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Policy brief for Pakistan

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

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Content

Acronyms

BHU	Basic Health Units
CMW	Community Midwives
DCP3	Disease Control Priorities
DPIU	Administrative Control, Policy Implementation
EPI	Expanded Programme for Immunisation
EPHS	Essential Package of Health Services
EmONC	Emergency Obstetric and Newborn Care
FY	Fiscal Year
FMoH	Federal Ministry of Health
GBV	Gender Based Violence
GGGI	Global Gender Gap Index
HPU	Health Planning Unit
IHP	Integrated Health Project
LMIS	Logistics Management Information System
LHW	Lady Health Workers
LHWP	Lady Health Worker Programme
MCH	Maternal and child health
MNHSR&C	Health Services, Regulations and Coordination
NCDs	Non-Communicable Diseases
PIU	Project Implementation Unit
PHC	Primary Health Care
PSDP	Public Sector Development Programme
PPIU	Planning, financing resource allocation
RHC	Rural Health Centers
SDG	Sustainable Development Goals
KP	Khyber Pakhtunkhwa's

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Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) towards achieving Universal Health Coverage and the health-related SDGs. It reiterated the urgent need to build sustainable PHC systems that are people-centred, responsive to community needs, holistic in scope, and able to engender socio-cultural changes among communities and providers to promote and preserve good health and well-being.

> We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.
>
> **Astana Declaration 2018**

Community Health Workers (CHWs) are the backbone of Primary Health Care systems. Evidence highlights the effectiveness of CHWs in delivering a range of preventive, promotive and curative services related to reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and neglected tropical diseases. However, CHW programmes often face several challenges including lack of clarity in roles, inadequate pre and in-service training, lack of clear career pathways, poor supervision mechanisms, and poor linkages with both the health system and communities.

South Asia has a rich history of vibrant CHW programmes and CHWs in the region continue to play a substantive role in Primary Health Care and act as bridges between the community and the health system. Simultaneously, countries in the region are witnessing demographic and epidemiologic transitions with increasingly ageing and urbanized populations and a rising burden of non-communicable diseases. In such a scenario, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

> CHWs are health workers based in communities (i.e. conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours.
> **World Health Organization**

Evaluation of Cummunity Health Worker programmes in the South Asia region

- Formative evaluation in seven countries – Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka
- Objectives
    - o To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
    - o To determine the key policy adjustments and interventions needed to address any gaps
    - o To assess the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans
- Desk review and key informant interviews at the national level in seven countries
- Analysis frameworks
    - o WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
    - o WHO health systems building blocks
    - o Operational framework for Primary health Care by WHO and UNICEF
    - o WHO gender responsiveness assessment scale

This policy brief presents the key findings from a formative evaluation of CHW programmes in the South Asia region conducted by the Centre for Maternal and Newborn Health, Liverpool School of Tropical Medicine, with support from UNICEF Regional office for South Asia. It details the policy and system support available for diverse cadres of CHWs in the region and measures to optimize the contribution of CHWs to PHC. It also highlights the reforms needed in CHW programmes and will be useful to inform the design of a set of feasibility and prioritization criteria that will support countries to develop an action plan aimed at optimizing the contribution of CHWs to Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) and to the strengthening of PHC. This brief is intended for policy makers at national and sub-national level in the South Asian region.

Pakistan - country context

Pakistan is a lower-middle income country, having primarily an agrarian economy. According to Pakistan's first official report on multidimensional poverty released in 2016, nearly 39% of Pakistanis live in multidimensional poverty.

Over the previous two decades, Pakistan has seen an improvement in maternal health indicators like maternal mortality ratio, skilled birth attendance and institutional deliveries. However, there are serious equity concerns as quality services are not available in many hard to reach areas, with significant variations among provinces and districts. Contraceptive prevalence is low, and 8 percent of pregnancies are among adolescent girls of age 15-19 years. Since 2000, the burden of disease has significantly shifted from communicable diseases to non-communicable diseases (NCDs). Pakistan and neighbouring Afghanistan are the only countries left in the world where the poliovirus continues to threaten the health and well-being of children.

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

At the district level, the healthcare delivery system includes, Basic Health Units (BHU) and Rural Health Centers (RHC), which function as PHC establishments. Maternal and child health (MCH) care units are based out of BHUs and RHCs which provide all the basic obstetric care through community outreach programmes. Overall, Pakistan has one of the lowest densities of health workers in the region and globally.

Pakistan has significant gender disparities that serve as a major impediment to economic and social development. Pakistan is number 151 on the 2020 Global Gender Gap Index (GGGI), having closed only 56% of the gender gap, the gap remaining large in terms of economic participation and opportunities. Pakistan is also among a group of four large countries trailing behind in closing the gender gap with regard to Health and Survival, with women in the country not yet granted the same access to health as men. Prevalence of spousal violence is high, and one in two Pakistani women who have experienced violence never sought help or informed anyone about the violence they had experienced.

Community Health Worker programmes in Pakistan

Community based health workers in Pakistan primarily include Lady Health Workers (LHWs) and Community Midwives (CMWs), Community Based Vaccinators (CBV), and malaria supervisors, among others. All LHWs and CMWs are women. Of these programmes, the most established is the **Lady Health Worker Programme (LHWP)**, introduced in 1994. In 2000, the programme was renamed the National Programme for Family Planning and Primary Health Care, but it is still commonly known as the Lady Health Worker Programme. Following the 18th Amendment, the management of the LHWP has been devolved to the Provincial Governments.

