Original Article

Problems Faced by Lady Health Workers (LHWs) in Punjab Province

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Objective: To assess the problems faced by Lady Health Workers in Punjab province.
Material & Methods: This cross-sectional study was conducted in 9 union councils of Punjab province. All 111 Lady Health Workers working in these nine union councils were included in the study and were interviewed on a structured questionnaire.
Results: Ninety two percent of the LHWs faced problems while providing services. Ninety five percent had salary related problems, seventy four percent had problems with supplies, thirty two percent faced problems in community services, 44.1% had difficulties with health facility liaison, 56.7% faced problems due to workload, 44.1% had problems in traveling, 8.8% in supervision, 20.6% in monitoring, 9.8% in reporting, 29.4% in feedback, 36.3% in security; 14.7% faced problems due to harassment, 18.6% due to training deficiency and 32.4% faced other problems.
Conclusion: Efforts must be focused to strengthen the program and increase the LHWs capacity as efficient health care workers by involvement of LHWs' own views and addressing the problems faced by them.
Keywords: Lady health workers, community workers, gender and female workers.

Introduction

Health is a fundamental right of people and most of the governments including Pakistan have taken responsibility of provision of health care services to all the people of their countries.

For achieving universal health coverage by addressing PHC at community level, the Government of Pakistan launched the National Program for Family Planning and Primary Health Care (NPFP&PHC) in April 1994. The program recruits local, literate girls as LHWs and after 3 months of classroom sessions and 12 months of field training they are deputed in the community. They work from their own house which is declared as a Health House. Each LHW caters for 200 households or 1000 population. About 25 LHWs are supervised by one supervisor.

LHWs are posted in their own communities and are involved in organizing community by developing women groups and health committees. They act as liaison between formal health system and community and are required to register all eligible couples (married women age 15-49 years). LHWs disseminate health education messages on hygiene and sanitation, provide family planning services, undertake nutritional interventions, coordinate with EPI for immunization of mothers against tetanus and children, carry out prevention and treatment of minor ailments and coordinate with TBAs (traditional birth attendants) and local health facilities.

Uptil now NPFP&PHC has more than 95,000 LHWs working in almost every part of Pakistan and providing primary health care facilities to the community.

The importance of LHW cannot be under estimated and all steps should be taken to strengthen their role. This cannot be done without knowing and solving the problems that are encountered by them. So evaluation of problems faced by them is of grave importance and their issues need to be highlighted and resolved.

Very little literature exists which has identified social and cultural, along with organizational barriers to efficient working of LHWs. Furthermore, no study has so far looked at LHWs perspective of the strengths and weaknesses of the program and how their role in PHC may be strengthened within the program.

Material & Methods

It was a cross sectional descriptive study conducted in 9 union councils of Punjab province from 17th June 2008 to 17th July 2008. The study was conducted in following union councils of the province (convenient sampling):

1. UC Dhamthal No. 28, Tehsil and District Narowal with 15 LHWs.
2. UCl C-1 of Walton Cantonment Board, Lahore with 9 LHWs.
3. UC C-6 of Walton Cantonment Board Lahore with 7 LHWs.
4. UC No. 110 Kharak District Lahore with 9 LHWs.
5. UC No. 32 Chak No.5 Kalan, District Nankana

7. UC No. 179 District Faisalabad with7 LHWs.
8. UC No. 28 Sinawa District Muzzafargarh with 27 LHWs.
9. Islamabad Capital Territory UC No. 7 Kirpa with 23 LHWs.

All lady health workers working in the study area were included. The total number the LHWs in study was 111.The data was collected on standardized questionnaires which included open ended questions and all LHWs were directly interviewed. Part A was based on socio-demographic information and part B was related to the problems. The data was entered into the computer, by using Epi Data and Epi Info version 3.5.1 was used to analyze the data. The permission from EDOs(H) and District coordinators of NPFP&PHC was sought formally. Confidentiality was ensured by not disclosing the identity of participants of the study to any body.

