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منظمة الصحة العالمية
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Agenda item 6 (c)

Pakistan's experience in Lady Health Workers (LHWs) Programme

Ministry of Health,
Government of Pakistan
Islamabad

National Programme for Family Planning & Primary Health Care

Promoting Health; Reducing Poverty

by Bridging the gap between the Health Services and Communities by providing QUALITY Integrated Health Services to the Doorsteps of our Communities.



Programme Structure:

Structure:

In order to address the objectives in as cost-effective approach as possible, the programme was designed to avoid heavy super-structure. Services at the community level are being managed by units attached to the Ministry and departments of Health – the Federal Programme Implementation Unit (FPIU), the Provincial Programme Implementation Unit (PPIU) and the District Programme Implementation Unit (DPIU). These Implementation Units are staffed either by health department employees on deputation or by contract employees.

A separate cadre of Lady Health Supervisors (LHS) is responsible for ongoing supervision and monitoring, and is employed by the Programme on contract basis. The LHS reports to and attends a monthly meeting at the DPIU. The LHW works from her home – where she is required to have one room designated as a 'Health House'. Each LHW covers 1000 population.

Nature of Activities:

The Lady Health Worker is the lynch pin for all activities of the National Programme. The Programme provides all services under the primary Health Care to the communities at their doorsteps. The activities include:

- LHWs register all the population of her catchment's area for provision of services focussing on the priority age groups i.e. children under five and eligible couples (Married women 15-49 year of age) of their area for motivation and counselling of family planning.
- LHWs organize the community by developing women groups and Health committees in her area – an important aspect of the primary health care approach.
- LHWs discuss with community issues related with better health, hygiene, nutrition, sanitation and family planning emphasizing their benefits towards improved quality of life.
- LHWs act as liaison between formal health system and community.
- To disseminate health education message to their community on hygiene and sanitation.
- LHWs provide essential drugs for treatment of minor ailments like diarrhoea, malaria, acute respiratory tract infection, intestinal worms etc. and contraceptive materials to eligible couples.
- LHWs strengthen the EPI Programme to improve vaccination status of the women and children.
- Lady Health Workers provide motivation and referral service to mothers for safe motherhood including ante natal, safe delivery and postnatal care. LHWs achieve this by close coordination with the nearest Health Facility, Traditional Birth Attendants (TBAs) and other Skilled Birth Attendants including midwives.

Background

Health Status in Pakistan:

The health status of the people of Pakistan is well below the averages for all low-income countries in key indicators, although its GNP per capita is above the average for low-income countries. Contributing factors include poverty, low literacy, lack of proper sanitation and water, weaknesses in the health care delivery system including insufficient focus on preventive interventions, gender imbalances, weak human resource development and insufficient funds.

MCH and FP Indicators in relation to the Pattern of Health Expenditure - Comparison with Countries of the Region

Country	Population (000)	Annual Growth Rate (%) 2001	TFR	IMR per 1000 Live Births	Prevalence of malnutrition in Under 3 (%)	EPI Coverage (%)- 1999	MMR per 100,000 Live Births - 2001	CPR (%) - 2001	THE as % of GDP - 2000	GHE as % of THE - 2001	Per capita THE in US $ 2000	Per capita GHE in US $ 2000
Bangladesh	140 368	2.2	3.6	67	47.8	72	600	43	3.8	36.4	14	5
Egypt	69 079	1.9	3.0	40	11.7	94	170	46	3.8	46.1	51	24
India	1 025 095	1.8	3.1	65	47	55	440	43	4.9	17.8	23	4
Indonesia	214 839	1.5	2.4	40	26.4	72	470	55	2.7	23.7	19	5
Iran	71 368	1.8	2.9	36	10.9	99	130	56	5.5	46.3	258	119
Pakistan	144 971	2.6	5.2	87	38.2	56	200	17	4.1	22.9	18	4
Sri Lanka	19 103	1.0	2.1	20	33	99	60	44	3.6	49	31	15
Thailand	63 583	1.4	2.0	21	18.6	97	44	70	3.7	57.4	71	41

Source: World Health Report 2002, World Development Report 2002
OOP - Out of Pocket Expenditure
THE – Total Health Expenditure
GHE –Government Health Expenditure

Launching of a National PHC Programme:

Being a signatory to the Alma Ata Declaration of 1978, the Government of Pakistan (GoP) is committed to the goal of achievement of "Health for All" through the Primary Health Care approach. To this end the GoP launched the Prime Minister's Programme for Family Planning and Primary Health Care (PMP-FP&PHC) through the Ministry of Health (MoH) in 1994 with the aim of preventing and treating common ailments at the community level in a cost effective manner.

The programme now covers almost all districts of Pakistan providing essential primary health care services to the community through female community health workers (the Lady Health Worker). The Programme was funded till June 2003. The program has been extended through a new PC-1 2003-2008 approved by ECNEC on 7th January 2004 at a cost of Rs. 21,533.502 million .



LHW educating a mother on preparation of ORS



LHWs play an important role during Polio NIDs,

Management:

The Ministry of Health and the National Coordinator of the FPIU liaise with the Provincial Coordinators - who remain employees of the Provincial Departments of Health and close co-ordination and co-operation between the Managers of the FPIU and the PPIUs is ensured with regular meetings and an effective reporting system.

The Executive District Officer, Health (EDO)/District Health Officer (DHO) has responsibility for staff at the district level.

Funding:

The Programme is funded by the Federal Government. The allocated budget for the programme was Rs 9.104 billion for the first 8-year phase of the Programme. Due to extension in the time period and added activities, an amount of Rs.9.487 billion was released till 30th June 2003, whereas the actual expenditure is Rs.9.362 billion.