LHWs are deployed across the nation in all four provinces and Federally Administered Territories of Pakistan. Though these workers may also be attached to a local health facility, their role is primarily community-based and LHWs often work from their homes. The scope of services provided by LHWs has grown from an initial focus on Maternal, Newborn and Child Health (MNCH) and routine immunisation to include participation in large health campaigns (such as polio immunisation), newborn care, and health education.

In 2017, there were 92,849 LHWs available across the country. A 2003 strategic plan set the goal of achieving 100,000 functioning LHWs by 2005 in order to reach optimal service coverage. Though coverage rates improved, this goal was not achieved. More recently, there has been a decline in absolute numbers of LHWs in all regions of Pakistan with the exception of Khyber Pakhtunkhwa. At the national level, despite explicit targets to increase coverage (i.e. 100 per cent rural areas and 30 per cent urban areas mainly slums/densely populated areas), there is stagnation in the overall population coverage across Pakistan at just under 60% for the period of 2014-2018.

A profile of the LHWs is given below.
As originally envisioned, LHWs were not government servants, and instead worked on a contractual basis.

	LHW
Total number (2017)	92,849
Density 1,000/pop	0.43
Gender	All women
Sector located in	Completely in the public sector
Place of location	Community
Payment structure	Salaried staff paid by government

Their jobs were regularized in 2012 following a national movement by LHWs. However, due to a series of administrative delays related to the financial burden of the LHWP, it has taken more than four years for the regularization to be adopted by each province. Following regularization, there has been a freeze on recruitment of any new LHWs, and the numbers of LHWs have decreased, with attrition resulting from resignations, terminations and the deaths of LHWs.

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

Health policy and system support for Community Health Worker programmes

In 2014, the Federal Government developed a detailed and ambitious **Pakistan Vision 2025,** in consultation with Provincial Governments and all key stakeholders, for the overall development of the country. In order to address gaps identified in the Vision document, the FMoH developed a detailed **National Health Vision (2016-2025).**

The **National Vision for Coordinated Priority Actions to address Challenges of Reproductive, Maternal, New-born, Child, Adolescent Health (RMNCH) and Nutrition** identified ten priority actions to accelerate improvements in new-born, child and maternal survival, with a special focus on reducing morbidity and mortality linked to common preventable causes. The first of these priorities refers to the role of the LHW in improving the access to and quality of MNCH community based primary care in rural districts and urban slums.

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

Objectives of the Lady Health Workers Programme

- To reach rural areas and urban slums with a set of 22 essential PHC services, including promotive, preventive and curative services
- To improve patient-provider interactions
- To facilitate timely access to services
- To increase contraceptive uptake

variation across the provinces. However, there are very little available data on the implementation and subsequent impact of these policies.

- **Punjab:** Punjab's Health Sector Strategy 2018-30 includes RMNCH & Nutrition as one of its key priority areas. The strategy aims to achieve increased equitable access to and quality of MNCH, Family Planning (FP) and Nutrition across all public and private sector facilities in Punjab. Some of the strategic directions towards this include establishing a Human Resource Planning and Development Unit to meet gaps in recruitment; ensuring political will and commitment; availability of both basic and comprehensive Emergency Obstetric and Newborn Care (EmONC) facilities; establishing urban MNCH centres; and the institutionalization of a well-defined referral mechanism.

- **Sindh:** Sindh's Health Sector Strategy (2012-2020) outlines a number of RMNCH related policy priorities, including the deployment and training of LHWs and multi-purpose health workers for the implementation of an enhanced and integrated community-based package of services targeting the entire household. It aims to enhance the quality and outreach of community-based workers and implement an aggressive coverage strategy for polio immunization.

- **Khyber Pakhtunkhwa:** The Government of Khyber Pakhtunkhwa's (KP) Health Sector Policy (2018-2025) sets a number of RMNCH policy priorities. There is specific focus on the provision of family planning services through a health facilities network and community-based LHWs and CMWs. Preventive healthcare services will focus on child immunization, reproductive health and malnutrition. It also prioritizes enhancing the capacity for education and training of nurses, LHWs, midwives, pharmacists, allied health workers/paramedics.

- **Balochistan:** The Comprehensive Development Strategy 2013-20 sets out policy priorities and includes a basic section on health. However, there is no complete RMNCH strategy for this province.

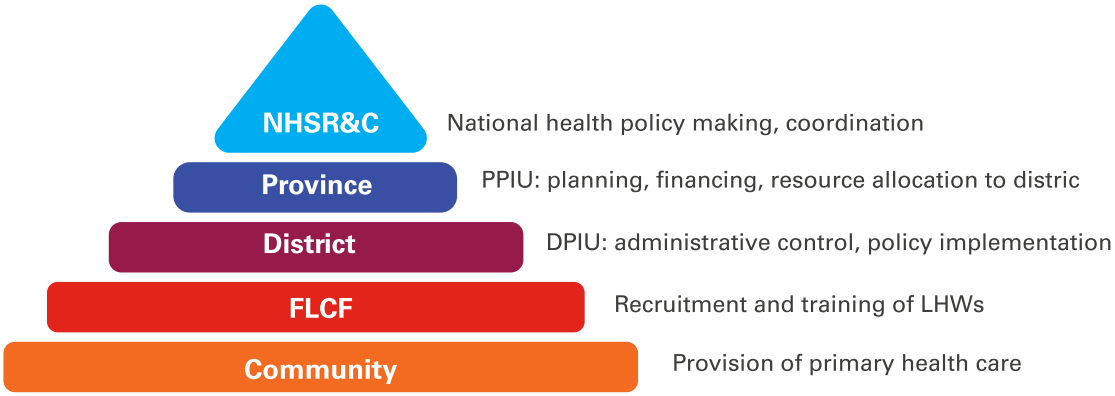
> To improve the health of all Pakistanis, particularly women and children, by providing universal access to affordable, quality, essential health services which are delivered through a resilient and responsive health system, capable of attaining the Sustainable Development Goals and fulfilling its other global health responsibilities.
>
> **Objective of National Health Vision (2016-2025)**

