and other health managers, regularization can be an opportunity to enhance motivation; improve accountability by defining responsibilities; assess and reward good performance by promoting good workers along a well-defined career pathway; and develop a new recruitment policy; institute procedures for availing leaves; and outline disciplinary actions and incentives based on performance. All these steps will help mitigate political interference and partial decision-making.

"The format of the program has been changed from being purely voluntary to that of regular government service employee. Keeping in view the new realities, such as changing epidemiological and demographic conditions, it is now necessary that the job description and modalities of the working of LHWs be revised." Provincial Manager, Sindh

"LHWs have now been given the status of permanent government employees but neither their salary has been increased nor is it paid on a regular basis. However, LHWs and LHSs are quite happy with their new job status. If they work efficiently, it is likely to have positive results for the whole community." IDI, In-charge, Primary Healthcare Facility, Sanghar

"Post-regularization, there is now a need to revise the job description of the LHWs, identify a clear chain of command, reporting system… for example, as government employees, to whom should they report and how frequently? These matters need to be looked into." Provincial Manager, Sindh

LHWs' Perspectives

LHWs are quite satisfied with being made regular government servants. They are happy that they will now be able to enjoy the long term benefits of a permanent government job, such as pension, gratuity, etc. The assurance that they will be receiving a higher salary has also helped in raising their motivation levels and they now sound more enthusiastic about their work. They also expect to receive arrears from the date in 2012 when their services were regularized. However, it must be cautioned that if their dues are not paid and they are not informed regarding their future job description, there is a possibility that they will get further demotivated.

"Since our salary will be increased, our financial condition will definitely be improved and we will be able to afford the school fees of our children. Our family members are also happy that our job is now regular." FGD, LHW, Larkana

"We cannot believe that we are regular employees. If we get salary on time, we can perform better. The private sector is better; at least it pays five to six thousand Rupees on time. However, then we console ourselves that working in the government sector will bring us long term benefits." FGD, LHW, Sanghar

"We believe making our permanent job will have its benefits. Now, people will respect us more; we will be more motivated that our salary has increased." FGD, LHW, Larkana

"The program should be restructured according to present needs. The provincial government should show its commitment and provide administrative support and sufficient funds for its smooth and effective operation." Representative, UNICEF

Restructuring can help to renew the focus of the LHWs on their original mandate of providing family planning services. For this to happen, it is important that they be able to offer communities the full range of contraceptives options. This is also an expressed need of the LHWs. During the FGDs in Sanghar and Larkana districts, all LHWs unanimously agreed they would welcome trainings on new family planning methods and would also like to give the first dose of the hormonal injectables.

Consensus on Enhancing Coverage

Although at present there are no immediate plans to enhance coverage because there is a ban in place on fresh recruitment by the Government of Sindh and, secondly, the Department of Health is preoccupied in dealing with the issues that have arisen after regularization that need to be resolved urgently (such as developing future recruitment policy, retirement and pension policy, new job description, policy for availing leaves, etc.). Policymakers and program managers are fully cognizant, however, that the program's benefits are only reaching half of Sindh's population. The program needs to be extended to provide universal coverage so the entire population can benefit from LHW services.

"There are no budgetary constraints. Program coverage could be increased." Policymaker, Sindh

"We need to extend the coverage of LHWs to uncovered areas." Policymaker, Sindh

"LHW coverage is only 46 percent in the province of Sindh. The new PC-1 that will be developed must address the coverage issue." Policymaker, Sindh

"We should aim at achieving 100 percent LHW coverage." Provincial Manager, Sindh

4.4: Major Threats

The major threat to the LHW program that can impact upon its future effectiveness and viability is linked to LHWs' motivation in the performance of their duties. This section discusses some of the potential demotivating factors that could jeopardize the program.

Politicization and Undue Interference

Almost all policymakers acknowledged that quite a few LHWs have been recruited based on political considerations, disregarding criteria of merit. Similarly, again, due to political pressures, the Department of Health has been unable to initiate disciplinary actions against underperforming LHWs. Continued political interference can severely impair and undermine program effectiveness.

In some cases, ineligible LHWs have been appointed in areas with available LHWs, leading not only to duplication but variation in level of services, with political appointees underperforming with impunity.

> *"A major programmatic concern that needs attention is that, in recent years, many of the ineligible LHWs' have been appointed on a political basis and irregular appointments have been made to such an extent that several LHWs have been allocated the same catchment area, resulting in overlapping and duplication of efforts, with poor accountability."* Provincial Manager, Sindh

Gender-based Victimization and Sense of Insecurity

Few of the LHWs reported opposition to their work from the male members of their families. Mainly these were related to neglect to their household chores and looking after their family members. Delay in receipt of salary was also cited as a reason for domestic disharmony.

> *"Some of us have to face opposition against our decision to work from our husbands and other family members. Our household chores remain undone as we spend most of the time in the community. Moreover, during community visits, some people pass really degrading and insulting remarks."* FGD, LHW, Larkana

> *"Our children and husbands complain when we go back to our homes late in the evening during the polio campaigns or after the daily home visits. They don't get to eat properly as we are on duty the entire day."* FGD, LHW, Sanghar

> *"Once I told my husband that I was going for a meeting. He dealt a blow to my head with a stick and I lost consciousness."* FGD, LHW, Sanghar

> *"Whenever I go to the field, my husband gets really angry. He says that people pass insulting remarks about him due to the nature of my work."* FGD, LHW, Sanghar

Since the rise of militancy and the war on terror in Pakistan, terrorists have been directly targeting LHWs in various parts of the country, including Sindh. Many LHWs mentioned feelings of insecurity and inadequate protection while visiting homes outside their catchment area for **polio related work,** which is a major concern as they have to work in unfamiliar surroundings. If their work remains confined to their catchment area the sense of insecurity will be mitigated. Mostly they complained of being taunted and threatened by local men who try to hinder their work.

> *"During the days of the polio campaign, we face a lot of problems at community level. The men harass us, passing various comments such as, 'Why don't you give us some polio drops?' and 'What cream do you use?' The women of the community also treat us very rudely, saying, 'You come after every few days—what is your problem?' Sometimes, people intentionally set dogs after us."* FGD, LHW, Sanghar

"We do not face much of a security issue while working in our own community, as most of the people know us. However, when we have to go beyond our catchment area, we face threats, especially from men. Some people in the community point fingers at us, saying these LHWs do not have anything to do except visiting the houses of others." FGD, LHW, Sanghar

"We face harassment many times from the people in the community. They speak ill of us. People sometimes set their dogs on us. A few LHWs have been bitten by dogs." FGD, LHW, Sanghar

"At community level, male members make fun of us and pass degrading remarks. Once, my area in-charge gave my mobile number to a local feudal lord who tried to harass me. But I told my Medical Officer about this. The area in-charge and that man apologized to me afterwards." FGD, LHW, Larkana

A critical part of supporting LHWs is providing effective security.

"Our family members remain worried when we go to the field." FGD, LHW, Larkana

"We take a male member with us on our field visits as we feel insecure. Sometimes the watchman of the facility accompanies me for the polio campaign, due to which community people slander my character." FGD, LHW, Sanghar

Chapter 5: Recommendations

This assessment's findings indicate that all stakeholders, including policymakers, political leaders, development partners, program and facility managers, as well as Sindh communities, recognize and acknowledge LHWs' critical role in healthcare service delivery. Based on the strengths, weaknesses, opportunities, and threats identified by stakeholders and the evaluation team, this section provides recommendations for strengthening and extending Sindh's LHW Program, as well as addressing the weaknesses undermining its performance. Some recommendations, especially those for supplies, supervision, and salary, were also made in the 2009 external evaluation and these issues still persist. Policymakers must ensure these are fully implemented so these longstanding issues are resolved and subsequent evaluations can focus on further improvement.

The recommendations are presented in three thematic sections:

- Policy and Program Interventions,
- Operational Interventions,
- Management Interventions.

Policy and Program Interventions

Formalizing and Streamlining the LHWs regularization

In the immediate future, we recommend consolidating the existing program by regularizing the LHWs, developing policies and procedures, developing training curricula, updating existing training manuals and developing a new training strategy, and revising LHWs' scope of work to ensure that they provide family planning and primary health care services effectively.

Adequate Budgetary Allocations (Immediate)

For the smooth functioning of the program, while developing the PC-I for the operational cost of the LHW program and salary component paid through the province's non-development regular budget, policymakers and program managers should strike a balance between the two amounts and reduce the current imbalance. For effective implementation of program activities, as pointed out by the finance department of the provincial LHW program, at least 40 percent of the total budget should be earmarked for operational support to cover expenditures such as POL and maintenance cost for vehicles; procurement of supplies; trainings; media, stationery and IEC materials; mobile health education campaigns, etc.; and most importantly, for transporting medicines and contraceptives from the district office to the facilities. Salary disbursement statuses should be collated and a report should be sent every month to the Special Secretary Health so that delays in payment of salaries can be identified and alternate approaches to expedite disbursement, such as bridge financing, can be considered. Another way to expedite disbursement of salaries could be transfer of funds through mobile phone services, such as the Easy Paisa Service for e-payments.

Enhancing Coverage (Long Term)

In the long term, the health department needs to develop a strategy for increasing the number of LHWs to cover the nearly 40 percent of rural and 10 percent of urban slum populations that are not presently covered by the program. A clear strategy needs to be specified to reach out to these communities. Several tried and tested models, such as the MARVI workers of HANDS and the Falahi workers of the Family Advancement for Life and Health (FALAH) project implemented by the Population Council, indicate that both male and female volunteer working as pairs with lower educational qualifications can be employed to reach out with a more concise package

of services than that offered by the regular LHWs (Contech International 2011). Another approach that is being implemented by Jhpiego in resource-constrained settings is to identify young volunteer girls who have completed middle school (8th grade), help them in completing their education up to matriculation level, and subsequently train them to become LHWs or community midwives (CMWs).

The Health Sector Strategy of Sindh 2012-2020 also suggests employing volunteers in areas where more qualified workers are difficult to find among local communities.

To improve access and outreach of the program within the LHW-covered areas, multi-purpose male health workers could be employed and paired with LHWs to target men with information and basic services. This model is currently being practiced in Iran where male and female workers called BEHVARZ mutually support each other. This has been suggested by all the LHWs who participated in the group discussions as well as members of the community. Evidence-based task shifting would also enhance access to a wider range of services, such as neonatal care and emergency obstetric first aid; for instance, LHWs could be trained to guide the use of chlorhexidine for umbilical cord care and misoprostol for preventing postpartum hemorrhage (PPH). This activity is already being carried out by Jhpiego in two districts.

Operational Interventions

Post-Regularization Steps (Immediate)

To fulfill the requirements introduced after the Supreme Court judgment regularizing LHWs, a number of steps need to be initiated at the earliest. Firstly, the Sindh assembly needs to pass an act entitled "Lady Health Workers Program and Employees (Regularization and Standardization) Act," which should cover:

- Selection criteria for new LHWs and LHSs as well as hiring new staff of Provincial Program Implementation Unit in future;
- Functions of the LHS and LHW and respective procedures, includes working hours;
- Length of service of LHSs and LHWs and entitlement for retirement;
- Catchment population to be served by an LHW;
- Policy on seniority, postings and transfers, as well as pension benefits, General Provident Fund, Benevolent Fund and Group Insurance, and procedures for casual, medical, and emergency leaves; and
- Procedures for staff performance assessment and promotion.

