

# *External Evaluation of the National Programme for Family Planning and Primary Health Care*

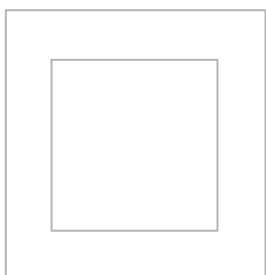
*Lady Health Worker Programme*

*Management  
Review*

Oxford Policy Management  
August 2009

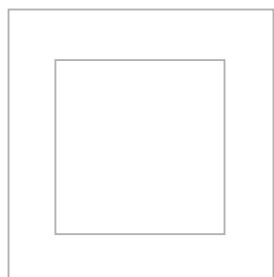






# *Lady Health Worker Programme*

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## **Management Review**

**Oxford Policy Management  
August 2009**



## **Reports from this evaluation**

1. Summary of Results
2. Management Review
3. Systems Review
4. Financial and Economic Analysis
5. Quantitative Survey Report
6. Punjab and ICT Survey Report
7. Sindh Survey Report
8. NWFP Survey Report
9. Balochistan Survey Report
10. AJK and FANA Survey Report
11. Lady Health Worker Study on Socio-Economic Benefits and Experiences

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# Executive summary

## Introduction

The review of management and systems is one of the areas covered by the 4th Evaluation of the National Programme for Family Planning and Primary Health Care (Lady Health Worker Programme). This 4th Evaluation of the LHWP, by Oxford Policy Management (OPM), began in December 2007 with the objective of evaluating the period covered by the PC-1,<sup>1</sup> from July 2003 to June 2008.<sup>2</sup>

### **The purpose of the 4th Evaluation was to explore whether the Programme had:**

- provided the level of services promised;
- to quality standards;
- to the agreed level of coverage;
- including the poor;
- with an impact on health; and
- at a reasonable cost;
- improved performance since the 3rd Evaluation (2000); and
- implemented the organisational developments planned in the Strategic Plan (2003–11) and the PC-1 (2003–08).

### **The objectives were to:**

- provide the Ministry of Health (MoH) and other stakeholders with accurate, credible and usable information on the performance of the LHWP;
- explore the determinants of performance;
- document the socio-economic benefits to the Lady Health Workers (LHWs) and the Lady Health Supervisors (LHSs), their families and communities of working with the programme; and
- provide findings and policy options which enable the Programme to further strengthen its performance.

## Management and systems review

The Management and Systems Review is presented as two reports.

The Systems Review Report provides findings on the performance of selected core systems using the targets in the Strategic Plan and the PC-1. These systems include: selection of LHWs, training, logistics, salaries and payments, performance management, transportation, and MIS.

The Management Review report evaluates seven key areas of management that were identified by the Programme managers as important to successful programme implementation:<sup>3</sup>

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<sup>1</sup> The core planning document of the Programme.

<sup>2</sup> The most recent independent evaluation of the LHW P was commissioned by the Ministry of Health in 1999, and implemented by Oxford Policy Management. This was the 3rd independent LHW Programme Evaluation. The key conclusion of this evaluation was that the LHWP had managed to buck the international and national trends of poor performing Community Health Worker Programmes and was, in fact, providing a service that had an impact on key health indicators.

<sup>3</sup> The evaluation team's main concern was to provide useful feedback to the management of the Programme on issues that they considered a priority. These questions were agreed with the Programme Management in March 2008.

- Do the management controls of the Programme support the implementation of the Strategic Plan and the PC-1?
- How has innovation and quality improvement been managed?
- What have been the benefits and tensions of expansion from 37,000 LHW to 90,000 LHWs?
- Has expansion led to greater coverage in remote areas and to poorer families? And, if not, what are the issues?
- How well has the Programme been implemented across different levels of government?
- How well has the LHWP been integrated with other Primary Health Care Programmes?
- Has the Programme managed to deal effectively with non-performing LHWs?

## **Management review findings**

The following is a summary of the main findings in response to each of the seven questions of the management review. They should be read in the context of Chapter 3 of this report which provides an overall judgement of Programme performance made on the basis of the findings from the quantitative survey, qualitative studies, the management and systems reviews and the finance and economic analysis.

### **1. Do the management controls of the Programme support the implementation of the Strategic Plan and PC-1?**

- While the Programme has nearly 90,000 LHWs working in their communities there has not been full implementation of the directions and key activities of the Strategic Plan and PC-1. This is attributable to a failure of governance processes and management control rather than a systems failure.
- There was insufficient strategic control of the Programme, to drive it into the planned Phase 2 outlined in the PC-1. This was both because of the absence of strategic review mechanisms (including not holding a mid-term evaluation and not convening the relevant high-level committees) and the high management turnover.
- The non-functioning of these committees left the programme vulnerable. The committees if fully functional would have been able to provide decision-making space for the Programme where important issues could be debated and determined. The committees would have been in a position to influence the appointment of experienced and motivated managers in the Implementation Units.
- In addition, the position of National Advisor remained vacant after September 2005. The purpose of this position had been to support the Programme in coordinating activities with the provinces in planning and piloting strategies for the future.
- Once Federal Government commitment and funding was assured through the approval of the PC-1, issues of sustainability and decentralization were clearly no longer a priority. However, the Programme has to manage for risks of a policy reversal that could put goals of poverty reduction and health improvement by a Programme operating at the grass roots at risk. For example, social sector investments being routed through provincial government and district government Annual Development Plans.
- To guarantee the provision LHW services there will always need to be some financial commitment from the federal government with a requirement for performance and adherence to the Programme's performance and quality standards. The Programme needs to increase its accountability. Annual reporting against key performance indicators has been weak or non-existent.



- The senior management positions in the MoH and the Programme have been subject to high turnover during these five years. Frequent changes in leadership in both the Ministry and in the Programme does not help with the implementation of any systematic appraisal process of senior programme managers. It is difficult to see how newcomers can hope to grapple with strategic issues within a one to two year time frame.
- To provide the Programme with the necessary control the senior management of the FPIU must be able to:
- Communicate the vision and the priorities of the Programme to the different levels of government, the community, those working managing the Programme and LHW
- Challenge norms both in the public service and the community that are barriers to the implementation of an effective service.
- Enforce compliance with Programme policies and standards.

## **2. How well have innovation and quality improvement been managed?**

- Planned innovations and quality improvements happen where the solution is under the Programme management's direct control and particularly is that solution is deemed to be training or conducting a pilot study.
- While most initiatives planned during the period under review were not implemented, those designed for improving the performance of the LHW were, and had the desired result.
- The processes for addressing the range of services of the LHW, as described in the Strategic Plan and the PC-1 were not utilised. The Programme Review Committee, which was to give approval for the involvement of LHWs in new areas, did not meet. Policy guidelines on clinical priorities and efficacy were not developed.
- The Technical Committee for Innovation was formed to give authority for pilot testing and evaluation of proposals for new services. It is unclear as to why the Programme management delegated this authority to a committee with external stakeholder membership.
- Most pilot studies were conducted in collaboration with development partners and a couple with other health programmes. However it is not obvious that these were selected on the basis of the priorities of the Strategic Plan. Several initiatives were adopted that initially were pilot studies; e.g. Injectable contraceptives, counselling cards and child health cards.
- Additional refresher trainings were developed and implemented in the period covered by the PC-1. They focused on maternal and child health; counselling skills and nutrition, all core skill areas of the current LHW curriculum. The evaluation has proven the success of refresher training in improving knowledge and performance of LHWs, particularly the training in counselling cards, food and nutrition and MIS tools.
- In addition to the refresher trainings planned and organised by the Programme there are a significant number of LWHs attending additional trainings many of which have not been approved by the Programme at the national or provincial level. It is important that the Programme maintain quality control of the LHWs knowledge and skills through approving training programmes to be attended by LHWs. The process for approval does need to be responsive to the needs of the districts where they are wishing to strengthen the LHW with in her defined role.

## **3. How well has the Programme been implemented across its different levels?**

- The Programme design of implementation units and the means by which they are integrated into the Ministry and Departments of Health and district government has proven successful in establishing a grass-roots community service.

- The government and the managers of the Implementation Units know the procedures, policies and standards of the Programme even if at times there is a lack of authority to enforce compliance and to deliver sanctions for non-compliance. One solution to this weakness is the functioning of oversight committees of senior people who have influence to promote the benefits of compliance to support the resolution of difficult problems. Another is for senior management to be able to deliver more effective sanctions to non-compliant districts and provinces.
- The Programme did not pilot different models for Programme operation in different districts, as it had planned to do after 2005.
- Different service delivery models implemented by the provincial or district governments can have an impact on the integration of the Programme as an outreach service delivering public health services. For example, the contracting out of Basic Health Units. It is important that different service delivery models allow for the benefits of integration to be retained.