The **National Human Resources for Health Vision 2018-30** provides guidance for deploying strategic measures to combat gaps and challenges in human resources and recommends the scope of work for national and provincial health systems. The Vision document elaborates on a number of measures including optimizing the performance, quality and impact of the health workforce, investing in the availability and distribution of the health workforce to meet the needs of the population, building the capacity of institutions at all levels for effective and quality pre-service and in-service training, and HRH leadership and strengthening HRH data for monitoring and accountability at all levels.

The FMoH was dissolved following the 18th Amendment in 2010 and the provinces took over the implementation of the government vertical health sector programmes, including the LHWP, along with the delivery and management of all other health sector activities. When the Federal Ministry of Health was re-established as the MNHSR&C, a **Health Planning Unit (HPU)** was created as part of the Federal Ministry, to reconnect with the MNCH and LHW programme and other programmes by holding regular meetings with all the provinces/regions. A dedicated forum for the LHW programme was not established.

The overall management model as envisaged for the LHWP in relation to the federal role following devolution is summarized in Figure 1.

Figure 1: Vision of integrated management of Lady Health Worker Programme



Source: ZHU, et al, 2014

To improve health and socio-economic outcomes in Pakistan by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate health system strengthening investments and the implementation of effective HRH policies and strategies at national and provincial levels.

National HRH Vision 2018-30

However, the handover following devolution was not structured enough to support a smooth transition, since the provinces lacked the technical capacity to support the LHW program. The shift of power also meant a loss of central coordination and implementation. This affected the quality control of the LHWP, which was previously regulated by a central committee with interprovincial coordination and consultations. Without central government support and facilitation, the LHWP reportedly started to deteriorate, with provinces having difficulties in paying salaries of LHWs and in providing equipment and refresher training to LHWs.

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

- In **KP,** the LHWP was merged with the Expanded Programme for Immunisation (EPI), the MNCH programme, and the Nutrition Programme into the Integrated Health Project (IHP), headed by a Project Director, working through the Project Implementation Unit (PIU). There have been no significant changes to the role of the LHW except that health education responsibilities have been expanded to include non-communicable diseases.
- In **Punjab,** maternal, neonatal and child health, family planning and nutrition programming have been consolidated along with the LHWP into the Integrated Reproductive, Maternal, New-born, and Child Health (IRMNCH) programme. LHWs now have an expanded role in disease treatment and referral.
- In contrast, in both **Sindh** and **Balochistan,** the LHWP remains as an independent vertical programme under its original name. This is also the case in the **Islamabad Capital Territory, AJK** and **Gilgit Baltistan.** In each of these regions, the management structures are broadly unchanged since devolution.

The Pakistan Vision 2025 document also recognizes that gender equity and women's development is strongly linked to a woman's independence to pursue economic growth and exercise her life choices freely.