A similar law has already been passed by the provincial assembly of Khyber Pakhtunkhwa.

To efficiently manage the LHW program's post-regularization transformation so it responds effectively to Sindh's current needs, focused and broad-based leadership will be required at the highest level. A Program Technical Committee should be constituted, with the Chair of the Oversight Committee for Primary Health Care (PHC) as its chair and a membership of senior policymakers, researchers, and development partners. The Committee should have a series of workshops on:

- LHWs' range of services and their working hours, with practices standardized for the entire province;
- Ways and means to improve performance and accountability;
- Deciding upon integration of all primary healthcare services at the primary level;
- Possible alternatives to improve access to services in non-LHW areas since locating literate women is difficult;
- Draft legislation for regularizing LHWs along with a planning document describing strategies, activities, monitoring indicators and time frame; and

- Key performance indicators (which must include FP).
- Clarifying the working relationship between the PPHI and the Lady health Workers program

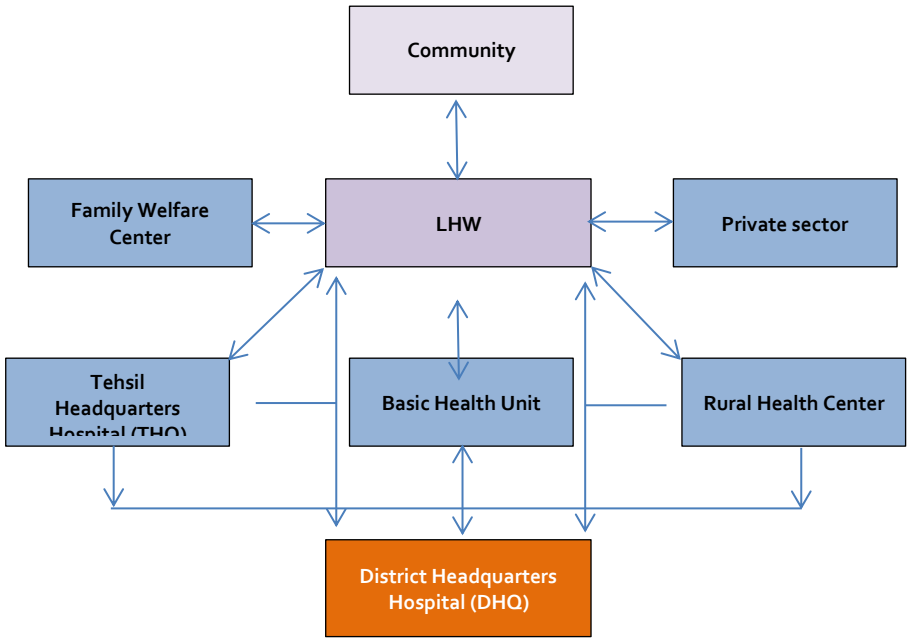
Establishing a Functional Referral System (Immediate)

As originally envisaged, LHWs were to act as a bridge between the community and the formal health system, and their primary responsibility was to provide preventive health services as well as curative services for minor ailments. Mainly, they were to refer the clients to higher level facilities for curative services and long term contraception.

This assessment reveals that the referral system is largely non-functional and needs to be reconstituted. Functionality can be established if providers at each referral facility are trained and sensitized to accord priority to cases referred by LHWs. Moreover, a record of all referred cases should be maintained, including details of the management of each case, and this information should be collated at district and provincial offices. In addition, all facilities should have a prominently displayed list of available services as well as services at other, higher level facilities in the vicinity. Referral forms must be made available at all facilities, and should be used for providing case management recommendations from higher to lower facilities. Furthermore, horizontal referral links need to be developed whereby LHWs can cross-refer clients to Population Welfare Department and private sector facilities. Figure 3 provides a representation of the proposed referral system.

LHWs must be compensated for their time and transportation costs in accompanying clients. This could help increase referrals. Compensation costs must be uniform for both public and private sectors, with the private sector regulated through the Sindh Health Commission, to be notified through an Act of the Sindh Assembly.

Figure 3: Proposed Referral System



Revising the Scope of Work of LHWs (Immediate)

After regularization, there is now a need to develop a new job description for the LHWs. This should also entail a re-examination of their current role to identify redundant tasks and those that can be revised and replaced by new and more relevant duties based on a formal workload analysis. Administration of polio drops can be a part of routine immunization activities by LHWs. LHWs should not, however, be involved in sub-national and National Immunization Days, which negatively affect their routine work. In the course of this analysis, current staff positions could also be realistically reexamined and redundant posts removed to reduce unnecessary costs.

To implement the activities listed in the job description, an activity roster can be developed that allocates the time required for each activity. Based on discussions with LHWs, program managers, and program beneficiaries, as well as global evidence, a revised job description for LHWs is suggested in Table 8 for the consideration of policymakers as part of the formal analysis. This list abridges the list of tasks that the LHW was originally stipulated to perform and the subsequent additional tasks that were later added upon. We feel that the LHWs tasks need to be carefully reviewed to ensure that the services she provides are impactful; instead of being involved in a multiplicity of activities that compromise effectiveness.

Table 8: Recommended Revised Scope of Work of LHWs

Community profile:

- Register and educate all households including eligible couples in the catchment population and issue family health cards identifying household family planning, immunization, and general health needs (details should be entered into a hand-held phone)
- Maintain a register of all pregnant mothers and children under age five in the catchment population and issue pregnancy cards

Family planning:

- Distribute contraceptive pills, condoms, injectable contraceptives (first and subsequent dose), standard days method (cycle beads), and emergency contraceptive pills
- Accompany women to Family Welfare Centers (FWCs) or social franchise facilities, if they require IUCD, and to Reproductive Health Services (RHS)-A centers, for implants and contraceptive surgery

Maternal health:

- Conduct antenatal examinations, and provide iron and folate tablets to pregnant women and all women of reproductive age
- Refer women who are at high risk of pregnancy complications (i.e., women who are younger or older than the safest age range, primiparous or multiparous, obese or short, or with a history of previous complications) to higher level facilities for comprehensive antenatal care and booking of the case at the higher care facility
- Liaise with skilled birth attendants (community midwives) or, if needed, facility providers, to perform the delivery
- Undertake four postnatal care visits and provide postnatal family planning advice

Child care:

- Manage newborn care during the "golden hour" and carry out key components of golden-hour practice, such as respiratory management, oxygen targeting, and thermal regulation
- Immunize all newborn and under-age-five children
- Carry out growth monitoring of children using a mid-arm circumference tape and weight scale and record data on family health card

Health education:

- Provide information based on the Nutrition Education Package to mothers of infants and children and treat micronutrient deficiencies
- Encourage breastfeeding and appropriate complementary feeding and record dates of initiation and completion of breastfeeding on the family health card
- Provide information on advantages of using iodized salt and its source
- Provide information on the prevention and control of diseases, including mosquito-borne diseases, i.e., malaria and dengue; blood-borne and sexually transmitted diseases, e.g. hepatitis and HIV/AIDS; and communicable diseases, such as childhood pneumonia
- Conduct community group meetings and health talks in schools to promote principles of basic hygiene

Record keeping:

- Visit the attached health facility every month to report data collected on the family health cards, attend refresher and skills development

trainings, and receive fresh supplies, including contraceptives

Treatment of minor ailments:

- Provide treatment for common ailments, such as childhood diarrhea and childhood pneumonia by providing counseling and medicines/supplies provided by the program
- Actively participate in the directly observed treatment short course (DOTS) management of all newly identified TB cases through case detection and retention to enhance treatment, completion, and cure rates

Enhancing Security (Immediate)

The growing sense of insecurity could, in the long run, demotivate workers and jeopardize program effectiveness. There is a need to revamp the current security strategy for LHWs,. A comprehensive security plan needs to be developed led by the communities and supported by the security agencies. For this purpose, a workshop should be organized to chalk out a foolproof community-based strategy to protect the LHWs and provide them a sense of security so they can perform their duties without fear.

It is suggested that commitments be obtained from the community leaders who should depute respected community members to escort the LHWs during their field visits.

Management Interventions

Closer Coordination Between LHW Program and Population Welfare Department (Immediate)

Closer linkage and working coordination between the LHW program and the PWD could help in substantially lowering unmet need for family planning and increasing the contraceptive prevalence rate (CPR). The following three-pronged approach is recommended to help foster this linkage, which should be formalized through a memorandum of understanding signed by both departments:

- Establish a formal referral system between the two departments whereby LHWs refer all clients wanting IUCD insertion, implants and contraceptive surgery to Family Welfare Centres (FWCs) and Reproductive Health Services A-type (RHS-A) centers;
- Organize quarterly trainings for LHWs in the client-centered approach (CCA) for delivering family planning services to be conducted by FWC in-charges of the PWD along with LHSs, and supervised by the in-charges of the RHS-A centers. CCA training should include a special focus on counseling and interpersonal communications; holistic assessment of client needs; meeting needs through negotiation in an atmosphere of equality; contraceptive technology; dealing with contraceptives' side effects; permissibility of birth spacing in Islam; and new contraceptive methods, such as Sayana Press and the Standard Days Method (SDM). CCA training has already been tried and tested by the FALAH project and was independently verified to show positive results. For this purpose, a training cascade should be initiated with the development of 20 master trainers who can train, in batches of 15, nearly 1,000 FW counselors and RHS-A in-charges, who, in turn, can train the LHWs in batches of 20.
- Identify key performance indicators (KPIs) for family planning against which LHWs' performance is to be measured. Some suggested indicators include number of family planning clients (new and old) counseled, number of referrals for family planning, number of clients followed up, and number of clients continuing to use a method after three months. Each of the indicators needs to be weighted.