**4. How well has the LHWP been integrated with other Public Health Programmes?**

- Federally funded primary health care programmes are designed to address issues that are of national priority. It is not possible to implement these programmes without the collaboration of the provincial Departments of Health and the district Health Offices.
- It is reportedly difficult to achieve policy coordination amongst the MoH's public health programmes. The PC-1 planning process, which essentially locks in activities, does not support collaboration and inhibits flexibility and responsiveness. In addition, Programme manager report spending a lot of their management time attempting to get permission from higher authorities for initiatives that appear to be already within the framework and intent of the PC-1.
- Coordinating public health services at the district level is the responsibility of the EDO-H: the day-to-day operation of the public health programmes is managed by his management team members, with whom he holds regular meetings. If there is a District Health Plan, then the LHWP is typically included in it and the District Assembly will have reviewed the plan.
- The EDO-H reported that the LHWP fit best with district health priorities of mother and child health care, family planning and National Immunisation Days (NIDs). Across the country there was consensus between District Coordinators (DCs), LHWs and LHWs that the Programme's top priority was maternal health, child health and family planning.
- LHWs are spending a significant amount of time on NIDs in collaboration with the EPI programme. This activity is the result of commitments made by the government to the World Health Organisation to participate in the international goal of polio eradication. Working on NIDs does not have a negative impact on the LHW's performance however nearly half of all LHWs are working outside their catchment area on this activity, which is against Programme policy. The high commitment in time required by LHW for NIDs needs to be monitored to ensure that other core priorities are not displaced.
- The EDO-H and his DC of the Programme manage the LHWP. Many of the EDO-Hs attend, even if briefly, the monthly LHS meetings chaired by the DC.
- There will always be a tension between the prescribed solutions that address National Health Priorities and the need to have some flexibility in service delivery to cater for district priorities. However there appears to be consensus between the district health management and the LHS and LHWs that the focus on service delivery should be on maternal and child health and family planning. While district managers would like an increase in budget allocation and salary incentives, there does not

appear to be a conflict between district health primary health care strategies and the Programme.

**5. Has expansion led to greater coverage in remote areas and to poorer families?**

- Through the Strategic Plan and the PC-1, the Programme is explicit in its intention to extend coverage to under-served areas and to poorer families.
- Recruitment targets were not met. None of the provinces had fulfilled its actual allocation as planned, by June 2005, or by June 2008. Registrations per LHW were lower in 2008 than in the previous evaluation of 2000. The average number of clients registered per LHW has dropped from 980 to 929 and the number of households registered from 145 to 133. The number of clients who knew their LHW was even lower at, 863.
- There has been a significant increase in the number of health facilities that have LHWs attached to them. The survey found that the Programme has expanded over the past 10 years, to serve populations that are somewhat more disadvantaged, on average, than those that they were serving at the time of the last evaluation. This is an important achievement. However, the population that remains unserved is significantly more disadvantaged still, and efforts must be made to cover those areas.
- Implementation strategies designed to increase coverage to under-served areas and to poorer households were not implemented in the life of the PC-1. This includes the plan for condensed education courses for areas with a shortage of educated applicants for the post of LHW and the development of incentives to ensure under-served areas are covered. The sheer increase of numbers of LHWs in some districts has probably been the main force in expanding into under-served areas.
- Districts provided a number of reasons as to why facilities remain unserved that include: lack of educated women; more than one facility/union council; the facilities are actually MCH centres or dispensaries; trainers not available; health facility accommodation not appropriate; remote area; and the catchment area is served by LHWs attached to another facility. Four out of five districts reported that they had unserved health facilities where this was happening.
- While in accordance with Programme policy, there has been a reduction in the overall number of LHWs working in urban areas. However, Punjab and Balochistan recorded an increase in the number of urban LHWs.
- There is a wide variation between the PSP database record of the number of allocated positions for each district as of June 2008 and those reported by the districts. Nearly 30 percent of sample districts had over 50 percent difference. As the overall number of allocated posts for the province remains the same, this could indicate a lot of fluidity in the allocation of posts between districts and within provinces, as well as outdated information in the PSP database.
- District micro-planning is the mechanism for determining allocation of LHW positions and planning how to resource the necessary monitoring and supervision. This annual process provides the opportunity for the Programme to ensure that the district is acknowledged for extending the Programme into difficult areas. The main incentive on districts is to recruit to their targeted allocation of posts, which results in a tendency to recruit LHWs to those health facilities already engaged in the Programme. Additional resources are required in order to support districts in expanding into difficult areas.
- The LHW now has a positive reputation in many of her communities, which should support her gaining access with community support to poorer families. She should be given further support to cover poorer families in her catchment area. The Programme is able to communicate key priorities for services. It will also be able to use its

communication channels backed up by supervision to provide the message that poor families need greater support.

- Increased collaboration with other organisations that provide basic safety nets would enable the LHW to provide services to the very poor.

**6. What have been the benefits and tensions of expansion from 37,000 LHW to 90,000 LHWs?**

- Given concerns about financing and management capacity being insufficient for Programme expansion, the Strategic Plan proposed a review that would include the options of reducing the target number of LHWs or allocating more resources, or modifying the level and package of services being provided by LHWs. It is not clear that these options were in fact reviewed. Rather it appears that the target of 100,000 LHWs was just retained and more resources were allocated.
- Proposals for expansion of the Programme by Government need to consider the implications re: funding, sustainability, the opportunities for increasing coverage into remote areas; the functioning of health facilities and the organizational capability of the Programme.
- The greatest period of expansion was between 2001 and 2003. The rate of expansion since then has slowed considerably.
- While provincial allocations remain fairly constant there is an uneven pattern of expansion between districts. In comparison with 2003, 13 percent of districts had fewer LHWs in 2008. A further 20 percent had only increased by within 10 percent. In 15 percent of districts, expansion was over 50 percent.
- Expansion has resulted in LHWs now having to cover fewer health facilities, due to health facilities increasing the number of LHWs per facility and in addition, the ratio of LHWs to LHWs has reduced.
- Expansion has resulted in greater coverage, although there are still poorer areas where there is no or very limited coverage.
- The Programme has also managed to upscale using the same mode of operation. It is a credit to the original designers of the Programme that this has been possible.
- However, there are tensions associated with expansion, in particular for larger districts. These are resolvable. Essentially there needs to be an increase in managers responsible for the LHWs. There also needs to be an increase in resources at the district level that support good human resource management and organizational development.

**7. Has the Programme managed to deal effectively with non-performing LHWs?**

- While the Programme has made a big effort with strengthening positive incentives for LHW performance there are still a significant number of non-performing LHWs. The benchmark used for service provision in the survey shows that the bottom 25 percent of LHWs are only delivering one third of the level of service provided by the top 25 percent, the High Performers.
- These High Performers are making a significantly higher impact on health in their communities. Communities with non-performing LHWs are not getting the services that they deserve and that the Programme is paying for. The Programme needs to strengthen its ability to manage non-performance by terminating those LHW who do not wish to provide a service.
- To do this the Programme could provide more accountability and support to the district. This might include additional managers for the teams of LHSs – and, in particular, increasing the number of Assistant District Coordinators (ADCs) to ensure one-on-one support and supervision is available. A maximum span of control needs to be established of one manager (in particular the ADC role) to around 15–20

LHWs. This would allow for an increase in focus on supervision and on training and management of human resource issues.

- As the community becomes increasingly aware of the role and value of the LHW, she in turn becomes accountable to the community. In future, it might be that communities do not accept non-performing LHWs.
- The Programme must increase its ability to gain compliance on core Programme policies and performance standards including dealing with non-performing LHWs.

## Conclusion

The Programme entered this five-year period with a Strategic Plan (2003–11) and a PC-1 (2003–08) with clear directions for the future.<sup>4</sup> The main challenges were to:

- improve the quality (knowledge and skills) and the level of services delivered by LHWs
- expand from 40,000 to 100,000 LHWs into under-served poor rural areas
- gain assurance of sufficient level of funding
- strengthen and develop the organisation for the future.

The Programme now has 90,000 working LHWs in all districts of Pakistan. The LHWs are working harder and are more knowledgeable than in the 3rd evaluation (2000). While the full allocation of funds was not received, the level of funding was significantly higher.

However while the Programme has made significant progress there was a failure of governance to drive the strategy and command accountability and there was a management failure to implement Phase 2 of the PC-1. Phase 1 (mid-2003 to mid-2005) was to be a time of consolidation and expansion; Phase 2 (mid-2005 to mid-2008) was to develop a sustainable programme.

By the end of Phase 1, there were to be 100,000 fully trained LHWs and 4,000 LHSs. Systems and procedures for training, implementation, monitoring and supervision were all to have been improved.

By the end of Phase 2, a capacity building process at the provincial and district levels was to have been conducted, along with the trialling of different models for the development of a sustainable and viable structure for the LHWP. This included exploring, through pilots, the transfer of management functions to the provinces and districts. This did not happen.

The Programme has also failed to implement a number of initiatives and systems developments outlined in the PC-1 and the Strategic Plan:

- The external evaluation planned for 2005 did not occur, though there was an internal assessment conducted in 2007 and an external evaluation in 2008;
- While there was expansion, 50 percent of the expansion occurred in just 15 districts;
- The Programme did not consistently stop recruitment in urban areas;
- While there was expansion into poorer areas, the incentive remained to increase LHWs at health facilities where the programme was already established;
- A mechanism was established to explore options for decentralization, but it was never utilized. The Inter-Provincial Committee for Decentralization never met. Decentralization was not pursued by government for this Programme during this period;

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<sup>4</sup> The PC-1 for the period 2003–08 was approved by ECNEC (the Economic Cabinet Committee) on 08 January 2004 at a cost of Rs. 21.534 billion.