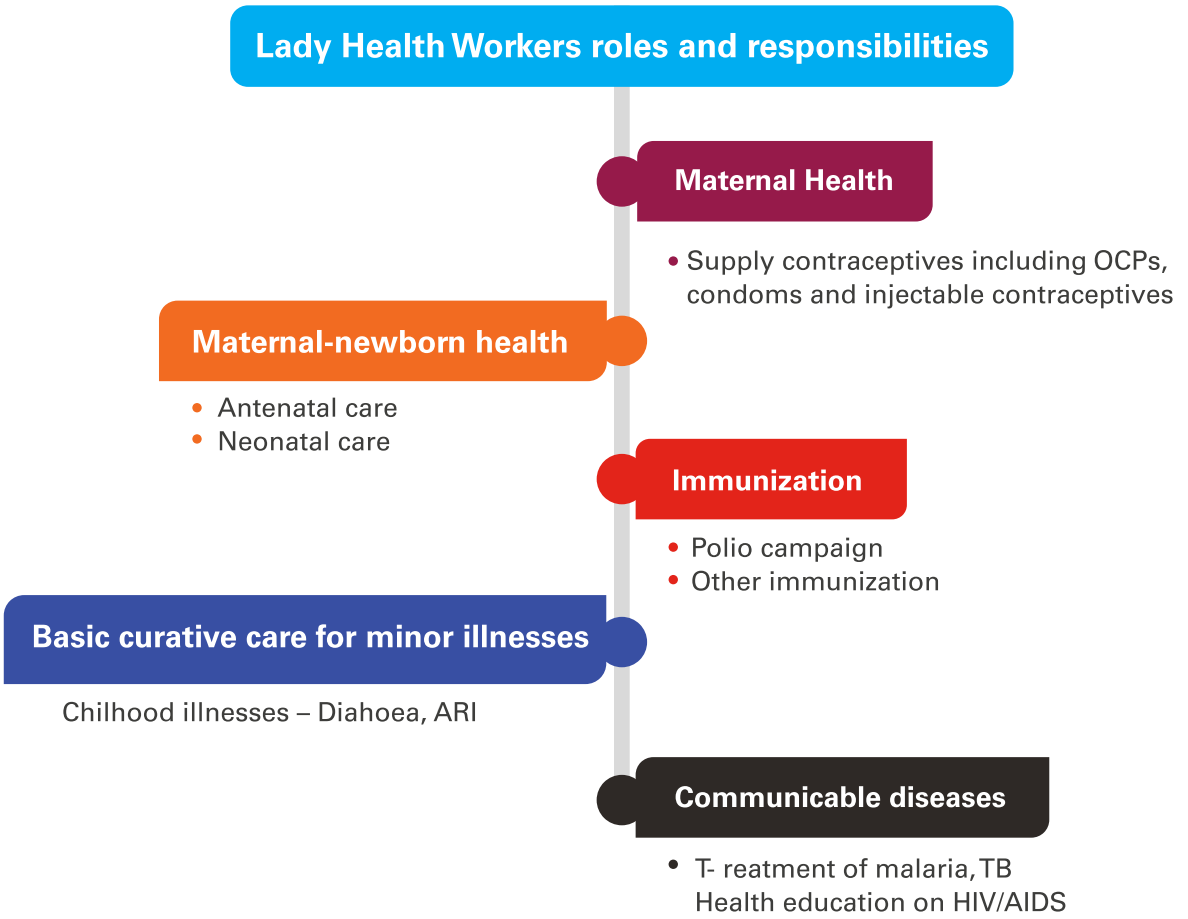
- Strengthening legislative frameworks to protect women's rights
- Increasing women's participation in decision making through affirmative action
- Protecting women from harassment at work
- Promoting the economic empowerment of women through ensuring access to education and enterprise
- Creating gender sensitive enforcement machinery to improve implementation of such initiatives
- Discourage practices based on gender discriminatory cultural patterns.

Pakistan Vision 2025

Roles and responsibilities of Community Health Workers

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

Figure 2: Different roles and responsibilities of Lady Health Workers



However, there are clear challenges faced by the LHWP. The **dilution of LHWs core mandate** is seen to be one of the leading causes of declining quality in their services. In particular, the over-burdening, lack of resources, inadequate training arising directly as a result of the expansion of services offered, are seen to be contributory.

Despite this, the programme continues to have an impact on the long-term health outcomes of the population it reaches. Past studies show that the strongest impact was seen in family planning and maternal care. Little impact was seen on infant and young childcare including immunisation rates, although the positive impact on polio is an exception, reflecting the massive diversion of resources to this area. The LHWP missed many marginalized communities, especially because of system support gaps, however, the impact of the LHWP was still strongest for the poorer households that it did reach.

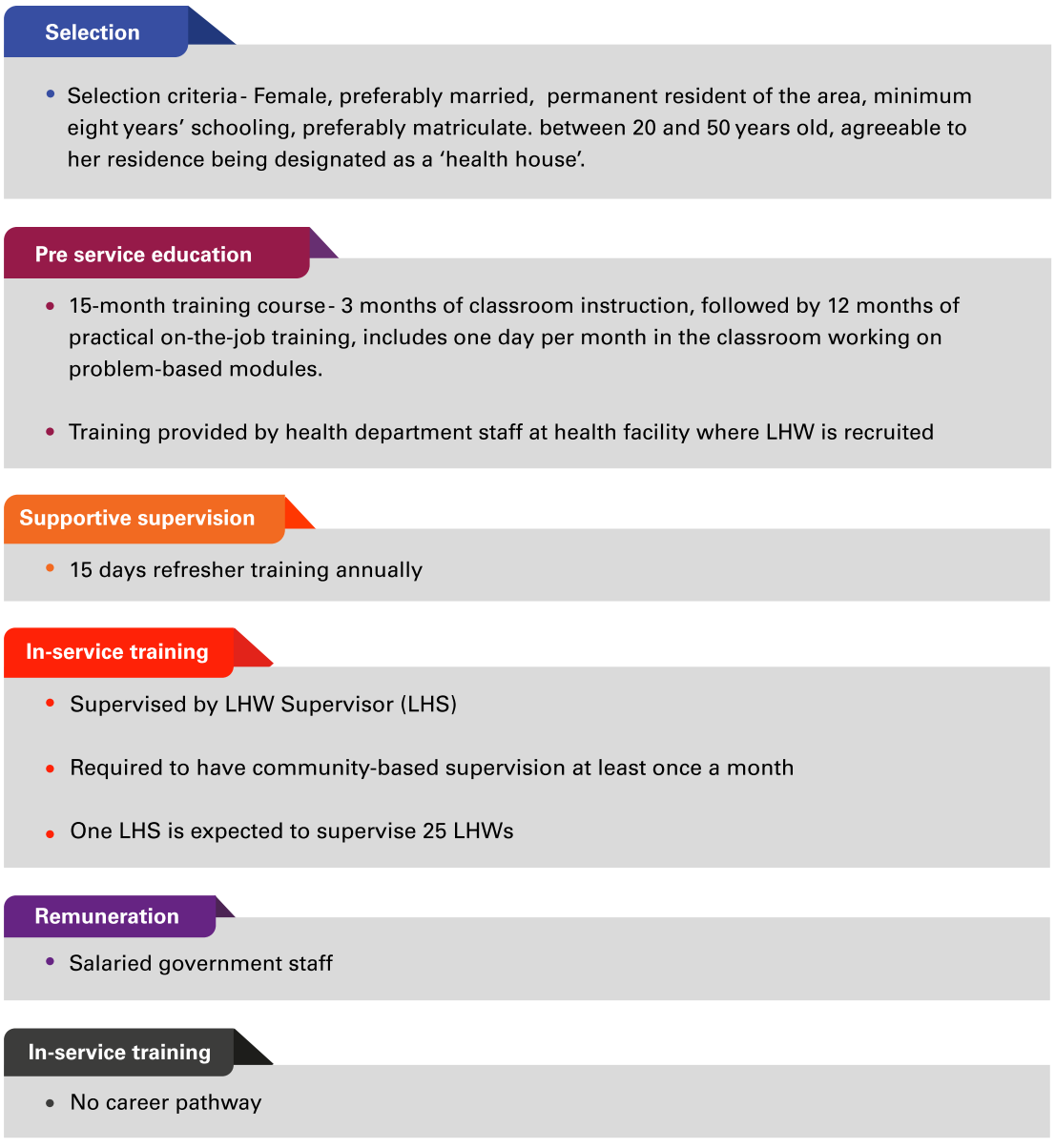
The Community Midwife cadre was introduced in 2006. Rural women with ten years of education were recruited and received 18 months of midwifery training. They were then deployed back to their home villages, where they were expected to establish private practices and provide domiciliary maternity care to a population of 10,000, in geographically defined catchment areas. Out of the planned 12,000, to-date, 8,000 midwives have been trained, most of whom have returned to their home villages. However, CMWs have yet to emerge as significant providers. Reportedly, a large proportion of CMWs are inactive. Recruitment of unsuitable and uninterested candidates, lack of community trust in CMWs' skills, the introduction and availability of 24/7 health facilities, perceived unaffordability, gendered mobility limitations, lack of health system support, including financing for stipends, and overall poor program implementation are seen as key reasons for the CMWs' failure to practice.