Details of Province wise Funding for the NP for FP and PHC, from FY1993-94 to 2003-04

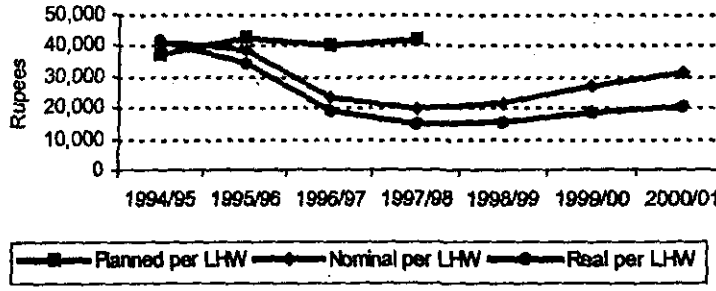
(Rs. In million)

Year	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	Total
mount llocated	49.6956	750	1000	1500	1200	1100	1200	1400	2256	1791	2,600.000	14846.696
mount ased	21.685	373.005	999.882	877.000	852.500	985.396	975.000	974.097	1796.386	1632.379	2,434.012	11921.342
nditure	21.685	373.005	999.882	877.000	852.500	984.375	891.327	974.097	1770.415	1617.891	2,427.012	11776.951
ederal	1.685	187.671	442.160	243.660	227.880	104.375	205.454	186.187	690.609	242.897	888.432	3414.644
unjab	16.000	86.470	235.051	282.660	279.327	418.288	294.472	362.491	490.946	607.129	667.056	3736.634
ndh	0.000	31.190	165.000	160.430	148.840	239.891	157.948	197.053	269.503	355.022	424.569	2148.458
WFP	0.000	25.520	67.411	75.270	77.649	97.340	116.683	95.417	140.584	215.281	208.892	1119.614
alochistan	0.000	9.450	30.670	50.950	48.930	50.920	58.259	58.135	89.248	95.736	118.908	609.337
IK	2.000	19.060	28.920	31.060	30.256	43.281	26.389	39.873	48.496	49.916	59.504	378.790
NA	2.000	11.030	21.470	22.060	24.138	18.209	25.279	21.451	26.192	28.960	32.781	234.476
TA	0.000	2.000	5.500	4.540	8.540	7.569	1.706	5.671	8.095	14.340	24.689	82.335
T	0.000	0.614	3.700	6.370	6.940	4.502	5.137	7.819	6.742	8.610	9.181	59.665

Item wise Expenditure of the NP for FP and PHC (Rs. In million)

Years	Establishment	Printing	Medicine	Non-drug items	Vehicle	Media	Contingencies (POL, Repair, Stationary)	Total
1993-94	0.000	0.000	0.000	0.000	0.000	0.000	21.685	21.685
1994-95	31.442	7.901	56.750	0.000	38.850	47.630	190.432	373.005
1995-96	320.291	16.103	140.857	32.068	216.000	37.000	237.563	999.882
1996-97	480.366	0.000	214.700	12.714	2.000	18.000	149.220	877.000
1997-98	573.232	28.000	173.406	2.563	0.836	23.564	50.899	852.500
1998-99	803.117	10.683	85.756	1.467	0.300	1.184	81.868	984.375
1999-00	636.297	29.698	98.812	12.215	19.305	51.853	43.148	891.328
2000-01	629.591	24.000	92.000	1.523	0.000	11.000	215.983	974.097
2001-02	969.417	41.357	501.103	28.717	102.898	40.791	86.132	1770.415
2002-03	1301.554	20.055	66.754	16.643	87.120	50.026	75.739	1617.891
Total	5745.307	177.797	1430.138	107.910	467.309	281.048	1152.669	9362.178

Expenditure per LHW, 1994/95 – 2000/01



Funds are released to the Federal PIU and Provincial PIUs of the Programme through the Federal Ministry Of Health and AGPR by the Ministry Of Finance.

Decision Making

Levels of programme responsibility are given in the table below

Levels of Responsibility

Federal MoH FPIU	PHC Policy formulation, National Reporting, Internal M & E, Curriculum development, Training, Programme, Procurement/Distribution, Operational Planning and budgeting, Financial Accounting, HMIS System
Provincial Health Department PPIU	Internal Monitoring, Programme Reporting, District LHW Allocation, Operational Plan Implementation, Accounting and Budgeting, Payroll, Organization of Training, Distribution, HMIS Data Collation
District Health Office DPIU	LHW-FLCF Allocation, Supervision, LHW Firing, LHS- Hiring/Firing, Training, Operational Plan Implementation, Distribution of supplies, Vehicle maintenance, Accounting, Programme Reporting, HMIS Data Collation
FLCF	Selection of LHWs, Training of LHWs, Collation of HMIS Data, Organizing Kit replenishment, Providing meeting point for LHWs and LHS

In its current structure, the Programme can be seen to be centrally funded and directed from the Federal level, but with key operational decisions taken at the provincial and district levels. These operational decisions have a major impact both on the efficiency with which services are delivered and their impact on health outcomes.

Supervision and Monitoring

The Programme has a multi-tiered supervisory system. Supervision of the LHW on a day-to-day basis is provided by the Lady Health Worker Supervisor (LHS) who uses a structured checklist for monitoring LHW performance. The Programme has a provision for one LHS for 20 – 25 LHWs.

At the Provincial level, Field Programme Officers (FPOs) are employed on contract to monitor the programme in two or three districts and report back to the PPIU on monthly basis.

