Government of Pakistan
Ministry of National Health Services,
Regulations & Coordination

Lady Health Workers' Strategic Plan (2022-28)

Primary Health Care for Universal Health Coverage

Government of Pakistan
Ministry of National Health Services,
Regulations & Coordination

LADY HEALTH WORKERS'

STRATEGIC PLAN

June 2022

Provincial/ Federating Areas
Health Departments
and
Ministry of National Health Services,
Regulations & Coordination

@ June 2022

Lady Health Workers' Strategic Plan (2022-28)

Endorsed by
Inter-Ministerial Health & Population Council on ??.??.2022

Reviewed by
Provincial/ Federating Areas' Health Departments and
National Advisory Committee on ??.??.2022

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Technical Assistance:
United Nations Children Fund
World Health Organization
British High Commission
US Agency for International Development

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Web: http://www.nhsrc.gov.pk/

National Health Vision

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

The Lady Health Workers' System

Promoting Health; Reducing Poverty

Improved health of all people of Pakistan especially women, girls and children, through providing high quality integrated primary health services at the doorstep of communities by Lady Health Workers

JOINT MESSAGE FROM THE HEALTH MINISTERS

Since the Alma Ata Declaration on Primary Health Care in 1978, we know that the stepping-stone towards better health, equity and universal health coverage (UHC) is building and strengthening a sustainable, integrated primary health care (PHC) system. The Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018 endorsed a new declaration emphasizing the critical role of primary health care with an aim to refocus efforts on PHC to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health.

In Pakistan, Lady Health Workers (LHWs) have significantly accomplished the reach of primary health care services to communities otherwise underserved or unserved by formal health systems. These community based workers are delivering a set of PHC services, including preventive, curative care and health education. Unfortunately, the coverage and quality of these services have declined over the last decade, as highlighted in the fifth evaluation of the programme.

In the agenda for sustainable development goals (SDGs), **universal health coverage (UHC) has become the main health outcome,** also having levarage points with other SDGs and sectors. For making progress towrds UHC, all provincial and federating areas have finalized their Essential Packages of Health Services (EPHS)/ UHC Benefit Packages. For the implementation of EPHS at community level, lady health workers are the core provider for essential preventive, promotive and curative healthcare services, in addition to their contibution in the inter-sectoral interventions and community empowerment.

Considering new developments in the health sector, horizontal integration of PHC programmes, lessons learnt, scientific evidence and emerging needs, it was essential to revist the roles & responsibilities and strategic direction of lady health workers. We appreciate the efforts of all stakeholders from the federal ministry, provincial & federating areas health departments, united nations agencies, development partners, academia and civil society organizations in setting a new strategic direction for these workers. We hope that this startegic plan would facilitate the sector to achieve better health, social and economic outcomes in Pakistan.

JOINT DECLARTION

We, **the Federal, Provincial and Federating Areas' Health Ministers in Pakistan**, pledge to building sustainable primary health care, as a foundation of strong health systems and universal health coverage in Pakistan;

We promise to putting people at the centre of health care, not diseases or conditions thus empowering people and communities to take care of their own health, and to advocate for it;

We believe that the lady health workers are the lynchpin in ensuring essential community based health services that meet people's health needs, throughout their lives;

We pledge to taking action across sectors to address the social, economic and environmental determinants of health.

The Strategic Plan (2022-27) for the Lady Health Workers is a unified and common intent with agreed strategic priorities and actions. We also pledge to work together for better health, social and economic outcomes in Pakistan and therefore endorse this document.

Mr Abdul Qadir Patel
Federal Health Minister

Mr Khawaja Salman Rafique
Health Minister, Punjab

Dr Azra Pechuho
Health Minister, Sindh

Mr Taimoor Khan Jhagra
Health Minister, Khyber Pakhtunkhwa

Mr Ehsan Shah
Health Minister, Balochistan

Haji Gul Bar Khan
Health Minister, Gilgit Baltistan

Mr Nisar Ansar Abdali
Health Minister, Azad Jammu & Kashmir

FOREWORD

The Government of Pakistan is cognizant of the fact that investment in the health sector and more specifically in the Primary Health Care (PHC) is of utmost importance to ensure that the people of Pakistan are healthy and have equitable access to quality essential health care services.

With the 18th constitutional ammendement, health as a subject is the responsibility of the provincial governments, whereas the federal government is the main interface with the international community, responsible for global commitments and developing consensus with the provincial governments to translate these commitments into actions. In addition, the federal government also coordinates to allocate additional resources for the provincial and area governments to effectively implement the agreed reforms.

In order to achive health-related sustainable goals (SDGs), Lady Health Workers are the lynchpin in our healthcare delivery system. They are the front line workers not only for provision of community based essential healthcare services but also an effective health workforce during health emergenices. Role of LHWs during earthquake in 2005, floods in 2010 and more recently during COVID-19 pandemic in Pakistan was examplary.

The LHWs' Strategic Plan (2022-28) is based on the National Health Vision (2016-25) and solidifies the intent of provincial/ federating areas Essential Packages of Health Services (EPHS)/ Universal Health Coverage (UHC) Benefit Packages. The making of the Strategic Plan is indebted to all Federal, Provincial and Federating Areas' Health and Population Welfare Ministers and other members of the Inter-Ministerial Health & Population Council for initiating the political dialogue and finalizing the process with endorsing this document. We are grateful to them for their trust and overall guidance.

I appreciate the dedication and commitment of the National Advisory Committee (NAC) under the leadership of Dr Rana Muhammad Safar, Director General (Health) and all provincial/ federating area Secretaries Health and Director Generals Health Services, for leading the dialgue with stakeholders for the development of this plan. However, their task is not over yet and they have a long road to travel for successful implementation and monitoring of the strategic plan.

On behalf of the federal and provincial / area governments, it is a call for all the relevant public and private sectors stakeholders, civil society organizations, academia, United Nations and development agencies to extend their full support for the sucessful implementation of this strategic plan, thus ensuring better health outcomes especially for the poor and disadvantaged population.

__ *Dr Muhammad Fakhre Alam, Secretary M/o NHSR&C* _____

ACKNOWLEDGEMENTS

The Government of Pakistan aims to ensure Primary Health Care (PHC) for Universal Health Coverage (UHC) by fostering investments and partnership to enhance the provision of integrated essential health service delivery. The LHW Strategic Plan (2022-28) has been developed considering results of the fifth evaluation of the LHW Programme in 2019, carried out by the Oxford Policy Management (OPM) with support of United Nations Children Fund (UNICEF). In addition, scientific evidence was also genertaed during the development of Essential Package of Health Services by all provinces and federating areas, based on the Disease Control Priorities - Edition 3 (DCP3) recommendations.

All available evidence was reviewed, presented and discussed in the national, provincial and area level dialogue, which became the basis for the development of the LHWs' Strategic Plan (2022-28). The strategic plan is owned by not only the public sector stakehodlers but also by the UN agencies, development agencies, civil society organizations, academia, LHWs, Lady Health Supervisors (LHS) and other staff.

National Advisory Committee (NAC) coordinated the process effectively under the guidnace of Inter-Ministerial Health & Population Council. Special thanks are due to all provincial / federating areas Health Departments and more specifically Secretaries Health, Directors General Health Services and Focal points/ management of the LHWs' System for their leadership and commitment for the reform measures.

Development of the Strategic Plan was not possible without the technical support of the UN and development agencies. Technical support specially from UNICEF, WHO, British High Commission, and US Agnecy for International Development is specially recognized, in addition to contribution and support extended from other partners and organizations. Advice and suggestions from the 'PHC for UHC Mission' to Pakistan are also acknowledged for setting the strategic direction and suggesting reforms in the LHWs' System of Pakistan.

The coordination efforts of the Ministry of National Health Services, Regulations and Coordination (NHSR&C) and more specifically the Health Planning, System Strengthening and Information Analysis Unit (HPSIU) is worth mentioning. The leadership role of Dr Baseer Achakzai, Director Programmes/ HPSIU and Dr Attiya Aabro, Deputy Director Programs is acknowledged.

Special gratitute is due to Dr Malik Muhammad Safi and his team including Dr Raza Zaidi, Dr Riaz Solangi, Mr Wahaj Zulfiqar, Dr Fauzia Aqeel, Dr Ifrah Javed and staff of HPSIU, FCDO, UNICEF, WHO, IHN and USAID who worked with full dedication to complete the task.

In the end, I am thankful to all LHWs, LHSs and management of the LHWs' System who proactively participated in the consultative process and shared their valuable feedback, comments and suggestions.

I pray for the achievements of all milestones and and targets set in the LHWs' Strategic Plan (2022-28). It is expected that LHWs will continue to play an effective role in the achievement of health related SDGs, UHC and PHC milestones and targets.

Dr Rana Muhammad Safdar, Director General (Health) _____

EXECUTIVE SUMMARY

The National Health Vision (NHV) 2016-25 provides an overarching unified policy direction in Pakistan and agreed upon common strategies, harmonizing federal and provincial efforts for achieving the desired health related sustainable development goals (SDGs). It was designed to represent an aspirational and ambitious target to achieve health related SDGs including universal health coverage (UHC).

The Ministry of National Health Services, Regulations & Coordination (NHSR&C) and Provincial / Area Health Departments have finalized respective costed essential package of health services (EPHS) / UHC Benefit Package of Pakistan to ensure UHC progress. The evidence generated for EPHS development suggests that without paying attention to primary health care (PHC) both at community and PHC centre level, achieving UHC service coverage in Pakistan will remain a dream. With just eight years away from the deadline of SDGs in 2030, half of the population in Pakistan (approximately115 million) do not receive the most essential health services they need (SDG 3.8.1).[1] Further, more than 10 million people are pushed into poverty every year from paying out-of-pocket (OOP health expenditure of >10% of total household income) for health services (SDG 3.8.2).[2]

The Government of Pakistan aims to ensure PHC for UHC by fostering investments and partnership to enhance the provision of integrated essential health service delivery. This will ultimately have impact on health outcomes through institutional accountability of service providers and health system strengthening, while facilitating community and key population as rights holders to voice their demands.

The partnership among the Ministry of NHSR&C, Provincial/ Area Health Departments, development partners and health related United Nations (UN) organizations has been recognized as leading the way in health programming in Pakistan due to collaborative structures as well as providing much needed technical assistance to the health sector's strategic priorities.

While the health sector and the Lady Health Workers (LHWs) system has made some gains since the start of Sustainable Development Goals (SDGs), with measurable positive impact, the road ahead remains challenging and uncertain. Considering emerging needs and results of the fifth evaluation of the LHW Programme (2019), it was decided unanimously to develop a new strategic plan for the LHWs' system. The medium-term Strategic Plan for LHWs' System 2022-28 - will guide the health

1 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.1 reported
2 WHO, 2021; Global UHC Monitoring Report – Number projected for Pakistan based on the indicator 3.8.2 reported

departments' work, responding to its specific priorities and institutional reforms needed to achieve national and provincial objectives and targets.

Based on the evidence, the LHWs System needs a clear roadmap in which:

1. The LHWs System should intensify its impact in communities already covered by LHWs; and
2. Provide a plan for future expansion of the LHWs system to areas not covered so far with a priority to rural and urban slums/ densely populated areas

In the new phase of the LHWs' System efforts will be made in increasing family planning choice and the uptake of family planning methods, reducing maternal and child morbidity and mortality with an emphasis on neonatal care, control of communicable and non-communicable diseases.

More specifically, the LHWs System through an enhanced integrated approach will:

1. Improve the quality of services provided by LHWs by addressing weakness in the non-salary component as identified in the fifth evaluation;
2. Expand the number of LHWs from current number of 89,282 (2021) to more than 135,230 by the end of 2027-28

Means to achieve the objective of improving the quality of services through LHWs will include:

- Enhance the non-salary budget to ensure that essential medicines, equipment, supplies etc. are available for effective services;
- Gaps in the supervisory system are addressed through increased mobility for LHS and other district and provincial staff;
- Formal training and refresher training system is revived re-enforcing knowledge and skills acquisition of LHWs and other staff;
- Communities are more engaged and empowered through an effective communication strategy ensuring improved communication skills of LHWs;
- New interventions are introduced based on local scientific evidence and using the platform of Technical Review Committees;
- Innovative approaches are applied including partnership with the private sector and use of digital technologies for quick processing of data and timely decision making.

Prioritization for expansion of LHWs coverage will require:

- Timely filling of vacant positions mainly as a result of retirement of LHWs
- Poor and unserved communities should be the top priority for improved coverage through LHWs;
- Strengthened supervision should ensure that LHWs is regularly offering services to poor and disadvantaged population in her catchment areas;
- Once rural areas have better coverage, then the priority should be urban slums and densely population areas, considering formal health services are better available in urban areas, both through public and private sector

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MOVING TOGETHER
TO BUILD A HEALTHIER PAKISTAN
UNIVERSAL HEALTH COVERAGE

ACRONYMS

ADC	Assistant District Coordinator
ADP	Annual Development Programme
AIDS	Acquired Immunodeficiency Syndrome
AJK	Azad Jammu & Kashmir
AKHSP	Aga Khan Health Services of Pakistan
AKU	Aga Khan University
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
BCG	Bacillus Calmette–Guerin
BEmONC	Basic Emergency Obstetric and New-Born Care
BHS	Basic Health Services
BHU	Basic Health Unit
CBA	Women of Child Bearing Age
CBO	Community Based Organization
CCI	Council of Common Interests
CDC	Centres for Disease Control and Prevention
CDR	Case Detection Rate
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHW	Community Health Worker
CMW	Community Mid Wife
COVID	Coronavirus Disease
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DAC	OECD Development Assistance Criteria for evaluation
DALY	Disability Life Adjusted Life Years
DCP 3	Disease Control Priorities – Edition 3
DFC	Direct Financial Cooperation
DG (H)	Director General (Health)
DGHS	Director General Health Services
DHIS	District Health Information System
DHO	District Health Office
DOTS	Directly Observed Therapy
DPWO	District Population Welfare Office
DRR	Disaster Risk Reduction
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunisation
FANA	(Ex) Federally Administered Northern Areas
FCDO	Foreign Commonwealth & Development Office
FPIU	Federal Programme Implementation Unit
FPO	Field Programme Officers
FRA	Fiduciary Risk Assessment
GB	Gilgit Baltistan
GDP	Gross Domestic Product
GHE	Government Health Expenditure
HACT	Harmonized Approach to Cash Transfer
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPSIU	Health Planning, System Strengthening & Information Analysis Unit
HPV	Human Papillomavirus
HR	Human Resource
HRH	Human Resource for Health
ICPD	International Conference on Population and Development
ICT	Islamabad Capital Territory
IDSR	Integrated Disease Surveillance and Response
IEC	Information Education and Communication
IHN	Indus Hospital Network
IHR	International Health Regulations

IMR	Infant Mortality Rate
IUCD	Intra-Uterine Contraceptive Device
JICA	Japan International Cooperation Agency
KP	Khyber Pakhtunkhwa
LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
LHWP	Lady Health Workers' Program
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal New-Born and Child Health
M/o NHSRC	Ministry of National Health Services, Regulations and Coordination
MTBF	Medium Term Budgetary Framework
NAC	National Advisory Committee
NACP	National AIDS Control Program
NCD	Non-Communicable Diseases
NHA	National Health Accounts
NHSC	National Health Sector Coordination mechanism
NHSP	National Health Support Project
NHV	National Health Vision
NMR	Neo-Natal Mortality Rate
OECD	Organisation for Economic Co-Operation and Development
OOP	Out of Pocket Expenditure
OPM	Oxford Policy Management
ORS	Oral Rehydration Solutions
PDHS	Pakistan Demographic and Health Survey
PFM	Public Finance Management
PHC	Primary Health Care
PHRC	Pakistan Health Research Council
PIMS	Pakistan Institute of Medical Sciences
PMMS	Pakistan Maternal Mortality Survey
PNC	Pakistan Nursing Council
PPIU	Provincial Programme Implementation Units
PPRA	Public Procurement Regulatory Authority
PSDP	Public Sector Development Programme
PSM	Procurement and Supply Chain Management
PWD	Population Welfare Department
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
SCI	Service Coverage Index
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
SWOT	Strength, Weakness, Opportunities and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
TT	Tetanus Toxoid
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
USAID	United States Agency for International Development
VBFPW	Village Based Family Planning Workers
WASH	Water, Sanitation and Hygiene

INTRODUCTION

The global community has committed, through the Sustainable Development Goals adopted in 2015[3], to end preventable child and maternal deaths, hunger, the epidemics, as well as to achieve universal health coverage (UHC), gender equality and the empowerment of all women and girls. To achieve these ambitious targets by 2030, particularly in resource-limited settings, strengthening the delivery of essential health services at the community level is instrumental, especially in those areas often far from health-care facilities and the formal health systems.

Recent global milestones that have contributed to building momentum for better community health include:

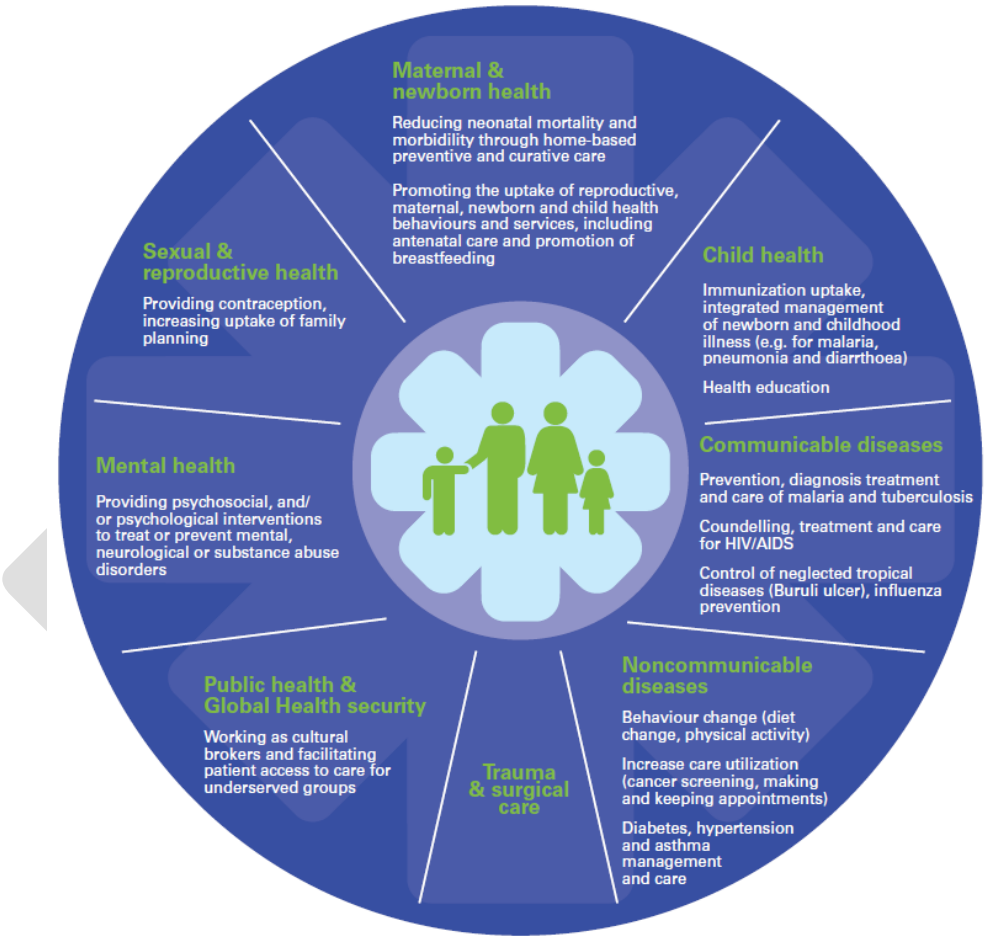
- One Million Community Health Workers Campaign in 2013
- Institutionalizing Community Health Conference in 2017
- The Declaration of Astana on Primary Health Care 2018
- Global Action Plan for Health and Well-being for All, in four cross-cutting "accelerator" areas: primary health care, community and civil society engagement, determinants of health, and digital health
- 2019 World Health Assembly second Universal Health Coverage (UHC) resolution recognizing the contributions made by community health workers (CHWs) to achieving UHC and the 2019 World Health Assembly resolution WHA72.3, which urged all Member States to "align the design, implementation, performance and evaluation of community health worker programmes, by means including the greater use of digital technology, with the consolidated evidence presented in the WHO guideline on health policy and system support to optimize community health worker programmes, with specific emphasis on implementing these programmes in order to enable community health workers to deliver safe and high-quality care". The resolution requested the Director-General "to continue to collect and evaluate data on community health worker performance and impacts, in order to ensure a strong evidence base for their promotion, especially in the context of low- and middle-income countries."
- WHO guideline on health policy and system support to optimize CHW programmes
- United Nations (UN) Political Declaration of the High-level Meeting on Universal Health Coverage: "Universal health coverage: moving together to build a healthier world" recognizing that "community-based services constitute a strong platform for primary health care" and CHWs are part of a "health workforce…who are an important element of strong and resilient health systems"
- WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas (2021)

3 Resolution A/Res/701. Transforming our world: the 2030 Agenda for Sustainable Development. In: Seventieth session of the United Nations General Assembly, New York, 25 September 2015. New York: United Nations; 2015.