Selection, education and certification

Figure 3 shows the selection and training pathway of LHWs. Challenges in the selection and training process include the following:

- **Inability to fulfil educational criteria:** The prior learning requirement excludes individuals and communities that have poorer than average access to education services.
- **Changing LHW roles:** Recruitment criteria have not been adapted to changes in LHW roles.
- **Salary costs:** Increased salary costs following regularization have constrained new recruitment.
- **Lack of updated curriculum:** Since devolution, not all provinces, with the exception of Punjab, Sindh, and KP, have updated the core curriculum of the LHWs and as a result, the LHW curriculum now differs between provinces. The current LHW curriculum being used in some regions will not provide accurate information or cover the full set of roles and responsibilities that an LHW is now expected to undertake.
- **Refresher training irregular:** Prior to devolution, it was found that 96% of LHWs had received at least one refresher training course in the previous year. However, since devolution, there have been significant constraints, mainly financial, on the ability of the provinces and regions to deliver refresher training. In some provinces, donors, including UNICEF and the WHO, have supported training sessions for LHWs. However, this type of training

Figure 3: Selection, training and management of Lady Health Workers



Education and Training for Community Midwives

CMWs receive 18 months of training. During the first three months, CMWs undergo classroom-based study in the training school, after which they sit an exam. After successfully passing the exam, the CMW undertakes 12 months hospital-based training in the hospital. After this, CMWs are sent to their respective communities where they are linked to the local health facility for the final 3 months of their training. Once the CMW has completed the community component of the training, she sits for the nursing examination board and is examined on midwifery and obstetrics skills and knowledge.

Management and supervision

Supportive Supervision for Lady Health Workers

LHWs are supervised by an LHW Supervisor (LHS). An LHS is provided with a vehicle and driver, and is expected to visit each LHW under her supervision at least twice a month. However, these supervisory meetings do not occur with the consistent regularity that they should. On average across Pakistan, there are sufficient numbers of LHS to cover the current workforce of LHWs. However, Sindh in particular appears to have a shortage of LHSs, with the Provincial Report indicating that some LHSs are supervising up to 50 LHWs. Despite adequate availability of LHSs, there has been a significant reduction in the capacity of LHSs to perform their supervisory tasks. A lack of funding, particularly for transport is a major barrier to the effective supervision of LHWs by LHSs.

Remuneration

Following devolution, the Federal Government continued to fund the salaries of LHWP staff in Provinces until the Fiscal Year (FY) 2017-18. Thereafter, the Provinces were given complete responsibility for funding the LHWP from their own budgets, with the Federal Government retaining responsibilities for funding the LHWP in the regions of AJK, Gilgit-Baltistan, and ICT within the MNHSR&C budget. However, this process has come upon several obstacles, including the financial burden on the provinces as a result of the doubling of LHWs' salaries. In the initial period after regularization motivation levels for LHWs had increased across all regions of Pakistan, mainly as a result of a perceived sense of job security. However, due to the poorly planned process

of regularization, this initial boost to motivation has been undermined by the lack of a career advancement structure, lack of access to the full benefit package (including pensions or medical allowance) enjoyed by other government civil servants, and considerable delays experienced in the payment of salaries across all regions.

Career progression

LHWs do not have access to a structured system of career progression.