Province	# of LHWs Working	Population Covered by LHWs	No. of Supervisors	Vehicles
Punjab	36651	37365588	871	1004
Sindh	18379	19013124	621	508
NWFP	10327	1174874	286	316
Balochistan	5372	5813520	197	192
AJK	2363	1765969	76	93
FANA	878	948240	44	57
FATA	1207	678095	23	37
ICT	306	275675	8	12
FPIU				05
Total	75483	77035085	2126	2224

Community Involvement

Each LHW is responsible for establishing a village health committee. The functions of the committee vary across the country. The women and men's health committees are mandated to meet regularly - at least once every month and keep minutes of their meetings.



LHWs form Women Committees for Mobilisation on Health

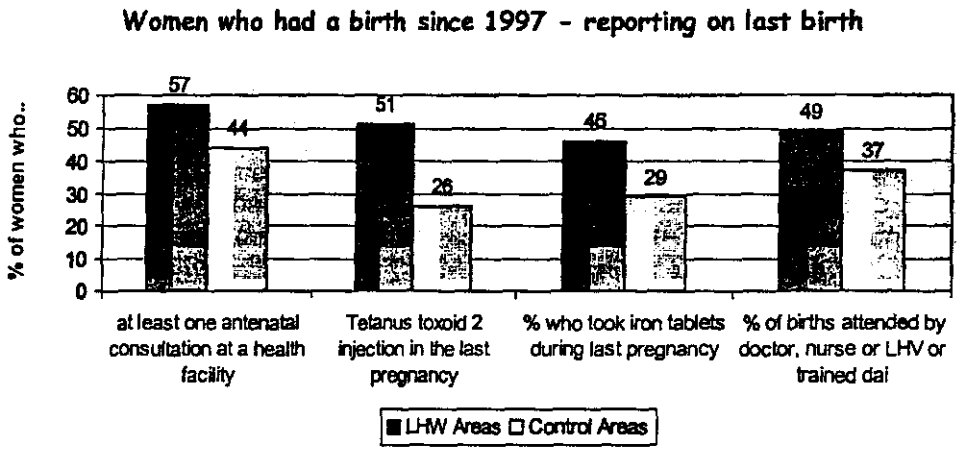
Third Evaluation Report: Community response on the LHW and her work (female respondents)

Measure	Value
% that know the LHW and know she is working as a LHW	98
% that state the LHW lives most of the time in the village/mohalla	94
% that state that it is usually possible to go for a consultation at the LHW's home	93
% that state that the LHW goes to visit households on most days of the week	78
% that state that the LHW has visited married women in their homes in the last month	72
% that state that there have been improvements in health due to the LHW's work	71
% that say that the LHW has generally improved people's lives in the community	78
% that say that women are usually respected after becoming LHWs	89

Key findings from the Third Evaluation

> *"The LHW programme has been very valuable in extending coverage of preventive services. Because the LHWs are from the communities where they work, and because they are women, they are able to have close interaction with the women in the community, and through them reach children as well."*[1]

While the monitoring reports and the two earlier Evaluations done in 1885 and 1996, by the Programme had indicated major achievements, it was decided to have an independent evaluation of the Programme. The Third Evaluation was initiated in 1999 and was completed in 2002. It was carried out by Oxford Policy Management – a UK based organization and funded by DFID[2]. The findings from this evaluation covered the impact of the Programme services on health outcomes, the level of service delivery, the effectiveness of organisational systems, and an analysis of the level of programme funding. **Overall the Third Evaluation demonstrated that the NP-FPPHC was delivering results that were unique both nationally and internationally.**



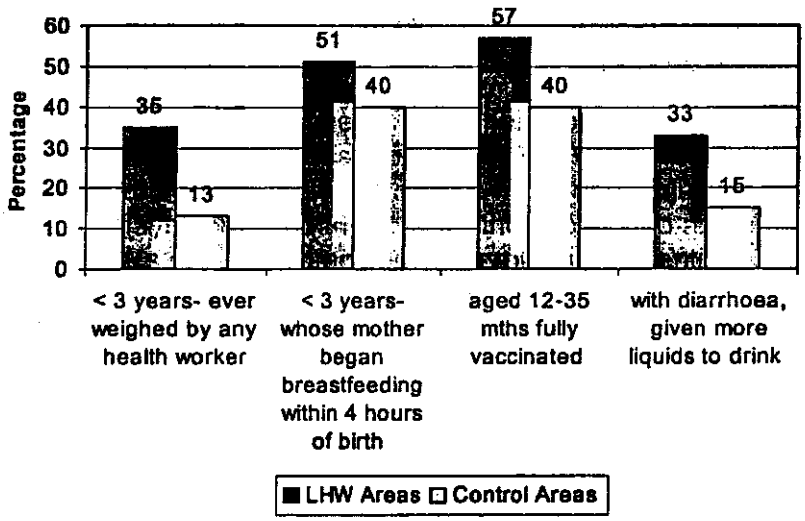
1 World Bank, Report No. 16695-PAK Pakistan Towards a Health Sector Strategy Nutrition and Population Unit, South Asia Region, World Bank, April 22, 1998 page 18

2 The Ministry of Health has commissioned three independent evaluation studies of the Lady Health Worker Programme in 1995, 1996 & 1999-20022. These studies focused on identifying strengths and weaknesses of the programme and have been used as the basis for planning in

Findings of the Third Evaluation

Strengths:

- ❖ The Programme has adhered to its 'Selection Criteria' i.e.
  - Almost all (98%) LHWs live in their catchment's area.
  - Almost all (97%) LHWs are educated at least 8th class or above.
- ❖ ALL (100%) LHWs have received full '3 months basic training'.
- ❖ Almost all (95%) LHWs have received 'Refresher training'.
- ❖ The LHWs have at an average 977 clients and 811 effectively registered clients; Visiting on average 23 households per week
- ❖ About 50% Contraceptives provided by LHWs in Program area.
- ❖ More than 20% of individuals who were ill or injured in the previous fourteen days consulted the LHW (if they consulted any care provider)
- ❖ Many LHWs are playing an important role in the identification and referral of serious cases.
  - ➢ Three quarters of LHWs had been consulted for an emergency
  - ➢ Almost 70 percent of these had seen an emergency within the last three months, meaning that about half of all LHWs (51 percent) reported seeing an emergency in the last three months.
  - ➢ Complications of delivery and pregnancy, together with respiratory infections, were the most common complaints.
- ❖ 75% of LHWs reported a supervisory visit in last month by supervisor.
- ❖ Significant difference in health status of communities in LHWs' catchment's area as compared to non-LHWs area



Weaknesses

The Evaluation Team also highlighted a number of weaknesses in the implementation of the Programme, most important of which are:

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subsequent years.