Results

Table-1 shows the socio-demographic characteristics of the LHWs. There were 35 (31.53%) LHWs between 20-30 years of age, 43 (38.73%) LHWs between 31-40 years of age and 33 (29.72%) were between 41-50 years of age. Educational status of the LHWs ranged from middle to graduate; 22(19.81%) LHWs were middle, 45(40.54%) LHWs were matric, 32 (28.82%) LHWs were F.A. and 2 (1.8%) LHWs were graduates. 80 (72.07%) were married, 21(18.9%) were unmarried & 10(9.02%) were divorced/widow. All had income less than Rs. 3000 per month.

Table-2 shows the problems faced by LHWs while providing services. 102 (91.89%) LHWs said that they faced problems. 95 (93.1%) had salary related problems, 76 (74.5%) had problems with supplies, 33 (32.4%) in community services, 45 (44.1%) with health facility liaison, 58 (56.7) faced problems due to workload, 45(44.1%) had problems in traveling, 9 (8.8%) in supervision, 21 (20.6%) in monitoring, 10 (9.8%) in reporting, 30 (29.4%) in feedback, 37(36.3%) in security, 15 (14.7%) faced problems due to harassment, 19 (18.6%) due to training deficiency and 33 (32.4%) faced other problems.

Table-3 shows the salary related problems faced by LHWs. 67 (70.5%) said the salary was low. 55 (57.8%) complained of delayed payments. 3 (3.2%) reported deductions in their salary.

Table-4 shows the frequencies of LHWs facing hardships due to problems of supplies. 60 (78.9%) had problems in medicine supply. 27(45%) said they received inadequate medicines, 47 (78.3%) said supply was irregular and 19 (31.6%) complained of deficiency of important medicines, 28 (36.8%) had stationary related complaints. 27 (96.4%) said stationary supply was deficient and 5 (17.8%) said that stationary was of poor quality. 19 (25%) LHWs faced problems due to weight machine. 2 (10.5%) said mothers were hesitant to use weight machine for kids, 15 (78.9%) felt it was not suitable for infant use, 3 (15,7%) said there are problems in repair of the weight machine and 3 (15.7%) felt need of adult weight machine as well. 5 (6.5%) said provision of BP apparatus was also necessary.

Table-5 depicts the problems in community services. 17 (51.5%) said there was resistance by males, 14 (42.4%) said there was resistance by females, 7 (21.2%) faced resistance to family planning and non-availability of mothers, 6 (18.2%) said community behaved rudely and 1 (3%) said there was resistance during Oral Polio Vaccine campaign due to fear of family planning.

Table-6 shows the problems in liaison with health facilities. 22 (48.9%) had problems with Basic Health Units, 21(46.7%) with Rural Health Centres, 7 (15.5%) with government hospitals and 2 (4.4%) with private hospitals. 33 (73.3%) said there was no cooperation from health facilities, 8 (17.7%) said

Table-1: Socio-demographic characteristics of lady health workers (n=111).

	Number	Percentage
Age in Years		
20 - 30	35	31.53
31 - 40	43	38.73
41 - 50	33	29.72
Marital Status		
Married	80	72.07
Unmarried	21	18.91
Divorced /Widow	10	9.02
Educational Status		
Middle	22	19.81
Matric	45	40.54
FA	32	28.82
Graduate	2	1.8
Income		
Less than 3000 Rs.	111	100

patients were mistreated, 6 (13.3%) said LHWs were maltreated, 3 (6.7%) complained that referral slip was not signed and 20 (44.4%) said that doctors were not available at health facilities.

Table-7 shows workload related problems faced by LHWs. 40 (68.9%) said they are overworked. 14 (24.1%) said workload is increased during campaigns, 8 (13.7%) felt there was excessive paper work, 6 (10.3%) were stressed due to political gatherings and 2 (3.4%) said workload increased after trainings.