## ***LHWP – Management Review***

- The building of partnerships with non-governmental organisations (NGOs) has been limited. There was limited partnership building with NGOs at the national level. Individual units of the Programme are not authorised to initiate projects and partnerships. However, we can use training programmes as an indicator of other activity. From the results of the survey of LHWs it is clear that a reasonable number of them have attended training courses that have not been authorised by the Programme. This presents risks, both in a lack of control of the quality of the training and of the LHW becoming confused as to her priorities in service delivery;
- The EPI policy of the national administration of various childhood vaccines by LHWs was not fully implemented<sup>5</sup>;
- The planned reviews in areas of high expenditure (salary policy; development of a fleet management system; improvement of the logistics management system.) did not occur;
- In addition, the Programme failed to address some difficult problems. These include: the significant number of LHWs in Sindh being non-resident in the area served; the lack of sanction on non-performing LHWs; the write-off, disposal and replacement of outdated vehicles; and on-time procurement of drugs.

Any organisation has limits on the amount of management attention available. In a bureaucracy working in a challenging environment, such as rural Pakistan, this attention is quickly absorbed by day-to-day operations. And so it is with the Programme. The governance arrangements of the Programme are there to allow management (both internal and within the ministry and departments of health) to provide leadership and to make and implement the necessary strategic decisions. That they have generally failed to do so became evident as we addressed the seven questions of the management review. Some of the issues that were not addressed are as follows: options for decentralisation, non-compliance with residency criteria in Sindh, issues of integration with Basic Health Units that have been contracted out to non-governmental organisations and further expansion in urban areas at the expense of development of the Programme into poorer rural areas. These are issues that needed to be exposed by the National Coordinator of the Programme, addressed through the governance committees, and on which decisions needed to be taken to resolve the issues by the Secretary of Health and the central agencies.

The Programme managers must now plan for the future. There are emerging risks that must be managed by the Programme. These include:

- Tolerating non-compliance; for example, by the 25 percent of LHWs providing a low level of service, LHWs not maintaining the residency criteria in Sindh, LHWs working outside their catchment area and/or for other organisations, and LHWs charging for services. The Programme needs support from government to apply sanctions for non-compliance.
- The lack of accountability of the Programme to the government for full implementation of the Strategic Plan and the PC-1 between June 2003 and June 2008. There needs to be a more formal system of reporting against key performance indicators. The Programme also needs support by government to implement initiatives that will ensure development and risk management.
- Rapid turnover in management positions at all levels in the Programme presenting a risk that managers are not in position for sufficiently long periods to provide leadership. In addition there is a shortage of expertise in the management of the fleet, procurement, and logistics management at senior levels.

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<sup>5</sup> This is a separate policy from that of using LHWs as mobilisers on National Immunisation Days.

There are also issues that Programme managers need to address ensure it can successfully expand into more disadvantaged areas and improve the level and quality of services provided by LHWs:

- Programme expansion has occurred both through the LHWP extending coverage to previously uncovered health facilities in more disadvantaged areas and by recruiting more LHWs to health facilities that were already a part of the Programme. Future expansion is going to require working with provincial and district governments to ensure functioning health facilities that take responsibility for the success of their outreach services
- Compliance with Programme policies and performance standards must be achieved in order to be able to introduce greater delegation to the provincial and district levels.
- District management who have a proven record of supporting Programme performance should be given increased responsibility as soon as accountability mechanisms are in place. There will need to be a strengthening the Programme's capability at monitoring and provision of management information. As the community becomes increasingly aware of the role and value of the LHW, she in turn becomes accountable to the community. In future, it might be that communities do not accept non-performing LHWs.
- The factors under the Programme's control that have been shown to improve LHWs performance need to be strengthened. This will include: further management and administrative resources to all districts but particularly those who have large Programmes; initiatives targeted at encouraging effective supervision by the LHS; ensuring health facilities have a person who is responsible for the Programme; refresher training.
- The budgets for management, monitoring and training are only a small percentage of the unit cost of the Programme yet they are important for increasing the quality of the services and should not be under-utilised.
- Collect high quality information to use for policy development and decision-making.

The Programme's vision of providing a service to the doorstep of the community has been retained over the past five years. The LHW is now established as a community service provider who is recognised by the community for the services that she is able to deliver. The LHWP is able to provide services to the community, and in all provinces and regions of the country. The goal now must to improve LHW performance and expand into even poorer areas, so as to maximise the impact on health.





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## Abbreviation

ADB	Asian Development Bank
ADC	Assistant District Coordinator
ADG	Assistant District General
AGPR	Accountant General Pakistan Revenues
AIDS	Acquired Immune Deficiency Syndrome
AJK	Azad Jammu and Kashmir
APC	Assistant Provincial Coordinator
BCG	Bacillus Calmette-Guerin
BHU	Basic Health Unit
CBO	Community Based Organization
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
CSD	Child Survival Development
DAO	District Accounts Office
DC	District Coordinator
DDG	Deputy Director General
DFID	Department for International Development (UK)
DG	Director General
DHO	District Health Officer
DoH	Department of Health
DPC	Deputy Provincial Coordinator
DPIU	District Programme Implementation Unit
DPT	Diphtheria, Peruses, Tetanus
DTO	District Treasury Office
ECNEC	The Economic Cabinet Committee
EDO-H	Executive District Officer of Health
EPI	Expanded Programme of Immunisation
FANA	Federally Administered Northern Areas
FATA	Federally Administered Tribal Areas
FLCF	First Level Care Facility
FP	Family Planning
FPIU	Federal Programme Implementation Unit
FPO	Field Programme Officer
FTA	Fixed Travel Allowance

## ***LHWP – Management Review***

FTO	Federal Treasury Office
FY	Financial Year
GoP	Government of Pakistan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Islamabad Capital Territory
IMR	Infant Mortality Rate
KPI	Key Performance Indicators
LHS	Lady Health Supervisor
LHW	Lady Health Worker
LHWP	Lady Health Worker Programme
LMIS	Logistic Management Information system
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Motility rate
MNCH	Maternal and Neonatal Health
MNT	Maternal Neonatal Tetanus
MoF	Ministry of Finance
MoH	Ministry of Health
NCHD	National Commission for Human Development
NGO	Non-Governmental Organisation
NIDs	National Immunisation Days
NIPS	National Institute of Population Studies
NP	National Programme
NPFP&PHC	National Programme of Family Planning and Primary Health Care
NWFP	North Western Frontier Province
OBSI	Optimal Birth Spacing Interval
OPM	Oxford Policy Management
PC	Provincial Coordinator
PC-1	Planning Commission 1
PHC	Primary Health Care
PLA	Personal Ledger Accounts
POL	Petrol, Oil and Lubrication
PPIU	Provincial Programme Implementation Unit
PSDP	Public Sector Development Programme
PSU	Primary Sampling Unit

RHC	Rural Health Centre
RHP	Reproductive Health Project
RPIU	Regional Programme Implementation Unit
Rs.	Rupees (Pakistani)
SCF-UK	Save the Children Fund- United Kingdom
SCF-US	Save the Children Fund- United States
SNIDs	Sub-National Immunization Days
SoEs	Statements of Expenditure
TAMA	Technical Assistance Management Agency
TB-DOTS	Tuberculosis-Direct Observation Treatment Short-course
TCI	Technical Committee of Innovations
TOT	Training of Trainers
TSIS	Training System Information System
TT	Tenuous Toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHP	Women's Health Project





# 1 Introduction

The review of management and systems is one of the areas covered by the 4th Evaluation of the National Programme for Family Planning and Primary Health Care (Lady Health Worker Programme).<sup>6</sup> This 4th Evaluation of the LHWP by Oxford Policy Management began in December 2007 with the objective of evaluating the period covered by the PC-1,<sup>7</sup> from July 2003 to June 2008.<sup>8</sup>

The purpose of the 4th Evaluation was to explore whether the Programme had:

- provided the level of services promised:
- to quality standards;
- to the agreed level of coverage;
- including the poor;
- with an impact on health; and
- at a reasonable cost;
- improved performance since the 3rd Evaluation (2000); and
- implemented the organisational developments planned in the Strategic Plan (2003–11) and the PC-1 (2003–08).

The objectives were to:

- provide the MoH and other stakeholders with accurate, credible and usable information on the performance of the LHWP;
- explore the determinants of performance;
- document the socio-economic benefits to the LHWs and the LHSs, their families and communities of working with the programme; and
- provide findings and policy options that enable the Programme to further strengthen its performance.

To fulfil these objectives, the key outputs of the evaluation are:

- district- and community-level data collection providing national and provincial estimates through six different quantitative surveys: the DPIU, health facility, LHW, LHS, household and community. The surveys were based on the questionnaires of the 3rd Evaluation to ensure comparability of results,<sup>9</sup>
- intensive qualitative studies; and
- reviews of management, organisational systems and unit costs.

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<sup>6</sup> The Programme is officially called the 'National Programme for Family Planning and Primary Health Care'. It is commonly referred to as the Lady Health Worker Programme and, hereafter, is referred to as the 'LHWP' or the 'Programme' in this report.

<sup>7</sup> The core planning document of the Programme.

<sup>8</sup> The most recent independent evaluation of the LHW P was commissioned by the Ministry of Health in 1999, and implemented by Oxford Policy Management. This was the 3rd independent LHW Programme Evaluation. The key conclusion of this evaluation was that the LHWP had managed to buck the international and national trends of poor performing Community Health Worker Programmes and was, in fact, providing a service that had an impact on key health indicators.