- LHWs were seriously under-supplied with drugs and contraceptives.
- Services are limited in health facilities to which patients are referred.
- Need to increase effectiveness of supervision, also need for provision of transport for supervisors.
- Need to make timely payment of stipends to LHWs.
- Need for improving knowledge & skills of LHWs

Impact of the programme--as assessed by the 3rd evaluation

- The Third Evaluation found that Programme is having a significant impact on a range of health outcomes. *This is a result that is very rarely found in community health programmes of this size*.
- Four types of evidence were used to assess the impact of the Programme i.e. (1) Direct service provision & referral, (2) Promotion (3) Trends, (4) Modelling.
- Overall, these four tests suggest LHWs are having a substantial impact on the uptake of important primary health services which include:
  - A large and positive impact on childhood vaccination rates;
  - A large and positive impact on reversible methods of contraception (pills, condoms) especially in rural areas, and on all methods of modern contraception in rural areas;
  - An increased uptake of antenatal services;
  - An increased provision of iron tablets to pregnant women;
  - Increased levels of child growth monitoring;
  - Lower rates of childhood diarrhoea;
  - More positive attitudes to family planning.
- Already the Programme is providing more services to low income and poor households than any alternative service provider in the public sector. However there is certainly scope to further increase the level and quality of services and to increase coverage to the underserved and to the poor.
- Almost all of the indicators shown are better in the LHW areas than in the control areas, usually by a reasonably large margin. This is the case for: most measures of use of antenatal and delivery services; family planning use and attitudes; health knowledge; and most of the child health measures.

Comparison of various health measures in LHW and control areas

Measure	LHW Areas	Control Areas	National (1)
(Women who had a birth since 1997 reporting on their last birth):			
% who had at least one antenatal consultation at a health facility	58	41	31
% who had at least two tetanus toxoid injection in the last pregnancy	51	26	--
% who took iron tablets during last pregnancy	43	26	--
% of births attended by doctor, nurse or LHV	27	19	19
% using any method of contraception (CPR)	33	26	28
% using any modern method of contraception	23	18	20
% who know at least one way to prevent diarrhoea	66	52	--

% who know how to prepare ORS (and what it is for)	73	61	--
% who know how malaria is caught	58	42	--
% of children aged under 4 months exclusively breastfed [2]	39	20	--
% of children under 3 years ever weighed by any health worker	38	13	--
% of children aged 12 to 35 months fully vaccinated (based on recall and record)	57	40	(49)
% of children with diarrhoea given ORS [3]	47	35	(54)
% of children with respiratory infections given more liquids to drink[3]	70	63	--

Notes: (1) The source of national data is the Pakistan Integrated Household Survey (1998-99).
(2) Children given only breast milk; given no other liquids, nor any food (excludes prelactils).
(3) Children aged 2 to 4 years.
(4) The source of national data is the Pakistan Integrated Household Survey (1998-99), except for contraceptive use rates, which are taken from the PRHFPS Preliminary, reported

Conclusions of the 3rd evaluation

- The Evaluation team has drawn some important conclusions from the findings of the Evaluation that may have a bearing in the future course for the Programme are:
  - The evaluation suggests that there is a case for expansion of the Programme;
  - Future expansion should redress the current imbalance in Programme coverage. This will require a targeted expansion policy, recruiting new LHWs from the underserved and poor areas;
  - Future expansion should be focused on rural areas;
- Improvement in the supervision of the LHWs through:
  - Improving supervisors' access to vehicles & provision of POL etc so that all supervisors have full time access to transport
  - Increasing the effectiveness of supervision
  - Improving the supervision of the supervisors;
- The evaluation team recommends that the NP-FPPHC should be continued for the medium term, as a high profile nationally funded and directed programme, signalling the government's intent to support effective low cost public health care interventions that address national priorities for mortality and family planning, whilst improving the access of the poor to health care.
- The evaluation team further recommended that the management of NP-FPPHC should not be further decentralised between national and provincial governments at this stage until such time as time as Provincial and District design, funding and management capabilities had been demonstrated.

Synergy in Health through LHWs:

The Programme has been rated as success by various national and international agencies. The results of recent evaluation carried out by Oxford Policy management group OPM (UK) shows that most of the health indicators in the population covered by the LHWs are significantly better as compared to the control area. LHWs are reaching at the doorstep of the community and are providing primary health care services to them.

The National Programme for FP & PHC has played a significant role in *women empowerment* by creating job opportunities to rural women by deploying more than 75,000 LHWs and 2000 supervisors in the field. The recent Evaluation Report showed that communities have shown confidence in LHWs and accepted them as preventive health care provides.