Improving Monitoring, Supervision, and Evaluation (Immediate)

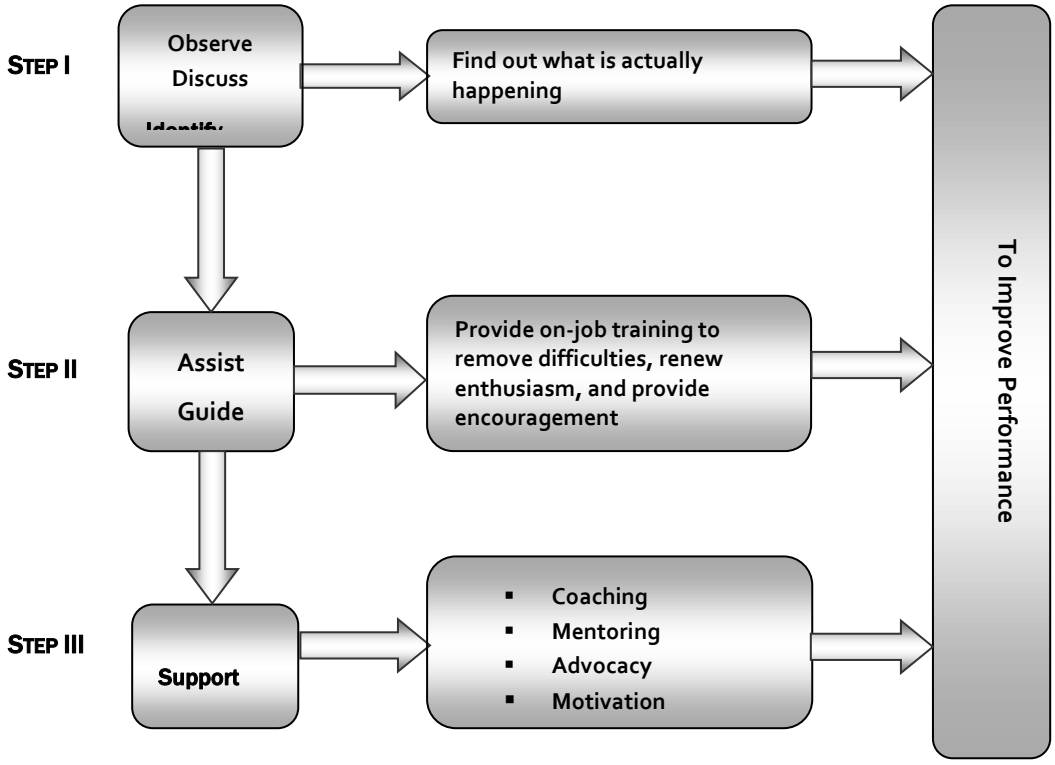
Periodic and systematic monitoring and supportive supervision is crucial for ensuring the continued success of the program. Post-regularization, there is a need to redefine the chain of command and supervisory approach. While the supervisory checklist is important, it is equally important to use the supervisory visit as an opportunity to identify, analyze and help in resolving problems confronting the LHWs and to provide constructive feedback. To facilitate the visits of supervisors to far-off and distant locations, it is recommended that instead of having a fixed POL quota for all supervisors, the POL allocation should be based on the distances that supervisors have to travel.

To improve daily monitoring and data management, the use of mobile-based technology is recommended as it entails a low cost but is effective as a monitoring, training, supervisory, and continuing education tool. Mobile technology can be used to improve the referral system. Introducing the technology could also provide an opportunity to develop a new and more effective MIS (In this regard, MCHIP is already developing an Information Dashboard). The basic data collection tool should be the Family Health Card, which should be used for registering new households and documenting all follow-up activities concerning them. The Family Health Card should be smart-phone based. This will ensure that the data collection process is systematic and the data collected becomes instantaneously available at the district level. Referral data can also be accordingly stored and retrieved. In addition, the m-health smart phone application can be used as a tool for diagnosis and treatment of conditions using an algorithm-based approach. The current minimum cost for the required appliance is 5,000 Rupees.

MIS data must be utilized for assessing performance and providing feedback. There is a need to further strengthen capacity to analyze routine MIS data and utilize it for feedback provision as well as decision-making.

Figure 4 presents the recommended supportive supervisory model. This model can be applied by the LHSs during their supervisory visits to the LHWs' health houses and also by the facility in-charges when LHWs visit their facilities for their monthly meetings.

Figure 4: Supportive Supervisory Model



In addition to routine internal monitoring, a third-party evaluation of the program must be conducted every five years. Periodic surveys and operations research should also be institutionalized in order to identify programmatic weaknesses and suggest appropriate interventions. One area that needs in-depth investigation is to identify the motivational and demotivation factors that can influence the LHWs' performance.

Improving Governance (Intermediate)

The current programmatic, managerial and operational issues that have been highlighted in this report need to be resolved through interventions at the highest level. For this, as a first step, it is recommended that the profile of this program be raised. Renaming it the "Chief Minister's Program for Family Planning and Primary Healthcare" would help to ensure the release of adequate funds, enhanced accountability, and more respect for the workers by the system. Examples of some high profile programs currently operating at the provincial levels in Pakistan include the Chief Minister's Health Initiative for Attainment and Realization of MDGs (CHARM), and Chief Minister's Initiative for Primary Health Care (CMIPHC) by the Government of Punjab, Chief Minister's Initiative for Hepatitis Free Sindh by the Government of Sindh, and Chief Minister's Special Initiative for Mother and Child Health by the Government of KP.[7]

Secondly, a change in the current perspective regarding the LHW program's place within the health system is also needed. Although it is no longer a federally administered vertical program, it is still viewed as a 'stand alone' entity. The activities of all vertical programs must be well-coordinated. For this, it is recommended that, on the pattern of Punjab, a post of Deputy Director-General Reproductive, Maternal, Neonatal and Child Health (RMNCH) be created to which all vertical programs report. The RMNCH directorate should develop a yearly work plan identifying the roles and responsibilities of each of the programs so as to develop better integration between programs and synergy of effort, and avoid duplication of efforts. Furthermore, to enhance coordination with other departments and initiatives, the forum of the District Health and Population Management Team (DHPMT) should also be reinvigorated. As recommended by the district-based staff of the Population Welfare Department, the DTC meetings should be called by the District Coordination Officer. The minutes of these meetings should be sent to the office of the Secretary Health, highlighting the status of compliance on various decisions taken at the meeting. Similarly, the meeting of the Provincial Technical Committee (PTC) should be headed by the Chief Secretary, Sindh. The PTC can help to foster greater collaboration between the health, population welfare, and other allied departments, PPHI, and development partners, and help improve governance at the provincial level.

Strengthening Management (Intermediate)

In the intermediate term, the following measures are recommended to strengthen the program's management and effectiveness:

- To improve management out of box approaches such as management outsourcing could be an option that can be considered, once all stakeholders are taken onboard.

[7] Some examples of other high profile programs being implemented in other countries include:
- Prime Minister's youth mental health program in New Zealand
- Prime Minister's Community Business Partnership Program in Australia
- Prime Minister's Rural Development Fellowship Scheme in India
- Chief Minister's Comprehensive Health Insurance Scheme by the Tamil Nadu State Government of India

- Toprovide sustained leadership, it is recommended that the Provincial Coordinators be selected on merit from within the department or from the private sector at a competitive salary; he or she must have a fixed contract for three years.
- To ensure that the LHW Program is not overburdened by additional tasks that are recommended by various agencies, it is recommended that the Technical Committee on Innovation (TCI), which was available at the federal level, be constituted at the provincial level. The provincial TCI should review all new innovations and tasks before they are assigned to LHWs.
- To further improve the identification and subsequent prevention of maternal deaths, all verbal autopsy reports should be further screened by a nosologist, preferably the district gynecologist, who can assess the causes and circumstances of these deaths and identify steps to prevent such deaths in the future.
- The program's effectiveness depends upon two basic prerequisites. First, its intended beneficiaries, communities, must be fully engaged as collaborative partners who are actively involved in the management of the program from recruitment of the workers to ensuring that they perform in a safe and secure environment. Second, a fully supportive health system must help the workers perform optimally by ensuring that they receive supportive supervision and that they have the necessary equipment and supplies, especially contraceptives. For this, it is recommended that a district Reproductive Health Oversight Committee be formed headed by an elected representative (provincial assembly member) of the area. The District Reproductive Health Oversight Committee should not only estimate resource requirements but also assess the effectiveness of utilization of these resources; assign tasks and responsibilities; review work plans; and allocate resources based on required needs. The committee should also review compliance with decisions made for program improvement. The committee can play an important role in preventing stock out situations by addressing issues such as storage of LHW supplies at facilities and ensuring procurement of supplies is through the contraceptive logistics management information system introduced by the USAID-supported DELIVER Project.

New and Continuous Educational Trainings for LHWs and Program Staff (Intermediate)

In the aftermath of regularization, to further strengthen the capacity of LHWs to offer a comprehensive set of primary healthcare services according to their new job descriptions, there is a need to develop a comprehensive training strategy and training package that includes new training curricula, new training manuals, relevant teaching aids, and a new training methodology, and to identify training institutions where the trainings can be imparted. The new training package should include areas such as the Nutrition Education Package, including community-based mother, infant and child feeding and micronutrient deficiency; management of childhood pneumonia; the use of misoprostol for prevention of PPH; use of emergency contraceptives and the Standard Days Method; water, sanitation and hygiene (WASH); use of chlorhexidine; and use of mobile health technology. The Nutrition Education Package can be used by LHWs to raise awareness and promote healthy behavior among women, children and young girls. Trainings must also be imparted in giving the first dose of injectable contraceptives as demanded by the LHWs themselves.

LHWs also need to receive refresher training in infant resuscitation; family planning coverage; and effective screening, identification and referral of high risk pregnant women and malnourished children, so they can provide clients the necessary treatment and refer cases of severe nutritional deficiencies to the appropriate facilities.

Moreover, LHWs need to be retrained in how to organize male and female group meetings and engage with men to prioritize and influence family decision-making.

A yearly training schedule should be developed well in advance outlining the various new and refresher trainings. Medical officers deployed at the health facilities to which LHWs are attached must be involved in providing refresher trainings during the monthly meetings taking place at the facilities as part of a continuing education program.

Trainings are also recommended for LHSs, district coordinators, and assistant district coordinators (ADCs) on supportive supervision and medicine, contraceptive logistics management system, and data management and analysis.

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Appendices

Appendix 1: Terms of Reference of the evaluation

For the Assessment of the LHW Program of Sindh Province

Background and Rationale

The Health Systems Strengthening Component is part of USAID's Maternal and Child Health (MCH) Program[8].JSI Research & Training Institute, Inc. (JSI) is the lead agency in the Health Systems Strengthening Component with Contech International, Rural Support Programmes Network (RSPN) and Heartfile as consortium partners. The goal of the five-year project, which started in 2013, is to develop and support innovative, cost-effective, integrated, quality programs, and services to strengthen systems around reproductive, maternal, and child health services for improved health outcomes. The primary focus of the Health Systems Strengthening Component is:

1. Strengthening systems that will foster improved Reproductive, Maternal, Newborn and Child Health (RMNCH) service delivery and outcomes, including accountability and transparency;
2. Strengthening management capacity at the provincial and district levels;
3. Developing innovative approaches to catalyze community outreach services and access to health services for marginalized populations (including financing schemes); and
4. Strengthening private sector delivery for the urban and rural poor populations.

One of the objectives of the USAID's Maternal and Child Health (MCH) Program is to provide RMNCH services in all underserved communities in the project districts. It supports innovative approaches to strengthen the capacity of Pakistan's public and private healthcare sectors to deliver high-impact services that reduce maternal, newborn, and child mortality and morbidity, as well as improve reproductive health outcomes and increase family planning utilization. USAID's MCH Program comprises five interconnected and mutually reinforcing components led by national and international public health organizations to implement evidence-based interventions.

The Government of Pakistan has taken several initiatives to improve the health of its population, particularly women and children. The National Program Family Planning and Primary Health Care (also known as the Lady Health Workers [LHW] Program) is one such initiative. Pakistan's Lady Health Worker (LHW) Program was launched in 1994 with the objective of providing essential primary healthcare services to low-income women and children to improve national maternal and child health indicators. Two national external evaluations of the LHW Program have been conducted by Oxford Policy Management (OPM) since 2002.