<sup>9</sup> The quantitative survey covered 5,752 households, 554 LHWs and their supervisors and health facilities (FLCFS). It was a nationally representative sample. The survey was conducted between July and November 2008.

## **1.1 Management and systems review**

The Management and Systems Review is presented as two reports. This is the Management Review. It includes findings on:

- **Systems** The performance of selected core systems using the targets in the Strategic Plan and the PC-1. These systems include: selection of LHWs, training, logistics, salaries and payments, performance management, transportation, and MIS;
- **Management** The evaluation of seven key areas of management that are important to successful programme implementation:<sup>10</sup>
- Do the management controls of the Programme support the implementation of the Strategic Plan and the PC-1?
- How has innovation and quality improvement been managed?
- How well has the Programme been implemented across different levels of government?
- What integrating mechanisms are there, between the LHWP and other public health and primary health care programmes?
- Has expansion led to greater coverage in remote areas and to poorer families?
- What have been the benefits and tensions of expansion from 37,000 LHWs to 90,000 LHWs?
- Has the Programme managed to deal effectively with non-performing LHWs?

The starting point for the Management Review is a description of the Programme's management arrangements (Chapter 2). This is followed by an overall judgement on the performance of the LHWP (Chapter 3). This judgement is informed by the results of the Quantitative Survey together with the additional analysis conducted for the Management and Systems Review, and the Finance and Economic Analysis. Chapters 4 to 10 cover each of the key questions and Chapter 10 provides conclusions.

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<sup>10</sup> The evaluation team's main concern was to provide useful feedback to the management of the Programme on issues that they considered a priority. These questions were agreed with the Programme Management in March 2008 after a series of interviews had been conducted with internal and external stakeholders.

## 2 Programme description

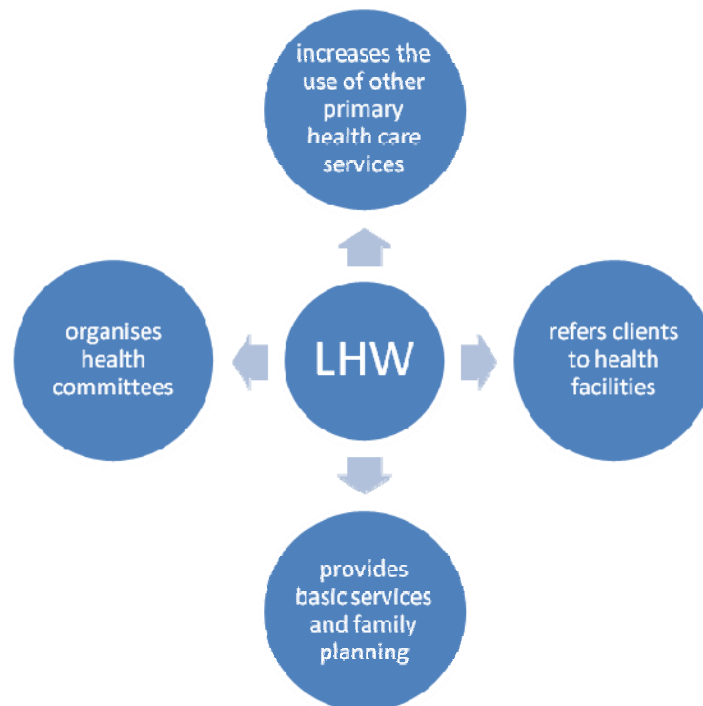
### 2.1 Background

**Purpose** The Lady Health Worker Programme (LHWP) is an initiative of the MoH in collaboration with the provincial and regional Departments of Health in Pakistan.

The Programme's purpose or mission, expressed in its Strategic Plan, is 'to promote health and reduce poverty by bridging the gap between health services and communities by providing high quality integrated health services at the doorsteps of communities'. The goal is 'to contribute to poverty reduction by improving the health of the people through cost effectively preventing and treating common ailments at the community level'.

**Role and services** From its inception in 1993, the Programme has expanded to cover almost all districts of Pakistan, providing outreach services to the poor in rural areas and urban slums. The aim was to deploy 100,000 LHWs, each LHW providing coverage to between 100 and 200 households in her community. The LHW was to be an agent of change in the community. She would provide family planning services, and services that addressed primary health care problems. She would be the catalyst for: increasing the utilisation of health facilities, through referral of patients; increasing community initiated health improvements, through organising village committees for men and for women; and increasing the use of other primary health care services – for example, through promoting vaccination and family planning (Figure 2.1).<sup>11</sup>

**Figure 2.1 The LHW through her outreach services**



<sup>11</sup> See Annex A, for a description of LHW services.

**Linkages and integration** The 3rd Evaluation showed that the Programme had difficulty in achieving response from health facilities to referrals from the LHW, and in the LHW gaining formal participation from the community. However, most communities were accepting of the LHW and her services.

The LHWP succeeded in promoting services at the community level for other development programmes initiated by the Ministry and Departments of Health. These included EPI, malaria, TB DOTS, Nutrition, HIV AIDS, Mother and Child Health, and Family Planning (Ministry of Population Welfare). The management position for coordinating these services at the district level is the Executive District Officer of Health (EDO-H).

**Health policy** The government of Pakistan (GoP) has indicated its continuing commitment to tackling the country's major health priorities in three major national strategy papers: the National Health Policy (2001), the Ten-Year Perspective Development Plan (2001–11), and the National Poverty Reduction Strategy.

The LHWP, through its services, contributes to five out of 10 key areas outlined in the National Health Policy by:

- reducing the widespread prevalence of communicable diseases (i.e. the EPI cluster of childhood diseases, TB, Malaria, Hepatitis B, and HIV-AIDS) (Key Area 1);
- addressing the inadequacies in primary/secondary health care services (Key Area 2);
- promoting greater gender equity in the health sector (Key Area 4);
- bridging the basic nutrition gaps in the target population (i.e. amongst children, women and vulnerable population groups) (Key Area 5); and
- creating mass awareness in public health matters (Key Area 8).

**Level of funding** The LHWP is funded, as a development programme, from the federal government through the budget of the MoH. Between 2003/04 and 2007/08, there was an 88 percent increase in the allocation of budgetary funds to the LHWP, increasing from Rs. 2,600 million in 2003/04 to Rs. 4,892 million in 2007/08. This increase was to fund additional LHWs. The real unit cost of an LHW was nearly the same in 2007/08 as it was in 2003/04.<sup>12</sup>

**Organisational structure** The LHWP is a programme within the MoH. The Programme is delivered through implementation units at the federal, provincial and district levels (FPIU, PPIU and DPIU, respectively). The Programme has responsibility through these units for implementation of the Strategic Plan and PC-1, and for providing policy advice to government.<sup>13</sup>

**Annual planning and budgeting** Until 2005, the Programme prepared both an annual plan and a budget. In 2005, the Ministry of Finance introduced the cash-book/work-plan. This now forms the basis for the release of funds from the government to the Programme.

There is an annual cycle of planning and budgeting within the Programme through the implementation units. All districts should have a District Plan of Action, which feeds into the Provincial Plan of Action that describes objectives and targets for the year. Through this process, decisions are made on recruitment, training, administration, requirements for logistics, and transportation.

Strategic and wider policy issues are either determined at the time of the development of the Strategic Plan and PC-1, or are the domain of the MoH and the Programme's governance and management committees.

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<sup>12</sup> See OPM, *Finance and Economic Analysis*, August 2009.

<sup>13</sup> See Annex B, for functions of the implementation units, and Annex C, for levels of decision-making in the Programme.

**Management information** The management information systems of the Programme, both formal and informal, provide the information necessary for operational management and reporting requirements. Management information is provided by internal administrative systems and by independent external evaluations. The external evaluations provide information on the systems' performance, quality of inputs, service delivery and outcomes.

**Risks** In the beginning, the main risk was that communities would not allow LHWs to provide their services. As the Programme became established, this risk diminished and, at the time of the 3rd Evaluation in 2000, the risk was, rather, that funding would be discontinued and that myths about the Programme would destroy a fragile reputation. Now, in 2009, the Programme has established itself as an important institution in delivering primary health care services at the community level. Of greater risk now is that the Programme might not have the level of control over LHW service delivery that is required to ensure improved health outcomes. Another risk is that the Programme becomes entrenched in its current mode of delivery, and lacks the management control and leadership necessary to ensure its ongoing development as envisaged in the Strategic Plan.

## **2.2 Planned achievements, 2003–08**

### **2.2.1 The 3rd Evaluation, the Strategic Plan and the PC-1**

The LHWP is a development project managed by the MoH (federal government of Pakistan) in collaboration with the provincial Departments of Health. It has a Strategic Plan (2003–11) that outlines the medium-term direction for the Programme under the umbrella of the government's strategic objectives. These include the Poverty Reduction Strategy Paper (PRSP) and the National Health Policy.