Integration into and support by health systems and communities

Integration into and support by the health system

- **Punjab:** The integration of the LHWP into the IRMNCH & NP has led to improved coordination between related health departments. However, there is a lack of clarity on the division of roles between front line staff. In particular, there is a lack of coordination, and indeed active competition, between LHWs and CMWs, which appeared to be related to the facility-based targets for referrals that are part of the LHW's performance management process.

- **Khyber Pakhtunkhwa:** The LHWP has been integrated into the IHP. This has provided administrative integration between the LHWP, the EPI, and MNCH. Planning documents for the IHP also defined a model for horizontal linkages between LHWs and CMWs. However, this has not in fact resulted in improved coordination between LHWs and CMWs for similar reasons as in Punjab.

- In other regions where the LHWP has remained as a standalone programme and had not been integrated, there are a lack of mechanisms for coordination between key stakeholders, in particular the Health Department, the Population Welfare Department and the PPHI.

- **AJK** was the exception, where there are strong inter-departmental linkages, facilitated by regular inter-departmental meetings.

Target population

The expansion of the LHW caseload from a maximum of 1,000 residents to 1,500 residents was reportedly undertaken without a careful assessment of the capacity and capabilities of the LHW. The expansion of the LHW's role to include participation in other activities, such as polio programming, also did not consider the implications of taking an LHW out of her community and diversifying her efforts away from her core RMNCAH functions. These have negatively affected the LHW's performance and the quality of the services that they deliver.

Availability of medicines and supplies

Prior to devolution, the procurement of supplies was managed centrally through the Ministry of Health, using competitive bidding procedures. Post-devolution, procurement is undertaken at the Provincial level. Continuing issues with the LHWP logistics management system have resulted in significant gaps in the provision of basic supplies and equipment, with frequent stockouts.

Collection and use of data

Progress has been made in upgrading the LHWP Management Information System (LHW-MIS) to a web-based system in KP, Punjab, and Sindh but in AJK, Balochistan, GB, and ICT the LHW-MIS is still manual. Effective quality control mechanisms and enforcement of reporting on all indicators are lacking across most regions. Consequently, MIS data does not appear to be used systematically to inform programme strategies in any region. Further, updates to the monitoring system, and in particular, reporting formats for LHSs and LHWs have not been accompanied by adequate training.

The lack of a harmonized Logistics Management Information System (LMIS) for all LHWP supplies, and the lack of capacity to fully implement the LMIS where it is available, severely limits the ability of the LHWP to adequately plan the distribution of supplies.

Community integration and engagement

LHWs and LHSs consistently report in past studies that the main driver of their empowerment is the sense that they have made a real contribution to improving health outcomes in the communities that they serve. Community response to their work is positive and they enjoy an elevated status within the community as a result. The recruitment criteria that requires LHWs to be recruited from the communities in which they live means that they are known, and more likely to be trusted, by the communities in which they work.

However, LHWs are being asked to engage in program activities that force them to work outside of their communities. This undermines the functioning of the client engagement mechanism, suggesting that LHWs may struggle to be accepted by communities where they are not known.

Fulfilment of World Health Organisation recommendations by the Community Health Worker programmes

The following table lists the recommendations by WHO on the policy areas around CHW programmes and depicts the fulfilments of these recommendations by the LHW programme in Pakistan using a colour code. (Green – complete fulfilment of all dimensions of the recommendation, Yellow – Partial fulfilment of some dimensions, but not others, Red – All or almost all dimensions of the recommendation not fulfilled).

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels		
	Require community membership and acceptance		
	Consider personal capacities and skills		
	Apply appropriate gender equity to context		
Pre-service training duration	Based on scope of work, roles and responsibilities		
	Consider competencies required		
	Consider pre-existing knowledge and skills		
	Social economic and geographic circumstances of trainees		Not considered
	Institutional capacity to provide training		
	Expected conditions of practice		
Competencies in pre-service training curriculum	Include core competencies domains -preventive & promotive, diagnostic, integration with wider health system, interpersonal skills, social determinants of health, personal safety		
	Include additional competency domains- treatment and care services- if required		
Training Modalities	Balance theory and practice		
	Use face-to-face and e-learning		
	Conduct training in or near the community		
	Consider interprofessional training approaches where relevant		
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training		No information
Supportive supervision	Establish appropriate supervisor – CHW ratios		Shortage of supervisory cadres in some provinces
	Train supervisors		
	Coach and mentor CHWs		Supervision not always supportive
	Use of observation of service delivery, performance data and community feedback		Not as regular as mandated
	Prioritise improving quality of supervision		Not prioritized

Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles		LHWs remunerated, but delays in payment
Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.		No information
Career Ladder	Offer career ladder to practising CHWs		No career pathway
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review		No career pathway
Target population size	Expected workload		Defined target population, but high workload
	Frequency of contacts		
	Local geography		Not considered
	Nature and time requirements of the services provided		
Collection and use of data	CHWs document the services they provide		
	CHWs collect, collate and use health data on routine activities		
	Train CHWs and provide feedback on performance based on data		Data use sub optimal
	Minimize reporting burden, harmonize requirements		High burden
Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams		
	CHWs with more selective/specific tasks to play a complementary role based on population health needs, cultural context and workforce configuration		CMWs as SBAs, but effectiveness low
Community Engagement	Involve communities in selecting & monitoring CHWs & in priority setting of CHW activities		No community involvement
	Support to community-based structures		
	Engage relevant community representatives in decision making, planning, budgeting & problem-solving		
Mobilization of Community Resources	CHWs to identify priority health and social problems and action plans		
	Community needs and develop required responses		
	CHWs mobilise and coordinate local resources		
	CHWs to facilitate community participation and links to health facilities.		
Availability of supplies	Ensure CHWs have adequate and quality-assured commodities and consumables through the integration in overall health supply chain;		Frequent shortages
	Adequate reporting, supervision, management, training, and mHealth to support supply chain functions		

Financing

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

Risks to funding and the financial sustainability of the programme vary across the regions.