Definition of Community Health Workers (CHWs):

The 2018 WHO guideline on health policy and system support to optimize community health worker programmes defines CHWs as "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". WHO recommends remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake. WHO also recommends contracting agreements for paid CHWs and suggests that a career ladder should be offered to them.[4] Compared to other types of health workers, CHW cadres across and even within countries are remarkably diverse in terms of their tasks, functions and degree of institutionalization into the formal health sector.

Primary health-care services for which there is global evidence of CHW effectiveness[4]



Community based Lady Health Workers in Pakistan

The health status of the people of Pakistan is well below the averages for low- and middle-income countries in key indicators, although its Gross Domestic Product (GDP) per capita was more than US$1500 in 2017-18 and 2020-21. While the health of the population in Pakistan has improved over the past decades, the level of improvement has not been satisfactory. Contributing factors include poverty, low literacy, poor access to health services, lack of proper sanitation and water etc. There are weaknesses in the health care delivery system

4 WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/hand le/10665/275474/9789241550369-eng.pdf)

including insufficient focus on essential health services especially at community and primary healthcare centre level, gender imbalances, in-sufficient human resources for health development and low health expenditures.

Health Indicators in relation to the pattern of Health Expenditure – Comparison with Countries of the Region in the year 2002

Country	Population (000)	Annual Growth Rate (%)	TFR	IMR per 1000 Live Births	Prevalence of wasting in under 5 (%)	Penta III Coverage (%)	MMR per 100,000 Live Births	CPR modern (%)	THE as % of GDP	GHE as % of THE	Per capita THE in US $	Per capita GHE in US $
Bangladesh	132 478	1.82	2.97	77	2.1	83	410	43	3.8	36.4	14	5
Egypt	71 485	1.88	3.17	41.5	1.8	97	60	46	3.8	46.1	51	24
India	1 093 317	1.68	3.17	84.6	6.8	59	336	43	4.9	17.8	23	4
Indonesia	217 357	1.35	2.51	3.5	0.8	70	265	55	2.7	23.7	19	5
Iran	67 284	1.24	1.92	30.6	1.4	99	41	56	5.5	46.3	258	119
Pakistan	**149 549**	**2.41**	**4.77**	**102.2**	**5.8**	**63**	**264**	**17**	**4.1**	**22.9**	**18**	**4**
Sri Lanka	19 062	0.79	2.25	15.5	3.1	98	50	44	3.6	49	31	15
Thailand	64 069	0.83	1.61	19.9	1.4	96	44	70	3.7	57.4	71	41

Source: https://databank.worldbank.org/; https://www.who.int/health-topics/health-accounts/;

Health Indicators in relation to the pattern of Health Expenditure – Comparison with Countries of the Region in the year 2019 & 2020

Country	Population (000)	Annual Growth Rate (%)	TFR	IMR per 1000 Live Births	Prevalence of wasting in under 5 (%)	Penta III Coverage (%)	MMR per 100,000 Live Births	CPR modern (%)	THE as % of GDP	GHE as % of THE	Per capita THE in US $	Per capita GHE in US $
Bangladesh	164 689	1.0	1.98	24	9.80	98	173	57	2	19	46	9
Egypt	102 334	1.92	3.24	17	9.50	95	37	58.9	5	28	150	42
India	1 380 004	0.99	2.18	27	17.30	91	145	50.1	3	33	64	21
Indonesia	273 523	1.07	2.28	20	10.20	85	177	59	3	49	120	59
Iran	83 992	1.29	2.14	11	4.00	100	16	64.2	7	50	470	233
Pakistan	**220 892**	**2.03**	**3.7**	**54**	**7.10**	**75**	**140**	**27**	**3**	**32**	**52**	**21**
Sri Lanka	21 919	0.53	2.17	6	15.10	99	36	54.6	4	47	161	76
Thailand	69 799	0.25	1.50	7	7.70	97	37	77.9	4	72	296	212

Source: https://databank.worldbank.org/; https://www.who.int/health-topics/health-accounts/; UNIA estimates; PDS 2020; & NHA 2017-18

Although there is gradual improvement in health and financing indicators of Pakistan, the country is still far behind from other developing countries in health outcomes.

The Government of Pakistan (GoP) recognizes that poverty will not be eliminated unless the causes of poverty are addressed and eliminated and that restoring economic growth and improving access to basic needs such as primary education, preventive health care and population welfare services are essential for winning the fight against poverty. To this end the GoP launched the Prime Minister's Programme for Family Planning and Primary Health Care[5] through the Ministry of Health (MoH) and Provincial/Area Departments of Health in 1994 to ensure provision of family planning and primary healthcare services at the doorstep of community mainly in rural and urban slum/ densely populated areas. The overall goal of the programme was to contribute to poverty reduction

5 The PMP-FP&PHC was later on renamed as the National Programme for Family Planning and Primary Health Care (NP-FP&PHC) and was commonly referred to as The Lady Health Worker Programme (LHWP).

by improving the health of the people of Pakistan. The main objective was to increase utilization of promotive, preventive, rehabilitative and curative services at the community level particularly for women and children in poor and underserved areas. The programme now covers around 38% of the total population spread over all districts of Pakistan providing essential primary health care services to the community through trained female community health workers (the Lady Health Workers).

The LHWs are recruited through a well-defined process according to strict selection criteria and that the lady must be acceptable to the community. Recruitment of LHWs is followed by 12 months of basic training at the PHC centre (Basic Health Unit / Rural Health Centre) or First level hospital (Tehsil / District headquarter hospitals) in two phases (3 months + 9 months), using training manual and curriculum. The basic training of the LHWs is complemented by one day "Continuing Education Session" each month and maximum of 15 days "Refresher Training" on various topics every year. The LHWs at community level are supported up by the Primary Health Care (PHC) centres with additional backup support at district and provincial levels.

It has been demonstrated through five external evaluations of the programme in 1995, 1996, 2001-02, 2008-9 and 2019-20 that 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 through the public health system. The Programme has provided more services to low income and poor households than any alternative service provider in the public sector.

The last strategic plan of the programme was produced in 2002, through a consultative process with the involvement of key stakeholders and formed the basis for the development of project document/s, which continued to be implemented till 30th June 2011.

With the 18th constitutional amendment, the concurrent list and the MoH were abolished on 1st July 2011. The residual health related functions in the Federal Legislative Lists (Part I & II) of the constitution were assigned to different federal ministries. To executive federal health functions effectively and in a harmonized way, the Cabinet decided in May 2013, to create Ministry of National Health Services, Regulations and Coordination Division (NHSR&C).[6] The new Ministry was created with the mandate to provide a common strategic vision, to achieve universal health coverage (UHC) through efficient, equitable, accessible and affordable health services, to coordinate public health and population welfare at national and international level, to fulfil international obligations and commitments, to provide oversight to regulatory bodies, to enforce drug regulations and to regulate medical profession and education.

On the decision of council of common interests (CCI), funding to LHWP continued through the federal public sector development programme (PSDP) at a level of Rs. 16.4 billion annually with additional funding from the provincial governments. After 2017-18, funding from the federal government stopped and the programme was completely provincialized. At provincial level, various modalities were adopted to access provincial development or recurrent budget through an integrated approach or only for the programme. On the decision of the court, lady health workers have been granted government pay scales replacing the contractual appointments with monthly honorarium. The programme is currently being fully integrated with the health system though horizontal integration and mainly through recurrent budget, along with other PHC vertical programmes.

The success of **Primary Health Care** (PHC) in Pakistan is dependent on community-based services delivered by LHWs, along with primary healthcare facilities. The health reform agenda of the Government in the shape of UHC is an ambitious, complex, and multi-sectoral agenda under the Sustainable Development Goal 3. In addition to the Declaration of Alma-Ata in 1978, the Astana Declaration in 2018 reaffirmed that the health and well-being of populations is most effectively, equitably and efficiently achieved through the renewal of primary health care approach, making it a cornerstone of a sustainable health system for universal health coverage. LHWs are integral in ensuring the achievement of these objectives.

6 Cabinet Secretariat, 4 May 2013; Memorandum 4-4/2013-Min-I

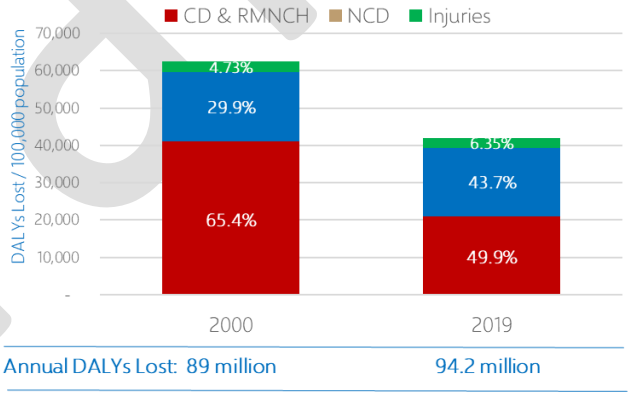
There is need to focus on those areas where understanding, change and impact are most important to the future direction of the health sector. For achieving **Universal Health Coverage** (UHC), Pakistan has developed a generic essential package of health services (EPHS)/ UHC Benefit Package of Pakistan in October 2020, followed by its adaptation at provincial and federating area levels during 2021, which are to be delivered through five platforms while not ignoring inter-sectoral interventions/ policies. LHWs are expected to play a key role in the implementation of EPHS at community level and selected inter-sectoral interventions.

The UHC and PHC frameworks suggest reforming the LHW initiative (also guided by the recent evaluation), to expand the coverage of LHWs, revisit the mandate in line with the district EPHS needs, strengthen, and mainstream their support system to optimize performance.

Current Health Status

Pakistan has made some positive strides in the social development and in the health of its people – but not all citizens have been able to benefit from this progress. The low level of human development, coupled with other politico-economic and environmental challenges over the last decade has resulted in a weak health system with a number of parallel and fragmented systems, health care structures and crises of health workforce. The task is further challenging, particularly for those who are poor or vulnerable, women and children, youth, persons with disabilities, people living with diseases, older people, refugees, internally displaced persons and migrants.

Pakistan is undergoing through epidemiological and demographic transitions. Burden of the communicable, maternal, child and nutritional group, which was more than 65 percent (40,962 DALYs lost per 100,000 population) of the total burden of diseases in the year 2000, has gone down to 49.9 percent (21,004 DALYs lost per 100,000 population) in 2019. However, the burden of non-communicable disease group which was 29.9 percent (18,869 DALYs lost per 100,000 population) of the total burden in the year 2000 has increased its share to 43.7 percent (18,385 DALYs lost per 100,000 population) in 2019. The share of burden of injuries increased from 4.73 percent (2,958 DALYs lost per 100,000 population) to 6.35 percent (2,669 DALYs lost per 100,000 population) over the same period.[7]



Top Ten Burdens/ Risks in Pakistan (2019)

	Cause of Death
1	Neonatal disorders
2	Ischemic heart disease
3	Stroke
4	Diarrheal disorders
5	Lower respiratory infections
6	Tuberculosis
7	COPD
8	Diabetes
9	Chronic kidney disease
10	Cirrhosis

	Premature Deaths
1	Neonatal disorders
2	Ischemic heart disease
3	Lower respiratory infections
4	Diarrheal disorders
5	Tuberculosis
6	Stroke
7	Congenital defects
8	Cirrhosis
9	Typhoid & Paratyphoid
10	Chronic kidney disease

	Years Lost with Disability
1	Dietary Iron deficiency
2	Depressive disorders
3	Headache disorders
4	Low back pain
5	Other MSK
6	Gynaecological diseases
7	Diabetes
8	Age related Hearing loss
9	Neonatal disorders
10	Anxiety disorders

	Risk
1	Malnutrition (MCH)
2	Air pollution
3	High systolic BP
4	Dietary risks
5	Tobacco
6	Unsafe WASH
7	High fasting plasma glucose
8	High body-mass index
9	High LDL cholesterol
10	Kidney dysfunction

In 2020, the death rate was 6.7 deaths per 1,000 population (approximately 1.5 million deaths) and 55.3 percent of all deaths were because of non-communicable diseases, while communicable, maternal, neonatal and nutritional group contributed to 38.9 percent of total deaths and the share of injuries was 5.69 percent. The birth rate was estimated at 27 (23 in urban areas and 29 in rural areas) per 1,000 population – around 6.13 million annual births - and a population growth rate of 2.03 in 2020.[8] Pakistan still has a very high fertility rate

7 Institute of Health Metrics & Evaluation, 2020; BOD data for Pakistan 2019: https://vizhub.healthdata.org/gbd-compare/
8 Pakistan Bureau of Statistics, 2020; Pakistan Demographic Survey

of 3.7 children per woman (3.1 in urban areas and 4.1 in rural areas) in 2020, indicating worse situation in rural areas. Life expectancy at birth was 65 years (64.5 years for males and 65.5 years for females) in 2020.[9]

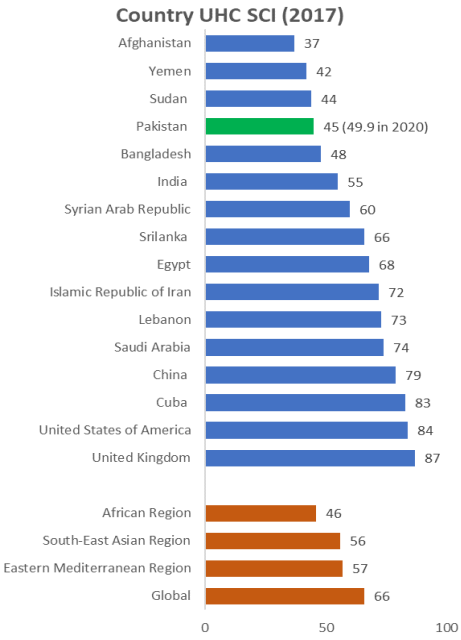
Universal Health Coverage (UHC) means that all people receive the health services they need. These services include public health services designed to promote better health (such as healthy diet, physical activity, anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and provide treatment (such as pneumonia and tuberculosis), rehabilitation (such as rehabilitation of drug users or injury cases) as well as palliative care (such as end-of-life care) of sufficient quality to be effective. Ensuring at the same time that the use of these services does not expose the user to financial hardship.

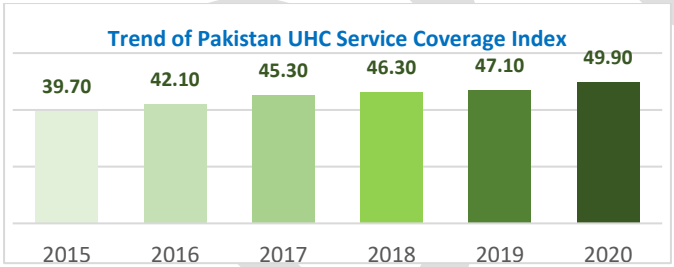
UHC (3.8) is a composite of two indicators – 3.8.1 on coverage of essential health services and 3.8.2 on the proportion of a country's population with catastrophic spending on health, defined as large household expenditure on health as a share of household total consumption or income.

A UHC Service Coverage Index – a single indicator computed from tracer indicators of coverage of essential services (that include reproductive, maternal, new-born and child health; infectious diseases; non-communicable diseases; and service capacity & access; among the general population) – was developed by WB and WHO. The index is correlated with under-five mortality rates, life expectancy and the Human Development Index (HDI).

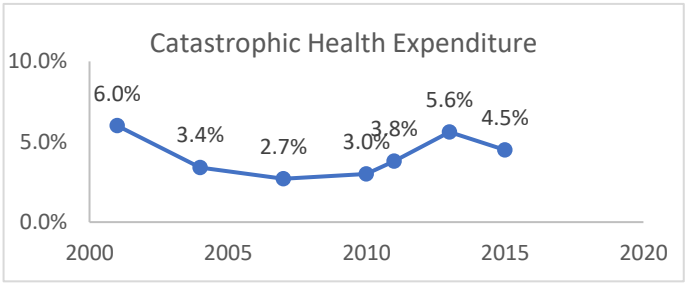
Pakistan's UHC service coverage index is improving but the pace of improvement is very slow and much low compared to other countries and regions.[10]

With significant variation in the UHC SCI among provinces and districts, trend in UHC SCI of Pakistan is positive but improvement is slow as shown below in the annual trend.





The affordability of healthcare is a key dimension for achieving UHC. Millions of people are pushed into vicious cycle of poverty every year due to compelling needs to pay for health care services. In Pakistan, population with household expenditures on health >10% of total household expenditure or income (%) was 4.5 in 2015 compared to 3% in 2010. This further highlights the importance of more primary, preventive and promotive health care services.