Findings from External Evaluations of the LHW Program Oxford Policy Management (OPM) in 2002 and 2009

As part of the 2002 evaluation, a representative household survey was conducted across Pakistan between October 2000 and April 2001. Interviews were conducted in 5,161 households and with 501 LHWs. The evaluation did not show evidence of the LHW Program having brought about reductions in child mortality and fertility: the level and trends in these two measures were similar in the LHW covered and uncovered areas. However, the evaluation did find reasonably good evidence for increased uptake of several key primary health care services associated with the LHW Program. In particular, regression analysis showed that the LHW Program had a large, positive impact on childhood vaccination rates and the uptake of modern contraception. The program had these effects in rural but not in urban areas. The performance of the program in terms of curative care was poor and there were serious problems in the supply of medical items to LHWs: 20% of the LHWs remained out of stock for 11 out of the 16 medical items in their kits for more than three months. Sindh had the largest problem with lack of stock and was one of two provinces with the lowest level of service delivery.

[8] The Health Systems Strengthening Component is the 5th Component of the MCH Program, and the others include: 1) Family Planning/Reproductive Health Services; 2) Maternal, Newborn, Child Health Services; 3) Health Communication; and 4) Health Supplies and Commodities.

The 2002 external evaluation also highlighted underperformance by a substantial proportion of LHWs. Across Pakistan, one-third of LHWs reported seeing ten or fewer clients per week. In Sindh, more than two-thirds of LHWs reported working less than 15 hours per week. Evaluators recommended that a strategy to deal with underperformance was needed prior to recruitment of additional LHWs. Since the evaluation failed to find significant evidence of any effect of the program in urban areas, the evaluators also recommended that further expansion of the program occur only in rural areas. One of the findings of the evaluation was that, in rural areas, LHWs were placed in socio-economically better off rural populations. Moreover, even within these populations, LHWs were not reaching the poorest households on their registers. As a result, the evaluators recommended recruiting LHWs from more underprivileged areas.

As part pf the 2009 external evaluation a representative household survey of 5,572 households was conducted across Pakistan in 2008. A total of 554 LHWs were also interviewed. Using regression analysis and comparing 2008 survey data with 2000-01 survey data, the evaluators found that the LHW Program had a positive impact on the use of modern family planning (served households were 11 percentage points more likely to use family planning), tetanus toxoid (13 percentage points higher among served households), neonatal checkups (15 percentage points higher among served households) and complete immunization (15 percentage points higher among served households). Overall, there were improvements in supervision, increased knowledge among LHWs and Lady Health Supervisors (LHSs) and an increase in service delivery since 2000-01.

However, in several other areas, including hygiene and sanitation behavior, breastfeeding, growth monitoring, skilled birth attendance and the incidence or diarrhea and respiratory infection, there did not seem to be an effect of the program. Moreover, while the program had penetrated more rural and less advantaged areas, the most disadvantaged areas were still not being reached.

The 2009 external evaluation found that while the LHW Program was able to maintain reasonable performance for the period 2000 to 2008, it was hampered by serious weaknesses in the provision of clinical referral services as well as in the provision of supplies and equipment. The lack of medicines was a particularly important problem in Sindh. Improved supervision, including the support structure required for supervision were highlighted as key areas which would lead to improved performance. Effective district management was also identified as an important factor contributing to better LHW knowledge and performance.

Proposed Assessment of the LHW Program

More than 6 years have passed since the last external evaluation of the LHW Program. Major changes have occurred in the structure of the LHW Program during this time, the most important of which has been transition of the program from central to provincial management.

The purpose of this assessment is to take stock of the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province at the beginning of 2015, and to determine how best the access to quality, community based services can be ensured in Sindh Province in the coming years.

Objectives:

- To assess programmatic, managerial and operational issues inhibiting more effective implementation of the program, with a view to identifying how barriers to better performance may be removed.
- To determine the government's (including DoH, PWD, P&D) vision for the program, including plans for increasing operational efficiencies of the program and plans for the coordination or expansion of work in geographic areas currently not covered by the program.
- To determine the space for further strengthening the functional integration/ coordination with other MCH programs (MNCH, Nutrition & EPI)

Scope of Work: The Consultants will review the literature and conduct the comprehensive assessment as follows:

Literature & Document Review:

- Review all project documents of LHW Program including PC-1s.
- Review the findings of the OPM evaluations conducted earlier and determine whether the weaknesses identified in earlier evaluations still exist or if there have been changes in Sindh.
- Review other small scale community workers initiatives by different organizations as well as the Punjab LHW program that has increased population coverage per LHW and have introduced few innovations for monitoring the field work and explore into LHWs own behavior change into family planning practices.

Comprehensive Assessment:

- Take stock of the strengths, weaknesses, opportunities and threats (SWOT analysis) of the LHW Program in Sindh Province
- **Employing qualitative methodology including interviews with persons at multiple levels of the health system that engage with the LHW Program from the policy to the community levels.**
- To explore the opportunity to scale up LHW model from its original design.
- The consultant should follow the interview guide, methodology, specific areas of interests and questions highlighted in the table-1. The methodology proposed has included the number of interviews and key person to interview for each specific area of interest.

Areas for Exploring During Qualitative Interviews

LEVEL		PERSONS TO BE INTERVIEWED
POLICY	1. Given concerns regarding the effectiveness of the LHW Program as per its original objectives and the scope and scale of issues related to maternal, n e w b o r n and child health in Pakistan, what is the department of health's vision for the LHW Program in the next 3-5 Year? What can be realistically expected from the program? 2. What are specific strengths of the program according to DOH/PWD? 3. Is Government planning to establish some functional/ programmatic integration between PWD & LHW program. 4. What specific weaknesses of the program are the DOH/ PWD planning to address in the next 3 years? How is the DOH/PWD planning to do this? What sources of funding are available for this? 5. How does the DOH/PWD expect that program will change now the LHWs are regularized, if any? 6. How is the DOH/PWD planning to provide outreach in areas not covered by the LHW Program? 7. What are the DOH's thoughts regarding coordination with (or absorption of) community health workers outside of the LHW Program?	Secretary Health, Secretary PWD, Secretary P&D Special Advisor Health. **(4 interviews)**
PROVINCE	1. Which areas of LHW/PWD performance are currently strong and which are weak? What are the reasons for the current performance of the LHW Program? 2. What are current human resource constraints? What is the long-term plan, particularly in a devolution environment? 3. What aspects of the program keep LHWs motivated? 4. What approaches is the DOH using to address financial and logistical challenges for keeping the LHW Program going? 5. Are there challenges in effectively monitoring LHW performance? 6. What would be required to overcome these challenges?	LHW Program Manager, DG Health, CEO PPHI, DG PWD. Managers of Nutrition, MNCH and EPI Programs, NGOs such as, CEO HANDS, Director Pathfinders, UNFPA,
DISTRICT	1. How are human resource issues (e.g. recruitment, deployment and retention of LHWs and LHS) being handled? 2. How is the quality of LHW outreach/capacity of LHWs ensured? What changes if any are needed to improve capacity and quality of services? 3. Which are the issues most commonly found in the LHW Program with regards to supply chain of medicines/supplies? How are they addressed? 4. How are LHSs supported in monitoring and supervision of LHWs? 5. What approaches is the DOH using to strengthen and enhance LHS capacities? 6. What impact has the regularization of LHWs had on performance/motivation? 7. What is Frequency, Regularity & effectiveness of Maternal Mortality Conference (MMC) at district level?	DHOs . DPW Os District Coordinator LHW MNCH program NGOs UN Agency representative. **(6 Interviews)**
FACILITY	1. How has the role of the LHW changed in the past ten years? 2. How well is the referral mechanism working? 3. On average how many referrals are generated by an LHW in a month? 4. What are the strengths and weaknesses of the LHW Program?	In-charge of Health Facility. 6 RHS-A In-charge, 2 Family Welfare Workers, 2 **(10 Interviews)**

LEVEL		PERSONS TO BE INTERVIEWED
SUPERVISOR	1. How frequently do they meet with LHWs? 2. How do LHS go about conducting their supervisory activities? 3. What are their priorities in supervision? 4. What mechanism of providing feedback to LHWs do they employ? Evidence of LHS feedback to LHWs should be reviewed. 5. How do they assess the quality of LHWs work? 6. Do they conduct any real time monitoring of LHWs work by making surprise visits/spot checks 7. How do they help LHWs set their priorities and review performance against priorities? 8. Is there any variation in the performance of LHWs and reasons for such variation in the performance of LHWs? 9. LHW records should be reviewed with LHSs to determine how updated the records are and to collect information on the average number of LHW household visits per month, provision of contraceptives, participation in campaigns etc. 10. How is this information shared with the district and what type of forum is used to highlight some of the weaknesses in the program with district and provincial management staff? What is regularity of monthly meetings at HF level & how they address the issues	LHSs. One focus group per district (8 to 10 participants) **2 FGDs** **2 In-depth Interviews**
LHW	1. Profile of LHWs in terms of age, marital status, dependents, education. Are they the sole breadwinners in their families? 2. What is their monthly income? 3. What are their financial responsibilities? 4. Some LHWs have dual employment. Are they doing so only for financial reasons? 5. How much distance do they have to travel to reach their clients? 6. What are their key responsibilities? 7. Average hours per week spend on LHW responsibilities. 8. How much time is spent in the community versus the facility? 9. On an average, how many referrals per month do they generate for their FLCF? 10. How are their referrals received at the facility? 11. What mechanism do they have of following up on their referrals? 12. What are the biggest challenges in their work? 13. How do they manage competing work priorities? 14. Do they consider certain types of outreach/ service provision more important? 15. Are they confident about their level of training? 16. How often and in what areas do they receive training? 17. What support do they get from their supervisor/the LHS? 18. How frequently do they meet with their supervisor? What occurs during these meetings? 19. Do they use their own transport to visit the households registered with them or they get some transport facility? 20. How big a problem is their personal security? 21. What precautions do they take to protect themselves? 22. Do they expect that their financial and work situation will improve now that they are regularized? 23. What might enable them to complete their work responsibilities with greater effectiveness? 24. Are they comfortable with additional assignments other than their assigned ToRs? 25. How far those additional assignments (Polio, others) hamper their regular activities/ quality of work? 26. How far are VHCs & Women Support Groups functional in their areas and regularity of	LHWs – 4 focus groups per district (one FGD per facility) Same facilities where MOs will be interviewed **(8 FGD with 8 to 10 LHWs per FGD)**

LEVEL		PERSONS TO BE INTERVIEWED
COMMUNITY	1. What is their perception of LHWs? Has this perception changed over time? 2. Did LHW ever visit to your house in last 03 months? 3. What services have they received in the last 3 months from an LHW? 4. Did LHW refer them to a health facility for ANC, delivery, postnatal or newborn care? 5. Did they visit the health facility as a result of the referral? 6. Were they satisfied with the care they received at the facility? 7. Do they value LHWs' advice/guidance? 8. What is LHWs role in the community? 9. Do they know that LHWs have group meeting (support groups) to educate women in the community on health related issues?	Pregnant women, women who have recently delivered. One focus group per facility **(8 FGDs with 8 to 10 eligible women)**

The following deliverables and timelines will be observed: The consultancy is for a total of 30 workdays from January 15 to February 25, 2015 (total number of days includes preparation of inception report, development and approval of assessment plan and tools, fieldwork, analysis and report writing, dissemination of findings. The team will be based in Karachi and Islamabad.