Table-8 describes the department related matters causing problems for LHWs. 6 (66.7%) had supervisory problems due to vacant LHS posts and 3 (33.3%) said LHS was overworked. 15 (71.4%) complained of irregular monitoring, 5 (23.8%) said monitoring was excessive and 1 (4.7%) said they were over monitored during campaigns. 7 (70%) said there was duplication in reporting and 9 (90%) said reporting was difficult. 29 (96.7%) said there was no feedback by department and 5 (16.7%) said there was no appreciation. 10 (52.6%) felt training deficiency in antenatal care, 6 (31.5%) in labor room and 7 (36.8%) in referral. **Table-9** depicts the problems in personal protection of LHWs. Traveling problems were due to non-availability of transport in 18 (40%) cases, 17 (37.7%) at night, 11 (24.4%) as no TA/DA was given and 3 (6.7%) due to weather. 34 (91.8%) complained of occasional security problems, 12 (32.4%) had security problems when they went to different areas. Of those who faced harassment 15 (100%) faced occasional harassment, 11 (73.3%) during campaigns, 11(73.3%) faced eve teasing, 4 (26.7%) faced physical harassment, 10 (66.7%) faced it from community members and 4 (26.6%) from colleagues. **Table-10** shows various problems faced by LHWs. 8(24.4%) said they were being charged for supplies. 6(18.2%) had problems in provision of services related to sanitation. 4(12.2%) said that trainings in far-off areas makes it difficult for them. 17(51.4%) mentioned vague problems.

Table-2: Problems faced by LHWs while providing services.

	Number	Percentage
Do you face problems while providing services? (n=111)		
Yes	102	91.89
No	09	8.11
Various problems (n=102)		
Salary	95	93.1
Supplies	76	74.5
Community Services	33	32.4
Health faciltiy liaison	45	44.1
Workload	58	56.7
Travelling	45	44.1
Supervision	9	8.8
Monitoring	21	20.6
Reporting	10	9.8
Feedback	30	29.4
Security	37	36.3
Harassment	15	14.7
Training deficiency	19	18.6
Any other	33	32.4

** Multiple responses allowed*

Table-3: Salary related problems faced by LHWs (n=95).

	Yes	Percentage
Low salary	67	70.5
Late payments	55	57.8
Deductions	3	3.2

**Multiple responses allowed*

Discussion

The study was conducted to identify problems faced

Table-4: Supplies related problems of LHWs (n=76).

	Yes	Percentage
A. Medicine (n=60)	60	78.9
1. Inadequate	27	45
2. Irregular Supply	47	78.3
3. Deficient important medicines	19	31.6
B. Stationary (n=28)	28	36.8
1. Deficient	27	96.4
2. Poor quality	5	17.8
C. Weight machine (n=19)	19	25
1. Mothers hesitant	2	10.5
2. Unsuitable for infants	15	78.9
3. Adult wight machine required	3	15.7
4. Repair problem	3	15.7
D. BP Apparatus	5	6.5

**Multiple responses allowed*

Table-5: Problems faced by LHWs in provision of community services (n=33).

	Number	Percentage
Resistance by Males	17	51.5
Resistance by Females	14	42.4
Resistance during campaigns	1	3
Resistance to family planning	7	21.2
Resistance to OPV (fear of family planning)	1	3
Mothers not available	7	21.2
Do not show newborn	1	3
Rude behavior	6	18.2

**Multiple responses allowed*

Table-6: Problems related to liaison with health facilities (n=45).

	Number	Percentage
Basic health unit	22	48.9
Rural health centre	21	46.7
Government hospital	7	15.5
Private hospital	2	4.4
No cooperation	33	73.3
Mistreatment of patient	8	17.7
Mistreatment of lady health worker	6	13.3
Refferal slip is not signed	3	6.7
Doctor not available	20	44.4

**Multiple responses allowed*

by LHWs in order to facilitate the provision of their services. About a quarter of the LHWs were found to have significant occupational stress. Factors associated with stress included having low socio-economic status and having to travel long distances for work. Inconsistent medical supplies, inadequate stipends, lack of career structure and not being equipped to communicate effectively with families were the main factors for job dissatisfaction among these workers. Improvement in remuneration, better administration of supplies and a structured career path should be ensured for better performance of community health workers. In addition, communication skills learning should be an essential part of their training program.The "Lady Health Worker" (LHW) of the National Program for Family Planning and Primary Health Care in Pakistan broadly fits into the definition of community health worker, and is a crucial component of the health care delivery system of the country. The Lady Health Workers Program (LHWP) is a federally funded development program working at the grass root level since 1994. About 96,000 workers and their supervisors have been trained and deployed in all the 135 districts of Pakistan. They currently cover about 65% of the target population (rural and urban slums), and full coverage is planned in the next few years.