9 National Institute of Population Studies (NIPS), 2018; Pakistan Demographic & Health Survey, 2017-18
10 WHO, 2021; World health statistics 2021, monitoring health for SDGs

Table: Current health outcome and coverage indicators at provincial and federating area level

Indicator	Punjab	Sindh	KP	Balochistan	Islamabad	GB	AJK	Pakistan
Maternal Mortality Ratio (per 100,000 live birth) (PMMS 2016-19)	157	224	165	298	na	157	104	**186**
Neonatal Mortality Rate (per 1,000 live birth) (PDHS 2017-18)	51	38	42	34	24	47	30	**42**
Infant Mortality Rate (per 1,000 live births) (PDHS 2017-18)	73	60	53	66	44	63	67	**62**
Under five Mortality Rate (per 1,000 live births) (PDHS 2017-18)	85	77	64	78	49	76	53	**74**
UHC Service Coverage Index (2019)	48.2	46.7	47.6	35	51.3	43.5	47.9	**47.1**
Immunization (Penta III) Coverage (%) (PDHS 2017-18)	89	59.2	64.9	37.3	84	61.1	84.3	**75.4**
Immunization (Measles 1) Coverage (%) (PDHS 2017-18)	85.4	61.2	63.3	33.3	82.8	66.1	82.6	**73.2**
Children with ARI symptoms whom advice/ treatment was sought (%) (PDHS 2017-18)	86.1	85.4	84.3	62.2	83.6	80.8	76.3	**84.2**
Children with Diarrhoea for whom advice/ treatment was sought (%) (PDHS 2017-18)	75.2	74	59.7	63.1	67.9	71.2	64.9	**70.8**
Number of Polio cases (NEOC 2021 to April 2022)	0	0	1	1	0	0	0	**84**
Stunting (%) (PDHS 2017-18)	29.8	49.9	40.4	47.4	24.4	47.2	30	**37.6**
Wasting (%) (PDHS 2017-18)	4	11.7	7.5	18.3	2.8	1.1	6.4	**7.1**
Total Fertility Rate (PDHS 2017-18)	3.4	3.6	4	4	3	4.7	3.5	**3.6**
Contraceptive (modern method) Prevalence Rate (%) (PDHS 2017-18)	27.2	24.4	23.2	14	34.7	30.2	19.1	**25**
Demand for FP satisfied with modern methods (%) (PDHS 2017-18)	50.3	50.2	45.1	33.8	55.1	46.4	38.5	**48.6**
Antenatal Care from Skilled provider (%) (PDHS 2017-18)	92.3	85.7	80.1	55.5	93.6	79.6	89.6	**86.2**
Mothers protected against Tetanus (%) (PDHS 2017-18)	81	61.9	58.9	26.7	79.8	64.2	80	**68.9**
Skilled Birth Attendance (%) (PDHS 2017-18)	71.3	74.8	67.4	38.2	86.6	64.4	64.1	**69.3**
Institutional Delivery (%) (PDHS 2017-18)	68.9	71.8	61.8	34.6	84	62.3	62.3	**66.2**
Tuberculosis Case Detection Rate (%) (NTP 2019)	62	56	48	32	28	70	48	**55**
Tuberculosis Treatment Success Rate (%) (NTP 2019)	92	85	93	86	87	98	93	**90**
HIV & AIDS Cases (%) (estimated #) (NACP 2020)	92,110	74,685	12,127	4,783	Added in Punjab	Added in Punjab	Added in Punjab	**183,705**
Hepatitis B Prevalence (%) (Punjab Prevalence survey 2018)* (PHRC 2007-08)**	2.2*	2.5**	1.3**	4.3**	na	na	na	**2.5****
Hepatitis C Prevalence (%) (PPS 2018)* (PHRC 2007-08)**	8.9*	5**	1.1**	1.5**	na	na	na	**4.9****
Annual Parasitic Incidence for Malaria (API) (DoMC 2019)	0.08	2.91	9.76	2.54	na	na	0.04	**1.88**

Key Results of the Fifth External Evaluation of the LHWs' Programme

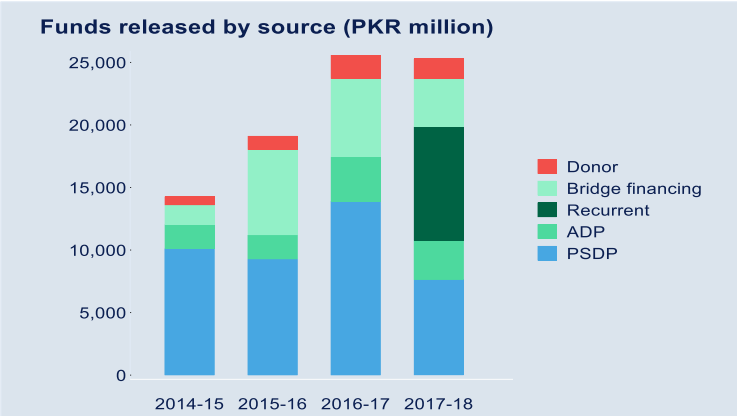
The LHWs' programme (LHWP) was evaluated independently during 2019-20 by the Oxford Policy Management (OPM) with technical assistance from UNICEF. Key findings include:

- Where the LHWP is operating, it does generally address the needs of marginalised and vulnerable women and children. However, the extent to which it does is compromised across all regions by: (i) the lack of an explicit focus on geographical areas and socio-economic groups with the greatest need; (ii) an increasing focus on immunisation relative to other health, health education, and nutrition needs; and (iii) management and resourcing problems.
- The LHWP plays a central role in Reproductive, Maternal, New-born, and Child Health and Nutrition (RMNCH&N) policy across all regions. Stakeholders both within and outside the government consider it a highly effective and appropriate instrument when it is appropriately resourced and managed.
- While in principle there is a federal level role in coordination, information sharing, and oversight, across regions this is not being fulfilled, and was not fulfilled even while federal funding continued.
- There is no systematic and evidence-based approach to the selection of areas for LHWP implementation in relation to health needs.
- A review of performance against health outcome targets presents a picture of mixed achievement across the various health outcome domains and across the provinces/ areas of Pakistan. Evaluation reports declining numbers of LHWs in almost all regions of Pakistan, which has led to decline in coverage.
- There are several significant challenges that limit the ability to meet its health outcome targets.
- The LHWP has generally worked for family planning, some aspects of maternal care, and polio immunisation. In Sindh and Gilgit Baltistan, and to some extent in Punjab the LHWP is reaching marginalised areas, but this is not the case elsewhere.
- The LHWP does seek to support the desire to achieve UHC through the delivery of doorstep PHC.
- The LHWP has been formally integrated into broader health programmes in Khyber Pakhtunkhwa and Punjab but in both cases this process is incomplete in effective management terms.
- All regions have encountered significant human resource and financial management problems.
- Total expenditure per LHW has seen a dramatic increase since the regularisation of LHWs. This Evaluation finds no evidence that this extra expenditure per LHW has been accompanied by increases in coverage, performance, or impact on long-term health outcomes.
- In Khyber Pakhtunkhwa, Punjab and Sindh, the LHWP is now appropriately resourced in terms of the funds budgeted, as provincial contributions have increased to offset former federal contributions.
- There are systematic issues with the functioning of management systems, including: Planning, Monitoring and Evaluation; Supplies and equipment; Recruitment and motivation; Supervision; Capacity-building; and Financial management.
- The current implementation of the LHWP systems is not supportive of the functioning of regular training; regular stocks; and non-salary expenditure.
- No evidence was found in any region, except for Punjab, of any attempts to systematically use MIS data, or to evaluate, support, or use research on the LHWP to learn lessons to improve performance.
- None of the provinces/ areas have been implementing a risk mitigation strategy.

- Despite the clear challenges, the LHWP continues to have an impact on the long-term health outcomes of the population it reaches including family planning, maternal care and infant and young childcare. Though a positive impact on polio is an exception, reflecting a diversion of resources to this area. The impact of the LHWP is strongest for the poorer households that it does reach.
- The LHWP has greatly contributed to the empowerment of LHWs and LHSs: greater social status and recognition within their communities; greater job security following regularisation; and greater knowledge through training sessions where they have occurred.
- There is evidence of continuing effective political commitment where provinces have taken over funding of the LHWP and have announced plans to increase coverage. However, this has been accompanied by a lack of strong political engagement to ensure effective management.
- The current allocations of expenditure are heavily skewed towards the payment of salaries.

Current Areas of Poor Performance

	Punjab	Sindh	KP	Balochistan	GB	AJK
Family Planning						
CPR						
Maternal Health Care						
TT2 immunisation						
ANC-1						
ANC-4						
Skilled Birth Attendance						
Institutional deliveries						
PNC visit within 24 hours						
Infant and Young child Care						
Early Breastfeeding						
Exclusive breastfeeding						
Fully immunised children						
Stunting						
Wasting						
Proportion achieved	***40%***	***0%***	***33%***	***0%***	***18%***	***25%***
Proportion almost achieved	***80%***	***33%***	***60%***	***29%***	***45%***	***63%***



Process for the Development of LHWs Strategic Plan 2022-28

After the fifth evaluation of the LHWP, the M/o NHSR&C and all Health Departments agreed to secure the services of a team of consultants to carry out the in-depth review of evidence including recommendations of the fifth evaluation of LHW programme, Pakistan: Human Resources for Health (HRH) vision , Provincial HRH strategies, Essential Package of Health Services/ UHC benefit package and facilitate a dialogue with provincial/area health departments, LHWs, Lady Health Supervisors (LHS) and other stakeholders to develop a costed strategic plan/ framework for implementing community-based EPHS at community level through lady health workers in light of the UHC benefit package. The scope of work included the considering the implication of 18th constitutional amendment, horizontal integration of vertical PHC programmes and need for province specific strategic options for the intervention.

A team of consultants was hired by UNICEF on 2021, while additional support came from WHO, British High Commission/ Foreign Commonwealth and Development Office (FCDO), US Agency for International Development (USAID) and Health Planning, System Strengthening & Information Analysis Unit (HPSIU) of the Ministry. Inception report and background discussion papers were produced, followed by following round of consultations:

23rd - 26th August, 2021: Workshop for National Consultation with all Provincial/ federating areas stakeholders

23rd - 24th September, 2021: Workshop for consultation with stakeholders in Sindh province + individual meetings

7th - 8th October, 2021: Workshop for consultation with stakeholders in Balochistan province + individual meetings

15th - 16th October, 2021: Workshop for consultation with stakeholders in Khyber Pakhtunkhwa province + individual meetings

21st - 22nd October, 2021: Workshop for consultation with stakeholders in Azad Jammu & Kashmir + individual meetings

27th - 28th October, 2021: Workshop for consultation with stakeholders in Gilgit Baltistan + individual meetings

30th November - 1st December, 2021: Workshop for consultation with stakeholders in Punjab province + individual meetings

6th December, 2021: Consultative meeting with health Development Partners.

8th - 9th December, 2021: Workshop for focused group discussion with LHWs, lady health supervisors and managers

February – June, 2022: Review of recommended reforms by the Ministry and Health Departments and development of draft LHWs' Strategic Plan

? July, 2022: National Advisory Committee meeting to finally review the draft Strategic Plan

? July, 2022: Inter-Ministerial Health & Population Council meeting to endorse the document

Summary of the SWOT Analysis

An extensive exercise of SWOT analysis was carried out during the provincial/area consultations summarizing the perceptions of an internal constituency (i.e., leadership and staff) regarding the internal strengths of the program/system, its internal weaknesses, the external opportunities for potential pursuit and the external threats to consider. Following table highlights the crux of the SWOT analysis of the LHWs program/system;

STRENGTHS	WEAKNESSES
▪ Community accepted conduit for provision of community level services in line with the EPHS interventions ▪ Equity focused and gender sensitive program ▪ Well cognizant community workforce supports in early diagnosis, reduced transmission and improved outbreak containment ▪ Localized community-based recruitment followed by regularization (Job security) ▪ Maximum coverage utilizing all the available workforce with the highest of 68% (88% rural &12% urban) in AJK; over all national coverage of 40% ▪ Existence of strong supervisory system; DHOs, district supervisors and LHSs ▪ Updated LHWs training module/ curricula in line with the EPHS/ UHC ▪ Well-developed training, monitoring and reporting/recording tools are available ▪ Real time data available for usage in strategic planning, policy level decisions and for carrying out future research ▪ Conduction of regular monthly meeting/ Jaiza karkardegi/ Mamta baithak ▪ Transparent financial system with in place audit mechanism as per protocols (now routine audit system in provinces) ▪ Provincial Procurement cells possess the capacity to procure commodities as per respective provincial/area PPRA bodies ▪ Existence of Standalone warehouses/District stores in all provinces and areas to accommodate buffer stock. ▪ Women empowerment ▪ Immediate action by community workers in case of any health emergency	▪ Irrational deployment and assigned duties beyond the scope weakens the provision of effective community services ▪ Deficient workforce due to delays in new recruitment and attrition of the present staff ▪ Inadequate on job/refresher training sessions mainly due to overlapping of field campaigns ▪ No ownership of policies at district level leading to its poor implementation ▪ Outdated selection, recruitment and deployment criteria ▪ Absence of HRH registry makes it difficult to track HR records ▪ Lack of proper guidelines/ capacity building/ supplies especially during natural/ manmade calamities ▪ Inadequate allocation of budget for procurement of medicine, contraceptives and supplies ▪ Frail M & E system and poor reporting compliance by the staff leading to questionable transparency and accountability of the program ▪ Tedious process causes delay in the release of budget (not inclusive of operational cost like POL, inventory management, tools printing etc) ▪ Field monitoring officers are not in place in all provinces ▪ Non engagement of districts in forecasting and quantification of supplies according to the community requirement ▪ Redundant vehicles and medical equipment making the system less efficient ▪ Fragmented LHW MIS thus limiting usage of the data ▪ Non-existent quality assurance mechanism; Poor quality of training without focus on attainment of key competencies ▪ Demotivation of the workforce due to non-existent performance appraisal mechanism ▪ Impaired career structure effecting the productivity and growth of the staff
OPPORTUNITIES	**THREATS**
▪ Enhanced literacy rate (social uplift/educated HR) ▪ National Health Support Project along with the support of Japan, FCDO etc may also serve as an opportunity for increased finances and technical support, aiding community-based interventions ▪ Government's political will to revamp PHC through UHC ▪ Periodic Third-party evaluation of the program ▪ Stakeholders interest in DHIS2 implementation ▪ International development partners well-poised to lend support for health extension services ▪ Technological advancements can be leveraged to augment program service delivery ▪ Security and law and order situation considerably improved to enable access to erstwhile restive areas in Newly Merged Districts and adjoining areas; Out of box innovative solutions are required	▪ Prolonged verticality within the system pose a threat to horizontal integration at district level and below ▪ Post devolution; weekend policy level planning and programmatic evolution ▪ Other government sectors reducing the fiscal space for health thus diverting the budget ▪ Exploitation/gender-based harassment/security issues ▪ Enhanced focus on curative care ▪ Political interference in selection, recruitment and deployment ▪ Risk of terrorist activities/Risk of LOC cross firing (AJK, KP-merged districts) ▪ Task shifting due to natural emergencies like COVID, EPI duties and administrative duties (elections etc.) divert the workforce from their routine duties ▪ Un-predictable Afghan situation having the potential of refugee's influx straining health system ▪ Myths and misconceptions

THEORY OF CHANGE

In past, the Lady Health Workers' Programme used to develop clear general and specific objectives and later on logical frameworks, which were used to measure the performance through third party evaluation. However, since devolution under the 18th constitutional amendment in 2010, there was no systematic performance framework for the programme/ system. During the fifth evaluation of the LHWs programme in 2018-19, the Theory of Change (TOC) was produced first as a framework for the evaluation and was directed by the following evidence and considerations:

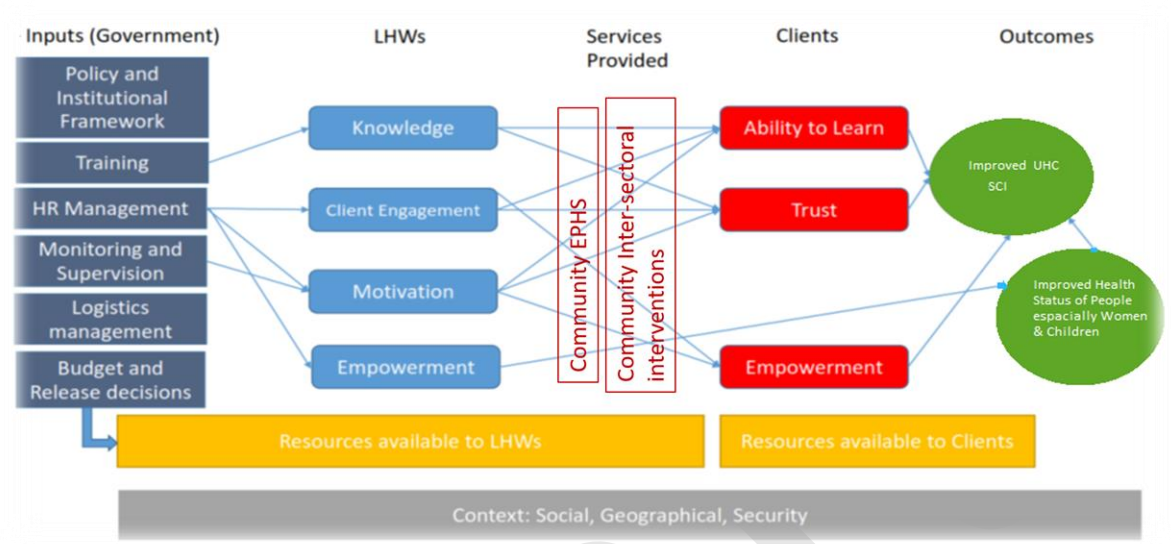
- Previous evaluations conclusively established that the LHWP can and has been effective, and also determined the main factors likely to influence LHW effectiveness, though no formal ToC had been developed before;
- Following devolution, there have been some changes in the details of the LHW role, functions, and organisational arrangements, these have not affected the key factors for LHW performance and hence the core intervention logic of the LHW role (whether as part of a standalone programme, or an integrated approach).

During the strategic planning exercise in 2021, further changes were suggested / agreed during the consultations and following approach was used to develop the new LHWP Theory of Change:

- A 'Realist Evaluation' perspective was used, focusing on identifying the key mechanisms by which LHWs are effective, and the contextual and policy factors influencing when, where, and how well these mechanisms work
- Evidence from the Fourth Evaluation as well as from a wider review of literature on Community Health Worker experience in Pakistan and internationally was used to identify and define the key mechanisms, contextual and policy factors
- No attempt was made to develop 'province-specific' ToC since the relatively limited changes in roles meant that only in an extremely detailed articulation of the ToC would these differences become apparent, and this would anyway not be helpful for understanding comparative experience, which is a main focus of the fifth evaluation
- The approach has therefore been to focus on the common core of the intervention logic of the LHWP that applies across all provinces, with a view to making comparisons of how differences in the context, management, and funding arrangements, and specific roles and tasks of LHWs have affected the performance and results achieved
- Lady Health Workers, appropriately selected, trained, supervised, and equipped, provide promotive, preventive, and basic curative healthcare to individual clients and families (especially women and children) and communities to achieve improved UHC index as main outcome. They act as agents of change in communities by organising health committees and women's groups. They bridge the gap

between families and the Primary Health Care delivery system, through referring clients to Primary Health Care system. They are themselves empowered by their role and experience, and empower women in their communities to obtain appropriate RMNCH and other PHC/ UHC services

Figure: LHW Theory of Change



The diagrammatic representation of the Theory of Change (Figure) highlights the key 'mechanisms' by which LHWs can be effective in bringing about behaviour change in their clients and the communities that they work with, and in achieving results, as well as the main elements of the context and inputs provided that are likely to influence the extent to which LHWs achieve results in diverse settings and circumstances.

These key mechanisms (identified on the basis of past Evaluation results and the wider review of national and international experience with community health worker programmes) are the following:

- **Knowledge:** LHWs possess practical, relevant, and accurate knowledge that they are able to use to perform their roles
- **Client engagement:** LHWs feel free to operate within, are accepted and trusted by, and are accountable to, the communities that they serve
- **Motivation:** LHWs feel supported, incentivised, accountable, and responsible for their work
- **Empowerment:** LHWs feel independent, respected, and confident to influence household and community decisions

Key aspects of the management arrangements (especially human resource management, training, and monitoring and supervision) impact directly on how effectively and under what circumstances these mechanisms perform. Other management factors – notably logistics management and budget / spending (fund release) decisions – determine the resources that are available to LHWs to perform their functions.