	Deliverables	Timelines
1)	Initial meeting for consultant to share study approach, Interview Guides and Study Methodology – Inception report	Day 3
2)	Summaries of Interviews	Day 9
3)	Summaries of Focus Group Discussions	Day 18
4)	Presentation of initial findings by consultant and interpretation	Day 25
5)	Draft Report for review and comments	Day 25
6)	Final Presentation	Day 29
7)	Final Report	Day 30

Appendix 2: Outline of the Main Report

In accordance with the Terms of Reference of the assessment of LHW program Sindh province, a comprehensive report will be developed. A very brief description of the major sections of the final assessment report is given below followed by a detailed table of contents:

Executive Summary

Executive Summary will provide an overview of the assessment report summarizing key findings and conclusions and a set of key recommendations.

Introduction

This section will include a brief justification of the project in country/ provincial context and a comprehensive detail on all the project components, coverage, resources, key stakeholders and management.

Methodology

This section will explain in detail the methodology employed by the assessment team to assess the program in line with the given principles. It will broadly cover the details of following components:

- List of Literature reviewed.
- Key Informants consulted.
- Data collection methodology (In-depth interviews, Focus Group Discussions).
- Analysis strategy
- Limitations of the Methodology
- Ethical Considerations.
- Quality Assurance Mechanisms.

Findings

The assessment will ensure that the audience does not lose track of main findings and conclusions. The report will, therefore, make key findings stand out so stakeholders can easily determine their significance and usefulness. Focus, in particular, will be placed on the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province.

Recommendations

The Report will include major recommendations for the consideration of the implementing agencies and the provincial government with special emphasis on the potential for scale up or replicability in different country/ provincial context.

The final report will be structured according to the following Table of Contents:

List of Tables

List of Figures

Acknowledgements

List of Acronyms

1. Executive Summary
2. Introduction
    - Project Background
    - Project components & Logic Model
    - Geographic Coverage
    - Project Objective and Management
    - Project Resources
    - Key Stakeholders
3. Methodology
    - Literature Review
    - Data collection and analysis

- Limitations of the methodology
- Ethical considerations
- Quality assurance mechanisms

4. Key Findings
5. Recommendations

Appendices

- List of documents reviewed
- Tools utilized for evaluation data collection
- Other project documents

Appendix 3: Ethical Guidelines

The Population Council requires all studies involving human subjects be reviewed by its Institutional Review Board (IRB) before the activity is initiated. The purpose of an IRB review is to assure that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in a research study. Ethical approval from the Population Council's IRB will be been obtained for this evaluation.

Informed consent from the respondents will be obtained after providing an in-depth briefing on the study, its objectives, procedures and uses. The approximate time required for the interviews and group discussion and the possible risks (if any) respondents may face will also be explained. An assurance will be provided to the respondents about the anonymity and confidentiality of their responses. Focus Group discussions and in-depth interviews will be conducted in private maintaining auditory privacy. All data collected for the study will be kept confidential. Data will be stored securely, without identifiers of individuals. All Focus Group participants will only be identified by codes; no names will be recorded. Participation will be voluntary and respondents will not be compensated in any way. The participants will be informed that they may refuse to answer any question that makes them uncomfortable, may terminate the interview at any time, and no sanctions will be taken against those who refuse to participate.

The Population Council throughout the evaluation exercise will adhere to ethical guidelines. The evaluation team proposed by the Population Council is well versed with local culture, customs and beliefs. Additional field staff to be hired for data collection will work under direct supervision of the Population Council evaluation team and will preferably be from Sindh. Every effort will be made to ensure highest standards of honesty, integrity and impartiality and avoid conflict of interest throughout the evaluation activities.

An orientation session will be organized for the data collection teams on the ethical standards to be followed during the implementation of field work. The orientation will ensure that evaluation team members are aware of differences in culture, local customs, religious beliefs and practices, personal interaction and gender roles, disability, age and ethnicity, and be mindful of the potential implications of these differences when carrying out the evaluation activities and reporting on evaluations.

Appendix 4: Sample Consent Form

PURPOSE OF THIS RESEARCH STUDY

To determine the Sindh government's vision for the program, including plans for increasing operational efficiencies of the program and plans for the coordination or expansion of work in geographic areas currently not covered by the program. The assessment will focus on programmatic, managerial and operational issues inhibiting more effective implementation of the program, with a view to identifying how barriers to better performance may be removed.

1. PROCEDURES

My name is _____ and I am from the Population Council, which is a research organization. We are conducting a study learn about the focus on programmatic, managerial and operational issues inhibiting more effective implementation of the program, with a view to identifying how barriers to better performance may be removed. We would like to seek your cooperation in getting a better picture of access and provision of LHWs program in Pakistan.

You will participate in interview / group discussion .Your responses will be completely confidential and will be used for research purposes only. No personal reference will be made to your participation in this survey. We will combine your responses with those of other participants in a report. The interview/ discussion will take 450-60 minutes to complete. The duration of the entire study is one month. We may need to contact you again to clarify a point made earlier, but you may agree or disagree to this. .

POSSIBLE RISKS OR DISCOMFORT

If this is not a convenient time for you, we can come back later. You may end the interview at any time without penalty or loss and you don't have to answer any questions that you do not want to answer.

2. POSSIBLE BENEFITS

There are no direct benefits to you for participating in the study. You may find an indirect benefit in knowing that you have participated in an important study that could help the LHWs program in the future.

3. FINANCIAL CONSIDERATIONS

Your participation in this study is purely voluntary. There is no penalty for refusing to take part. If you agree to participate in this study, you may end your participation at any time without penalty or loss of existing benefits to which you are entitled.

4. CONFIDENTIALITY

Your responses to this interview/ discussion will be completely confidential and will be used for research purposes only. No personal reference will be made to your participation in this study. We will combine your responses with those of other participants to describe the general picture in Pakistan. If you give permission, this whole discussion will be audio recorded to ensure that the information provided by you is accurately captured. The study team will write down the whole discussion on paper after listening to this recording. This recording will be stored in a computer accessed and protected by a password and written material will be stored in a locked cabinet dedicated to this study. This information will only be accessible to the study team.

5. TERMINATION OF RESEARCH STUDY

If you decide to take part, you are free to skip any questions. You are free to withdraw at any time without affecting your relationship with the interviewing team.

6. AVAILABLE SOURCES OF INFORMATION

You will not be paid for participating in this study. If you have a concern about any aspect of the study, you should ask to speak to the researchers who will do their best to answer your questions. Any complaint about the way you have been treated during the study or any possible harm you might suffer will be addressed. You may call Mrs. Iram Kamran at this number 0092-51-8445566 Ext. 165 for any complaints. For information about your rights or in case of violation of rights you may contact Dr. Gul Rashida at this number 0092-51-8445566 Ext. 129

7. AUTHORIZATION

I have read / heard the Informed Consent for this study. I have received an explanation of the planned discussion and its procedure, risks and benefits and privacy of my personal information. I agree to take part in this study. I understand that my participation in this study is voluntary. "I understand that information obtained in this study will be transmitted only in a form that cannot be identified with me.

Your name: _____

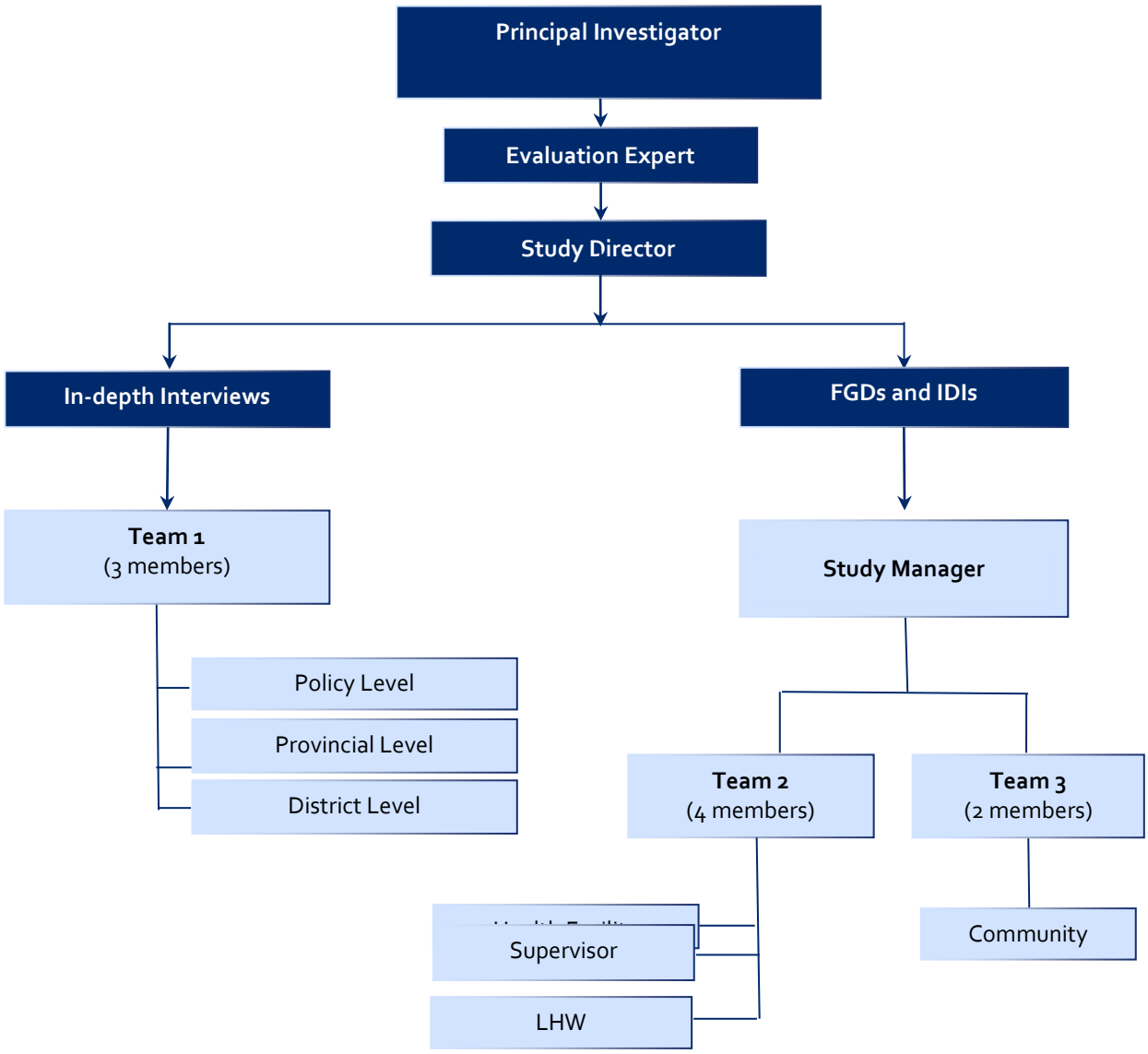
Your signature: _____**Date:**_____

Investigator or person who conducted Informed Consent discussion: I confirm that I have personally explained the nature and extent of the planned research, study, procedures, potential risks and benefits, and confidentiality of personal information.