**3rd Evaluation** In 2002, the 3rd Evaluation of the Programme had been completed and the Strategic Plan for 2003 to 2011 was being developed. The reputation of the Programme had been significantly enhanced by the 3rd Evaluation as, prior to those results, there had been scepticism in some quarters as to whether the Programme was actually functioning at all. The evaluation had shown that the Programme was having an impact on health outcomes, and that personnel were complying with many of the operational standards. However, the Programme was under-performing due to lack of funding and a low level of performance by around one quarter of the LHWs.<sup>14</sup>

**Strategic Plan** The Strategic Plan was developed on the basis of extensive consultation in order to cover the years 2003 to 2011. It forms the basis for the PC-1, and is included as an Annex. It is not a component of the development budgeting system.

The Strategic Plan is described as 'providing a vision and a direction for the future of the Programme'. Its focus is on how to improve 'the quality of the services delivered by the LHW and ensuring that these services are reaching the rural poor'.<sup>15</sup>

The Strategic Plan defined the Programme's key objectives as:

- improving the quality of services provided by the Programme by addressing the weaknesses recently identified in by the 3rd Evaluation; and
- expanding the coverage of the Programme from approximately 40,000 communities in the late 1990s to approximately 100,000.<sup>16</sup>

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<sup>14</sup> The sheer size of the Programme with its proven impact on health indicators make it unique internationally.

<sup>15</sup> Strategic Plan: p. 3.

The quality of services was to be improved by: enforcing recruitment standards, improving the training systems, additional skills training to support health behaviour change, improving the supply of medicines and family planning supplies, increasing the quality of LHW supervision, and reaffirming the focus on community mobilisation.

The Strategic Plan called for an increase in funding, per LHW, from Rs. 26,000 to Rs. 46,000. This funding would be used to increase the level of supervision (ensuring that supervisors were mobile and given adequate training), improving LHW training and knowledge, insuring supplies of drugs and medicines to LHWs, and improving the pay and management systems.

The expansion of Programme coverage would be achieved through giving priority to: communities that are predominantly poor and under-served by primary health care services; communities that are unserved or under-served; households that are under-served, despite being in LHW-serviced communities; and non-expansion in urban areas, where the impact is lower.<sup>17</sup>

The Strategic Plan had four key objectives and key performance indicators covering: the expansion of coverage to under-served and poor areas, improving quality, expanding the scope and mix of services of LHWs, and improving performance monitoring and evaluation for evidence-based programming.

**PC-1 (2003–08)** The PC-1 sets out the objectives of the LHWP, the time frame of the project, and the annual budget requirements. Once approved by the GoP's planning processes, the Programme budget is incorporated into the federal development budget. The PC-1 also describes the purpose of the Programme, defining governance and management arrangements, and service delivery (including standards), and specifying controls that monitor critical areas of performance. It is possible to request a revision from the government in the light of changing circumstances and strategic opportunities.

The goals of the PC-1 were to:

- develop the necessary health manpower in support of the Programme through selection, training and deployment of 100,000 LHWs: 87,600 under the National Programme for Family Planning and Primary Health Care, 8,000 under Women's Health Project (WHP), 4,400 under Reproductive Health Project (RHP) throughout the country (an input).
- address the primary health care problems in the community (an outcome), providing promotive, preventive, curative and appropriate rehabilitative services to which the entire population has effective access (an output).
- bring about community participation (an outcome) through the creation of awareness, changing of attitudes, and organisation and mobilisation of support (an output).
- expand the family planning services available in urban slums and rural areas of Pakistan (an output).

**Management environment in 2003** In 2003, these plans appeared feasible. The Programme was 10 years old and operating in a supportive environment; political support continued under the change of government; the Programme had over 50,000 LHWs; budget and sponsorship was available; the reputation of the LHWP as a core primary health care programme was improving. While there had been some management changes in the Programme, many of the former managers were still employed in primary health care and –

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<sup>16</sup> Strategic Plan: p. 7.

<sup>17</sup> Strategic Plan: p. 8.

either through professional effort in their new roles, or through personal effort – they were providing support. The core management team comprised people who had had a long relationship with the Programme: Dr Larik had been the National Coordinator for seven years; Dr Zulfiqar, who had been a Deputy National Coordinator, was now employed on contract as the National Advisor; Dr Raza Zaidi was Deputy National Coordinator; the Procurement and Logistics Manager, the Financial Manager, the Training Coordinator and the Monitoring Officer were all long-term members of the management team or key advisors, and were involved in the formulation and support of the new PC-1 and Strategic Plan.





### **3 Overall judgement of performance**

This chapter provides an overview of the key findings of the 4th Evaluation. It covers: health impacts, adherence to core values and purpose, Programme expansion and consolidation, service delivery, organisational competence, systems performance, funding of the Programme, governance failure to drive Programme strategy, and management failure to implement Phase 2 of the PC-1.

The Programme entered this five-year period with a Strategic Plan (2003–11) and a PC-1 (2003–08) with clear directions for the future.<sup>18</sup> The main challenges were to:

- improve the quality (knowledge and skills) and the level of services delivered by LHWs;
- expand from 40,000 to 100,000 LHWs into under-served, poor rural areas;
- gain assurance of a sufficient level of funding; and
- strengthen and develop the organisation for the future.

The following section provides an overall judgement of performance of the Programme between July 2003 and June 2008, followed by the findings for each of the seven questions addressed by the Management Review.

#### **3.1 Health impacts**

The analysis of the quantitative survey confirmed that the LHWP has had a positive impact on the use of modern family planning methods, in ante-natal care (tetanus toxoid vaccinations and the use of iron tablets), neo-natal check-ups, deliveries of babies by skilled birth attendants, the uptake of ante-natal services, knowledge in preparing oral rehydration salts, and vaccination rates. The impact of the Programme was greater for poorer households, especially in relation to maternal and neo-natal health practices, immunization and growth monitoring. However, knowledge-based interventions, such as treatment of diarrhoeal diseases, were more effective amongst better-off households. The same applied for some demand-driven services, such as family planning.

Overall, the impact on health knowledge and sanitation has been weak; there is no evidence of a positive effect on breastfeeding. Some of these areas present more difficult behavioural issues, although it was found that high-performing LHWs had an impact on a number of them, suggesting there is scope for improvement if LHW performance can be strengthened and these activities made a priority.

#### **3.2 Adherence to core values and purpose**

The Programme has succeeded in gaining the commitment of many thousands of LHWs to providing a valuable service in their community. The Programme's ethos of providing a service to the doorstep has been retained throughout this latest period of expansion. LHWs, LHSs and district management understand that the priorities are maternal health, family planning and child health.

However, there are factors that present a risk to these values. These include:

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<sup>18</sup> The PC-1 for the period 2003–08 was approved by ECNEC (the Economic Cabinet Committee) on 08 January 2004 at a cost of Rs. 21.534 billion.

- tolerating non-compliance; for example, by the 25 percent of LHWs providing a low level of service; not maintaining the residency criteria in Sindh, and LHWs working outside their catchment area; LHWs charging for services; not enforcing the minimum levels for registration of household and client per LHW;
- the lack of accountability of the Programme to the government for full implementation of the Strategic Plan and the PC-1 between June 2003 and June 2008; and
- rapid turnover in management positions at all levels in the Programme, presenting a risk that managers are not in position for sufficiently long periods to become effective.

### **3.3 Expansion and consolidation**

Between 2001 and 2003, the Programme underwent a period of rapid expansion, from 38,000 LHWs to around 70,000. Between 2003 and 2008, the period covered by this evaluation, expansion was at around 25 percent. The Programme is now only 10,000 short of the target of 100,000. Programme expansion occurred both through the LHWP extending coverage to previously uncovered health facilities in more disadvantaged areas and through the recruitment of further LHWs to health facilities that were already a part of the Programme.

The LHW is now established as a community service provider that is recognised by the community for the services that she is able to deliver. The LHWP is able to provide services to the community, and in all provinces and regions of the country.

### **3.4 Service delivery**

The LHW is delivering a higher level of service to her eligible clients (although she has fewer of them than she had eight years ago) in all provinces/regions. However, the average number of clients registered per LHW has dropped from 980 to 929, and the number of households registered has fallen from 145 to 133.

There also remains a substantial group of under-performing LHWs, however, that are providing a very low level of service to their community and are failing to have an impact.

LHWs play an important role in the provision of preventive and promotive health care services. The level of provision varies with the type of service. Many services reach around half of the eligible clients, but some have higher coverage: vaccination promotion reaches three quarters of children under three years of age. There have been substantial improvements in the coverage of family planning services. High-performing LHWs are likely to deliver relatively high levels of all services.

The 4th Evaluation has identified some factors under the control of the Programme that contribute to an increase in LHW performance and knowledge:

- LHSs who provide monthly supervision (where they visit the LHWs and their households – with and without the LHWs – and use their checklist) have higher-performing LHWs. The ratio of LHSs to LHWs, whether it is 1:10 or 1:30, does not affect performance. What is important is that the LHS monitors, on a monthly basis, according to procedure;
- the more knowledgeable the LHS, the more knowledgeable the LHW;
- functioning health facilities where an individual person has responsibility for the Programme;
- district management support where the EDO-H fulfils a leadership role, and there is managing and monitoring by the DPIU;

- consistent priorities for service delivery (adopted by the district, the LHS and the LHW) result in higher performance;
- provincial monitoring by the field programme officers;
- attendance at refresher trainings – in particular, counselling card training increases knowledge and MIS refresher training increases performance; and
- high-performing LHWs also have functioning women's health committees.