One major **limitation** of the ToC was the limitation of outcome to RMNCH, whereas LHWs are offering wider PHC and UHC related services at community level. It was therefore critical to revisit the ToC considering new policy dimensions and reforms in line with community level interventions finalized in respective essential packages of health services in context of Universal Health Coverage agenda for four key areas. i.e., RMNCAH & Nutrition, Communicable disease, Non-communicable diseases & Mental Health and health services access. In this regard, the services provided be in line with community-based interventions finalized by provinces and areas leading & contributing towards achievement of the main outcome of Universal Health Coverage index while keeping the voluntary spirit as well, despite LHW being regularized.

Principles Guiding the Strategic Plan

The key principles agreed that will guide the LHWs Strategic Plan are reflective of those which underlie the Sustainable Development Goals (SDGs), Primary Health Care for Universal Health coverage (PHC for UHC) as per Astana declaration, Universal Health Coverage (UHC) and National Health Vision (2016). Putting these principles into action in the LHWs Strategic Plan development process means:

- **Leaving 'No one' behind** – The agreed LHWs strategic agenda is based on a critical analysis of the health situation using the SDGs, PHC and UHC as the frameworks for analysis. It is supported by disaggregated data to ensure equitable approaches that address the needs of all people and especially the disadvantaged & vulnerable groups, women and children
- **Universality** – All geographical areas are called on to achieve the SDGs and UHC in Pakistan. Accordingly, LHWs are responsive to needs of all people of different geographical areas, income levels and circumstances, including fragile situations
- **Multi-sectoral approaches** – Increased inclusiveness in the LHWs processes strengthens links with other sectors (Inter-sectoral), fostering a multi-sectoral approach to addressing Health Policies and Strategic Plans' priorities and actions, in order to take forward the SDGs, UHC and Astana PHC agenda
- **Integrated and indivisible** – The evidence-based LHWs Strategic Agenda ensures that the economic, environmental and social pillars of health in sustainable development are considered, with a strong focus on equity, gender and adequate involvement of other interventions, and support for health
- **Community Engagement & empowerment** – Empower individuals, families & communities in self-care and social services (related to health)

Both the federal and provincial/ federating area governments aim to achieve UHC by fostering partnership to enhance the integration of essential health service delivery to remove gaps in quality care and in coordination. This will ultimately affect health outcome efforts through health system strengthening and institutional accountability of duty bearers, while facilitating community and key population as rights holders, to voice their demands in Pakistan. The LHWs' Strategic Plan is guided by a focus on:

- **Country, provincial & federating areas ownership of the processes:** The Strategic Plan prioritizes a country-led approach and aligns its cooperation with the health-related SDGs, working towards UHC and strengthened primary healthcare system in support of health policies and strategic plans.
- **Results:** The LHWs Strategic Plan prioritizes evidence-based and results-focused approaches along with country/ provinces needs and capacity-determining support within the new policy environment. It encourages innovation and experimentation, exploring tailored solutions based on the changing global and local environments, country/ provincial contexts and needs.
- **Priority to Gender and Equity issues:** The LHWs Strategic Plan will prioritise the needs of women and children especially living in rural, hard to reach areas and urban slums while ensuring long term sustainable reforms.
- **Inclusive partnerships for sustainable development:** To advance the PHC and UHC reforms, inclusive partnerships are needed, involving not only governments and parliaments, but also development partners, civil society, media, the private sector and academia, among others.
- **Accountability:** The implementation of the 2030 Agenda will rely on political will, accountability and national/ provincial/ local ownership, where targets are prioritized and adapted. Trust and credibility are essential, including with the most vulnerable and marginalized people, and including through upholding national and international agreed norms and standards.

Vision, Goal, Mission & Objectives

LHWs are the backbone of the community-based health care system in Pakistan. The LHW program performance, achievements and deficiencies were deliberated upon by a carefully selected group of stakeholders. In order to align the health services provided by LHWs with the recently developed essential packages health services (EPHS) to achieve Universal Health Coverage (UHC), the vision, goal and mission of the LHW' intervention were revised considering current commonly agreed 'National Health Vision' and other developments in the sector. The **'National Health Vision (2026-25)'** is:

''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''

VISION OF THE LHWs SYSTEM:

'Contribute to the well-being of people of Pakistan by Promoting Health and Reducing Poverty'

GOAL:

'Improved health of people of Pakistan especially women, girls and children, through providing high quality integrated primary health services at the doorstep of community by Lady Health Workers'

MISSION:

'Build individuals, families, community and system capacity for accessing integrated essential primary health care and bridge the gap between community and health facility'

OBJECTIVES:

Main objectives of the LHW system are contributing towards universal coverage of effective promotive, preventive and basic curative services at the community level particularly to women and children in poor and underserved areas. Main as well as specific objectives were set in the consultative process with all the concerned stake holders during the provincial/area consultations.

Main objectives of LHWs system by the end of 2027-28 include:

Main objectives of the LHW System							
Indicators		**Punjab**	**Balochistan**	**KP**	**Sindh**	**GB**	**AJK**
IMR	Baseline (2017-18)	73	66	53	60	63	47
	Target (2027-28)	60	45	43	45	51	38
NMR	Baseline (2017-18)	51	34	42	38	47	30
	Target (2027-28)	40	28	34	32	39	22
MMR	Baseline (2018)	157	298	165	224	157	104
	Target (2027-28)	<100	<160	<110	<140	<120	<90
UHC Index	Baseline (2020)	52	35.2	50.3	48.6	45.2	49.8
	Target (2027-28)	60	55	58	60	55	58

Specific objectives of the LHWs system by the end of 2027-28 include:

Specific objectives of the LHW Intervention							
Indicators		**Punjab**	**Balochistan**	**KP**	**Sindh**	**GB**	**AJK**
Contraceptive Prevalence Rate (modern methods)	Baseline (2017-18)	27.2	14	23.2	24.4	30.2	19.1
	Target (2027-28)	>30	>20	>29	>30	>40	>28
Assistance during deliveries (skilled providers)	Baseline (2017-18)	71.3	38.2	67.4	74.8	64.4	64.1
	Target (2027-28)	>80	50	80	85	80	80
Breast-feeding in 1 hour of birth	Baseline (2017-18)	12	59.6	18.1	28.3	54.8	25.8
	Target (2027-28)	20	65	25	38	65	34
(Penta 3) Immunization coverage	Baseline	89 (2017-18)	42.2 (2020)	74.3 (2020)	59.2 (2017-18)	82.2 (2020)	95.4 (2020)
	Target (2027-28)	>96	>80	>82	>80	>90	94.7
Percent of mothers in LHWs' areas protected against Tetanus	Baseline (2017-18)	81	26.7	58.9	90	64.2	80
	Target (2027-28)	>85	>45	>70	>95	>75	>90
TB CDR	Baseline (2020)	49	23	43.5	47.4	36	36
	Target (2027-28)	>70	>45	>70	>70	>70	>70
Hypertension & Diabetes cases referred by LHWs	Baseline (2021)	NA	NA	NA	NA	NA	NA
	Target (2027-28)	TBD	TBD	TBD	TBD	TBD	TBD
Proportion of Good performing LHWs	Baseline (2021)	NA	NA	NA	NA	NA	NA
	Target (2027-28)	>70	>70	>70	>75	>70	>70

Islamabad will follow the objectives of Punjab province, as in third party evaluation Islamabad will be in the sampling framework of Punjab. However, results for ICT will also be monitored separately on a regular basis.

Objectives will be regularly monitored by the health departments through national and provincial/ area surveys, MIS and administrative data of health departments (including PHC interventions). Mid-term evaluation will also be an integral component of the M&E mechanism.

STRATGEIC DIRECTIONS

The global policy of providing primary level care was initiated with the 1978 Alma Ata Declaration. The countries signatory to the declaration considered establishment of a community health workers' programme synonymous with the primary health care (PHC) approach. During the 1980s, many countries trained large numbers of community health workers and they are still providing care in the remote and inaccessible parts of the world.

A policy debate in the context of community health workers was whether these workers would be static providers or should provide services at the doorstep of communities. Evidence suggests that community workers who have access to households through doorstep services contribute positively to the health outcomes especially related to PHC and more specifically Maternal and Child Health (MCH).

Most countries have largely relied on females as community health workers. Although both men and women are employed at grass-roots level, globally, there is evidence that female workers are able to deliver care more effectively than male workers at community level. Nonetheless, there has been even an explicit policy-shift in some countries to replace male health workers with female workers at community level.

In Pakistan, the community health workers (CHW) intervention started during 1980' or even earlier on pilot basis. Aga Khan Health Services of Pakistan (AKHSP) and Aga Khan University (AKU) played a key role in promotion of primary healthcare services including community health workers especially in (former) Federally Administered Northern Areas (FANA) - currently known as Gilgit Baltistan (GB). Ministry of Health (MoH) promoted the concept through the Basic Health Services Cell - later on became famous as Primary Healthcare Cell. The Ministry and WHO started a community health worker intervention in rural areas of Islamabad through Paediatric Department of Pakistan Institute of Medical Sciences (PIMS) hospital. WHO also provided support to start community based interventions in all provinces on a limited (one tehsil) scale. In the border areas of Azad Jammu & Kashmir (AJK and GB male workers were also deployed at health posts (static facilities) for provision of first aid to communities.

The Ministry of Health studied different PHC and community health workers projects in other countries. In 1994, the government of Pakistan decided to merge the concept of Alma Ata Declaration on PHC and International Conference on Population and Development (ICPD) on reproductive health and launched a nation-wide Prime Minister's Programme for Family Planning & Primary Health Care through the BHS Cell which also became the Federal Programme Implementation Unit (FPIU) in addition to provincial/ area Programme Implementation Units (PPIUs) in all provinces and federating areas. Lady Health Workers (LHW) and Lady Health Supervisors (LHS) were selected and trained in all parts of the country. Later, Village Based Family Planning Workers (VBFPW) of the Ministry of Population Welfare (MoPW) were also merged into this programme in 2002. More than 100,000 LHWs were deployed when on 1st July 2011, the programme was devolved to provinces as a result of 18th constitutional amendment and abolishment of MoH.

After devolution, LHWs and LHS were given a regular pay scale (replacing monthly stipend) on the orders of courts and gradually these workers were absorbed as regular government servants.

In 2021, Provincial/ Federating Area Essential Package of Health Services (EPHS)/ UHC Benefit Packages were developed and community platform emerged as a key approach not only to deliver PHC services but also to make progress towards achieving UHC targets and improved health outcomes in the country. LHWs are the most important service provider in the community platform of EPHS in all provinces and federating areas.

The changing scope of services of LHWs is vital in the delivery of the policy priorities of the Ministry of NHSR&C and Provincial/ Area Health Departments through providing integrated community level health services to improve the health status of the population, contribute to achieving developmental, national security and poverty reduction objectives. In particular, the LHWs' System will further promote the health of poor and disadvantaged communities and in particular the health of women, girls and children by not only bridging the gap between static PHC facilities and communities but also dealing with critical gender and equity related issues.

Bringing the themes of the previous strategic priorities of the Lady Health Workers' Programme/ System, reflecting the latest scientific evidence / results and taking into account the opinions during consultative process with a wide range of stakeholders, following strategic directions were agreed to tackle issues/ challenges and achieve newly defined objectives for the LHW system.

MAJOR ISSUES AND STRATEGIC ACTIONS

For the LHWs' System to deliver results, a number of key issues need to be addressed including:

Key Issues needing resolutions at Strategic level:

1. Horizontal integrated approach
2. Clarification of roles and responsibilities in the LHWs' System
3. Scope of the LHW's Services and her Capabilities
4. Quality of Services
5. Target Population, Coverage and Expansion
6. Strengthening Internal Accountability and to the Community
7. Governance and Management
8. LHWs' Intervention in the context of Conflict, Disasters and other Health emergencies

Key Issues related to System Support for the Lady Health Workers

A. Selection and Recruitment
B. Training and Continuing Education
C. Deployment and Scope of Work
D. Supervision, Monitoring & Evaluation
E. Behaviour Change Communication
F. Procurement, Logistics and Supply Chain
G. Financing
H. Innovations

1: Horizontal Integrated Approach

LHWs are expected to deliver proactively family planning and primary health care services to their own communities at their doorstep and contribute to the improved delivery of other priority development and humanitarian health interventions. LHWs are not expected to operate as a stand-alone vertical intervention but an integral part of the provincial / federating area and district health system. It relies on the involvement of District Health Offices, functional health facilities, private sector (preferably through formal collaboration) and the successful operation of other PHC interventions / programmes.

In order to show performance, the LHWs' system will need strengthening of district health system, PHC centres, other health programmes/ interventions and the referral health care system/services. For example, the posting of trained doctor/ Lady health visitor in a Basic Health Unit (BHU) will support the training of LHWs; Improved management and availability of medicines in health facilities will support the referral function of the LHWs and also the management of medicines and supplies of the LHWs system.

A vertical approach which may be efficient initially for ease of decision making but on the other hand may lead to duplication of efforts and wastage of meagre resources. Further, chances of achieving results will diminish through a vertical approach.

ACTIONS:

1. **Punjab, Sindh, GB, AJ&K** and **Islamabad** will adopt a horizontal integrated approach, whereas there is inclination of **KP and Balochistan** towards maintaining the vertical approach.
2. Strengthen linkages with other primary health care interventions to ensure coordination of policy and support to service delivery.
3. LHW will work as a multipurpose health worker to provide primary and reproductive health services only in her catchment area, for which she is responsible for.
4. LHW will be linked to the nearest health facilities, which are appropriately functional and capable of providing backup support to LHWs.
5. Provincial and district health officers (and implementing partners through formal collaborations at provincial/ area level) will be involved in supportive supervisory activities both for health facilities and at the community level.
6. Information needs of different PHC interventions will be integrated into a single Health Information System also using digital technologies.
7. Existing system for logistics support for medicines and supplies to the facilities will also be used for the LHWs' system.
8. Lady health supervisors (LHS) will be posted as staff of PHC health facility/ district health office, with mainly field supervisory responsibilities.

2. Roles and Responsibilities in the LHWs' System

LHW provide services to her community that contribute to the operation of a number of the other priority development, regular and humanitarian health interventions. The LHWs' system does not operate as a stand-alone programme. It relies on the involvement of provincial and district health officers, functional health facilities, implementing partners, private sector (for referrals) and the operation of other health interventions.

The LHWs' system needs to collaborate with other health sector interventions/ programmes to ensure that policy priorities are reflected in the service delivery of the LHWs. However, there is a need to further strengthen policy and analysis functions at the provincial/area level, efficiency of the district health offices and performance of health facilities.

The development and functioning of the LHWs' system is dependent on the capabilities of the provincial/area and district health managers. The management, recruitment and supervision of the LHWs' System would be according to provincial/area rules and regulations. Direct oversight, selection and training is done by the health facilities. Where horizontal integration is implemented, dedicated provincial/ district staff for the LHWs' system would not be required.

Developments in community participation, as planned by the LHWs' system, raise the quality of services issues through feedback to LHWs on their performance and in providing opportunities for engaging in health improvement initiatives. Role of LHW working closely with other community workers (Vaccinators, environmental workers, community midwives (CMW), traditional birth attendant (TBA etc.) is important for the success of intervention. High performing LHWs are more likely to have active Women groups and Health Committees.

ACTIONS:

Functions related to LHWs System	Federal	Provincial /Area	District	Health Facility
1. Policy and Strategic Planning	National Planning	✓		
2. Annual Planning		✓	✓	
3. Inter-Provincial Coordination	✓			
4. Intra-Provincial Coordination		✓		
5. Community engagement			✓	✓
6. Coordination with UN and Development Partners	✓	✓		
7. Inter-Sectoral Coordination		✓	✓	✓
8. Standards setting		✓		
9. Curricula development	✓	✓		
10. Refresher Training		✓	✓	
11. Legislation		✓		
12. Community based disease surveillance & response		✓	✓	✓
13. Monitoring & Evaluation and Research	✓	✓	✓	✓
14. LHW-MIS and integration with HIS		✓	✓	✓
15. HRH Registry of LHWs and LHSs etc.		✓	✓	
16. Development of package of services through LHWs		✓		
17. Provision of community-based services			✓	✓
18. Supervision and quality assurance		✓	✓	✓
19. Administrative authorities		✓	✓	
20. Financial authority, budget planning and execution		✓	✓[11]	
21. Audit		✓		
22. District Planning, Review & Implementation		✓	✓	
23. Backstopping of district health offices		✓		
24. Forecasting of medicines, contraceptives & supplies		✓	✓	✓
25. Procurement		✓	✓	
26. Supply and Logistic Management		✓	✓	✓
27.Emergency Preparedness & Response	✓	✓	✓	✓
28. Equity and Gender considerations		✓	✓	✓

1. Strengthen capacity of health departments on policy development, analysis and monitoring functions.
2. The district health managers/ supervisors will work closely to ensure coordination of policy implementation and support to the integrated service delivery. Where the policies of different PHC interventions overlap, health departments will ensure consistency of procedures and performance standards.
3. Implementation that includes using LHWs services must be in accordance with procedures and performance standards which are to be defined by respective provinces/ area health department. An example is that LHW is expected to provide services only in her catchment area (core principle) and her working outside of her catchment areas for other intervention or at health facility, will be discouraged.
4. Provincial and district health managers will advocate for the improvement of health systems at all levels that support service delivery by LHWs.
5. All will focus on improving the performance of LHWs in order to maximize their contribution to the targets of policy priorities.
6. Community participation and empowerment will be strengthened through the LHWs role in Women groups and Health committee; Community representative will be involved in the selection of LHWs.

11 Considering provincial/area local government legislation, rules and responsibilities

7. Linkages will be strengthened among community level health workers – Vaccinators, environmental workers, TBA and CMW – and health facility

3. Scope of LHW's Services and her Capabilities

The LHW provide primary, preventive, promotive and some curative & rehabilitative care services to the community in her catchment area and cover both regular PHC and humanitarian aspects through:

- Developing and organizing women groups and health committee. She will arrange meetings of these groups in order to effectively involve them in primary health care with a focus on family planning services, immunization, maternal and child health, nutrition, control of communicable and non-communicable diseases and related community development activities.
- Discussing with the community, issues related to health, hygiene, nutrition, sanitation, MCH and PHC emphasizing their benefits towards improved quality of life.
- Liaising between the formal health system and her community and ensuring coordinated support from public health system and private sector.
- Registering all people living in her catchment area, and maintaining up to date information about children, women and other high-risk groups. LHW visit on average 5-12 household per day, working six days a week. She will motivate and counsel clients for adoption and continuation of healthy practices. To promote healthy behaviours and increased utilization of services, she will maintain a close liaison with influential women of her area including lady teachers, CMW, TBA and satisfied clients.
- Providing medicines and supplies to patients/ clients in the community and informing them of proper use and possible side effects. She will also refer clients, needing skilled services to the nearest appropriate health facility.
- Coordinating with local CMW, TBA, midwives or other skilled birth attendants and local health facilities for efficient antenatal, natal and postnatal services.
- Undertaking nutritional interventions such as prevention and treatment of anaemia, screening, assessing risk factors causing under-nutrition and nutritional counselling. The LHW is able to treat iron deficiency anaemia among women especially pregnant and lactating mothers as well as young children. She will promote nutritional education with emphasis on breast feeding and weaning practices, maternal nutrition and micronutrient deficiency.
- Coordinating with EPI for immunization of mothers against tetanus and children against vaccine preventable diseases. The LHWs trained in giving vaccines themselves will ensure timely vaccinations with support from the local health facility staff. The LHW will be participating in various campaigns for immunization against EPI target diseases e.g., polio, measles, tetanus etc. The LHW will be involved in the community-based surveillance activities.
- Preventing and treating common ailments including communicable and non-communicable diseases e.g., tuberculosis, malaria, diarrheal diseases, acute respiratory infections, intestinal parasites, primary eye care, scabies, injuries and other minor diseases using essential drugs. Prevention of hypertension and diabetes are new areas added in their scope of work. The LHW will refer cases to nearest appropriate PHC centres as per given guidelines. For service provision, a kit of certain inexpensive basic drugs are provided to LHW. The LHWs are also involved in DOTS, malaria control and promotion of mental health.
- Disseminating health education messages on individual and community hygiene and sanitation, as well as information regarding preventive measure against spread of sexually transmitted infections including HIV & AIDS.
- Submitting a monthly progress report to in charge of the PHC centre containing information regarding all activities carried out by her including home visits, number of patients & clients and stock position of medicines and supplies.