Name of person obtaining consent:_____

Signature of person obtaining consent: _____**Date:**_____

Appendix 5: Project Organogram



Appendix 6: List of Stakeholders

Policy Level

- Secretary Health
- Special Secretary Health
- Secretary PWD
- Secretary P&D
- Dr Azra Fazal Pechuho, Chairperson, President's Polio Oversight Committee and Member, National Task Force on polio
- Ms Shahnaz Wazir Ali, technical advisor to Sindh government on primary health care

Provincial Level

- LHW Program Manager
- DG Health
- CEO PPHI
- DG PWD
- Manager Nutrition
- Manager MNCH
- Manager EPI
- CEO NGO (HANDS)
- Director Pathfinder
- UNFPA
- UNICEF
- JSI/DELIVER

District Level

- DHO
- DPWOs
- District Coordinator LHW
- MNCH program
- NGOs/ UN Agency rep.

Facility Level

- In charge THQ (1) RHC (1) and BHUs (1)
- In charge RHS-A
- FWC (FWWs)

Supervisor Level

- Lady Health Supervisors

Appendix 7: Plan for IDIs with managers

Date	Team	District	IDI Meetings	Remarks
Monday 02/03/15	1	Karachi	Travel To Karachi from Islamabad	
Tuesday 03/03/15	1	Karachi	**Travel to Hyderabad** DG Health	
Wednesday 04/03/15	1	Karachi	Provincial Coordinator, Deliver Secretary Health Special Secretary Health Secretary PWD	
Thursday 05/03/15	1	Karachi	DG PWD Representative UNICEF CEO PPHI Representative JHPIEGO	
Friday 06/03/15	1	Karachi	CEO HANDS Technical Advisor Primary Healthcare Packard Foundation Secretary P&D	
Saturday 07/03/15	1	Karachi	Compilation of IDIs and summery reports	
Sunday 08/03/15	1	Karachi	Consolidation Meeting **Travel to Hyderabad**	
Monday 09/03/15	1	Hyderabad	Provincial Coordinator LHW Program Buy-in for district activities	
Tuesday 10/03/15	1	Sanghar	• DHO • District manager MNCH • District Coordinator LHW Program	
Wednesday 11/03/15	1	Sanghar	• District Coordinator JSI • Representative of UNICEF • Representative HANDS	
Thursday 12/03/15	1	Hyderabad	Meeting with DH health describing policy documents and recommendation (if any)	
Friday 13/03/15	1		**One team travel to Islamabad (Team-2)** **Travel to Larkana (Team-1)**	
Saturday 14/03/15	1	Larkana	Finalization of IDIs summaries	
Sunday 15/03/15	1	Larkana	Consolidation meeting	
Monday 16/03/15	1	Larkana	• DHO • District manager MNCH • District Coordinator LHW Program	
Tuesday 17/03/15	1	Larkana	• District Coordinator JSI • Representative of UNICEF • Representative HANDS **Travel to Karachi**	
Wednesday 18/03/15	1	Karachi	• Representative UNFPA • Manager EPI • Program Manager MNCH Program • Provincial Manager Nutrition • AMAN Foundation	

Thursday 19/03/15	1	Karachi	**Travel to Islamabad**	

Appendix 8: Field Plan for Conducting FGDs and District IDIs

Day	Date	Team	Activity	Amount of FGDs
1	Wednesday 4/3/15	A+B	•Travel from Islamabad- to Hyderabad and Sukkur	
2	Thursday 5/3/15	A+B	• IDIs In charge = 4 • Summaries =4	IDI In charge = 4
3	Friday 6/3/15	A+B	• IDIs In charge = 4 • Summaries =4	IDI In charge = 8
4	Saturday 7/3/15	A+B	• IDI In charge = 2 • IDI LHS = 2 • Arrangements for FGDs • Arrival of Field Teams • Training on Guidelines	IDI In charge = 10 IDI LHS = 2
5	Sunday 8/3/15	A+B	• Training on guidelines • Travel to Sukker (Team A)	
6	Monday 9/3/15	A+B	• FGD LHWs=2 • FGD Women=2 • Summaries =4 • Community profiles =2	LHWs= 2 Women =2 Com. Profiles=2
7	Tuesday 10/3/15	A+B	• FGD LHWs = 2 • FGDs Women =2 • Summaries = 4 • Community profiles =2	LHWs= 4 Women =4 Com. Profiles=4
8	Wednesday 11/3/15	A+B	**Compilation Day**	
9	Thursday 12/3/15	A+B	• FGD LHWs = 2 • FGD Community=2 • Summaries= 4 • Community profiles =2	LHW= 6 Women =6 Com. Profiles=6
10	Friday 13/3/15	A+B	• FGD LHWs = 2 • FGD Community = 2 • Summaries= 4 • Community profiles =2	LHW= 8 Women =8 Com. Profiles=8
11	Saturday 14/3/15	A+B	• FGD LHWs = 4 • Summaries= 4	LHW= 12
12	Sunday 15/3/15	A+B	• **Compilation** • Travel back (Field Teams)	
13	Monday 16/3/15	A+B	• FGD LHS = 2 • Summaries= 2	FGD LHS= 2
14	Tuesday 17/3/15	A+B	Travel back (Core Team)	

Appendix 9: Letter, Inclusion of LHWS Program Provincial ADP 2015-2016

Ph: 022-9201558 Fax: 022-9201559 E-mail: ppiusindhlhwp@gmail.com

OFFICE OF THE PROVINCIAL COORDINATOR,
NATIONAL PROGRAM FOR FAMILY PLANNING & PRIMARY HEALTH CARE, PROVINCIAL PROGRAM IMPLEMENTATION UNIT SINDH.
BUNGALOW NO. 37, DEFENCE HOUSING SOCIETY, CIVIL LINE HYDERABAD, SINDH

NP/Estt-Sec1`/- Dated:

To,

The Director General,
Health Services Sindh,
Hyderabad.

SUBJECT: **Inclusion of Lady Health Workers Program Provincial ADP 2015-16.**

I have the honour to submit that since the capping of National Program for Family Planning & Primary Healthcare from July 2012 : Rs. 2,310.528 million, there is serious significant shortfall to execute many activities as per approved scope of program. From this amount, hardly salaries and a bit operational activities of PPIU could be met and rest remained standstill.

Attached statement fairly portrays the actual financial requirements, releases and gaps of the program since 2012-13 to 2014-15 and estimated requirement of Rs. 5671.77 million for the next financial year i-e 2015-16. During the last years, insufficient funding had a negative bearing on program activities and its outcomes. Further the staff of the program has been regularized, however, additional funding of approx. Rs. 1500.00 million per year, are essentially required to meet the regular staff salaries, which were quite higher than the contract salary/ stipend ceilings, is still awaited from the Federal Government.

'To keep the program operational for the benefit of community, the scoped out gaps needs to be addressed. It may be worthwhile to mention that other provinces, either through development or non-development, are meeting the financial gaps of programmatic activities for making the services available down to the community level from their respective provincial resources.

In the light of above facts & figures, it is requested that scheme may be got included in the ADP 2015-16.The financial requirement of the program 2015-16 comes to Rs. 5671.77 million. This may be adjusted in accordance with the provisions of the PC-I, the preparation process of which had been initiated.

Provincial Coordinator
National Program for FP & PHC
PPIU Sindh @ Hyderabad

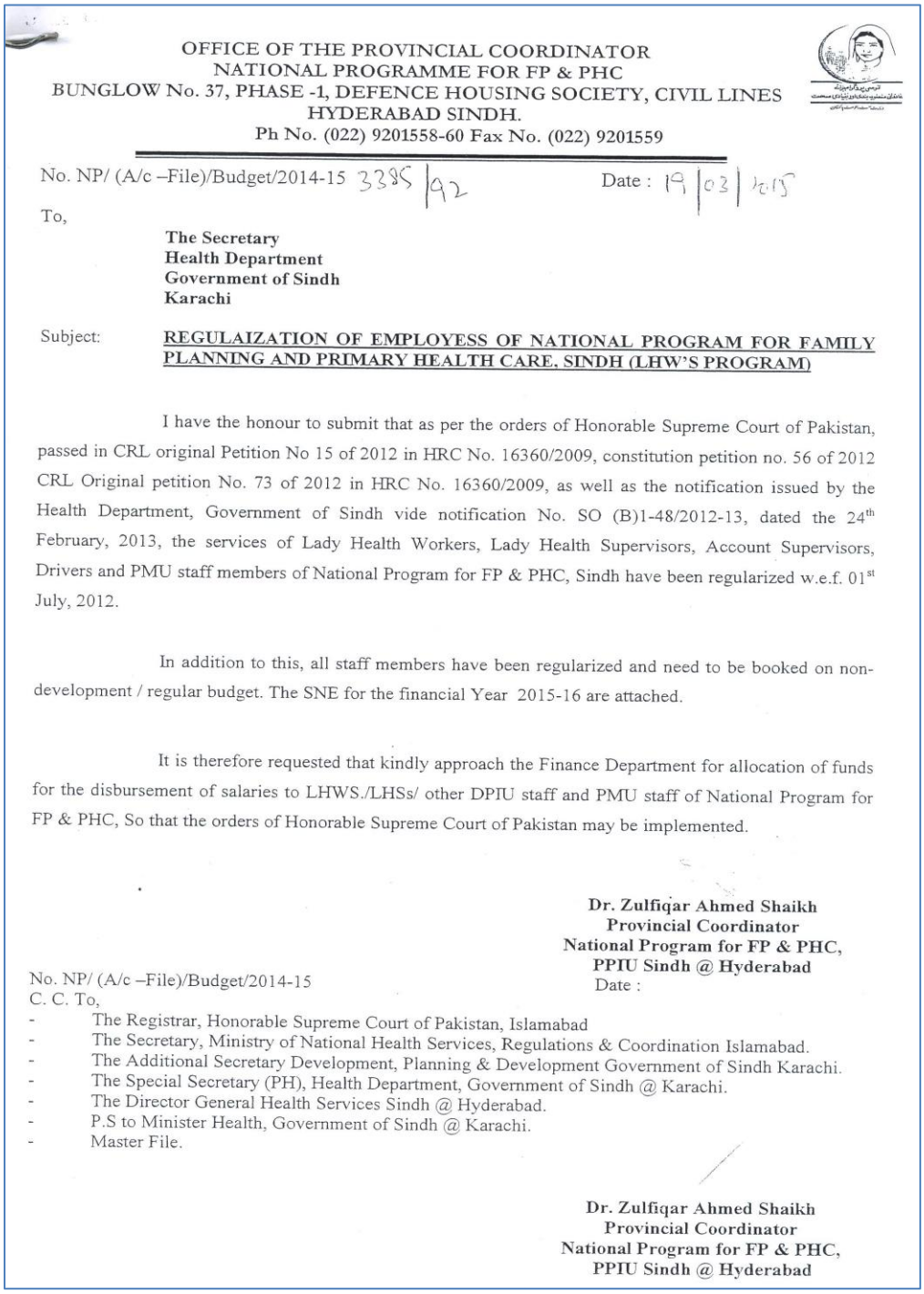
No. NP/Estt-Sec1`/- 1316/21 Dated: 27/1/15

CC to :