Table-7: Workload problems faced by LHWs (n=58).

	Number	Percentage
Over worked	40	68.9
Increased during campaigns	14	24.1
Paper work	8	13.7
Increased after campaigns	2	3.4
Political gatherings	6	10.3

**Multiple responses allowed*

Table-8: Supervisory, monitoring, and training related problems (n=102).

	Number	Percentage
Supervision (n=9)	**9**	**8.8**
LHS post vacant	6	66.7
LHS overworked	3	33.3
Monitoring (n=21)	**21**	**20.6**
Excessive	5	23.8
Over during campaigns	1	4.7
Irregular	15	71.4
Reporting (n=10)	**10**	**9.8**
Duplication	7	70
Difficult	9	90
Feedback (n=30)	**30**	**29.4**
Nil by department	29	96.7
No appreciation	5	16.7
Training deficiency (n=19)	**19**	**18.6**
Antenatal care	10	52.6
Labor room	6	31.5
Referral	7	36.8

**Multiple responses allowed*

Table-9: Difficulties faced by LHWs related to travelling and personal protection (n=102).

	Yes	Percentage
Traveling (n=45)	**45**	**44.1**
Weather	03	6.7
Transport	18	40
Not at night	17	37.7
No TA/DA	11	24.4
Security (n=37)	**37**	**36.3**
Occasional	34	91.8
Different Area	12	32.4
Harassment (n=15)	**15**	**14.7**
Occasional	15	100
During campaign	11	73.3
Eve Teasing	11	73.3
Physical	05	26.7
Community	10	66.7
Colleagues	04	26.6

**Multiple responses allowed*

Table-10: Other problems faced by LHWs (n=33).

	Number	Percentage
Changes for supplies	08	24.4
Community sanitation	06	18.2
Training in far off area	04	12.2
Miscellaneous	17	51.4

**Multiple responses allowed*

The job description of the LHW has evolved over time. Initially it included health education and basic preventive services for family planning, maternal and child health, improving nutrition, basic hygiene and sanitation and child immunization. Today it also includes mass immunization for polio eradication; newborn care, maternal immunization with tetanus toxoid (TT), referral of eligible cases to health facilities, regular record-keeping for updating the management information system (MIS) of the program, community management of tuberculosis and health education on HIV-AIDS and Hepatitis.

Lady Health Workers are seldom consulted when their job description changes. This ever-enlarging scope of work of the LHW in which they have little say can result in occupational stress. This condition defined as "any physical or psychological event perceived as potentially constituting physical harm or emotional distress", if present in health workers depicts the problems in community services and can have an adverse impact on their efficiency.

The program succeeded in creating a large sized organization comprising of female community health workers and establishing a functional program management and supply system. It found evidence that the program improved the uptake of important health services in areas covered by its LHWs. At the same time it recommended that the quality of work needed improvement. Efforts must be focused to strengthen the program and increase the LHWs capacity as efficient health care workers.

But there was no information on the LHWs' own views about their job description and levels of occupational stress. These factors would be important in the improvement of quality of service delivery and under performance/utilization of existing LHWs. The domain in general is poorly researched and systematic reviews have pointed out knowledge gaps in areas like job satisfaction/dissatisfaction and job retention/attrition describes the department related matters causing problems for LHWs.

The most common problem reported was dealing with administrative inefficiency such as irregular supply of medicines and vaccines (70%) and not getting their salary on time. Inadequate salary was the next biggest problem reported by over 60% of the respondents. Other problems included difficulty motivating mothers and families to get their children immunized and take preventive measures, difficulty in communicating on family planning issues, non cooperative attitude of community and inadequate information, education, communication (IEC) material and other job aids.