Considering UHC reforms, future scope of work entail the responsibilities aligning with the essential package of health services - community level platform - defined and agreed by all provinces/ federating areas. Following table describes the finalized essential/ top priority scope of work for LHWs and other community workers:

COMMUNITY LEVEL INTERVENTIONS

Reproductive Health/ Birth spacing

– Education and counselling on birth spacing during antenatal and post-natal care (LHW, CMW, LHV)
– Provision of condoms, hormonal pills and injectable contraceptives (LHW, CMW, LHV)
– Referral and linkages for IUCD insertion (LHW)
– Referral and linkages for surgical contraceptive methods (LHW)

Antenatal Care

– Counselling on providing thermal & kangaroo care to new-born (LHW, CMW, LHV)
– Counselling on breastfeeding and growth monitoring (LHW, CMW, LHV)
– Monthly monitoring of pregnant women using MCH card and referral to Skilled birth attendant (LHW)
– Nutrition counselling and provision of Iron and folic acid to pregnant women (LHW)
– Referral/ immunization for TT immunization (CBAs and Pregnant women) (LHW, CMW)
– Screening for hypertension during pregnancy and immediate referral (LHW, CMW. LHV)

Delivery Care

– Referral to skilled birth attendant for low-risk labour and delivery (LHW)
– Identification of danger signs and referral to BEmONC or CEmONC facility considering complications (LHW, CMW, LHV)
– Low risk normal delivery (Only where CMW or LHV is available)

Post-Natal Care

– Use of PNC checklist for mother within 24 hours after delivery (LHW) +3 follow up visits for 40 days after delivery (LHW, CMW)
– Education and counselling on birth spacing during post-natal care and service provision/ referral (LHW, CMW)

New-born Care

– Use of PNC checklist for new-born within 24 hours after delivery (LHW) + care of new-born including care of cord (3 follow up visits) (LHW, CMW, LHV)
– Early initiation of breastfeeding (within ½ hour of birth) and initiation of growth monitoring (LHW, CMW, LHV)
– Ensuring thermal & kangaroo care to new-born (LHW)
– Ensure initiation of immunization for BCG and zero dose polio (LHW with support of area Vaccinator)

Nutrition

– Screening for malnutrition in children; growth monitoring, ensure provision of food supplements for moderately acute malnourished cases and refer severely acute malnourished cases to stabilization Centre (LHW, PW councillor)
– Ensure provision of vitamin A (after National immunization days are stopped) and zinc supplementation (LHW, PW councillor, etc.)
– Provision of micro-nutrients (iron and folic acid), ensure food supplementation to women/adolescent girls (LHW)

Child care

– Community based integrated management of childhood illnesses (LHW); immediate referral for complications and danger signs and follow up visits (LHW, PW councillor)
– Childhood Vaccination (BCG, Polio 0,1,2,3, Penta 1,2,3, Pneumococcal 1,2,3, Rota 1,2, Measles 1,2) – Typhoid vaccine from 2022 (LHW, PW councillor with support of Vaccinator)
– Education on hand washing and safe disposal of children's stool (LHW, PW councillor)

School age Child Care

– Education of schoolchildren on oral health (LHW, PW councillor)
– Vision pre-screening and referral if required (LHW, PW councillor)
– School based HPV vaccination of girls (vaccinator, LHV) – after 2022-23 and through special initiative
– Drug administration against soil-transmitted helminthiasis (LHW, PW councillor, volunteer)

Adolescent Health

– Education and counselling for prevention of sexually transmitted infection, screening and referral (LHW)

Infectious Diseases

– Community based HIV testing, counselling and referral (In high-risk groups by CBO worker)
– Provision of condoms and disposable syringes (In high-risk groups by CBO worker)
– Health education on Hepatitis B and C and referral of suspected cases (LHW, PW councillor)
– Health education on STI and HIV (LHW, CBO worker)
– Systematic screening and routine contact tracing exposed to Tuberculosis (LHW, CBO worker)
– Referral of malaria suspect (LHW, PW councillor)
– Conduct larvicidal and water management (LHW & PW councillor with backup support from CDC/ Environmental technician)
– Identification and referral of suspected cases of Dengue, Influenza, Trachoma etc. (LHW, PW councillor)
– Identification, reporting and referral of notifiable diseases (LHW, PW councillor and CDC / Environmental technician) - Conduct simulation exercises/ training

Non-Communicable Diseases

– Exercise based pulmonary rehabilitation of COPD (LHW)
– Screening for hypertension (LHW)
– Health education on CVD prevention (LHW, PW councillor)
– Health education on Diabetes (LHW, PW councillor)
– Self-managed treatment of migraine (LHW)
– Clap test for screening of congenital hearing loss among new-born and referral (LHW)
– WASH behaviour changes interventions (LHW, PW councillor with backup support from CDC / Environmental technician)

Health Services Access

– Health education on dental care (LHW, PW councillor)
– Health education scabies, lice and skin infections (LHW, PW councillor)
– First aid, dressing and care of wounds and referral (LHW)
– Identification and screening of early childhood development issues and referral (LHW)
– Basic management of musculoskeletal injuries and disorders and referral (LHW)

LHW capabilities

- Previously, the LHW was expected to have a minimum of 8 years of education, which has now been enhanced to 10 years of education. This is to ensure her career growth and meeting the criteria for government service. She should be capable of learning the basic knowledge in the curriculum. Global evidence and third-party evaluation of the programme suggests that community workers acquire a reasonable level of knowledge through their basic training and refresher trainings, if they have more than 8 years of schooling. Improvements are also attributable to experience and training.
- The LHW should serve on average 600-1500 people in her community (with variation among provinces /areas). She is expected to visit 5-12 households per day and to work 6 days a week. She should also be available to the community to provide services in the case of emergencies. She will work around 6-8 hours a day and nearly eighty percent of her work time will be spent in household visits. Apart from household visits the major activity of the LHW will be visiting attached PHC centre and working on special immunisation activities.
- Any new proposed services by LHWs need to be assessed for their impact on her time and how well they integrate into the current model of service delivery, which is primarily through household visits. The demands on LHWs' time and services are likely to increase in future. It is therefore necessary to guard against overburdening the LHWs. The involvement of LHWs in new areas will require the approval of a **Technical Review Committee** at provincial/ area level after having completed a detailed study or analysis of the benefits for the community and the health system. Demands on LHWs time need to be defined in terms of safety, LHW capabilities, workloads and remuneration, cost effectiveness of interventions and the ability of the health system to support new services to high quality standards.

ACTIONS:

1. The LHW will provide services to her community and will be given salary as per respective provincial / area government rules and regulations) in recognition of this service. The priorities of the LHW services will be implementation of community level EPHS relevant to LHWs and as defined in her curriculum.
2. For new recruitment of LHWs, there will be no compromise on the basic education criteria of minimum 10 years of schooling. Confirmation of literacy through an entrance test should be ensured.
3. All new services will continue to be approved by the **Technical Review Committee** (to be notified by each health department with clear TOR and processes) after a detailed analysis. The Review Committee will publish a set of clear guidelines for the priorities for future development of services.
4. The LHW system will allow LHWs to deliver routine immunisation services under supervision. Further she will work closely with the skilled birth attendants.
5. Special immunization days will be a high priority activity.

4. Quality of Services

Evidence from Pakistan and other developing countries suggests that dedicated and knowledgeable female community health workers have an impact on Hygiene (hand washing practices), sanitation improvement, diarrhoea treatment, pneumonia management, full immunization of children at the appropriate age, pregnant women receiving tetanus toxoid injections and taking iron tablets, safe delivery practices, birth spacing and neo-natal check-ups. On the other hand, poor performing workers may be a very significant drain on resources and are unlikely to deliver services that change health outcomes.

To ensure quality of services, the strategy is to identify the poor performers and provide regular feedback, supportive supervision and training. However, where the LHW has no motivation or is unable to provide the necessary services, she needs to be replaced as per government rules and regulations.

The selection criteria for LHWs should be maintained to ensure the potential for improvements in service quality. Once recruited the LHW should be well trained, supervised and provided with supplies.

Evidence suggests that dedicated and hardworking workers can produce results in spite of poor systems, although good systems provide incentives for all staff to do a better job, and maximize their capacity to spend their time on priorities and not be distracted or impeded by unnecessary administrative concerns. Management and supervision capability at the district level needs to be developed further and supported. Good performing lady health supervisors (LHSs) are also expected to make a difference to the performance of LHWs. Managers and supervisors need to be mobile in order to provide supportive supervision.

The training system has to ensure that all LHWs and their supervisors have knowledge and skills to provide high quality services. The training system facilitate integration and collaboration between the health facility and the LHWs' intervention by using health facility staff as trainers for their basic training, continuing training and refresher training. There is a need to strengthen supervision and quality control over the training system.

The LHWs and LHSs are now getting regular salaries as per government rules and regulations for her services in the community.

The LHWs' system needs annual procurement and distribution of drug, non-drug and printed items to LHWs and through them to the communities. Issues like delays in procurement and distribution should be avoided.

ACTIONS:

1. The most cost-effective way to improve impact of the LHWs' system will be by increasing productivity and quality of services by LHW.
2. Recruitment of new LHWs and redefining of catchment areas will be to achieve maximum coverage, while facilitating overburdened LHWs with appropriate catchment population
3. The delivery of core functions/scope of work of the LHW will be their main responsibility
4. Regular refresher training with an appropriate feasible plan will be conducted along with provision of training materials, proper classrooms with sitting arrangements, white boards and teaching aids.
5. Digital reporting tools in the form of tablets etc. may be provided in a phased manner to reduce the workload of the LHWs and timely reporting
6. Synergies among health departments will be developed to improve coordination.
7. Merit based selection, better basic training and supportive supervision will be ensured
8. Processes for dealing with poor performance should be strictly followed.
    a. Initiation of accountability process after 1-2 warnings for poor performance and as per government rules
    b. Career opportunities as an incentive to motivate LHWs and LHSs
    c. Appreciation in the form of certificates to good performing LHWs, LHSs, District & Provincial staff
    d. Communication skills of the workers to be improved by increasing presentation skills using pictorial lessons.
9. Management, supervision and systems to support high quality of services will be important prerequisite for the success.

5. Target Population Coverage and expansion

Whereas the priority is first to fill the system gaps in the LHWs' System, the need for expansion for LHWs coverage is also critical for achieving UHC service coverage index. Expansion of LHW coverage will also further improve health outcomes, particularly if the expansion is to poorer areas.

To be efficient, the coverage of LHWs in urban areas, which have nearby referral facilities, can be avoided as they already have access to health services. However, provision of services through LHWs in all rural and urban slums/ densely populated areas will be a priority.

Although attrition rate has reduced and now the challenge is retirement of LHWs and LHSs at the age of 60 years. There is a need to closely monitor the attrition and drop-out rate of LHWs and LHSs and to identify the reasons for attrition as this can have serious implication on the coverage targets.

Another important consideration before expanding the intervention is the recurrent cost of the intervention. Funds are required for payment of salaries and incurring non-salary expenditures, once LHWs are deployed in their community after completion of training. A predictable financing is an important consideration, before expansion at a large scale.

The poor are the people who have the fewest options available to them, and for whom the consequences of illness are perhaps the greatest in terms of disability, death and lost income. As the intervention is likely to expand, it will cover some of the poorer areas but it will also increase the workload on services in the health facilities. The areas that will remain uncovered by the intervention may even be more disadvantaged.

Expanding services to a larger share of the rural population, might lead to severe constraint in terms of the availability and the quality of the health services at health facilities. Recruitment of LHWs and their supervisors may be more difficult, as fewer candidates are likely to reach the selection criteria. Similarly, training and LHW support will be difficult in areas with non-functioning PHC centre. Remote areas will imply higher transport costs. These limitations might hamper the effectiveness of the intervention. Maintaining the selection criteria would be a key to success of the intervention.

The district health office should prepare plans based on areas to be covered and where LHWs are required. These areas should then be further prioritized by them indicating which facilities will be taken up first and at later stages. These plans should then be consolidated at the health department to provide a comprehensive picture of the areas and availability or otherwise of health facilities.

Number of LHWs and LHSs in the country (in 2021) were as following:

Province/ Area	Number of LHWs		Number of LHSs	
	Allocated	Deployed	Allocated	Deployed
Punjab	44,770	42,648	1,799	1,759
Sindh	22,576	20,446	770	711
Khyber Pakhtunkhwa	16,100	15,334	775	705
Balochistan	6,720	6,147	262	230
Islamabad	330	285	11	11
Gilgit Baltistan	1,385	1,360	66	57
Azad Jammu & Kashmir	3,068	3,020	142	142
TOTAL	**94,949**	**89,240**	**3,825**	**3,615**

ACTIONS:

1. Health Departments will provide guidelines to develop plans before any expansion of the LHWs' System into poor and underserved areas.
2. A mapping exercise with regard to working LHWs and un-covered areas will be the basis of micro-planning and future recruitment of LHWs. To supplement enhancing coverage, **Punjab** and **Khyber Pakhtunkhwa** will restructure/ upgrade already existing PHC centres including Zila council/local government dispensaries as PHC centres thus including urban slums and densely populated areas.
3. Implementing partners will be engaged where feasible for accelerated education of girls especially in deprived areas.
4. Any expansion of the LHWs' System will take place preferably in those health facilities which are functional. Vacant positions will also be filled on priority basis.
5. Measures to ensure the quality of services will be maintained also in areas where health facilities are not fully functional.
6. Improved coverage in rural areas will remain a priority with further expansion in urban slums and densely populated urban areas to have a maximum health impact.

7. Some innovative ideas like piloting of accelerated education program with collaboration of educational institution like Allama Iqbal Open University may be piloted to address the equity issues.

8. Milestones agreed for expansion of LHWs in a phased manner are as following, which are also critical for achieving UHC service coverage index and SDGs. During the period focus should be on consolidation before expansion in other areas.

Table: Planned Cumulative Numbers of LHWs Year Wise						
	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28
Punjab	42,648	50,000	55,000	60,000	60,000	60,000
Sindh	20,446	25,000	27,000	28,000	29,000	30,000
Khyber Pakhtunkhwa	15,334	20,000	23,000	25,000	27,000	27,000
Balochistan	6,174	10,000	11,000	11,000	11,000	11,000
Islamabad	300	800	1,150	1,150	1,150	1,150
Gilgit Baltistan	1,360	1,560	1,860	2,060	2,080	2,080
Azad Jammu & Kashmir	3,020	3,100	3,500	4,000	4,000	4,000
TOTAL	89,282	110,460	122,510	131,210	134,230	135,230

6. Strengthening Internal Accountability and to the Community

The LHWs' system needs to be accountable for the appropriate use of funds and for the quality and efficacy of the services that it provides to the community. It is important that the core services provided by the LHWs are agreed and protected. There may be a high demand on LHWs' time from a range of health and non-health interests. These may have risks of reducing health impacts and of reducing accountability.

Internal accountability needs strengthening at the Provincial/ Area, District and Health facility levels, along with an oversight role of all stakeholders. Delegation of functions within the LHWs' System requires that the district health offices and Implementing partner (if contracted out) can be held accountable for their performance.

The information system should be made operational at all levels. However, care should be taken that time spend by LHW in administration which is essentially providing data for the information system should be as minimum as possible. Health information system should ensure that it captures critical information required for decision making and risk management.

External evaluation and audits should be used to improve the quality of management and to increase internal accountability. Results from the evaluations should be disseminated at all levels of the intervention.

Community accountability means that the LHWs' System should continue to strengthen the Village/Area Health Committees and Women Groups. Each LHW should be involved with the committee along with her supervisor and other community workers – Vaccinator, Environmental worker, TBA and CMW. The system will provide the opportunity for households to give feedback on the LHW and her services, through visits to households by her supervisor, independent of the LHW. Households will also be surveyed by the third-party evaluation to get insights.

The community should preferably be involved in the recruitment of the LHW, with a community member on the selection panel, while considering government rules and regulations.

ACTIONS:

1. The intervention should develop and improve the MIS integrated with Health Information System and conduct evaluation to increase transparency and accountability for performance.
2. Use of digital technologies should be encouraged where feasible.
3. Annual progress report will be published by all health departments and will include a specific section against its key performance indicators.

4. Annual progress report will be published by all health departments and will include a specific section against its key performance indicators.
5. the existing supervisory tools like LHWs/LHSs checklists and *Jaiza karkardaki* (performance monitoring) will be reviewed and revised.
6. Culture of regular review meetings at facility, district and provincial level will be revitalized and strengthened.
7. Village/Area Health committees and Women group will be strengthened with involvement of other community workers.

7. Governance and Management

The Ministry of NHSR&C and Provincial/ Area Health Departments are working closely on a number of PHC and UHC reforms in the health sector, which also needs to ensure governance arrangements and mechanisms at each level.

The LHWs' System is an integral part of the PHC and UHC reforms in the country and key strategic directions are given by the Inter-Ministerial Health & Population Council. The council is headed by the Federal Health Minister with Health Minister and Population Ministers from all provinces and federating areas, as its members. The fifth evaluation of the LHW Programme and development of this strategic plan is also under the guidance of the council.

At programmatic and system level, decisions at national level are made by the UHC Country Platform chaired by the Federal Health Minister and consisting of Federal/ Provincial/ Area Secretaries of Health, concerned United Nations (UN) Country Representatives, Donors' Representatives and observed by representative of civil societies, health academic institutions and private health sector. UHC Country Platform also plays a central role in facilitating collaborative action across stakeholders to enhance the status of the UHC in Pakistan.

Technical decisions and strategic recommendations at national level are made by the National Advisory Committee (NAC) chaired by the Director General (Health) and membership of all Director General Health Services (DGHS), Chairs of Technical Working Groups, technical experts and stakeholders.

National Technical Working Groups (TWG), whose membership consists of concerned focal points in the Ministry of National Health Services, Regulations & Coordination (NHSR&C), members from all Health Departments, concerned UN agencies, donors 'representative and other stakeholders. Recommendations of the National TWGs are guided by the recommendations of the Provincial/ Area Technical Working Groups (PTWG) or Sub-committees/ Task forces formed by the NAC or National TWGs. Technical recommendations/ decisions preferably should not be made outside of the official committees and should be endorsed by the Director General (Health)/ Secretary NHSR&C. All decisions must be documented in minutes, which are approved by the ministry.

On the similar pattern UHC Steering Committees and UHC Technical Committee with specific Technical Working Groups and sub-committees have been formed at the provincial and federating area levels. At district level District Health & Population Management Teams are established.