- The Secretary Health, Health Department, Government of Sindh, Karachi
- The Special Secretary (P.H), Government of Sindh, Karachi
- The Additional Secretary (Dev), Government of Sindh, Karachi
- Dr. Shabeer Chandio, Us-Aid, Karachi
- Master File

Provincial Coordinator
National Program for FP & PHC
PPIU Sindh @ Hyderabad

Appendix 10: Letter, Regularization of employees of National Program for Family Planning and PHC



OFFICE OF THE PROVINCIAL COORDINATOR
NATIONAL PROGRAMME FOR FP & PHC
BUNGLOW No. 37, PHASE -1, DEFENCE HOUSING SOCIETY, CIVIL LINES
HYDERABAD SINDH.
Ph No. (022) 9201558-60 Fax No. (022) 9201559

No. NP/ (A/c –File)/Budget/2014-15 3385 /92 Date : 19/03/2015

To,

The Secretary
Health Department
Government of Sindh
Karachi

Subject: **REGULAIZATION OF EMPLOYESS OF NATIONAL PROGRAM FOR FAMILY PLANNING AND PRIMARY HEALTH CARE, SINDH (LHW'S PROGRAM)**

I have the honour to submit that as per the orders of Honorable Supreme Court of Pakistan, passed in CRL original Petition No 15 of 2012 in HRC No. 16360/2009, constitution petition no. 56 of 2012 CRL Original petition No. 73 of 2012 in HRC No. 16360/2009, as well as the notification issued by the Health Department, Government of Sindh vide notification No. SO (B)1-48/2012-13, dated the 24th February, 2013, the services of Lady Health Workers, Lady Health Supervisors, Account Supervisors, Drivers and PMU staff members of National Program for FP & PHC, Sindh have been regularized w.e.f. 01st July, 2012.

In addition to this, all staff members have been regularized and need to be booked on non-development / regular budget. The SNE for the financial Year 2015-16 are attached.

It is therefore requested that kindly approach the Finance Department for allocation of funds for the disbursement of salaries to LHWS./LHSs/ other DPIU staff and PMU staff of National Program for FP & PHC, So that the orders of Honorable Supreme Court of Pakistan may be implemented.

Dr. Zulfiqar Ahmed Shaikh
Provincial Coordinator
National Program for FP & PHC,
PPIU Sindh @ Hyderabad

No. NP/ (A/c –File)/Budget/2014-15
Date :

C. C. To,

- The Registrar, Honorable Supreme Court of Pakistan, Islamabad
- The Secretary, Ministry of National Health Services, Regulations & Coordination Islamabad.
- The Additional Secretary Development, Planning & Development Government of Sindh Karachi.
- The Special Secretary (PH), Health Department, Government of Sindh @ Karachi.
- The Director General Health Services Sindh @ Hyderabad.
- P.S to Minister Health, Government of Sindh @ Karachi.
- Master File.

Dr. Zulfiqar Ahmed Shaikh
Provincial Coordinator
National Program for FP & PHC,
PPIU Sindh @ Hyderabad

Appendix 11: Guidelines and protocols for FGDs and Key Informant interviews

Guidelines for IDIs with Policymakers

Basic Information

Name of the respondent	
Designation	
Contact Number	
Duration of working?	
Address	
Date of Interview	

1. In your opinion what has been the impact of de-federalization of LHW program after devolution.

   Do you think it has strengthened the program or weakened it?
2. What is the department of health's vision for the LHW Program in the next 3-5 Year?
   - Do you expect the program will follow its original objectives or do you envisage a change in the working of the program?
   - What can be realistically expected from the program?
3. What are specific strengths/achievements of the program according to DOH/PWD?
4. What are specific weaknesses of the program?

   Is the department:
   - Planning to address these issues in the next 3 years?
   - How is it planning to do this?
   - What sources of funding are available for this now and in the future?
5. What are the various opportunities that can be tapped into in the future that can further strengthen the program?
6. What could be the possible threats outside the program that can jeopardize its continuation in the future?
7. How is the working relationship between the LHW program and PPHI?
8. Do you think that the focus of LHWs has shifted from the original mandate? If yes, in what ways?

Existing issues (salary etc.)

9. Are the LHW's receiving their salary regularly, what contribution is being made by the Sindh government through any bridge financing mechanism.
10. Is the any policy/funds available for refresher trainings/continuing education of LHWs?
11. What is the current process by which the LHW's work priorities are determined
    a. Community demand
    b. Donor priorities

c. Departments own priorities

d. Federal government instructions.

12. How is the current LHW performance assessed at the district and provincial level? Are there any district/provincial KPI's?
13. Are sufficient funds available for P.O.L for LHS?
14. Does the Provincial Technical Committee meet regularly and does the LHW program's working come under discussion?
15. In the past, there was a Technical Advisory Group at the federal level that approved any innovations that were introduced into the program? Is there such a mechanism at the provincial level?

Issues with regularization

16. How does the DOH/PWD expect that program will change now the LHWs are regularized, if any?
17. Can LHWs be terminated after being regularized?
18. What is the retirement age? If any?
19. What is the policy for replacement of those LHWs who retire? Will the new appointees get a temporary contract or regular job?
20. What will be the policy for availing leave/medical benefits/gratuity/provident fund?
21. After regularization, are there any plans for developing a career pathway for the LHWs?

Future Plans

22. Once the federal funds end, what are the future plans for sustainability / funding for the LHW program?
23. Are there any existing plans for expansion of LHWs and how many (targets) and where and when?
24. How is the DOH/PWD planning to provide outreach in areas not covered by the LHW Program?
25. Is Government planning to establish some functional/ programmatic integration between PWD & LHW program, If yes what?
26. What are the DOH's plans regarding coordination with (or absorption of) community health workers outside of the LHW Program?
27. Finally in your opinion is there a need to restructure the LHW program, if so, how?

Guideline for IDIs with Provincial/NGO Heads

Basic Information

Name of the respondent	
Designation	
Contact Number	
Duration of working?	
Address	
Date of Interview	

1. What do you know about the LHW program being implemented in the province of Sindh?
2. Have you been involved with LHW program? If yes, in what capacity and since how long?
3. In your opinion, which areas of LHW program are currently strong?
4. In your opinion, which areas of LHW program are currently weak?
5. What are the reasons for the weak areas?
6. What are your suggestions to improve the weak areas?
7. How has the role of LHWs changed in the last 10 years and more specifically in last 4 years after devolution?
8. What are the various opportunities that can be tapped into in the future that can further strengthen the program?
9. What could be the possible threats outside the program that can jeopardize its continuation in the future?
10. What are current human resource constraints?
11. What is the long-term plan, particularly in the post-devolution environment?
12. What aspects of the program keep LHWs motivated?

Existing issues

13. Are there challenges in effectively monitoring the performance of LHWs? Please mention?
14. What would be required to overcome these challenges?
15. Currently are there any measures being taken to improve the quality of LHWs work. If so describe?
16. Do LHWs receive any refresher trainings?
17. Are the LHW's receiving their salary regularly, what contribution is being made by the Sindh government through any bridge financing mechanism.
18. In the past, there was a Technical Advisory Group at the federal level that approved any innovations that were introduced into the program? Is there such a mechanism at the provincial level?
19. How is the current LHW performance assessed at the district and provincial level? Are there any district/provincial KPI's?
20. Are sufficient funds available for P.O.L for LHS?

Issues with regularization

21. How does the DOH/PWD expect that program will change now after regularization of LHWs, if any?
22. After being regularized, how will the program cope with issues of retirement/ replacement/ dismissal from service?
23. Are there any plans for developing a career pathway for LHWs?
24. What will be the policy for availing leaves/medical benefits/gratuity and provident funds?

Future Plans

25. What approaches is the DOH using to address the financial and logistical challenges for keeping the LHW Program going?
26. How is the DOH/PWD planning to provide outreach in areas not covered by the LHW Program?
27. What are the DOH's plans regarding coordination with (or absorption of) community health workers outside of the LHW Program?
28. Finally in your opinion is there a need to restructure the LHW program, if so, how?

Guideline for In-depth Interview (IDIs) with facility In-charge

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

Demographic profile of In-charge of facility

Guideline for In-depth Interview (IDIs) with facility In-charge

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

Demographic profile

District: _____ Tehsil:_____ Union Council: _____

Facility name:_____ Moderator: _____ Note taker:_____

Date: _____

S. No	Questions	Responses
1	Name	
2	Designation	
3	Age	
4	Education	
5	Working experiences (overall)	
6	Years working at this facility	
7	Marital status	Married: _____ Unmarried: _____
8	Contact number	_____
9	Facility Address	_____ _____ _____

Guideline for In-depth Interview (IDIs) with facility In-charge

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

1. Consent form
2. Profile of in-charge

As you know that, the Government of Pakistan has taken several initiatives to improve the health of its population, particularly women and children. The National Program Family Planning and Primary Health Care (also known as the Lady Health Workers [LHW] Program) is one such initiative. The purpose of today's discussion is to take stock of the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province at the beginning of 2015, and to determine how best the access to quality, community based services can be ensured in Sindh Province in the coming years.

Responsibilities

1. Are you involved with the LHW program?
2. In what capacity?

Monthly meeting

3. How often monthly meeting of LHWs held at your facility?
4. Who conducts this meeting?
5. What is discussed in these meetings
6. How do you address the issues highlighted/ discussed during these meetings?
7. How effective is the monthly meeting?
8. Is it used as a forum for continuing education? What is your opinion about the importance of monthly meetings in terms of continuing education for LHWs?

Stock

9. What is the situation regarding the availability of stock of medicines/supplies and contraceptives for LHW? (If stocked out then how do they manage)?

Referral

10. How well is the referral mechanism working? What is the referral outcome?
11. On average how many referrals are generated by LHWs in a month?

    ANC, Delivery, PNC, Child Care, Family Planning,

LHW Program

12. How has the role of the LHW changed in the past ten years?
13. In your opinion, what are the strengths/achievements of the LHW program?
14. In your opinion what are the gap and weaknesses of the LHW program?
15. In recent years, do you think that the LHWs have shifted away from their original mandate?
16. Is there any change in any aspect of LHWs job in past 4 years (after devolution) in terms of salary, regularization, medicines/ contraceptive availability, supervision, capacity building and management?

Challenges

17. In your opinion, what challenges LHWs have to face while performing their job duties?
18. In your opinion, what challenges LHSs have to face while performing their job duties?

Suggestions

19. . What type of suggestions do you have to improve the LHW program?

Guidelines for IDIs with District Managers

Basic Information

Name of the respondent	
Designation	
Contact Number	
Duration of working	
Address	
Date of Interview	

1. What do you know about the LHW program being implemented in your district?
2. Have you been involved with LHW program and in what capacity, since how long?
3. How many LHWs are working in your area?
4. Are there any human resource issues (e.g. recruitment, deployment and retention of LHWs and LHS)? If yes how are they handled?

Quality of Outreach

5. How is the quality of LHW outreach/capacity of LHWs ensured?
6. What changes if any are needed to improve capacity and quality of services?

Supply chain

7. Which are the issues most commonly found in the LHW Program with regards to supply chain of medicines/supplies?
8. How are they addressed?
9. Post-devolution, has the number of medicines available with LHWs increased/decreased/same?