In addition, the increase in service levels has probably been supported by the enhanced reputation of the Programme, community awareness of the role of the LHW, and their placing increased accountability on her.

### **3.5 Organisational competence**

Since the previous evaluation, reported in March 2002, the Programme has retained its core competence in recruiting, training and supervising village-based women. The professional knowledge and skills of the LHW and her supervisor have increased, although there are still areas of weakness where improvement is needed. The evaluation has found that education levels, effective training and supervision, and good district management practices are important factors in determining LHW levels of knowledge.

### **3.6 Systems performance**

The systems under control of the Programme have worked reasonably well, including a salary system for the large and dispersed workforce. There has been an increase in the supervision of both LHSs and LHWs. The training system has successfully trained all the LHWs and provided them with refresher training. However, there have been insufficient funds for the planned level of supplies and transport, and many LHWs are missing basic equipment. At the time of the survey, there were delays in salary payments, reportedly due to insufficient funds being released by the Ministry of Finance. This was attributed to the economic crisis. However, the system was successfully providing all LHWs with their wages, albeit delayed.

### **3.7 Funding of the LHWP**

In the previous evaluation, it was concluded that the Programme needed to spend significantly more resources per LHW, with the objective of increasing the quality of its service delivery. Budgets and expenditure per LHW did increase between 2003 and 2008. Sufficient funds were provided for the Programme to expand from approximately 70,000 to 100,000 (if donor contributions are included).

Over the five-year period, real expenditure per LHW remained fairly stable, with the exception of a large increase in 2006/07 to pay for salary arrears. However, there was a disproportionate increase in the wages of the LHWs in comparison with other areas of expenditure. These wages have increased in real terms, and command a significantly larger share of the budget than planned. Inflation was also at a higher level than predicted by the Programme, resulting in decreased purchasing power. In addition, budgets on inputs such as supplies and vehicles were under-spent.

The budgets for management, monitoring and training comprise only a small percentage of the unit cost of the Programme, yet they are important for increasing the quality of the services and should not be under-utilised. To provide their services, LHWs require medicines and contraceptives; these need to be procured in sufficient quantities.

Supervisors need to be mobile, either by having access to operational vehicles with drivers and POL, or by having sufficient travel allowance and access to other forms of transport.

The budget had provision for initiating developments in Phase 2 through one budget for research and a further budget for relationships with NGOs. These budgets were not utilised.

The conclusion from the financial analysis is that the cost structure of the PC-1, if implemented, would have resulted in LHWs who had the resources required to provide services, adequate supervision levels, and stronger management and monitoring to allow for higher delivery of services and the implementation of Phase 2 of the PC-1.

### **3.8 Governance failure to drive programme strategy**

Any organisation has limits on the amount of management attention available. In a bureaucracy working in a challenging environment, such as rural Pakistan, this attention is quickly absorbed by day-to-day operations. This is also the case with the Programme. The governance arrangements of the Programme are there to allow management (both internal and within the Ministry and Departments of Health) to provide leadership, and to make and implement the necessary strategic decisions. That they have generally failed to do so became evident as we addressed the seven questions of the management review. Some of the issues that were not addressed are: options for decentralisation, non-compliance with residency criteria in Sindh, issues of integration with basic health units that have been contracted out to non-governmental organisations, and further expansion in urban areas at the expense of development of the Programme into poorer rural areas. These issues need to be exposed by the National Coordinator of the Programme, resolved through the governance committees, and decisions must be taken to resolve the issues by the Secretary of Health and the central agencies.

### **3.9 Management failure to implement Phase 2 of the PC-1**

Where the Programme management has failed is in moving from Phase 1 to Phase 2, as defined in the PC-1. Phase 1 (mid-2003 to mid-2005) was to be a time of consolidation and expansion; Phase 2 (mid-2005 to mid-2008) was to develop a sustainable programme.

By the end of Phase 1, there were to be 100,000 fully trained LHWs and 4,000 LHSs. Systems and procedures for training, implementation, monitoring and supervision were all to have been improved.

By the end of Phase 2, a capacity-building process at the provincial and district levels were to have been conducted, along with the trialling of different models for the development of a sustainable and viable structure for the LHWP. This included exploring, through pilots, the transfer of management functions to the provinces and districts. This did not happen.

The Programme has also failed to implement a number of initiatives and systems developments outlined in the PC-1 and the Strategic Plan:

- The external evaluation planned for 2005 did not occur, although there was an internal assessment conducted in 2007 and an external evaluation in 2008;
- While there was expansion, 50 percent of the expansion occurred in only 15 districts;
- The Programme did not consistently stop recruitment in urban areas;
- While there was expansion into poorer areas, the incentive remained to increase LHWs at health facilities where the Programme was already established;
- A mechanism was established to explore options for decentralization, but it was never utilized. The Inter-Provincial Committee for Decentralization never met:

government did not pursue decentralisation for the Programme during the period covered by this PC-1;

- The building of partnerships with NGOs has been limited, including at the national level. Individual units of the Programme are not authorised to initiate projects and partnerships. However, we can use training programmes as an indicator of other activity. From the results of the survey of LHWs, it is clear that a reasonable number of them have attended training courses that have not been authorised by the Programme. This presents risks, both in a lack of control of the quality of the training and a likelihood of the LHW becoming confused as to her priorities in service delivery;
- The EPI policy of the national administration of various childhood vaccines by LHWs was not fully implemented;
- The planned reviews in areas of high expenditure (salary policy, development of a fleet management system, improvement of the logistics management system) did not take place; and
- In addition, the Programme failed to address some difficult problems. These include: the significant number of LHWs in Sindh being non-resident in the area served; the lack of sanction on non-performing LHWs; the write-off, disposal and replacement of outdated vehicles; and the on-time procurement of drugs.



## **4 Strategic and management controls**

**Key question: Do the management controls of the Programme support the implementation of the Strategic Plan and PC-1?**

### **4.1 Introduction**

The Programme provides an important health service to the poor communities of Pakistan. Over the past 15 years, the Programme has improved health indicators and increased its coverage.

To continue to fulfil its purpose, it needs to have the necessary strategic and management control over its future direction, its policies, and its performance and quality standards. For the period under review, these controls are outlined in the Strategic Plan (2003–11) and the PC-1 (2003–08).

A judgement of governance failure to drive key strategic initiatives, and management failure to implement Phase 2 of the PC-1 was given in Chapter 3. Examples were provided from evaluation findings of non-compliance with some key policies, and non-implementation of initiatives that were designed to implement the agreed strategic directions.

This chapter describes the core control mechanisms, the operation of which should have supported full implementation of the Strategic Plan and PC-1.

### **4.2 Description of controls**

The functions and committees described in the next sub-section are to provide the Programme with the level of strategic and management control necessary to provide direction, ensure compliance, mitigate the risk of corruption, manage service delivery, and strengthen the Programme's capability for ongoing development.

The Programme is monitored by: the Secretary of Health (and, through him, the Director General, Health Services and the Deputy Director General of Health and Planning and Development), the Planning Commission and the Ministry of Finance.<sup>19</sup> The Programme is also subject to external audit by the Auditor General, and there is provision for an audit officer to be posted at the FPIU from the Auditor General's office in order to provide continuous internal audit.

The PC-1 also specified that there be progress reports that would be prepared by expert agencies and reviewed by the provincial and federal Health Management Committees. These reports would aim to review progress against targets, and evaluate the effectiveness of the strategy. They would be in addition to the two external evaluations planned for 2005 and 2008.

In addition, the Programme has two high-level cross-sectoral committees, the Programme Review Committee and the Inter-Provincial Committee on Decentralisation.<sup>20</sup>

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<sup>19</sup> The day-to-day interface of the Programme with the Ministry of Health is with the Director General of Health Services.

<sup>20</sup> There are a number of oversight and coordinating committees specified in the PC-1. The establishment of such committees is very typical of how the Public Service operates in Pakistan. Committees can provide a way to facilitate decision-making and action within the framework of the bureaucracy. Their role is to:

improve collaboration between the Ministry of Health and the federal level of government, and the Departments of Health and provincial level of government; to improve decision-making and policy development; and

### **4.2.1 Programme Review Committee**

The PC-1 specified the establishment of the Programme Review Committee, subsequently renamed the Interagency Coordination Committee. Its mandate was to review the progress of the Programme, and to agree on modifications that might be necessary during the course of implementation. It was envisaged that the committee would function as a steering committee. Membership was to be as follows:

- Secretary Health, MoH (Chairman);
- Director General, Health;
- Joint Secretary (Finance and Development), MoH;
- National Coordinator (Secretary);
- National Programme Advisor;
- Provincial Health Secretaries/Director General Health Services;
- Representative of Ministry of Population Welfare;
- Representative of Ministry of Finance;
- Representative of Ministry of Planning and Development Division.

### **4.2.2 Inter-Provincial Committee on Decentralisation**

Under the PC-1, an Inter-Provincial Committee, also chaired by the Federal Secretary of Health, was to be established. The members were to include the: Provincial Additional Chief Secretaries (Development), Provincial Health Secretaries, Representative from the Planning Commission (i.e. the Member, Social Sector or the Chief of Health), and the National Coordinator of the Programme (Secretary). The committee could also co-opt additional members.