LHWs related decision making whether strategic or technical are expected to use the above-mentioned governance arrangement depending upon the nature of decision required.

Most of the activities under the LHWs' System are expected to be at provincial/ district level or below, which means the system is designed under a devolved setup. However, sometimes challenges are faced in those provinces/ areas where health facilities have been contracted out or have a different management structure like a company. In such cases, it is important to engage these organizations and companies in the decision-making process.

The management of the LHWs' Programme / System will vary from province/area to province/area. Those provinces/ areas who have opted for horizontal integration, would manage the programme from the office of

Director General Health Services at provincial level and District Health Office at district level and the separate distinction of vertical management will wither away. However, those provinces/ area which will opt for a vertical structure mainly through development budget will have to establish vertical management structures at provincial and district level. There are expected variations among provinces and areas on management structures considering provincial strategic priorities.

ACTIONS:

1. The LHWs' System will either be a part of regular recurrent budget through horizontal integration or that of development budget through vertical management at provincial and district level.
2. In both management options, the LHWs' System will follow the same governance arrangement at national, provincial and district level which is emerging under the UHC reforms in the country.
3. The implementing partners for managing contracted out PHC centres will be involved in the decision-making process for their ownership to the LHWs System. Contractual clauses will be amended to include the scope of work related to the LHWs' System.

8. LHWs' System in the context of Conflict, Disasters and other Crises

The geographic location and topography of Pakistan predisposes the country to many natural disasters, notably earthquakes, droughts and floods. There is also a high risk and vulnerability particularly to cyclones at coastal belt. Pakistan also experiences the adverse effects of climate change – especially extreme temperatures, melting glaciers, landslides, salinity intrusion, heavy monsoon downpours, river erosions, etc.

Human induced hazards that threaten the country relate to transport, industry, oil spills, forest fires, city fires, civil conflicts and internal displacements of communities as a result of multiple factors. Increasing urbanization means larger urban populations inhabiting peri-urban, marginal and at-risk areas. Vulnerability to disasters is growing in both urban and rural areas, placing ever more lives at risk.

These disasters trigger outbreaks of communicable diseases (mainly waterborne diseases, skin infections and pneumonia), as well as malnutrition and injuries. They also seriously affect peoples' health and overall national economic development. Disasters have a disproportionate impact on women and children, who comprise 70 percent of disaster-affected populations. Due to cultural norms, women and children – particularly girls – face greater risks of ill-health in the wake of disasters. They are also less likely to safely access assistance. As women are not sufficiently included in community consultations and decision-making processes – both before and after disasters – their needs are often not met, and their concerns are not adequately addressed.

LHWs have played a significant role during disasters and emergencies whether this was earthquake in 2005, floods in 2010 or the COVID-19 epidemics. LHWs have always acted as the front-line workers to restore essential PHC services not only in their own communities but also in areas outside of their catchment area.

LHWs' System is therefore an essential component of health system not only to strengthen the provision of essential health services but to ensure a resilient system able to tackle crises situation effectively. The role of LHWs is not limited to regular or development activities but also humanitarian aspects when needed.

ACTIONS:

1. No district should be ignored while implementing the LHWs' intervention as this ensure establishing a resilient system and works effectively both for routine health services and also dealing with emergencies.
2. The LHW's System should be adoptable to the changing circumstances in case of any humanitarian crises. For example, if there is internal migration due to drought; it is likely that LHW will also migrate along with her community. In such cases, she should continue to provide services to her community and should have linkages with the district health offices to get supplies and regular guidance.
3. To ensure adoptability in case of any calamity, contingency plans will be developed with written instructions from the higher-ups, notification of Minimum Initial Services Package (MISP) following regular capacity building of LHWs for emergency preparedness while ensuring required logistics.

RESOLUTIONS/ACTIONS RELATED TO SYSTEM SUPPORT

A. Selection and Recruitment

1. The selection criteria for a candidate as LHW or LHS will be:

Selection criteria for LHWs	Selection criteria for LHSs
▪ **Female,** preferably married ▪ **Resident** of the catchment to serve ▪ **Education:** Minimum Matric preferably with Science ▪ **Age: 18-35** years at the time of selection[12] ▪ **Preference:** Community work experience ▪ **Test:** As Per Minimum Required Qualification. Test will be conducted by a committee. (Chair Person: DHO, Members: Provincial office rep, district office rep and representative of concerned health facility)	▪ **Female,** preferably married ▪ **Resident** of the Concerned Catchment Area to serve ▪ **Education**: Minimum Graduate ▪ **Age: 22-35** years at the time of selection[13] ▪ **Preference:** Health sector / field related work experience ▪ **Test:** As Per Minimum Required Qualification Test will be conducted by a committee (Chair Person: DHO, Members: Provincial office rep, district office rep and representative of concerned health facility

2. The criteria for recruitment of new LHWs and LHSs will be communicated officially to district health offices before starting the recruitment process/ mapping exercise.
3. The recruitment and deployment will entirely be done following Government/ Health Department procedures. The initial process of recruitment will include:
    - A formal application hard or online application (Specified Form) for the job, addressed to the District Health Officer
    - Evidence of education
    - Evidence of the residence (ID card and any other official document).
    - Test and interview on the announced date
4. Following conduction of test and interviews, recommended candidates list and waiting list will be finalized by the district committee. Later, District health office along with the health department will conduct verification and successful candidates will be issued appointment letters w.e.f. start of formal training.
5. In case of violation of the selection criteria, regular employee will be dismissed following Efficiency & Discipline (E&D) rules whereas for a contractual employee continuous (3) poor performance assessed through supervisory checklist will be considered as a dismissal criterion.

B. Training and Continuing Education

1. Newly recruited LHWs will be trained as per the newly developed curriculum with revised scope of work. The concurrent trickle-down training plan to be followed by all Provinces/areas is as under;
    - **Level-1**: Training of Provincial/ District Master Trainers
    - **Level-2**: Master trainers impart training to the staff of health facilities
    - **Level-3:** Facility trainers impart training to LHWs in their own health facility.

    The same approach for trainings of LHSs will be used, but the final training will be conducted at the first level hospital.
2. Criteria for the Provincial and District master trainers will be:

12 For Balochistan, KP and Sindh the recommended age group is 18-28 years, 20-30 years and 18-28 years respectively
13 For Balochistan, KP and Sindh the recommended age group is 22-28 years, 22-30 years and 22-28 years respectively.

- Senior health provider/ staff with good clinical knowledge and experience in public health
- Previous experience of imparting training; and
- Committed and willing to spare time for training of health facility staff in future.

3. Master trainers train (Medical Officer/ IC, LHV and health technician)
4. For training of LHSs, doctor of the district/ referral hospital also acts as the trainer of LHS
5. On completion of 3 months basic training of LHWs at health facility, class room cum field training will follow for a period of 9 months. Training phases include:

    - **Initial phase** of **3 months'** intensive class room training with clinical training in health facility;
    - **Second phase** of **9 months'** field (3 weeks) cum class room (1 week) training;
    - **Third phase** of continuing education – on going 1 day per month augmented by different refresher courses (of maximum **15** days/ year);
    - LHSs will also help LHWs through identification of capacity issues and on the job training/ recommending refresher training.

6. On completion of the first two phases of training, trained LHWs will visit health facility for one day at the start of month for continuing education session, to discuss issues and challenges, submit monthly report and replenishment of medicines, commodities and supplies.
7. Training and Deployment of LHSs will include:

    - **Initial phase** of **3 months'** intensive class room training with clinical exposure and supervision skills (13 weeks including 8 weeks for LHW's trainers manual and 5 weeks for LHS's manual)
    - **Second phase** of **9 months** training - field (3 weeks/month) cum class room (1 week/ month)
    - **Third phase** of refresher training (of maximum 12 days/ year)

8. District and Provincial supervisors will support LHSs through identification of capacity issues and on the job training/ recommending refresher training

C. Deployment and Scope of Work

1. On completion of three months basic training, each LHW will be deployed in her pre-defined catchment area under supervision and support of her LHS and health facility staff.
2. LHW will start her work by drawing a map of her catchment area (please refer to training manual) followed by registration of all households and family members in Family (*Khandan*) register and filling area information chart. She will establish Women group and Health committee with support of LHS. A corner in her house will be designated as kit corner and health education charts and treatment protocols will be displaced.
3. LHW will serve on **minimum 1,000 and maximum 1,500 people (with exception in hard-to-reach areas / scattered population)** in her own community. Approximate number of households will range from **140 to maximum 220.**
4. LHW will visit **05–12** households on average with some variation among provinces/ areas to provide services **6 days** a week. – **6-8 hours a day**.
5. **More than 80%** of her work time is spent in household visits.
6. **LHWs' core services:** Community based EPHS (essential package of health services) will be a priority as mentioned earlier. For detailed scope of work / services, please refer to the training manual.

7. One LHS will be responsible to supervise around **20 -25 LHWs (with some variation among provinces)** in a district / area being a permanent resident of that area.
8. Each LHS will be responsible for visiting each LHW twice a month while using a supervisory checklist
9. Each LHS will be based in one of the health facilities in the same district/ catchment area.
10. For job description of LHW and LHS, please refer to their training curriculum.
11. At present, no documented career development/structure of the LHWs system exists. **Punjab** has suggested the following plan for the time scale promotion.

    - **Initial recruitment** – LHW Scale 05 / LHS Scale 10
    - **First Promotion** – After 10 Years LHW to Scale 07 & LHS to Scale 12
    - **Second Promotion** – After next 05 years LHW to Scale 09 & LHS to Scale 14
    - **Third Promotion** –After next 05 years LHW to Scale 11 & LHS to Scale 15 with exceptional performance

    Rest of the provinces/areas are developing a proper career structure, but did not propose structured plan. However, qualification, experience, performance and completion of relevant courses as continuing education will be linked with her professional growth and promotions.

D. Supervision, Monitoring & Evaluation

Supervision, Monitoring and Evaluation (M&E) is done continuously as a management or leadership function to assess if progress is made in achieving expected results/ objectives, to spot bottlenecks in implementation and to highlight whether there are any unintended effects (positive or negative) from a health programme and its activities.

Supervision is one of the functions of both management and leadership, and has been defined as ***the overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work***. Supervision thus appears as the interface between management techniques and the qualities of leadership, which all primary health workers in positions of responsibilities should in theory possess and in practice display at all levels of the health system.

Monitoring is directed at three questions: i) the extent to which the intervention / services are reaching the appropriate target population, ii) whether or not its delivery of services is consistent with the design specification, and iii) what resources are being or have been expended in the conduct of the intervention/ services. Monitoring is defined as ***the systematic examination of coverage and delivery***. Assessing coverage consists of estimating the extent to which the intervention/ services are reaching its intended target population; whereas estimating delivery consists of measuring the degree of congruence between the plan for providing services and treatments and the ways they actually are provided. In addition, the monitoring includes collecting information about resource expenditures, information that is essential for estimating whether the benefits of intervention/ services justify its cost. Monitoring also may include assessing whether activities comply with legal and regulatory requirements—for example, whether affirmative action requirements have been met in the recruitment of staff.

Evaluation is ***a systematic determination of a subject's merit, worth and significance, using criteria governed by a set of standards*** (in health OECD Development Assistance Criteria (DAC) is usually used for evaluation). It can assist an organization, program, design, project or any other intervention or initiative to assess any aim, realisable concept/proposal, or any alternative, to help in decision-making; or to ascertain the degree of achievement or value in regard to the aim and objectives and results of any such action that has been completed. The primary purpose of evaluation, in addition to gaining insight into prior or existing initiatives, is to enable reflection and assist in the identification of future change.

1. Ratio of one LHS to LHWs would be 1:20-25 with some variation considering geographic terrain and population density and access issues. For example, considering different terrain, **AJ&K** will deploy 1 LHS for 15 LHWs, whereas **Balochistan** will designate 1 LHS for 20-25 LHWs in thickly populated areas, whereas 1 LHS for 15-20 LHWs in less densely populated areas. 1 Field Programme Officer/ Provincial Monitoring Officer will supervise 3-4 districts.
2. During the era of LHWs Programme, the dedicated supervisory structure included Field Programme Officers (FPO), District Coordinators, Assistant District Coordinator and LHSs and they were using supervisory checklists and other tools for the purpose of supervision. In provinces with devolution and horizontal integration, supervisory functions are being integrated at health department, district health office and health facility level. Supervisory checklists and tools also needs to be revised for aligning them with the revised scope of work under the community Interventions of EPHS and its targets.
3. Partnership will be developed with implementing partners to strengthen integrated supervisory & monitoring functions, where PHC functions have been transferred through public private partnership arrangement.
4. To further strengthen the supervisory mechanism, one core list of indicators for all provinces/areas, covering the key national commitments under SDG3 and UHC is to be formulated.
5. Provinces/ areas may also include some of their priority supervisory indicators linked to the LHWs interventions in different level checklists.
6. For strengthening of supervisory mechanism, provinces/areas will provide vehicles along with drivers to LHSs appointed especially in rural and hard to reach areas; whereas provision of Fixed Travel Allowance to LHSs serving mainly in urban areas.
7. The nationally agreed indicators list will be centrally linked at LHW-MIS dashboard for analysing data to show progress on the agreed indicators.
8. LHW-MIS will be linked with DHIS, IDSR and other vertical information system for horizontal integration,
9. Digital technology will be used for easy processing of data, quick analysis and use of information for quick decision making.
10. Digital referral system will be introduced for quick referral of patients along with digital bed registry system. Building a strong referral mechanism, is another aspect how we can strengthen primary health care. Presently, a referral system exists for maternal, neonatal & child health but linkages with tertiary care hospitals will be developed.
11. The mid-term evaluation of the LHWs system and other external reviews will stay as a policy level decision lying with the provincial health authorities, so it will be provincially driven with national inputs for a close coordination with the Ministry of NHSR&C and development partners.
12. For experience sharing and lesson learning, interprovincial visits/ meetings, workshops will also provide opportunity for transfer of knowledge and technology. Such initiatives are the need of an hour as it will further strengthen interprovincial coordination. These plans will be centrally coordinated with health departments on rotation basis. Also, the Federal Ministry in consultation with provinces/areas may request partners to organize the interprovincial visits.

E. Behaviour Change Communication

Communication can be defined as the symbolic exchange of shared meaning and all communicative acts have both a transmission (e.g., it helps one acquire knowledge) and a ritualistic component (humans as members of a social community). Communication is a dynamic process in which sources and receivers of information continuously interchange their roles. One of the central tenets of health communication interventions – the

need to conduct extensive formative evaluation, audience needs assessment and message pretesting – is the direct offshoot of this understanding.

In Pakistan, health system has been trying to grapple with infectious diseases, malnutrition, maternal and child morbidity and mortality etc. The epidemiological data from the last decade or so shows increasing incidence of non-communicable disease previously considered to be problems of a relatively small affluent section of the society. Fortunately, most of these conditions are behaviour related and can be addressed by providing appropriate information to the people and enabling them to take care of their own health.

It is high time that focus should be made on public health measures like health education, safe drinking water; proper sanitation; good nutrition; healthy life style and basic immunization that can help improve health. Health Education is the key to success of all the preventive as well as curative services. It is an integral part of all the health services. Main aim of the Health Education is to improve health of people by helping them to make wise decisions relating to health matters and motivating them to improve health with their own actions and efforts (getting children immunized, seeking prenatal care, having deliveries done from the trained birth attendants, using ORS during diarrhoea, hand washing & improved sanitation etc.). Health education, also aims at promotion of healthy lifestyles i.e., no smoking, a lot of exercise, encouraging use of balanced diet, discouraging junk foods, keeping mental tensions away from life etc.

In past, the LHWP has played a key role in disseminating health messages using multiple channels – the most effective of which was inter-personal communication. LHWs are still the most cost-effective means of dissemination behaviour change messages to individuals, families and communities. However, these messages should be aligned with messages disseminated through other messages.

Considering horizontal integration in health departments, it is important to integrate behaviour change communication and should also be reformed through following actions:

1. The brand colour of the LHWs system will remain '**Silver Grey**' in all provinces and federating areas.
2. Development of Behaviour change communication (BCC) strategy for the health sector at national and provincial level based on formative research and other scientific evidence.
3. Health Education Cells should be established/ strengthened in all health departments at provincial/ area level as a hub for all population level interventions.
4. Investment in conducting formative research to monitor health behaviour, issues and testing of prioritized messages.
5. LHWs should be the centre of health-related communication campaign/ health education activities through inter-personal communication interventions, which should be aligned with other interventions at provincial/ area level through an integrated approach.
6. Advocacy level interventions at national, provincial and district level will highlight the importance of LHWs for effectively delivering health education messages and PHC services at community level.
7. Social mobilization campaigns by the provincial and district health offices will engage LHWs to mobilize communities and families in the catchment areas.
8. For Community mobilization, LHWs will play a central role in coordination with other community-based workers and organizations. With support of LHWs, communities will be better organized by strengthening of village health committees and women groups that will be engaged in decisions regarding health of their communities, families and individuals.
9. Institutional mobilization at health facilities will be improved with support of health departments and district health offices, while ensuring linkages between community and facility level interventions.
10. Health promotion activities will take place through an integrated approach by developing IEC material and both print and electronic media campaigns with a priority to PHC related behaviour.

11. Approaches at national, provincial and district level that translate BCC strategy into action will include capacity building activities, evidenced based scaling up of communication interventions, consumer based and research guided design, synergized mass media campaigns, public-private partnerships, resource mobilization, cooperate partnerships and regular monitoring and evaluation including formative research.

F. Procurement, Logistics and Supply Chain

Procurement and supply chains aims to improve access to healthcare, and this can be attained only when health commodities appropriate to the health needs of the target population are developed, manufactured, and made available when and where needed. The weak links in the health supply chains hinders the access of essential healthcare resulting in inefficient use of scarce resources and increase in morbidity and loss of preventable deaths. After 3rd party evaluation of the LHWs program, many existing bottlenecks in supply chains and health systems were identified which are mainly impeding the accurate forecasting of demand, and without the ability to forecast demand with certainty, the stakeholders cannot plan and make commitments for the future.

1. Considering the identified shortcomings, first and the foremost decision taken by all provincial/area officials is to continue/shift the procurement through the recurrent budget subject to the availability of sufficient funds.
2. The whole process of procurement will be executed following respective provincial PPRA departments. **AJ&K** and **GB** will be following federal PPRA rules in all types of procurement.
3. Regular capacity building of the existing and the newly inducted staff shall be made mandatory to keep the staff acquainted and for quality procurement.
4. For maintaining uninterrupted supplies, State of the art provincial warehouse will be established for LHWs' System out of the recurrent budget or through third party contracting. Dedicated and purpose-built stores will be put in place at district and health facility level by health departments.
5. Considering **Punjab** province as an example, the transportation from the warehouse to the health facilities will be preferably contracted out to 3rd party to rule out the problems faced due to delayed delivery of supplies.
6. For cost-efficiency, the procurement (rate contracting) shall be done at provincial/area level, however the districts will be involved in the forecasting exercise so that the exact demand can be put forth. Along with this, capacity building of the districts particularly on forecasting and quantification techniques will be planned in order to bring them at par with provincial capacity.
7. **Punjab** and **Balochistan** provinces may introduce E-Procurement at provincial level first and later on at district level under the provincial PPRAs.
8. Procurement of contraceptives particularly imported items and vehicles may be done via pool procurement, if consensus is built.
9. **AJ&K** will be adopting open competitive bidding and direct Contracting for procurement of contraceptives and vehicles respectively.
10. **Balochistan** province will be practicing direct procurement method for vehicles procurement under provincial government rules.
11. **Sindh** province will opt for an open competitive bidding and have decided to continue to procure contraceptives through PWD jointly and vehicles through development budget.
12. Apart from provision of generic medicinal supplies, LHWs do provide FP commodities in the community which used to have an imprinted logo on the box. This practice shall continue with the same printing/ colour coding all the boxes and bottles, including instructions in Urdu language for their ease.