- Some of the Programme achievements during last few years are:
  - 60% of the target Population is being covered under Programme.
  - No of lady Health Workers (LHWs) has been increased to more than 75,000 in 2004
  - No of Lady health Supervisors (LHS) increased to 2300 in 2004
  - No of LHWs trainers increased to more than10,000.
  - Village Based Family Planning Workers (VBFPW) Programme of Ministry of Population Welfare has been merged in the National Programme and 11,000 VBFPWs have been absorbed and trained as LHWs in National Programme for FP&PHC.
  - LHWs have been actively involved in national level health related activities e.g.
- Polio National Immunization Days (NIDs) - out of 30 million children, about 16 million are immunized by LHWs, during every round.
- Maternal & Neonatal Tetanus Elimination Activities in high risk areas of 54 districts (Out of 5 million target women, 4.5 millions were vaccinated by LHWs),
- Approx. 40,000 LHWs have been trained in giving EPI vaccines.



LHW immunizing a child



LHW immunizing village women in a cotton field during MNT vaccination campaign

- Directly Observed Therapy, Short Term (DOTS) an approach for treatment of tuberculosis – LHWs ensure TB patients take medication regularly, in proper dose at the proper time,
- Involvement in nutrition activities i.e. promotion of breast feeding, iodised salt, and provision of vitamin A to approx. 16 million children during NIDs,
- AFP surveillance for detection of polio cases and
- Safe Motherhood activities including promotion of antenatal care, clean delivery practices and post natal care.
  - Contraceptive prevalence rate increased to 35% in LHW areas.
  - Distribution of ORS in flood/rain affected areas in Punjab

- Assistance in relief activities like Gas Poisoning and Hepatitis outbreak in Lahore
- Assistance in relief activities for earthquake/flood/drought affected areas
- in Balochistan
- Participation in mopping-up exercise during polio outbreak in Bannu and Lakki Marwat districts of NWFP and district Quetta of Balochistan.
- Assistance in cyclone /drought affected areas in Sindh.
- President of Pakistan awarded 10 LHWs for their best performance in provision of family planning services in July 2002.

Planning for the Future:

Poverty Reduction and Health; Rationale for the LHWS' Programme:

The LHWs Programme through the new PC 1 will be the main instrument in the health sector to achieve the goals and objectives of the I-PRSP and the PRSP.

The Programme provides an important strategic arm both for the new National Health Policy (2001) and for poverty reduction. The overall vision of the Policy is to ensure 'Health-For-All' with priority attention directed towards the primary and secondary levels of the health care system

The National Health Policy-2001 outlines ten key areas of reform in the health sector and the implementation strategies to address them. Of these ten strategic areas, five sets of strategies are directly relevant to the work of the National Programme for Primary Health Care. They include:

- The reduction of the widespread prevalence of communicable diseases (i.e. the EPI cluster of childhood diseases, TB, Malaria, Hepatitis-B and HIV-Aids) (Key Area 1).
- Addressing the inadequacies in Primary/Secondary Health Care Services (Key Area 2)
- Promoting greater gender equity in the Health Sector (Key Area 4)
- Bridging the basic nutrition gaps in the target population i.e. amongst children, women and vulnerable population groups (Key Area 5), and
- Creating mass awareness in public health matters (Key Area 8).

The cost per LHW per year is Rs. 44,041. The cost per beneficiary per year therefore comes to Rs.44 only. **The Programme is almost certainly having more of an impact on health outcomes and health status, per unit of cost than comparable alternative services provided in the public health system i.e. the First Level Care Facilities.**

The Programme will continue to contribute to improvement of community access to FP and PHC services. This will lead to the improvement of all health indicators such as decrease in IMR, MMR and increase in CPR, Ante natal care, EPI coverage, ORS utilization, health education and utilization of health facilities.

This, in turn will improve the impact indicators such as infant and maternal mortality, nutrition of children etc. By improving contraceptive prevalence rate, the rate of growth of population will be brought down. **The estimated population covered and served by the LHWs is close to 100 million.**

Maternal and Child Health – An Entry Point for Social Development

- The Programme places special emphasis on maternal and child healthcare (MCH). The protection of mothers and children is singled out because of their special needs that must be met to ensure not only the survival but also the healthy development of the fetus, child and mother. Investment in the health of women and children is a direct entry point for improved human resources, social development and productivity.
- Trained LHWs will deliver MCH services such as antenatal (e.g. screening of pregnant women to identify those at risk, immunization of pregnant women with tetanus toxoid to prevent neonatal tetanus and tetanus in the mother), natal (e.g. helping the mothers get access to skilled birth attendants and proper care during delivery) postnatal, child care.
- The government has identified the high maternal mortality as a major problem and is working on various strategies for addressing this problem. One of the strategies is to increase the availability of skilled birth attendants across the country. The training of an adequate number of Midwives is being considered. The National Programme for FP & PHC as the major initiative of the government to provide MCH services to the communities provides a logical base for the launch of these activities. Based on the strategies adopted by the government, the National Programme funds may be used for providing supervisory support for the activities in the overall MCH Programme. The funds available for drugs and training may be used for strengthening the MCH Programme.
- The LHWs will be provided additional training in Safe motherhood to enable them provide the expectant mothers better advice, counseling and referral. The LHWs will be encouraged to work and provide support to the expectant mothers and the birth attendants in ensuring better ante natal, natal and post natal care.

Strategic Plan 2003 - 2011

A strategic plan (2002) has been prepared through a consultative process with the involvement of key stakeholders and forms a basis for the development of the PC-1. The consultative process included senior officers of the Ministry of Health, Ministry of Population Welfare, Ministry of Planning & Development, Ministry of Finance, Provincial Departments of Health, Finance, P&D, elected representatives i.e. Nazims/ councillors, representatives from National Reconstruction Bureau, National Commission for Human Development, donor agencies, NGOs, teaching/academic institutions and LHWs/Supervisors. This was achieved through a series of workshops and meetings. Five provincial and one national workshop was organized during which inputs from different stakeholders were obtained.