Supervision

10. What is the Supervisory System of LHWs?
11. How are LHSs supported in monitoring and supervision of LHWs?
12. What approaches is the DOH using to strengthen and enhance the LHS capacities?
13. What impact has the regularization of LHWs had on their performance/motivation of LHWs?
14. What type of trainings they have attended/ received in last 6 months to improve their skills in conducting supervision and monitoring?
15. Are there any performance indicators to assess the progress of LHW and LHSs? If yes what?
16. What is the feedback mechanism to improve the performance of LHWs and LHSs?

Maternal Mortality Conference

17. Are you involved in the conduct of MMC:
    a. If yes, how
    b. How often is it held
    c. Who are the members, who attend the MMC?
    d. Is it regularly conducted?

e. What is outcome of these meetings?

18. Is there any follow-up/verification of the maternal deaths Referral System?
19. What is the current referral system and how is it implemented?
20. Is there any horizontal referral mechanism between PWD and DoH?

Trainings

21. Is there any system of regular refresher trainings being provided to LHWs? If yes, what?
    a. Type of training
    b. How often
22. What are future plans for these trainings? Are there any funds allocated for future trainings?
23. In your opinion, is the program been effectively implemented?
24. In your opinion, what are the strengths or achievement of the program (Please mention)?
25. In your opinion, what are the gaps in implementation? How can they be improved?

Guideline for Focus Group Discussion (FGDs) with LHSs

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

1. Consent form
2. Profile of LHS

As you know that, the Government of Pakistan has taken several initiatives to improve the health of its population, particularly women and children. The National Program Family Planning and Primary Health Care (also known as the Lady Health Workers [LHW] Program) is one such initiative. The purpose of today's discussion is to take stock of the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province at the beginning of 2015, and to determine how best the access to quality, community based services can be ensured in Sindh Province in the coming years.
Supervision

1. How frequently do you meet with LHWs and where?

2. How do you go about conducting your supervisory activities? Are you able to follow what you plan or there are some issues/ problems in following that?

- What issues do you face?

3. Do you conduct any real time monitoring of LHWs work by making surprise visits/spot checks?

4. How do you travel for your supervisory visits to LHWs?

- Vehicle provided by department
- POL provided
- Travel cost provided (if yes , do you get it regularly)
- Does these problems compromise supervision

5. What are your priorities during supervision?

6. What mechanism of providing feedback to LHWs do you employ? Evidence of LHS feedback to LHWs should be reviewed? (See their visit notes)

7. How do you assess the quality of LHWs work?

8. Is there any change in any aspect of LHWs job in past 4 years (after devolution) in terms of salary, regularization, medicines/ contraceptive availability, supervision, capacity building and management?

9. How do you help LHWs set their priorities and review performance against priorities?

10. Is there any variation in the performance of LHWs and reasons for such variation?

11. LHW records should be reviewed with LHSs to determine how updated the records are and to collect information on the average number of LHW household visits per month, provision of contraceptives, participation in campaigns etc.

12. How the information regarding LHWs' performance (on the average number of LHW household visits per month, provision of contraceptives, and participation in campaigns) shared with the district office?

13. What type of forum is used to highlight some of the weaknesses in the program with district and provincial management staff?

13. Do LHWs have adequate stock of medicines and contraceptives?

14. Do you think LHWs are currently over burdened by doing activities other than they are normally supposed to do?

15. How regular are the monthly meetings with LHWs at HF level?

- What is discussed in these meetings
- How do you address the issues highlighted/ discussed during these meetings?

Challenges

16. What are the biggest challenges in your work?

17. How big a problem is your personal security?

18. What precautions do you take to protect yourselves?

Suggestions

19. What type of suggestions do you have to improve the LHW program?

Focus Group Discussion (FGDs) with LHSs

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

District: _____ Moderator: _____ Note taker: _____ Date: _____

Sr. No	Name of respondent	Tehsil	Age	Education	Marital Status	No of children	Working Experiences as LHS	Attached LHWs	Distance from far most LHW
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Guideline for Focus Group Discussion (FGDs) with LHWs

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

Demographic profile of LHWs

S. No	Questions	Responses
1	Name	
2	Age	
3	Education	
4	Working experience in the community	
5	Joining year as LHW	
6	Population attached	
7	Registered house hold	
8	Eligible couples in catchment area	_____
9	FP use status of clients	Current User: _____ Past users: _____ Never Users: _____
10	How much distance you travel to reach your far most client	KM:_____
11	Frequency of visit of LHS to you	
11	Average hours per week spend on LHW responsibilities	Hours:_____
Personal information		
12	Marital status	Married: _____ Unmarried: _____ (go to 16)
13	(if currently married) Husband's education	
14	Husband's occupation	

15	Number of children	Sons:_____ Daughters:_____
16	Any other work than LHW	Yes _____ No _____
17	If yes, what do you do	_____
18	Reasons for any doing other job	
19	Monthly income (LHW salary+ other work)	RS:_____
20	Contribution in financial responsibilities of household	

Guideline for Focus Group Discussion (FGDs) with LHWs

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

District:_____ Tehsil:_____ Facility name:_____

Facility In charge name: _____ Designation: _____

Total attached LHWs: _____ Total LHWs Participants: _____

Moderator: _____ Note taker: _____ Date: _____

3. Consent form (To be filled by LHWs)
4. Profile of LHWs

As you know that, the Government of Pakistan has taken several initiatives to improve the health of its population, particularly women and children. The National Program Family Planning and Primary Health Care (also known as the Lady Health Workers [LHW] Program) is one such initiative. The purpose of today's discussion is to take stock of the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province at the beginning of 2015, and to determine how best the access to quality, community based services can be ensured in Sindh Province in the coming years.

Responsibilities/ Routine

1. What are your key responsibilities as LHW?

2. How much time is spent in the community (in a month)?

3. How much time is spent at facility (including accompany referred clients, meeting, receiving stock) in a month?

4. If you need a transport to visit clients, do you use your own transport to visit the households registered with you or you get some transport facility from the program?

5. If you use your transport, do you get compensation?

Trainings

6. How often and in what areas do you receive trainings?

7. Are you confident about the level of trainings you received?

- If yes how?
- If No, why not?

8. Do you want refresher trainings and if yes in which areas?

Referrals

9. On an average, how many referrals per month do your generate for your FLCF?

(ANC, PNC, New born care, family planning, general health)

10. How are your referrals received at the facility (details)?

11. What mechanism do you have of following up on your referrals?

Supervision/ meeting

12. What support do you get from your supervisor for your work/the LHS?

13. How frequently do you meet with your supervisor in a month?

- Purpose of the meeting
- What occurs during these meetings

Stock

14. Do you have adequate stock of contraceptive and general medicines?

- If you face any stock out , how often
- What action do you take in this situation

Challenges

15. What are the biggest challenges in your work?

- At household level
- At Community level
- At facility level

16. How big a problem is your personal security?

17. What precautions do you take to protect yourselves?

18. How do you manage competing work priorities?

19. Do you consider certain types of outreach/ service provision more important?

20. What might enable you to complete your work responsibilities with greater effectiveness?

(Salary, allowance, security, transport, other)

21. Are you comfortable with additional assignments other than your assigned ToRs?

22. How far those additional assignments (Polio, other) hamper your regular activities/ quality of work?

23. How far are Village health Committees (VHC) & Women Support Groups functional in your areas and how regular are these meeting?

24. Do you expect that your financial and work situation will improve now that you are regularized?

- If yes, how
- If no, why not

25. Is there any change in any aspect of your job in past 4 years (after devolution) in terms of salary, regularization, medicines/ contraceptive availability, supervision, capacity building and management?

26. Do you receive your salary regularly?

Suggestions

27. What type of suggestions do you have to improve the LHW program?

Guideline for Focus Group Discussion (FGDs) with community women

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

1. Consent form
2. Profile of Community women
3. Selection Criteria: (pregnant women, women who have recently delivered within 6 months)

As you know that, the Government of Pakistan has taken several initiatives to improve the health of its population, particularly women and children. The National Program Family Planning and Primary Health Care (also known as the Lady Health Workers [LHW] Program) is one such initiative. The purpose of today's discussion is to take stock of the strengths, weaknesses, opportunities and threats of the LHW Program in Sindh Province at the beginning of 2015, and to determine how best the access to quality, community based services can be ensured in Sindh Province in the coming years.

1. What health facilities (especially for women) do you have in your area?
2. What is your perception regarding role of LHWs in the community?
3. Has this perception changed over time and how?
4. In your opinion, is there any change in priorities of LHW's job responsibilities in last few years?

- Home visits
- FP services
- Polio/ immunization
- Any other

5. Has LHW ever visited your house in last three months? How many times?

Anti natal (Pregnancy)

6. What did she do during pregnancy? What information did she provide?
    - Diet, anemia checkup, TT shorts, danger signs, preparation for delivery etc.

Natal (delivery)

7. Who delivered you/ who usually conducts deliveries?
8. Where do women have their deliveries conducted/ where were you delivered?
    - At home / at facility
9. Does LHW of your area usually present at the time of delivery?

Post Natal

10. Did she visit you for post-natal checkup and what did she do and advice?
    - Information regarding FP, information about new born, growth monitoring, immunization, breast feeding, weaning etc.

Referral

11. Did LHW refer you to a health facility for ANC, delivery, postnatal, newborn care or family planning?
12. Did you visit the health facility as a result of the referral?
13. Are you satisfied with the care you received at the facility?

General

14. Do you value LHWs' advice/guidance?

15. With whom does the LHW talk when she visits the household? Does she address other family members also?

16. Do you know that LHWs have group meetings (support groups) to educate women in the community on health related issues? If yes, what are you views about this meeting?

17. Have you attended any group meeting / has your husband attended any health meting?

Suggestions

18. How can the role of LHW be improved to better serve the community? On which services, should she focus more?

19. Do you think there is a need for a male health worker for your area as you have LHW?

Profile of FGDs with community women

"Assessment of Lady Health Workers (LHWs) Program, Sindh"

Selection Criteria: (pregnant women, women who have recently delivered within last 6 months)

District: _____ Community Name: _____ LHW attached with facility (name): _____

Moderator: _____ ___ Note taker: _____ Date: _____

Sr. No	Name of Respondent	Age	Education	Occupation	Husband Age	Husband Education	Husband Occupation	Current status P Months * D Months **	No. of children S/ D	Age of Youngest child
1										
2										
3										
4										
5										
6										
7										
8										

P* currently pregnant D**Delivered within last 6 months

Appendix 12: Profile of LHWs who participated in FGDs

			Sanghar	Larkana	Total
Marital status	Married	%	91	72	81
		n	53	43	96
	Unmarried	%	9	28	19
		n	5	17	22
Education status	Middle	%	41	23	31
		n	24	13	37
	Matric & above	%	59	77	69
		n	34	47	81
Dual employment (Yes)		%	3	12	8
		n	2	7	9
Distance to farthest client	Less than 1 KM	%	83	88	86
		n	48	53	101
	1 KM	%	12	10	11
		n	7	6	13
	2 KM	%	0	2	1
		n	0	1	1
	3 KM	%	5	0	2
		n	3	0	3
Total LHWs		**n**	**58**	**68**	**118**