- **Sindh** shifted both salary and operational costs in their entirety to the recurrent budget, offering greater security in funding for the programme.
- A similar situation is found in **Balochistan**, where all expenditure has been shifted to the ADP.
- In **Punjab**, funding of the LHWP remains heavily reliant on PSDP funding.
- In **Khyber Pakhtunkhwa**, salary expenditure was also shifted to the recurrent budget from 2016. However, Khyber Pakhtunkhwa remains heavily dependent on both donor and PSDP funding, placing risks on the financial sustainability of the programme in that province.
- The situation is less clear elsewhere.

In summary, in the majority of regions across Pakistan, the LHWP is appropriately funded in terms of budgeted cost. However, this funding is heavily skewed towards salary expenditure, which means that despite there being sufficient funds for planned budgets, there remains a significant risk to the ability of the LHWP to effectively deliver.

Private sector involvement in Community Health Worker programmes

Low levels of public expenditure on health care in Pakistan has meant that the private sector plays a large role in the delivery of health services. While the LHWs might refer someone to a government health facility, often they do not have the service delivery they are looking for. However, there is no formal mechanism of engagement with the private sector.

Prioritized measures to optimize the contribution of Community Health Workers to respond to post-Astana requirements and Primary Health Care strengthening

This section identifies measures that could be prioritized to optimize the contribution of CHWs to Primary Health Care and help the country meet Post Astana requirements. The section is organised into two sub-sections – policy support measures and system support measures.

Policy support measures

Primary Health Care policies and reforms

To transform the National Health Vision into reality, one of the key actions was to develop a UHC Benefit Package for Pakistan, informed by the global review of evidence by Disease Control Priorities (DCP3), with prioritization of health interventions at community and PHC centre level for inclusion in the EPHS. This benefit package consists of i) an Essential Package of Health Services (EPHS) to be delivered at five platforms (population, community, PHC centre, First Level Hospital and Tertiary Level Hospital), and ii) inter-sectoral Interventions/policies. The basic PHC system in Pakistan needs to be strengthened, which will require expanding the existing infrastructure. There has been no overarching policy shift, however some provinces have begun testing updated frameworks.

- **Political commitment and stakeholder participation:** Sustained political commitment and robust and transparent leadership that promotes multisectoral stakeholder participation and engagement at all levels will be vital for operationalising and institutionalising the UHC Benefit Package.

- **Intersectoral linkages:** There is also a need to strengthen intersectoral linkages. Strengthening partnership with actors from other government sectors, the private sector and development partners will enhance efforts to mobilise the necessary human, financial and technological resources for effective PHC strengthening.

- **Transparency:** There seems to be a degree of misapprehension about the current reforms and PHC reorganisation, based on past experiences with the devolution process. There is a need to establish effective coordination and communication mechanisms and monitoring standards and systems, which will promote transparency and provide quality and reliable information to help allay stakeholders' fears and concerns about the effects of the UHC benefit package.

- **Sub-national leadership:** Building robust leadership and management capacity of sub-national leaders, managers and supervisors at provincial, division and district levels will be critical for ensuring a smooth transition to effective local governance. These groups will also need the support, resources and in some cases, the authority, to make decisions to ensure PHC reforms, associated workforce polices and CHW programmes respond to local realities and the needs of the population.

- **Community engagement:** Community engagement, education and empowerment are necessary conditions for effective use of PHC services. Harnessing the potential of LHWs, who have established trusting relationships, accumulated significant social capital and achieved the status of influential social actors and change agents, will enhance such engagement as well as improve the coverage, and reach and equity of PHC programmes.

Health workforce policies

The HRH Vision aims to scale up the health workforce with a medium- and long-term uniform strategy in advancing towards UHC and the SDGs. Within the HRH Vision 2018-30, a number of steps are outlined that target the development, expansion and support of CHWs. Despite the recommendations of the HRH Vision, no training or recruitment plans have yet been developed to address the identified workforce challenges.

Financing

The major challenges of health financing in Pakistan include inefficiencies in public health spending, duplication of activities, and limited coverage of the health insurance programme which is currently only available to particular disadvantaged groups. Pakistan needs to invest more in the health sector to improve social protection and the health of the population. Policy

makers should encourage more stable and flexible financial plans, along with an increased budget allocation, taking into account the priorities of the health sector.

Community Health Workers and the Primary Health Care workforce

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

System support measures

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

Optimizing *Community Health Workers* roles and responsibilities

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

There is a contrary view among some key informants that suggests expanding the scope of work of the LHWs, particularly in the areas of communicable and non-communicable diseases. If LHWs are to play a role in NCD prevention and control efforts within the scope of their current roles and responsibilities, appropriate systems support, including training, supervision, remuneration, and an enabling environment to address deficiencies that have been identified will be required. Any additional tasks and expectations related to NCD health promotion and education or other services, should be clearly defined and should not interfere with or undermine their ability to undertake their core RMNCAH and other functions.