The purpose was to 'guide the process of crystallisation of the further decentralisation and devolution of powers in the context of the Programme'.<sup>21</sup> This committee was to meet biannually to discuss plans and review progress towards the decentralisation of Programme activities. The committee would also explore the possibility of allocation of resources to the Programme from the provincial funds.

#### **Box 1: What was the intention with decentralisation?**

*'This program should not be delegated to the District level. If it was delegated to district government they would not apply the criteria even the selection criteria. They will say give pay to LHW whether she has worked or not because there is a close attachment with the community and they want the vote. So it should be with the PPIU.'* District Coordinator

From its inception, the Programme provided a higher degree of authority to the district and provincial levels of government than the core public services. It encouraged community involvement in the selection of LHWs and in their ongoing work through health committees in the village.

Health facilities are responsible for selection, training and the oversight of the LHWs, who meet at the facility on a monthly basis. District management, through the EDO-H, is chairman of the DPIU, and accountable for the performance of the Programme in his/her district. Provincial Departments of Health provide monitoring and management functions.

- to increase cooperation and synchronicity between other health programmes (e.g. EPI); to promote appropriate innovation in service delivery; to explore ways of decentralising the Programme if this would lead to improved performance; explore alternative funding arrangements.

<sup>21</sup> PC-1: p. 55.



However, it has remained a nationally funded and directed Programme, with Programme policies and standards being the responsibility of the federal government. One justification has been that the Programme 'redresses an historical weakness in primary health services to villages and to poor urban women'. And that 'there needs to be evidence of a significant shift in those social attitudes at the provincial, district and local levels before key levers of control over the Programme are delegated or devolved or the Programme will fail'.<sup>22</sup>

The decision reflected in the Strategic Plan was for the Programme to remain, in the medium term, as a high-profile, nationally-funded and nationally-directed programme, signalling government's intent to tackle inequity and modelling an effective way of doing it. The strategy was to extend and consolidate the Programme at the village level, which would contribute to the national goal of enhancing long-term local governance and participation; where the provincial government could provide accountability, the levels of delegation could be increased.<sup>23</sup>

During the course of this PC-1, it was planned to have a further decentralisation of powers in a phased manner. This decentralisation/devolution was to be piloted in selected districts/provinces in tandem with the development of mechanisms that would ensure accountability for results. This would need to be accompanied by capacity-building at all levels, strengthening of Programme management information systems, and demonstration of increased involvement at the district and provincial levels.

## **4.3 Review**

### **4.3.1 Mechanisms in place, but not used**

In 2003, the Programme was well aware of the risks of relying on capacity in central agencies, and even their own ministry, to control and drive Programme development. The leadership of the Programme ensured that the results from the 3rd Evaluation were widely communicated, and used as a basis for gaining the consensus and funding necessary to develop the Strategic Plan and the PC-1.<sup>24</sup>

The two oversight committees, the Programme Review Committee and the Inter-Provincial Committee on Decentralisation, were established to ensure momentum. Unfortunately, these committees never met during the period under review. The first meeting of the Provincial Review Committee was called in October 2008, with the objective of: reviewing progress to date, reviewing the proposals for a change to the target recruitment of LHWs from 100,000 to 200,000, and providing guidance on how the Programme should deal with the national financial crises that were resulting in low availability of funds.

In addition, the role of National Advisor – which was designed to support Programme development by coordinating activities with the provinces, and planning and piloting strategies for the future – remained vacant after September 2005.

Most of the activities planned to support the delegation of decision-making did not take place (Table 4.1).

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<sup>22</sup> Strategic Plan: p 16.

<sup>23</sup> Strategic Plan: p. 16.

<sup>24</sup> This is the fourth external evaluation (4th Evaluation) of the Programme. The first and second evaluations were held in 1995 and 1996, respectively, followed by the third evaluation (3rd Evaluation) conducted between 1999 and 2001.

**Table 4.1 Strategic Plan activities for supporting delegation of decision-making**

	<b>Actions in Strategic Plan to support delegation of decision-making</b>	<b>Did it happen?</b>
1	Assessments of district and provincial management capabilities	No
2	Delegating further financial management to the districts	Indirectly and partially through District Accounts Office
3	Opening district level PLA/commercial accounts to be operated by the EDO-H and DC	No
4	Developing procurement mechanisms to allow districts to place local orders and settle payments	No
5	Capacity-building exercise for provinces and districts	Yes
6	Decentralisation of decision-making plan based on: Improved management efficiency and effectiveness; Demand by province and district; Demonstrated province level and district level resource commitments; Implementation of accountability mechanisms.	No
7	Plan for further decentralisation of Programme based on milestones achieved at the provincial and district levels over the period 2003–08	No

#### 4.3.2 External review of performance

The Auditor General’s department conducts annual audits of the Programme. These are not systems audits and do not address wider questions of value-for-money or implementation against plan.

The Planning Commission requests performance feedback, but only on a few key indicators. While the Annual Report produced by the Programme for the MoH reports on some of the targets of the PC-1, it does not provide a full report of its implementation.

Within the MoH, the Development DG Health has a role designed to guide the development of the PC-1, project planning and monitoring. The role also includes evaluation of donor projects. The MoH has lacked capacity in this area. In 2007, a project monitoring unit was established that might, in future, take on a monitoring role.

In addition, the progress reports to be written by external experts and presented to the provincial and federal Health Committees were not produced; neither was there a mid-term external evaluation. There was an internal assessment conducted by the Field Programme Officers in 2006–07, supported by external agencies.

#### 4.3.3 Programme leadership

The working relationship between the National Coordinator of the Programme and the Secretary of Health and the Director General of Health Services tends to focus on operational issues and crises. These are complex senior-level management jobs that have all been subject to high turnover during the five years under review, with three changes in each position. Frequent changes in leadership, in both the Ministry and in the Programme, do not help with the implementation of any systematic appraisal process of senior Programme managers or the Programme. It is difficult to see how newcomers can hope to grapple with strategic issues within a one to two year time frame. In addition, frequent changes cause stress to Programme staff.

Given the importance of the Programme and the challenges it faces, high quality leadership is essential with the FPIU. The selection criteria for the National Coordinator emphasise

public sector, management, and public health experience. This should be the minimum requirement. To provide the Programme with the necessary control, the senior management of the FPIU must be able to:

- communicate the vision and the priorities of the Programme to the different levels of government, the community, those working managing the Programme, and LHWs;
- challenge norms, both in the public service and the community, that are barriers to the implementation of an effective service; and
- enforce compliance with Programme policies and standards.

#### **4.4 Findings**

1. While the Programme has nearly 90,000 LHWs working in their communities, there has not been full implementation of the directions and key activities of the Strategic Plan and PC-1. This is attributable to a failure of governance processes and management control, rather than a systems failure.
2. There was insufficient strategic control of the Programme to drive it into the planned Phase 2 outlined in the PC-1. This was both because of the absence of strategic review mechanisms (including not holding a mid-term evaluation and not convening the relevant high-level committees) and the high management turnover.
3. The non-functioning of these committees left the programme vulnerable. The committees, if fully functional, would have been able to provide decision-making space for the Programme where important issues could be debated and determined. The committees would have been in a position to influence the appointment of experienced and motivated managers in the implementation units.
4. In addition, the position of National Advisor remained vacant after September 2005. The purpose of this position had been to support the Programme in coordinating activities with the provinces in planning and piloting strategies for the future.
5. Once federal government commitment and funding was assured through the approval of the PC-1, issues of sustainability and decentralization were clearly no longer a priority. However, the Programme has to manage for risks of a policy reversal that could put goals of poverty reduction and health improvement by a Programme operating at the grass roots at risk – for example, social sector investments being routed through provincial government and district government annual development plans.
6. To guarantee the provision LHW services, there will always need to be some level of financial commitment from the federal government, with a requirement for performance and adherence to the Programme's performance and quality standards. The Programme needs to increase its accountability. Annual reporting against key performance indicators has been weak or non-existent.
7. The senior management positions in the MoH and the Programme have been subject to high turnover during the five years under review. Frequent changes in leadership, in both the Ministry and in the Programme, does not help with the implementation of any systematic appraisal process of senior programme managers. It is difficult to see how newcomers can hope to grapple with strategic issues within a one to two year time frame.
8. To provide the Programme with the necessary control, the senior management of the FPIU must be able to:
  - communicate the vision and the priorities of the Programme to the different levels of government, the community, those working managing the Programme, and LHWs;
  - challenge norms, both in the public service and the community, that are barriers to the implementation of an effective service;
  - enforce compliance with Programme policies and standards.



## **5 Innovation and quality management**

**Key question: How well have innovation and quality improvement been managed?**

### **5.1 Introduction**

By 2003, the Programme had high quality information from the 3rd Evaluation and stakeholder consultations and experienced managers. This provided the basis for prioritising the issues that needed to be addressed, and where innovative solutions were to be developed and implemented.

The initiatives that would provide for innovation and quality improvement were incorporated into the Strategic Plan and the PC-1, together with budget and the assumption that sponsorship from development partners would also be forthcoming.

Issues identified by the Strategic Plan and PC-1 included:

- increasing the range of services to be provided by the LHW;<sup>25</sup>
- improving the performance of the LHW;
- developing a sustainable programme;
- ensuring integration of primary health care services at the community level; and
- increasing the number of eligible LHWs in areas where the problem was illiteracy.