PC 1 2003 - 2008

The PC 1 is prepared for the period of 2003 – 2008, the key features of the PC 1 are:

Goals and Objectives

The goals of the Programme by 2011 are to:

- Develop the necessary health manpower in support of the Programme by selection, training and deployment of 100,000 LHWs throughout the country.
- Address the primary health care (PHC) problems in the community, providing promotive, preventive, curative and possible rehabilitative services to which the entire population has effective access.
- Bring about community participation through creation of awareness, changing of attitudes, organization and mobilization of support.
- Expand the family planning services availability in urban slums and rural areas of Pakistan.

Specific Objectives:

The Programme targets include – by 2011- contributing to

- A reduction of IMR from 85 to 55 per 1000 live births,
- A reduction of MMR from 400 to 180 per 100,000 live births,
- An increase in the Contraceptive Prevalence Rate from existing 22% to 42% in rural area and from 40% to 58% in urban area.
- An increase in immunization coverage in children aged 12-35 months fully vaccinated from 45% to 80% in rural areas, and from 64% to above 90% in urban areas. (In liaison with EPI),
- An increase TT-5 immunization coverage amongst women of childbearing age from 12% to 40%.
- An increase in the percentage of children being exclusively breastfed till age of 6 months from existing 18% (current) to 50%.
- An increase in births assisted by skilled birth attendant from existing 12% to 30% in rural areas and from 43% to 80% in urban areas covered by the Programme.

The principal sources for the verification of the Programme's contribution to these targets will be through independent Programme Evaluations and the PIHS. In addition there will be a strengthened programme of internal monitoring and evaluation.

The Implementation Plan:

There will be two phases of implementation during the period between 2003 – 2008:

a. **PHASE I: Consolidation and Expansion** From July 2003-June 2005, the activities of the Programme will be consolidated and services will be expanded. At the end of this phase there will be 100,000 fully trained LHWs, and 4000 LHW Supervisors along with other necessary staff,

equipment and supplies. The improved training, implementation, monitoring and supervision mechanisms will be put in place. At the end of this phase there will be an extensive evaluation of the Programme.

b. **PHASE II: Development of a Sustainable Programme** From July 2005- June 2008, the capacity building process at the Provincial and District levels will be completed. During these three years different models for the development of a sustainable and viable structure for the Programme including the possibility of transferring management functions to the Provinces and the Districts will be piloted in selected districts. At the end of this period, there would be another evaluation of the Programme.

   Based on the Strategic Plan, the findings from the implementation of the Programme and the Pilot initiatives, a comprehensive Plan for the future structure and activities of the Programme will be prepared in consultation with major stakeholders and the Provincial governments. If required a new PC1 will then be prepared. By the end of 2011 and the current Perspective Plan period, it is expected that a viable structure will be developed with assured sources of funding.

Devolution

The Programme already stands delegated to the district level. However further decentralization of powers will be carried out in a phased manner over the next 3–5 years. This decentralization/devolution will be piloted in selected districts/provinces in tandem with the development of mechanisms to ensure accountability for results. This will need to be accompanied by capacity building at all levels, strengthening Programme Management information systems and demonstration of increased involvement at the district and provincial levels.

Inter Provincial Committee on Decentralization

In order to guide the process of crystallization of the further decentralization and devolution of powers in the context of the National Programme for FP & PHC, a high-powered committee will be constituted. This committee will be an Inter-Provincial Committee to be chaired by the Federal Secretary Health. The members of the Committee will include the Provincial Additional Chief Secretaries (development), Provincial Health Secretaries, representative from the Planning Commission i.e. the Member Social Sector or the Chief Health. The National Coordinator of the Programme will be the Secretary of this Inter Provincial Committee.

The Committee will meet biannually to discuss the plans and review progress towards decentralization of the Programme activities.

The committee will also explore the possibility of allocation of resources to the Programme from the Provincial funds.

Although the resources for the Programme during its first two phases of implementation will be undertaken by the Federal Government, alternative ways of financing of this priority health programme have to be considered. This includes action to utilize/involve the resources of the provincial and district governments or seek local community solutions.

Financial and Material Resources:

The successful implementation of the Programme will depend on mobilizing the necessary and timely financial and material resources. To assess the magnitude of the total financial needs to implement the Programme, an analysis of the cost of programme components has been undertaken during the 3rd Evaluation and it has been concluded that the LHWs are the cost effective means of providing PHC services to the communities.

The LHWs are largely providing preventive and promotive health services with some curative services to poor population of the rural areas of the country. These services being public goods, it is desirable that they be made available to the communities without any direct cost.

The estimated budget for the National Programme for FP & PHC for the period 2003 – 2008 is Rs. 22,460.660 million, of which approx. Rs. 8 billion may be provided by donors/lending agencies. Annual recurring cost for the Programme is estimated at Rs. 4,448.164 million.

The cost of a LHW per year is approximately Rs 45,000 and she is providing services to approximately 1000 population the cost per person per year therefore comes to Rs. 45. It therefore is a low cost intervention with major benefits, providing adequate justification for the government to support this Programme and allocate resources.

Sources of Funding for the Programme

To ensure efficient service delivery by the LHW the Programme needs to budget on the basis of an appropriate unit cost and spend accordingly. Based on recommendations of the Third Evaluation aimed at improving impact, efficiency and increasing service delivery per LHW, the appropriate annual cost per LHW would be Rs. 46,150, in 2001 prices. A target level of 100,000 LHWs providing services to almost 100 million people would therefore require annual recurrent cost financing of approximately Rs.4.6 billion.

THE LHW Programme - A success story:

The LHWs Programme has been termed as a success story in the health sector in Pakistan, following are some comments in support of the Programme:

On July 12, 2002 the President of Pakistan Gen. Pervaiz Musharaf gave merit shields to 10 lady health workers from different parts of the country. The President announced cash awards of twenty five thousand rupees each to the lady health workers and family welfare workers who received the awards.