Selection criteria and availability and distribution of Community Health Workers

The requirement that a certain level of prior learning is required for selection as an LHW excludes communities that have poorer than average access to education services. A key priority of the LHWP should be to ensure that the selection, deployment and transfer of LHWs, as well LHS, is based on merit. Any further expansion of the LHWP should be informed by reliable information on the areas with the poorest health outcomes, lack of access to health care facilities, and high rates of poverty.

Education and training

Skills development, capacity building and supportive supervision are key priorities for ensuring LHWs have the latest knowledge and skills to provide quality services and for strengthening the overall LHWP. Regular curriculum review and revision, and systematic and regular refresher and in-service training and mentoring are necessary to ensure LHWs have access to new knowledge and have opportunities to maintain and upgrade their skills and competencies, enabling them to effectively deliver quality services and achieve the expected health outcomes and targets.

Remuneration and allowances

The regularization of LHWs has created significant human resource management challenges as it was not accompanied by the definition of an adequate service structure nor a careful assessment of the workload of an LHS or LHW relative to the remuneration offered. The failure to effectively manage and resolve these issues may result in decreased motivation, increased attrition, and an increased risk of wider strike action. These need to be immediately addressed.

Career progression

Career mobility opportunities need to be built into CHW programming to encourage and enable LHW and other CHW cadres to advance to higher levels of the health system, as well as leadership positions, if they so desire. Providing these cadres with the opportunity to progress in their careers would not only motivate them, but as role models within the community, they could also encourage and attract others to this career.

Supportive Supervision

Capacity building of the supervisors and to support these LHS to ensure that they have the capacity to provide on-the-job coaching and on-the-job training of LHWs is urgently needed. LHS cadre should be provided with a field travel allowance that would enable them to manage their own transportation and conduct supervision visits as scheduled.

Community Health Workers integration into the health system and community

Strengthening the integration of the LHWP and improving coordination mechanisms across all provinces will help to ensure the LHWs can continue to play a central role in the provision of Family Planning and RMNCAH services.

Engaging LHWs in program activities outside their communities where they are not known may be challenging for this cadre and should be well managed. Further, as one respondent warned, expanding their target population may be difficult for the LHW, firstly, given the gender related constraints on her mobility, and secondly, will reduce the number of visits she can make as well as the time she can spend with clients, which may in time affect her relationship with the community.

Data collection

The structure of the HIS in Pakistan remains fragmented with multiple vertical information systems that are not integrated at the subdistrict, district, provincial and national levels. The DHIS is undergoing digitization at the reporting and management levels in several provinces across the country. In the next phase, a gradual shift to DHIS-2 is being planned across the country, which will build coherence across health and management information systems and support the implementation of an integrated disease surveillance and response system across the country.

Making the Community Health Workers programmes gender transformative

At the time of this study, there were no updated comprehensive measures or analytical data available to accurately assess the gender responsiveness of Pakistan's health sector policies.

Although the LHWP hires primarily women to serve women in the community, the program was not designed or conceived with an explicit human rights and gender equality approach. However, the LHWP is perceived to be supportive of the empowerment of both LHSs and LHWs in terms of their improved economic status and greater social status in the communities in which they work, and the programme does seek to support the goal of achieving UHC through the delivery of doorstep PHC, as well as addressing the specific health needs of women and children. Whilst access to PHC is not an obligation of the LHWP, in the areas that it currently serves, it acts as a bridge for communities with no access to first level care facilities and is supportive of a continuum care in the RMNCAH domain. In the context of the limited mobility of women, this is a crucial aspect of the programme that is supportive of reducing gender inequalities in access to health. In addition, with its focus on family planning, the LHWP is well placed to make gains towards the realization of gender equality.

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

Sexual and Gender Based Violence (SGBV) Services

There are numerous barriers to the prevention of, and response to, Gender Based Violence (GBV) in Pakistan, including misperceptions around GBV, limited or ineffectual legislation, and a lack of support systems and safety nets for those who do attempt to seek support. Insufficient systems at the state, civil society and community levels are serious obstacles to comprehensively addressing GBV in the country.

The area of GBV and SGBV falls under the ambit of the Ministry of Human Rights (MoHR), who have taken steps to mitigate its effects in Pakistan. For the protection of women's rights and the elimination of GBV, the MoHR has formulated National Policy Guidelines on Gender Based Violence. However, there were no publicly available data to determine the role of CHWs in countering GBV and SGBV in Pakistan. The Domestic Violence (Prevention and Protection) Act, 2012 does not make mention of LHWs or any other CHWs.

Conclusions

The contribution of the LHW cadre in Pakistan to the achievement of positive RMNCAH outcomes as well as strengthening health promotion and prevention in communities is well recognized. LHWs are well accepted and enjoy a high status within the communities they serve.

However, a number of policy and health system support areas need to be strengthened to optimise CHW programs in Pakistan and ensure the continued availability and retention of these cadres to reach and address the health needs of all population groups, especially those that are underserved, marginalized and vulnerable. Robust supervision and monitoring and evaluation systems must be designed and implemented to allow for the routine coordination of the services they provide and the necessary performance improvements. This will require an all-of-government approach, sustained political commitment, predictable financing, robust leadership and governance, strong partnerships and multisectoral stakeholder collaboration at all levels.

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Policy brief for Pakistan

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