The potential role of CHWs in improving community health has been acknowledged especially in resource poor countries. Haines et al[47] have described that owing to the inverse relationship of density of health workers (doctors, nurses, midwives) with maternal, infant and under 5 mortality coupled with high cost of training of doctors and nurses and the low use of services based in health facilities in many areas, there is a possibility to make substantial health gains from the use of community health workers. The Task Force for Scaling up Education and Training for Health Workers[48] recommended

improving education of these workers through quality assurance programs and urged international action to scale up the production of quality health workers.

Other studies have also reported areas for improvement in the structure and performance of CHW programs including the LHWP of Pakistan. The low salary and lack of career path was highlighted by Afsar et al [17] as a reason for job dissatisfaction among the LHWs. Mumtaz et al[40] reported abusive hierarchical management structure, disrespect from male colleagues, lack of sensitivity to women's gender-based cultural constraints, conflict between domestic and work responsibility and poor infrastructural support as the important problems faced by female primary health care workers from their study conducted in 1998 when the program was only four years old. Our study suggests that the disrespect from male colleagues and conflict between domestic and work related responsibility has improved while the other factors remain the same.

Douthwaite & Ward[49] found that the LHWP succeeded in increasing the use of modern contraceptives by rural women. According to them women served by LHWs were significantly more likely to use a modern reversible method than women in communities not served by LHWs after controlling for various individual and household characteristics. They advocated for continuation of providing doorstep services through community-based workers to achieve universal access to safe family planning methods. Our study suggests that communication on family planning is still perceived as a difficult area by these workers and, while the program should be continued, some interpersonal communication (IPC) capacity building measures are needed to further improve performance and outcome.

Multifaceted interventions (e.g. training plus supervision) which address multiple determinants of performance have been recommended[50] to improve CHW performance. We add that improvement in remuneration; clear career path and improved administration are also required. In addition, empowering communication techniques should be built into the training and on-going supervision processes to improve the effectiveness of the community health workers.

Independent evaluations of the program conducted to date have shown mixed results, with some regions in the country performing better than others. The evaluation conducted by the Oxford Policy Management, UK, reports that the performance of about 17% of LHWs was poor and 35% was below average. Moreover, the government's decision to introduce a more comprehensive reproductive health package[5] would increase LHWs responsibilities and could further decrease efficacy. Therefore, efforts must be focused to strengthen the program and increase the LHWs capacity as efficient health care workers.

In low income countries, the task of providing primary health care is often the responsibility of community health workers. In Pakistan, community workers called Lady Health Workers (LHW) deliver basic health care at the doorstep in the rural areas and urban slums. Evaluations show that it is a successful program but point out inconsistencies in the quality of service provided. In order to achieve this, it would be important to obtain the workers' viewpoint on their job-description, the problems they face and the levels of problems they encounter.

Conclusion

After 15 years of the National Program for Family Planning and PHC has acquired maturity, and has expanded from a limited pilot project to an enormous program with nation wide coverage. The workers form an invaluable body of skilled human resource, the services of whom are often utilized for many other programs. LHWs have mostly succeeded in establishing trust and community acceptability and are providing essential PHC services across the country. This is all the more significant in a culture where government programs are considered suspect by most. The following recommendations are being made with the aim to strengthen the role of LHWs in PHC in Pakistan.

- LHWs should be made permanent government employees with all relevant benefits after an initial probation period.
- Salaries should be increased and salary disbursement mechanism be made efficient
- Eligible LHWs be given incentives (skills, career development, financial) and positive feedback for motivation
- Any incentives or remuneration policies must always be monitored and adapted over time to ensure that they produce the desired outcome
- Community be educated about assigned role and responsibilities of LHWs
- Program staff must not be involved in other programs like polio eradication campaigns

- Patient referral system by the LHWs must be strengthened and referrals by LHWs be given priority at FLCFs
- A mix of payment systems and incentives should be used where possible. If institutional capacity is limited, caution should be exercised in adopting approaches with complex administrative requirements
- The number of LHWs should be increased to cover the whole population.
- Workload of LHWs should be equalized.
- Supply of medicines should be regularized and increased.
- Refresher trainings should be given regularly.
- Regular feedback should be taken from LHW for improvement of program

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