The Programme has been termed as a success story in the Report of the President's Task Force on Human Development, and it has been concluded

that "The Programme has also been a source of socio economic uplift of the LHWs and their families. There is a need to increase the number of LHWs and integrate other programmes with the LHW Programme to form a network of health care delivery." "Immunization, sanitation, malaria control, maternal & child health and family planning are provided by outreach workers, which include LHWs, EPI vaccinators, CDC Supervisors, & TBAs. Of all these workers, the LHWs of the National Programme for FP & PHC have been the most successful in achieving their targets." *Report of the President's Task Force on Human Development, Islamabad January 2002*

The President's Task Force on Human Development has recommended the recruitment of 122,000 LHWs to cover all rural population of the country.

"More women health care providers have been hired and trained; and the promising Lady Health Workers Program has begun providing the kind of community-based outreach that has proved successful in improving health in programs across the world." *'Raising a Healthier Population in Pakistan', The World Bank, June 1998*



An LHW receiving shield of merit in the presence of Dr Gro Harlem Bruntland, WHO Director General



LHWs with President General Pervez Musharaf after receiving awards

> "The Lady Health Worker's Project struck me as an excellent example of health care in rural and remote areas". *Mr Tony Badry, Chairman International Development Committee, House of Commons, UK. (7th December 2001.)*

"The I-PRSP also confirms the government's commitment to sustaining and expanding targeted interventions that focus on disadvantaged sections of society, especially in rural areas, namely programs like Lady Health Workers Program and Women Health Project. The preliminary results of an evaluation of the federally funded Lady Health Workers program are promising, and a continued commitment to the program is expected to have significant impact on the health of the poor." *Interim Poverty Reduction Strategy Paper on Joint Staff Assessment Prepared by Staffs of the International Monetary Fund (IMF) and the International Development Association (IDA), November 15, 2001*

The USAID funded *National Consultation on Maternal & Child Health in Pakistan, held in January 2003 recommended the* "Strengthening and enhancement of the National Programme for FP & PHC (LHWs Programme)

with an improved capacity to deliver quality care in MCH (including key elements of safe motherhood and perinatal/newborn care)".

Government of Pakistan's Commitments to International Donors:

Being a signatory to the Alma Ata Declaration of 1978, the Government of Pakistan (GoP) is committed to the goal of achievement of "Health For All". The NP-FP&PHC is a major step in that direction.

The government of Pakistan has committed to support 100,000 LHWs in the I-PRSP. The same commitment is reflected in the "Table of Tranching & Commitments" as part of the Project Memorandum prepared between the government of Pakistan and the Western Asia Department of Department for International Development (DFID) Govt. of UK for the National Health and Population Welfare Facility. As part of this Memorandum, the govt. of Pakistan will approve the "LHW PC 1 with resource indications consistent with PRSP target for no. of LHWs, by August 2003 after which the tranche of £ 7.5 million will be released. The total grant assistance to be given under the National Health Facility by the Government of UK is £ 60 million.

The government of Pakistan has further implied the target for selection of 100,000 LHWs in the project agreements for the Women Health Project and the Reproductive Health Project with Asian Development Bank.

Conclusion:

Role of National Programme for FP & PHC in Promoting Health; Reducing Poverty

The National Programme for FP & PHC is increasing the overall awareness of the community for the improvement of their quality of life by having smaller families, self-development initiatives and community social programmes. Further improvement may occur from an intersectoral collaboration that will result from the Programme implementation. By improving health status, investments in the Programme contribute to poverty reduction in the country.

The Programme will create 100,000 jobs for females at the grass root level, 4,000 LHWs' supervisors and supporting staff like drivers in District Health System etc. Providing means of respectable livelihood to women in the rural communities of the country will contribute towards women empowerment.

Support of International Agencies:

DFID

DFID has supported National Programme with other bilaterals through the "Social Action Programme" which finished last year. Further DFID is provided the support to the Program as following:

- **Third Evaluation of LHW Programme:** DFID has also supported an exhaustive evaluation of the LHW programme by **Oxford Policy Management** (OPM), which substantiates the success of this programme.
- **DFID/Dutch grant for contraceptive:**
  - 42 million condoms
  - 0.163 cycles of contraceptive pills
- **Grant Assistance to National Programme for FP & PHC:**

  UK £ 5 millions for
  - Procurement of medicines for LHWs.
  - Procurement of contraceptives.
  - Procurement of vehicles for LHS.
- **Technical Co-operation / Assistance:** UK £0.2 million for
  - Strategic Planning Process based on Evaluation results.
  - Operational Research in Programme.
  - Strengthening of Management capacity.
  - Strengthening of Monitoring and Supervision.
- **NHF for six priority programmes including LHWP =** UK £ 60million
- **Technical Assistance for LHWP along with other six priority programs of health and population = UK £ 4 million**

WHO:

- Integrated PHC Project
- Integrated Management of Childhood Illness (IMCI)
- Basic Development Need (BDN) Programme
- Home Health Care
- Quality Assurance and DTPS

UNFPA:

- Promoting Interventions for Safe Motherhood (PRISM)
- LHWs' Supervisors Project
- MIS/GIS Project
- Contraceptive Grant

UNICEF:

- Promotion of Safe Delivery Practices
- Integrated Management of Childhood Illness (IMCI)
- Community based Nutrition and Breastfeeding Promotion

JICA

- Grant in kind Assistance for contraceptive, baby weighing scales
- Technical Assistance for Nutrition wing of LHW Programme

ADB

- Women Health Project (Support to LHW Programme)
- Reproductive Health Project (Support to LHW Programme)