13. Inclusion or exclusion of new items in essential medicine and equipment lists of LHWs will be done at provincial levels. Further, **Punjab** and **Sindh** added that Provincial program management and technical leads of departments will also have a say in this decision.

14. To bring innovation in the procurement process and to make it more efficient, **KP, AJ&K**, and **GB** will be developing and implementing online LHW-MIS. Whereas in **Balochistan** and **Punjab** where a manual LHW-MIS system already exists, digitization of the information system is being considered as a next step. Following this, all other present online information systems like cLMIS, vLMIS, MNCH-MIS, DHIS and LHW-MIS will be integrated for ensuring end to end data visibility and developing further proficiency. A third-party IT firm or relevant development partners will be engaged for this desired action.

G. Financing

A well-functioning health financing system ensures that people can access the health services they need without suffering financial hardship and that resources are used efficiently and equitably. The financing of both public health and healthcare activities is essential, complex, and subject to substantial variation. The LHWs system lacks enough budgetary support by the government thus effecting its major tasks, which is ultimately leading to poor performance.

Fifth evaluation of the LHWP has indicated serious expenditure imbalances between the salary component and health system support. With rising inflation, there is risk of further worsening of the situation. For health services to run effectively and efficiently, optimal allocation and timely release of budget is a prerequisite.

1. Appropriate medium-term budgeting and costing exercise will be done at provincial/ area level, while considering scaling up of interventions and inflation rate.
2. A substantial budget will be allocated for the implementation of activities. This whole budgeting process will be done via conventional course of action for what capacity of the HR will be build, through MTBF or recurrent budget.
3. Depending upon provincial/ area priority, the funds will be channelled either through development or recurrent budget.
4. Donor budget support, if any will be channelled from State Bank to account 1 of the provincial/area governments, whereas in kind support and technical assistance could also be worked out at national or provincial level.
5. The donor community may be requested to support the Health department by investing (preferably recurrent side or in-kind support) and filling the financing gaps. New interventions through LHWs may also be implemented with support of development partners initially and sustained with government financing later on.
6. A mixed approach can also be adopted i.e., Components like salaries and operational cost will be drawn from recurrent side, whereas activities like procurement can be financed through the development side.
7. The unit cost in line with any revised scope of work of LHW shall be calculated before going into expansion. Non-salary component should be given equal importance to salary component.
8. Provinces/areas will practice decentralization and devolution of funds flow through DHO and each district is going to oversee their respective financial component of the program. However, the power of decision-making regarding purchasing of commodities shall remain with the Provincial department.
9. For auditing, despite existence of multiple mechanisms in the government, provinces/areas will also hold a third-party review in addition to routine audit.
10. Fiduciary risk mitigation plan and public financial management (PFM) improvement plans will be developed and implemented by all health departments.

Financing Sources

Currently the system is financed out of taxation (domestic, and to a small extent international – foreign donors). The principal alternatives to financing the systems are:

- Taxation for public expenditures – distributed to the federal and provincial governments as per National Finance Commission Award
- Budgetary and technical assistance from development partners and CSOs
- User charges (contraceptive sale receipts)

The funds are channelled for the LHWs' System through federal funding, known as Public Sector Development Programme (PSDP) or Provincial Annual Development Programme (ADP) or Recurrent budget. Funding for the LHWs System has now ended at provincial level and activities are mainly supported through the recurrent budget. At this stage funding for AJK, GB are still through development budget and will soon be replaced with recurrent budget. As LHWs' system funding across the provinces continues to stabilise - the provinces have assumed full financial responsibility for the funding of the LHW system.

The LHWs offer free of cost services in the community. However, as per previous policy, she is allowed to keep the sale receipt of contraceptives as an incentive.

H. Innovations

Innovation, is referred to something new or to a change made to an existing product, idea, or field that result in the introduction of new goods or services or improvement in offering goods or services. For LHWs system, innovations will be made in all building blocks of the system. Some of such innovations will include:

1. Innovations in service delivery: Some of the global best practices have been included in EPHS (community level) which will be implemented through LHWs. However, these new services will preferably be pilot tested initially after getting approval of Technical Review Committee. These interventions will be scaled up, once successful results are available for decision-making.
2. Innovations for capacity development of human resource: New digital technology may be used for imparting training. Especially during health emergencies, digital media may be used for capacity building of LHWs, LHS and other health staff. Communication innovation may also be strengthened by using internet, what's app and other digital platforms.
3. Innovations for health information: Digital technology may be used for data entry even at LHWs level by providing tablets with specific software, provided availability of internet facilities or alternate options. Different information systems may be linked digitally for quick use of information and decision making at different levels.
4. Innovations for medicines and health technologies: E-procurement may be used to make quick, efficient and transparent decisions related to procurement and supply chain
5. Innovations for health financing: Digital technologies may be used for quick disbursement of funds and financial monitoring.
6. Innovations for Governance and Leadership: Digital communication may be used for review meetings and consultations using digital technologies.

These are only some examples and evolution of new technologies will be used in the LHWs system for improvement in offering goods and services.

RISKS AND MITIGATION MEASURES

The health portfolio including Lady health workers' system in Pakistan is ambitious, challenging and of a high-risk category. There has been much uncertainty in the sector since devolution 2011 and also considering the current political, security and economic environment. Recent reforms in the health sector including transfer of PHC vertical programmes from development to recurrent budget, uncertainty on the implementation of EPHS and need for urgent organizational restructuring also enhance the risks which needs to be mitigated appropriately.

To mitigate the main risk, there is a need to carefully monitor and have risk mitigation measures, where ever possible. Risk mitigation can be strengthened by the strong leadership role of the government in the sector, supported by technical assistance from partners to enable system strengthening.

Risk mitigation is also a requirement for the development and implementation of community level essential package of health services and more specifically the Lady Health Workers' intervention. Considering importance of risk assessment and mitigation, the Ministry of National Health Services, Regulations and Coordination decided to jointly assess the risk in the health sector and the LHWs' Intervention as a part of the strategic planning exercise.

Main risk to the health sector in Pakistan are as following which needs to be reviewed on annual basis (preferably on six-monthly basis) at national and provincial level:

A: Political Risk

B: Conflict Risk

C: Economic Risk

D: Fiduciary Risk

E: Corruption Risk

F: Institutional Risk

G: Partnership Risk

H: Behavioural Risk

I: Disasters Risk

These risks are considered to be manageable up to certain extent. The summary risk table below indicates that the overall current risk in the health sector and the lady health workers' system in Pakistan is High.

Table: Summary Risk Matrix in 2021-22

RISK		Impact			
		Low	Medium	Substantial	High
Probability	Low				
	Medium		I	H	
	Substantial			F,G	A,D,E
	High				B,C

These risks should be monitored regularly and appropriate mitigation measures should be taken, which may result in Residual risk to be **MEDIUM**.

Table: Summary Risk Matrix in 2021-22 with Mitigation Measures

RISK		Impact			
		Low	Medium	Substantial	High
Probability	Low		H,I		
	Medium		F,G	A,B	D,E
	Substantial			C	
	High				

Key:

RISK PROBABILITY/IMPACT

- : High
- : Substantial
- : Medium
- : Low

PROGRESS

- : Negative trajectory
- : Static
- : Positive Trajectory

Risk Matrix for the Health Sector/ the LHWs System in Pakistan – January 2022

Main Risk	Mitigation Measures	Progress	Probability	Impact	Future Actions	Trajectory
A. Political: Lack of political commitment to own the health sector development at national and provincial level	• Implementation of NHV 2016-25 and SDGs/ UHC agenda/ EPHS/ LHWs strategic plan to contribute effectively to support stability, political process, economic growth and development. • Have a regular dialogue at the highest political level in the sector. • Highlight health service delivery and health related SDGs/UHC as a key pillar of health	• The political will of the government in health sector has been expressed in the National Health Vision 2025, SDGs/ UHC agenda and other policy documents including LHWs strategic plan. • M/o NHSR&C took a proactive role to finalize different policies, strategies (including LHWs strategic plan) and plans in the country covering different aspects of universal health coverage (UHC) and monitoring. • NHV 2016-25 and the 12 five-year development plan have been developed. Provinces/ areas health departments have developed/ are developing new health sector strategy. • Inter-ministerial Health & Population Council is functional and meeting regularly. Multisectoral governance mechanism for COVID19 is functional. • An SDGs committee has been formed in the parliament along with standing committees on health both in national assembly and senate.	**Medium to High**	**High**	• Implementation and regular monitoring of SDGs, UHC and NHV to generate evidence on the progress. • One of the neglected policy areas is non-communicable diseases. Development and implementation of the NCD & mental health action plan should be a priority for the ministry/ health departments, so as to cover all strategic aspects of the UHC. • Development of Health policies/ costed strategic plans in all provinces aligned to 12 five Year Development Plan, NHV, SDGs and UHC. • Organize regularly the inter-ministerial H&P Council meetings. Develop National & Provincial Health Sector Coordination mechanism, • Regular interaction/ briefings to the parliamentary committees on health / SDGs related reform agenda.	**On track**

	reform agenda during political interaction. • Prioritise health in the new legislation and to empower authorities to perform health functions smoothly. • Provide high quality advocacy and technical assistance to build capacity of the provincial/ area health departments and district governments. • Ensure political will of the government towards health of its people through enhanced health sector expenditures in the public sector. • High level advocacy through multiple channels to scale up cost effective	• Legislation on Federal healthcare authority approved in 2018. Previously legislation to form healthcare commission in Punjab, Sindh and KP were also approved. • M/o NHSR&C developing consensus on different aspects of SDGs (including UHC Benefit Package of Pakistan and LHWs strategic plan) through coordination with provinces/ areas and other stakeholders under different fora and highlighting investment in the health sector through an integrated approach as a major development pillar. • Public health expenditure in Pakistan increased from the lowest of total government expenditure equivalent to 0.23% of the GDP in 2010-11 to >1% of the GDP at present. However, still the target of GHE to a level of 3% of the GDP by 2025 is very challenging. • In coordination with UN and donors, high level advocacy is being carried out to support the sector to express political commitment towards achieving			• Consider to work on UHC legislation. Legislation to form healthcare commission in Balochistan, AJK and GB in addition to other legislative measures. • Continue regular dialogue with the provincial and district political and technical authorities and make efforts to further strengthen the coordination mechanism at different levels for effective and efficient people-centred integrated health services. • Cross the milestone of total GHE equivalent to 1.5% of the GDP in 2023. Ensure more investment at community and PHC centre level with appropriate referral system. • Avoid fragmentation in the health sector response to ensure equity and contribution to peace building agenda. Also strengthen district health system with true devolution of decision-making	

	interventions in the health sector.	SDGs and UHC (including LHWs Intervention).			process within the framework of UHC.	
B. Conflict: Conflict and security concern poses a threat to the programmatic interventions	• With improvement in provision of quality health services to all, contribute effectively to incentivise peace and stability process in the country. • Capacity building and application of 'Do No Harm' principles. Provide continuous review of the local contextual analysis (socio-cultural, political, institutional, conflict, etc.) • Extensive consultations at all levels and using participatory processes • Ensure good quality integrated essential UHC services to communities with maximum coverage. (Communities with UHC are likely to be more resilient).	• Achieving UHC and mitigating epidemics of COVID19 and dengue are the key strategies also to ensure contribution towards peace-building and stability in the country. • M/o NHSR&C is leading the inclusive decision-making process with technical support and advice from UN agencies and partners. Strategies, plans and interventions are based on assessments and reviews to carefully analyse the context and to avoid any conflict. • Some governance structures have been activated since after devolution to ensure consensus building at national level through a participatory process. • Provision of integrated and essential UHC services are being worked out for more effective coverage along with launching of new interventions.	**High**	**High**	• Review the governance and service delivery structures for more effective delivery of UHC and mitigating health emergencies. • Conduct conflict sensitivity assessment in the health sector, if possible. • Strengthen health sector reform/ UHC units at national and provincial level, including research teams/units, to conduct local contextual analysis on a regular basis. • Review and establish more effective national & provincial health sector coordination mechanism and other governance structures at all levels while ensuring effective participatory process. • Efforts are required to sustain integrated quality services at local level and to set the example of early nation-building as people start to see and experience the 'state coming to their village/ community and providing quality services'.	**Static**

	• Share information about programmatic achievements, progress and challenges with the general public using media channels and involve them or their representatives in decision making processes • Strengthen people's voices and consider their point of view in strategic/programmatic choices and decisions • Establish and strengthen regulatory and quality assurance systems to build trust of the people on the services. • Effective coordination among partners to meet health needs, also in the conflict affected areas • Federal government to play a proactive role to ensure equity in health and support the poor performing provinces/ areas.	• Some BCC interventions are being implemented. • Data is collected as part of different assessments to understand people's point of view for programmatic choices. • Some regulatory and quality assurance systems are working but a lot more is required to be done with full force implementation. • Pakistan successfully established the 'health cluster' system with support of WHO during earthquake in 2005, during floods in 2010 and now multisectoral governance mechanism to control COVID19 epidemic. • The federal government is providing some support to the health sector in hard to reach and socioeconomic areas.			• Develop and implement BCC strategy through effective demand creation interventions. Use carefully the electronic and print media to deliver messages identified in the BCC strategy. Establish BCC units at national and provincial level. • Comprehensive websites/ media interventions should share updated information with the general public and stakeholders regularly. • Gradually scale up investment in establishing and strengthening regulatory bodies along with continuous capacity building. Healthcare commissions to be made fully functional in all provinces. • Regular interaction and capacity building of the emergency health teams to deal with any crisis's situation, focusing more on conflict affected areas. • Enhance presence of federal and UN schemes in hard to reach and security risk areas. Have a close eye on the political developments in the country as these may have a serious impact on the security situation. Health	

					sector activities needs to be adjusted accordingly.	
C. Economic: Poor economic situation of the country and inadequate availability of required public funds for the social sector	• With current governments at federal and provincial level, advocate to enhance investment in human development (including health, population and nutrition) for capital gains. • Ensure cost efficiency and effectiveness for provision of integrated quality essential UHC services with maximum coverage. • With partners continue supporting the financial management system at different levels for effective reforms. • Advocate for the pooled funding mechanisms in line with the Paris Declaration and to avoid duplication of activities	• Since devolution in 2011, there is significant increase in public sector expenditure in health sector reaching to a level of >1% of the GDP. However, the target of public sector investment in health to a level of 3% of the GDP is still very ambitious target, considering economic situation in the country. • Health Insurance programs launched in addition to development of EPHS at national and provincial/ area level. • With support of partners, there are opportunities to strengthen financial management systems, having positive impact on the health sector also. • Pooled funding options are working for EPI, Polio and other health priority interventions.	**High**	**High**	• Continue to highlight the importance of government financing in the social sector and especially in health. • Continue enhancing coverage of essential health services and health workforce, while prioritizing integration of quality UHC services. • Carry out the public expenditure review in health sector on a regular basis and proactively share financial information with stakeholders to ensure transparency and to avoid duplication of activities. • Develop and implement joint TA plan for UHC interventions. Pool funds for implementation of EPHS.	**Static**
D. Fiduciary: High fiduciary Risk in the health sector	• Releases of funds using government financial systems, procedures and risk management systems	• Fiduciary risks are mitigated mainly by using the government financial systems and procedures. • Government and UN/WHO agencies transfer funds under	**High**	**High**	• Regularly review and use risk assessment reports in decision making. Ensure safeguard to mitigate risk.	**Static**

	• Regularly update fiduciary risk and help the government to implement mitigation plan and regular review of the financial flows • Ensure observations/ recommendations, arising from any audits, reviews and/or evaluations, are followed up upon and implemented where relevant, including investigations to assess irregularities • Apply globally accepted principles on anti-corruption and public procurement regulatory authority (PPRA) rules and regulations. • Routine liaison with partners on forecasting and spending to allow early detection of under-spend. • Ensure regular communication and advocacy with donors	Government Financial Management / HACT/ DFC guidelines. UN agencies regularly conduct risk assessment of implementing partners. • Government and partners agencies have a regular audit mechanism for the funds received and used. • Relevant procedures are followed both in the public sector and in partner agencies. • PPRA rules and regulations are applied in the public sector, while partners have their own protocols and procedures for anti-corruption / fraud. • Ongoing activity both in public sector and UN. • On-going activity			• Donors to regularly support Fiduciary Risk Assessment of the health sector, along with development of Fiduciary Risk Mitigation Plan. After completion of the review of Public Financial Management, technical assistance should be provided for developing and implementing Financial Management Improvement plans. • More investment in capacity development to strengthen financial systems of public health authorities based on findings of review/ audit. • Strengthen coordination with development partners through formal meetings and joint reviews.	

	• Develop and implement Resource Mobilization Strategy	• NHSP is being developed			• Generate more resources to deliver prioritized interventions	
E. Corruption: High corruption risk in the sector	• Major procurement and financial management using PPRA / UN rules & regulations • For public funds use government systems, while following good procurement, supply chain and financial management practices. • Provide disincentive to corrupt behaviour and early identification of corrupt activities. • Implementing anti-corruption interventions	• All major procurements are done using PPRA/ UN procurement and financial management systems. • Government PPRA rules are followed in the public sector, both at federal and provincial level. • Corrupt practices are immediately notified to investigate it further. • Third party monitoring systems are working in some cases. In addition, third party reviews are also carried out directly by donors.	**Substantial**	**High**	• Implement audit observations to further strengthen the financial management systems. • Close coordination with the government to introduce further reforms in procurement and supply chain system along with review of legislative and regulatory mechanisms. • Conduct FRA. A close coordination with donors is required in this regard. Zero tolerance to corruption should be ensured by all. • Third party monitoring system should be used more frequently not only to see progress of activities but also for transparent use of resources.	**Static**
F. Institutional: Weak capacity of the national, provincial and district offices and concentration of powers at the provincial level	• Coordination among partners and alignment with government's strategic priorities • Devolution to district and support districts through technical assistance on system strengthening and	• Draft 12th Five-year Plan and NHV & UHC framework offer development agencies and partners to align their investments with the government strategic priorities. • Real point of essential UHC package/ LHW intervention is district, which have varied degrees of power and weak institutional capacities. Patchy	**Substantial**	**Substantial**	• Institutionalize joint reviews and planning aligned to national strategic priorities. • Complete development of next generation of health strategies in all provinces. • Strengthen District Health Management Teams/ System and consider developing planning capacity at that level aligned with national and provincial strategic	**Static**

	setting planning priorities • More clarity and separation of roles and responsibilities between federal, provincial and district level of healthcare delivery system. • Strengthening federal, provincial and district capacity to monitor service delivered and support integrated essential health service delivery reforms. Regular review of the changes and help the governments to take evidence-based decisions. • Invest on human resource development in health to address gaps in the system	technical support is available to some. • Devolution of power from federation to provinces was ensured in 2011. However, there are still ambiguities on roles and responsibilities among different levels. • M/o NHSR&C and health departments are focusing more on prioritised and essential health interventions. However, there is a need to institutionalize an appraisal process to ensure prioritization of cost-effective interventions. • National HRH Vision. National HRH vision, EPHS and LHWs strategic plan have been/ are being agreed.		priorities in a more comprehensive way. • Political reforms would be critical in coming years before further institutional reforms in the health sector. Observe closely the work on political issues and be ready for institutional reforms in the health sector accordingly. • Review the governance mechanism of the sector and reinforce the leadership and ownership plus oversight roles and responsibilities of the health authorities at different levels. • Support HRH strategy development at provincial level and scale up investment in HR development, deployment and monitoring while ensuring needs of rural and disadvantaged population. Consider using diaspora/ digital health to fill gaps in HR. Ensure partnership with the private sector in this regard. Implement LHWs strategic plan in true spirit.	