World Bank

- SAP
- Possible Financing of the LHW Programme for the period 2003-2008

ANNEXURES

PROVINCE–WISE ALLOCATION OF LHWS (YEAR 2002-2003)

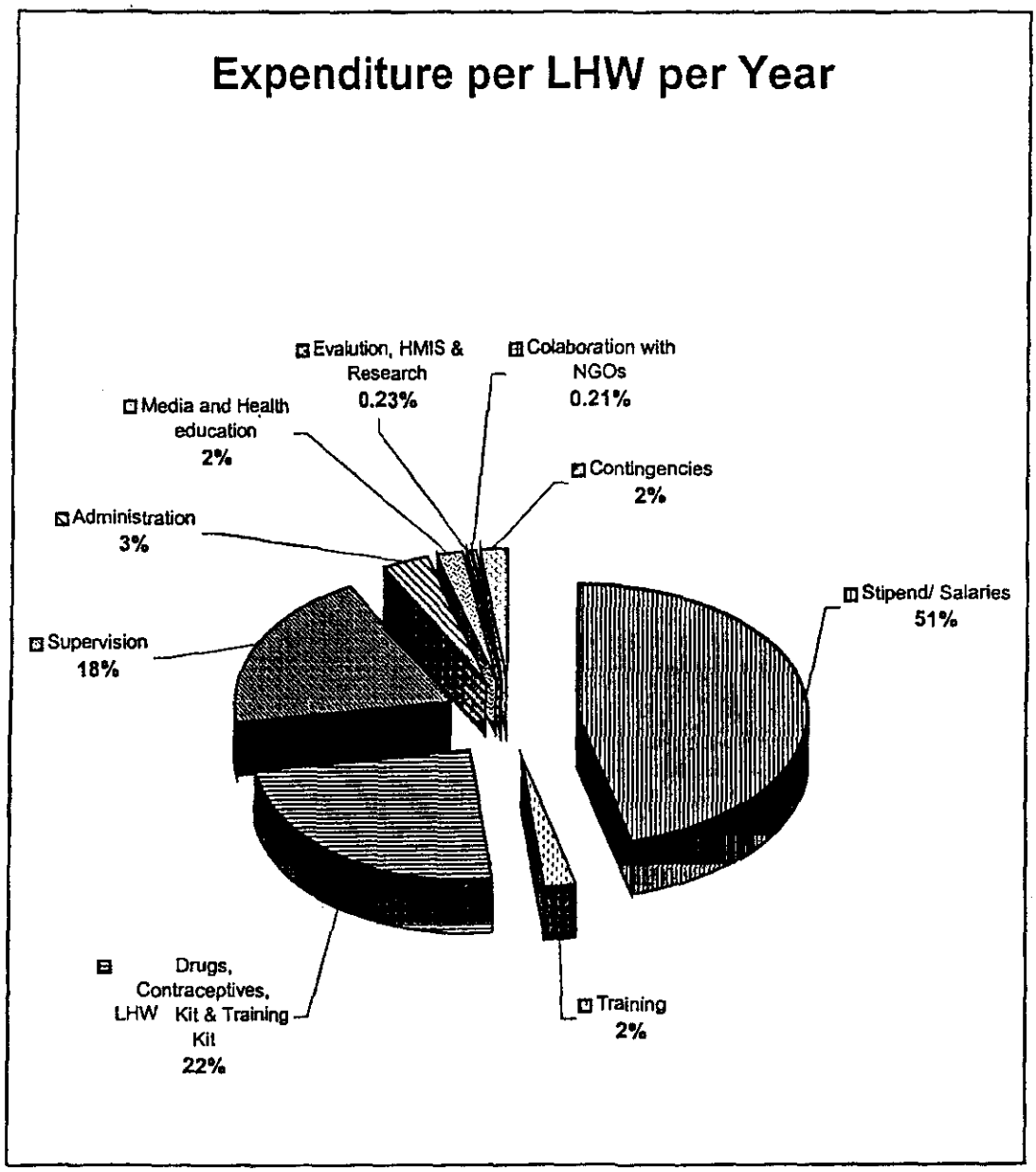
NP=National Programme for Family Planning& Primary Health Care
WHP = Women Health Project
RHP = Reproductive Health Project

Province	TOTAL ALLOCATION			
	NP	WHP	RHP	TOTAL
Punjab	46033	4701	1647	52381
Sindh	18519	1468	1238	21225
NWFP	12881	1427	800	15108
Balochistan	4564	521	715	5800
AJ.K.	2500	0	0	2455
F.A.N.A.	1267	0	0	1267
FATA	1600	0	0	1600
ICT	325	0	0	325
National	86689	8117	4400	100206

Expenditure per LHW per Year

2003-2008

S. No.	Activity	Detail Cost/LHW (Rs.)
1	Stipend/ Salaries	20,706
2	Training Training material Training workshops	996
3	Drugs, Contraceptives, LHW Kit & Training Kit	10,923
4	Supervision Supervisors salaries, training and materials TA/DA Vehicle Purchase Petrol Repair & Maintenane Driver salaries	8,801
5	Administration Staff salary Project allowance Procurment Repair & Maintenane Transportation (PPIU-DPIU) Rent of Offcial Building Entertainment	1,481
6	Media and Health Education	929
7	Evalution, HMIS & Research	104
8	Colaboration with NGOs	100
9	Contingencies	881
	Total:	**44,041**


Expenditure per LHW per Year
Evalution, HMIS & Research 0.23%
Colaboration with NGOs 0.21%
Media and Health education 2%
Contingencies 2%
Administration 3%
Stipend/ Salaries 51%
Supervision 18%
Drugs, Contraceptives, LHW Kit & Training Kit 22%
Training 2%