G. Partnership: Weak partnerships and duplication of activities with other donors, government departments, private sector including general practitioners, and CSOs	• Encourage strong Public and Private Health Sector coordination mechanism • Provide technical support to health departments and district health offices to strengthen regulatory mechanism in consultation with all stakeholders. • Ensure strong coordination of UN agencies and Donors in the health sector • Encourage M/o NHSR&C and health departments to take a lead in aligning donor support with policy priorities under a single governance mechanism. • Align finances behind NHV and health strategies • Regular interaction with other sectors relevant to health sector.	• Public private partnerships (contracting out and working with general practitioners) are ensured for provision of service delivery with more effective leadership role of health authorities and backstopping of partner agencies. • The governance mechanism of the regulatory bodies ensures inclusive decision-making process and coordination with all stakeholders. • Development partners' forum in health sector is functional. • Interagency coordination forum is functional. • Implementation of NHV and health strategies should also be the top priority for partner agencies. • International Health Regulations (IHR) Task force/ governance mechanism for COVID19 formed and made functional with representation of other sectors.	**Substantial**	**Substantial**	• Continue supporting a transparent public private partnership mechanism. Make changes in the governance mechanism of the sector considering new realities and political decisions at constitutional level. • Review of Regulatory bodies and District Health Management Teams to be completed followed by restructuring (if required) and capacity building. • Review and develop National & Provincial Health Sector Coordination mechanism for further strengthening of coordination. • Make NHSC mechanism a reality and encourage joint planning, supervision, review, mutual accountability and monitoring activities. • Review and produce next generation of health strategies though an inclusive consultative process and align all financing behand the strategic priorities. • Hold regular meetings of IHR Task force for more coordinated response.	**On Track**

	• Support to the health emergency coordination mechanism with a lead role of the health authorities and backstopping from partners.	• Health cluster and multisectoral governance mechanism for COVID19 were exemplary in Pakistan in past.			• Invest in capacity building to manage health emergencies and to tackle any crises in future effectively and efficiently.	
H. Behavioural: Slow change in RMNCH & nutrition, communicable diseases and non-communicable diseases related behaviours and low utilization of health services	• Implement EPHS and develop consensus on integrated essential UHC package (considering DCP3 priorities and local needs) along with minimum service delivery standards. • Behaviour Change interventions supported through programmatic interventions and assessed through external assessments • Effective use of electronic and print media • Contextual analysis informing programme design and implementation includes a strong systematic gender analysis and analysis of local customs and beliefs	• Earlier, EPHS was developed in Punjab and KP but some key elements were missing. • Formative research completed earlier, followed by development of key BCC messages. • Weak use of electronic and print media for BCC • Contextual analysis is part of the assessment process before starting key activities. Once revised essential UHC package is rolled out, its standards need to be reviewed on a regular basis.	**Medium**	**Substantial**	• Implement national and provincial/ area integrated package of essential health services along with minimum service delivery standards and pilot test the same in selected districts. • Development and implementation of BCC strategy based on formative research. • Use electronic and print media for BCC agreed strategies and interventions. • Scale up community and population-level service delivery interventions to influence behaviours focusing on essential UHC along with monitoring of quality standards. • Generate more information and use for revisiting activities and strategies.	**On Track**

	• Regular clinical quality audits through reviews and disseminate results • Ensure availability of skilled human resources by developing human resource policies and plans with emphasise on motivation, career development and retention of health staff to serve remote areas.	• National HRH vision and LHWs strategic plan developed/ being developed.			• HRH policy and plans developed in all provinces/ areas. HR production and deployment interventions becomes a priority.	
I. Disasters: Disasters posing a threat to the routine programmatic interventions	• Highlight the importance of integrated essential UHC interventions while dealing with humanitarian challenges. • Support Disaster Risk Reduction interventions; and through partnership with health and nutrition clusters train health staff to deal with humanitarian challenges along with effective coordination with donors, availability of disaster preparedness and response plan and mechanism for sharing information with general public and partners.	• Health and Nutrition clusters taking lead on DRR interventions and capacity building. • Donors provided support for humanitarian interventions in case of crises. However, there is a need for resilience and development programmes to work in a harmonized way and learn lessons from each other.	**Medium**	**Medium**	• Early and complete roll out of essential UHC packages as early as possible so that services are available in case of any humanitarian crises. Closely watch possibility of drought/floods, epidemics and other crises and prioritise provision of immediate humanitarian services. • More advocacy and capacity building to strengthen humanitarian response while strengthening development and routine interventions. • Website operational and information available to all stakeholders.	**On Track**

BUDGET ESTIMATES AND UNIT COST

The budget estimates for LHW strategy plan provide an outline for the fiscal implications, whereas province/ area wise detailed information was also worked out. The estimates were produced considering milestones and recommendations agreed in the strategic planning exercise. However, detailed estimates will be produced at the provincial and district level at the time of implementation. In addition, this section does not provide any sensitivity analysis based on changes in the key drivers of the cost (e.g., salaries, supervision costs, training costs, pharmaceutical cost), however inflation rate at a rate of 8% was applied.

This section uses consolidated estimation of budget using the governments objective classification. This is followed by a unit cost approach for a "model" unit cost per LHW per year.

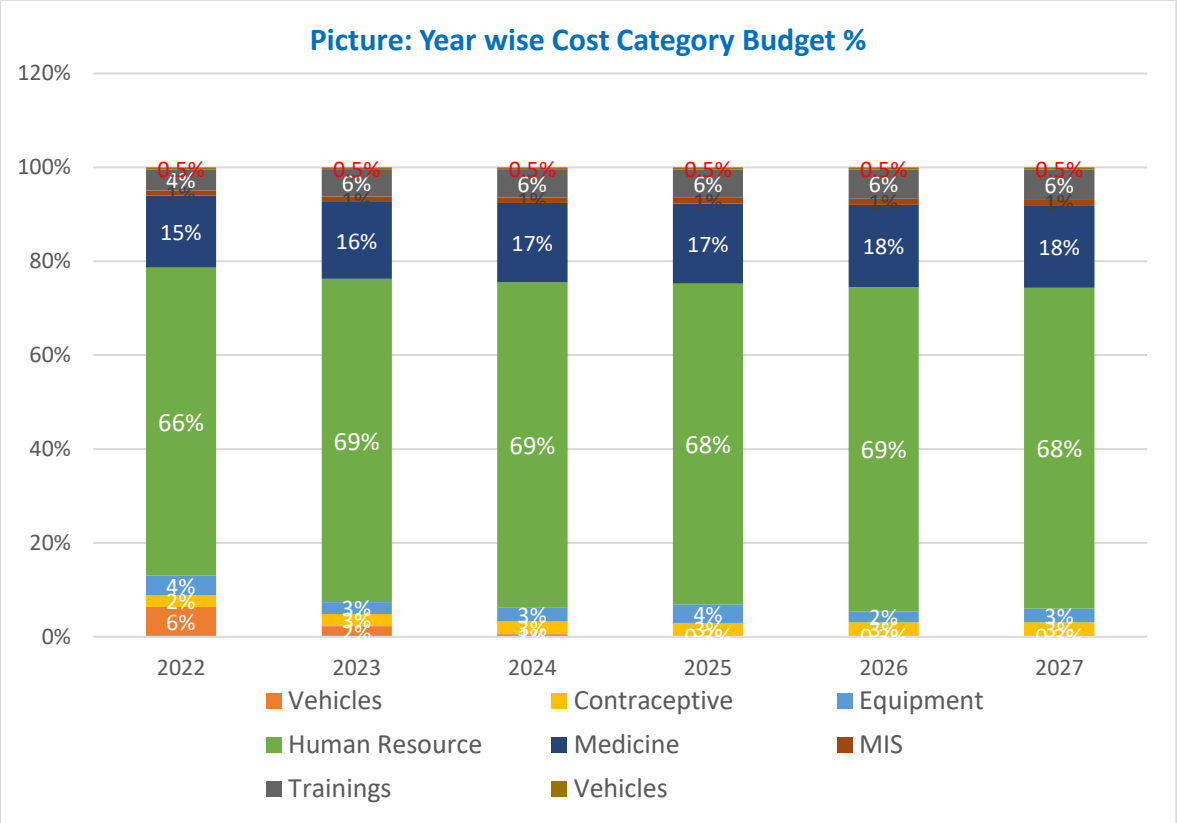
Annual Cost of the LHWs' System:

The 5th Evaluation showed that non salary inputs appear to be under-funded. The LHWs' system needs to allocate more resources per LHW, for quality delivery of essential health services and positive impact on the health status of people. A shortage of resources does not fully explain the difference between high and poor performing LHWs; however, it does contribute to it.

Annual budget estimates should rise from PKR 40 billion in 2022-23 up to PKR 73 billion in 2027-28. **Year wise cost estimates at provincial/ area level are as follows**:

Province/ Federating Area	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28
Punjab	18,932,386,652	21,869,406,683	25,536,671,545	29,701,616,502	30,591,743,927	32,493,290,618
Sindh	8,941,677,648	11,096,746,403	12,519,877,934	13,804,162,965	14,851,948,055	16,314,164,748
Khyber Pakhtunkhwa	6,891,704,755	8,775,007,883	10,728,653,704	12,378,297,570	13,892,476,835	14,628,773,270
Balochistan	2,722,120,939	4,517,773,403	5,115,869,014	5,411,430,579	5,618,091,930	5,967,189,101
Islamabad	528,316,275	339,048,799	509,580,529	600,151,398	587,500,074	624,004,301
Gilgit-Baltistan	613,656,445	689,957,063	880,171,784	1,031,902,226	1,073,065,164	1,138,355,926
Azad Jammu & Kashmir	1,714,767,773	1,359,819,613	1,625,449,378	1,996,367,953	2,050,427,359	2,177,746,027
Total	**40,344,630,486**	**48,647,759,847**	**56,916,273,887**	**64,923,929,192**	**68,665,253,345**	**73,343,523,991**

Approximate year wise share of cost components of LHW systems are shown below:



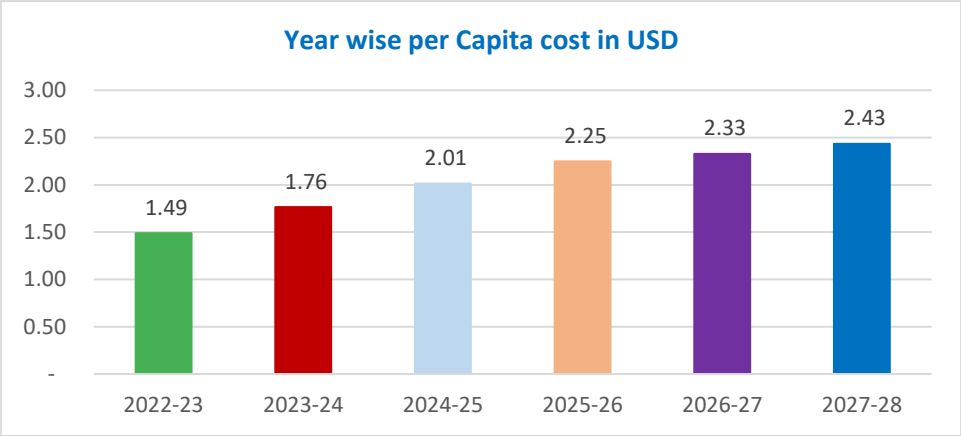
Unit cost (Per Person and Per Capita)

The Provincial/ Federating Areas EPHS/ UHC Benefit Package documents produced in 2021 are summarized as below:

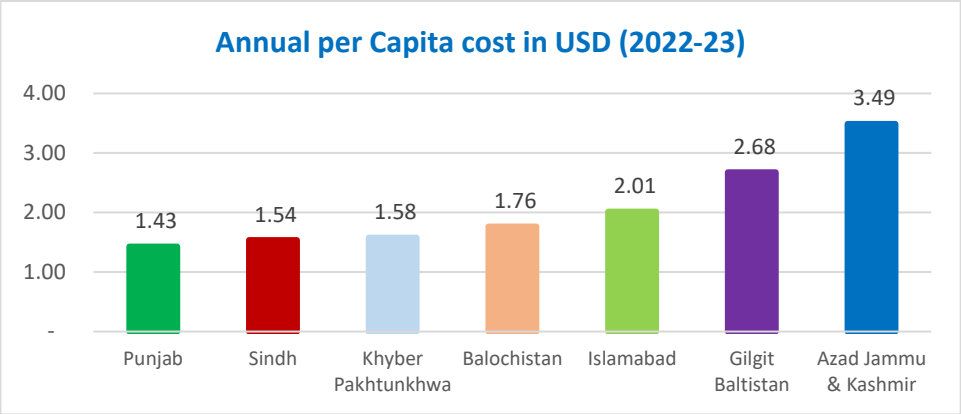
	Platform	Number of Interventions Range	Unit Cost US$ (person/ year) without inflation	DALYs avert [in millions]
District EPHS	**Community level**	19-23	3.12	3.52
	Special Initiatives	10-12	4.99	0.88
	PHC Centre level	35-39	3.23	7.6
	First Level Hospital	36-42	9.47	4.2
	Tertiary Hospital	22-25	6.93	2.1
	Population level	10-12	(0.79 National)	?
	TOTAL	**132-153**	**28.53**	**18.3+**

It is obvious that investment at community level (including LHWs, vaccinators and other community-based interventions), is only US$ 3.12 per person per year whereas DALYs avert is 3.52 million in 2021. By all means PHC level essential interventions are highly cost effective and avert more DALYs compared to first level and tertiary hospital essential interventions.

The cost analysis for the LHWs System (2022-28) indicate that the unit cost person will increase PKR 282.89 in 2022-23 to PKR 462.39 in 2027-28, while considering maximum 60 percent of the total population covered by LHWs, rising population growth rate and inflation rate. Year wise rise in per capita cost (in USD) is shown in the following table:



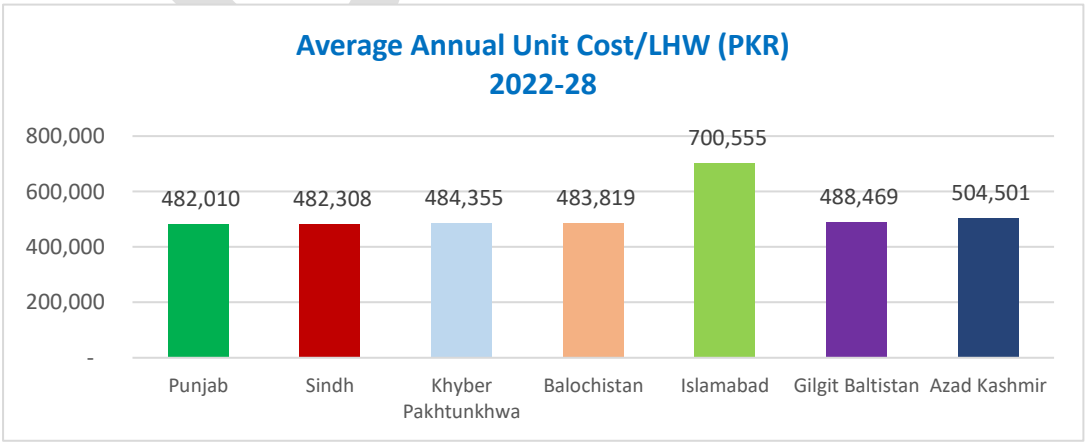
Whereas annual per capita cost (USD) for the year 2022-23 by province/ area will be as following;



The summary of year wise estimated unit cost per LHW during 2022-28 is as follows:

Financial Year	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28
Annual unit Cost/ LHW in PKR	**451,879**	**440,411**	**464,585**	**494,809**	**511,549**	**542,361**

Province wise average annual unit cost for each province is shown in the following figure:



Unit cost in Islamabad is the highest considering covered population with LHWs is the least at present and more resources would be required for expansion.

The cost estimates were based on the government objective classification for budgeting. The main components costed for LHW strategic plan 2022-28 are:

a. Human Resources
b. Equipment
c. Contraceptives
d. Medicine/Drugs
e. Trainings
f. Vehicles
g. Operational Expenditure
h. MIS tools

A: Human Resources:

The latest Government Basic pay scales 2021-22 were used to estimate the budget required for the human resources as defined in the strategic plan. As per the new pay scales and the deliberation/discussion with the provincial governments, the average monthly pay of the LHW was Rs. 22,394 in 2020-21. If the LHWs were to maintain on the same scale their salaries would be increased by 5% each year. In addition to LHW, LHSs, Accounts Supervisors and Drivers were also costed.

B: Equipment

Each LHW is issued a set of non-drug items: Thermometer, LHW Kit Bag, Health House Board, Pencil Torch with battery cell, Bathroom scale for antenatal/ childcare, Scissors (Stainless), BP Apparatus, Stethoscope, Baby Weighing Scale, Salter Scale, MUAC Tape for Children, MUAC Tape for Mother, ARI Timer. These are the capital items that need to be replaced when they wear out / as per guidelines. With the deliberations of Health Departments, all the above-mentioned items were listed, and their duration of replacement mentioned on each item and then the 2020-21 prices were used to cost these items.

C: Contraceptives

Each LHW is issued with set of following contraceptive items: Emergency pills, Condoms, Oral Contraceptive pills, Injectable contraceptive (3 Months). These are consumables items which are replenished on monthly basis to each LHW. The average prices are taken from the latest procurement of Provincial Population Welfare Departments for the year 2020-21.

D: Medicines/Drugs

LHW`s are issued with the set of medicine/drugs and supplies for the service delivery in her community. The list of medicines is taken from the Essential Package of Health Services (EPHS) community platform medicine list with the consensus from the Health Departments. The procurement prices for 2020-21 were used to calculate the cost of each medicine, notwithstanding the lack of knowledge on quality.

E: Training

LHWs and LHSs should adequately be trained to perform their roles. The Health Departments have to recruit and train new LHWs and LHSs to fill the vacant and new positions. The refresher training will be provided to remaining all LHWs and LHSs – 15 days per year. The duration of the training, prices, allowances used in costing exercise were agreed in the deliberations at provincial/ area level.

F: Vehicles

1 vehicle (Suzuki Ravi) is costed for each LHS @ 1,000,000/vehicle which is inflated @ 8% per anum over the next 6 years. The price of the vehicle was taken from the Suzuki in Oct-Nov 2021. The ratio of driver to LHW is 1:25.

G: Operational Expenditure

As per the deliberations with the health departments, an amount per driver for POL and repairs was suggested on the average km travelled by an LHS in a month and 40 litres of fuel was costed for each vehicle per month on the standard maintenance norms of vehicle.

H: MIS Tools

LHWs are issued with the set of MIS Tools: Registers, Pads, Dairy, Posters, cards etc. These all are consumable items which will be replenished on monthly basis. Use of digital technology will be used where feasible.

ANNEXURE

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