Many of these issues are covered elsewhere in this report and in the systems review including: the integration of primary health care services at the community level, increasing coverage, dealing with non-performance, and the lack of governance required to develop a sustainable programme.

This chapter provides an overall finding on whether the Programme's process for innovation and quality improvement is successful, and looks in detail at how the Programme addressed the issue of increasing the range of services to be provided by the LHW.

### **5.2 Planning for innovation and quality improvement**

A summary of the issues, planned activities and their achievement is provided in Table 5.1. It is clear that developments happen only where the solution is under the Programme management's direct control – and, particularly, if that solution is deemed to be training or conducting a pilot study. Issues requiring policy development, and therefore the active engagement of higher-level decision-makers and collaborators, were not resolved.

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<sup>25</sup> The PC-1 (2003–08) did formalise the agreements to increase the range of services to include provision of TB DOTS; provision of injectable contraceptives, the use of LHWs as vaccinators and to act in liaison with Community Midwives to be trained under the MNCH; screening females in the advanced stages of pregnancy; immunisation of pregnant women for tetanus toxoid; involvement in primary eye care; greater involvement in National Immunisation Days and measles campaigns.

**Table 5.1 Response by the Programme to issues requiring innovation or quality improvement identified in the Strategic Plan and PC-1**

Issue	What was planned to ensure innovation or quality improvement in the PC-1 (2003–08)	Did it happen?
<b>Increasing the range of services provided by the LHW</b>	<p>For the involvement of LHWs in new areas of work, approval had to be given by the Programme Review Committee after a detailed study and analysis of the benefits for the community and the Programme.<sup>26</sup></p> <p>Strategic Plan key performance indicators were developed:<sup>27</sup></p> <ul style="list-style-type: none"> <li>- Clear guidelines on clinical priorities and efficacy;</li> <li>- Percentage of LHWs providing 'new' services;</li> <li>- Percentage of LHWs providing services guided by other national programmes;</li> <li>- Percentage of LHW households covered by EPI, TB DOTs and FP services.</li> </ul>	<p>A new committee was formed, the Technical Committee of Innovations (TCI), with the authority to pilot test and evaluate proposals for new services.</p> <p>The policy guidelines on clinical priorities and efficacy were not developed.</p> <p>The new service for which approval was gained during the period of PC-1 (2003–08) was the distribution of Sprinkles. A number of pilots were conducted (see Table 5.3).</p> <p>The evaluation provides the information on services level for NIDs, and the percentage of households covered by EPI, TB DOTs and FP services.</p>
<b>Improving LHW performance</b>	<p>Introduction of mandatory annual 15 days' refresher training to increase knowledge<sup>28</sup></p> <p>Significant purchase of vehicles agreed with development partners, with the aim of each LHS having a vehicle, as well as each FPO.<sup>29</sup></p> <p>Development of a specific checklist and feedback report for LHS.<sup>30</sup></p>	<p>Yes.</p> <p>There was a significant purchase of vehicles by the Programme. However, the Programme did not succeed in providing each LHS with a vehicle (see Systems Review).</p> <p>The Jaiza Karkardegi is a new tool developed by the LHWP for measuring the performance of the LHW. The LHS enters the scores for all LHWs of a set of indicators from the performance checklist. Eventually, an aggregate of all LHW scores is reached.</p> <p>This performance checklist is used by the LHS (see Quantitative Survey results).</p>
<b>Insufficient literate girls available for selection as LHWs in some areas</b>	<p>Condensed education courses to be provided in collaboration with the education department and NGOs.<sup>31</sup></p>	<p>This activity was piloted in a district but was never replicated in the course of PC-1.</p>

<sup>26</sup> PC-1: p. 34.

<sup>27</sup> Strategic Plan: p. 24.

<sup>28</sup> PC-1: p. 31.

<sup>29</sup> PC-1: p. 39.

<sup>30</sup> PC-1: p. 39.

<sup>31</sup> PC-1: p. 17.

Issue	What was planned to ensure innovation or quality improvement in the PC-1 (2003–08)	Did it happen?
<p><b>Developing a sustainable programme</b></p>	<p>To develop different models for the Programme between 2005 and 2008, including piloting the possibility of transferring management functions to the provinces and districts in the PC-1.<sup>32</sup></p> <p>The position of National Advisor was to be retained to support the FPIU in coordinating activities with the provinces and districts, including planning and piloting strategies for a sustainable future.<sup>33</sup></p>	<p>Different models were not developed.</p> <p>The post of National Advisor was vacant after September 2005.</p>
<p><b>Ensuring integration in service delivery of basic primary health care services</b></p>	<p>The new EPI policy was further validated by being included in the PC-1 (in conjunction with the EPI programme).</p> <p>For LHWs to act as a liaison with the Community Midwives to be trained under the MNCH Programme, and for LHSs to be involved in administrative monitoring.</p>	<p>LHW training as vaccinators took place, but they have continued as mobilisers rather than vaccinators.</p> <p>Since 2005, the EDO-H is has the option of utilising trained LHWs as vaccinators.<sup>34</sup></p> <p>The training of Community Midwives through the MNCH Programme was delayed.</p>

### 5.3 Increasing the range of services to be provided by the LHW

**Management process** The Strategic Plan was clear that ‘ultimately the use of LHWs for work other than her carefully chosen Programme duties dilutes her health impact’.<sup>35</sup> The Programme management in 2003 were well aware of the considerable pressure by various organisations to conduct their activities at the community level using LHWs. The Strategic Plan outlined the process and plan (Table 5.2) for managing developments in the scope and mix of services provided by the LHW, with the aim of improving health impacts and fulfilling public health priorities.

An internal management committee is referred to in the PC-1 as being responsible for approving piloting and proposals of new strategies and additional assignments.<sup>36</sup> The approval for the ongoing involvement of LHWs in new areas was the responsibility of the Programme Review Committee.

The objective of the plan was to ‘ensure that the services delivered by LHWs are those that have the maximum impact on mortality reduction and fertility choices while at the same time being safe and within the capabilities of both LHWs and the Programme’. The Strategic Plan references the national programmes for EPI, TB and HIV/AIDS as having national clinical priorities that could guide any expansion in the scope of LHW activities and, thus, provide opportunity for integration between national programmes (helping to reduce costs or increase impact).

<sup>32</sup> PC-1: p. 22.

<sup>33</sup> PC-1: p. 44.

<sup>34</sup> The reasons for the not utilizing LHWs as vaccinators requires further research.

<sup>35</sup> Strategic Plan: p. 15.

<sup>36</sup> PC-1: p. 34.

**Table 5.2 Plan for managing the development of the scope and mix of services provided by the LHW**

Process	
1	Produce a clear statement of priorities in extending the scope of the LHW work that would utilise her time and capabilities effectively. The statement would reflect: clinical priorities for achieving reductions in mortality and increases in family planning choices; therapies that have proven clinical efficacy; can be safely administered by the LHW; are low-cost; reflect the workload, motivation and remuneration of the LHW; and,  Capabilities of Programme systems to support the training and delivery of new therapies.
2	Development of a strategy for expansion of the scope of the LHW's services based on the statement.
3	Provide review guidelines for the process of the selection of new activities.
4	Provide review guidelines for the implementation of provincial- and district-level initiatives that expand the clinical scope of the LHW's activities.
5	Advise the provinces and districts of the guidelines.

Source: Strategic Plan (2003–11), LHWP, MoH.

**Review of process for increasing the range of services** As has been mentioned previously, the Programme Review Committee never met during the five year under review. A committee was formed in 2006, the Technical Committee of Innovations (TCI), which had the aim of evaluating proposals for new initiatives. It is unclear whether this was to replace the originally planned internal management committee referred to in the PC-1 that was to be chaired by the National Coordinator and included the National Advisor, Deputy National Coordinator, and two Provincial Coordinators. The TCI membership included development partners and external stakeholders. By 2008, the TCI had met four times. However, some members/participants thought the Committee had unclear terms of reference and lacked a mandate to make decisions.

Neither the internal management committee nor the TCI carried out the important task of establishing the statement of priorities that would provide the criteria for making judgements on the LHW's scope of work.

## 5.4 Use of pilots and refresher training

The discussion that follows focuses on the Programme's use of pilots and training as their approach to increasing the range of services provided by the LHW, and in developing her professional competence in service delivery.<sup>37</sup>

Pilot studies and trainings are of particular interest, as they are often funded by development partners in partnership with the Programme. Pilots are inexpensive for the Programme but are, reportedly, very time-consuming of management attention. Pilots might distract from initiatives already in the PC-1 that were intended to expand the scope of LHW services and that were not fully implemented – for example, the EPI policy (approved in 2001/02), and the plan to provide opportunities for LHWs to observe child deliveries in different settings.<sup>38</sup>

<sup>37</sup> The scope of work of the LHWs is described in the PC-1: p. 33.

<sup>38</sup> This was to be a part of the Training on Safe Motherhood. The results of this evaluation show it is still unusual for the LHW to be present at the birth: LHW presence at a birth is Programme policy.



There is also a risk of LHWs that have been in a pilot study being unsure about the importance of the skill she has been taught unless it is already a part of the core curriculum.<sup>39</sup>

#### **5.4.1 Pilot studies**

In 2006, it was decided that all the new innovations or pilot studies need approval by the newly constituted TCI.

A committee structure (whether the internal management committee or the TCI) provides external agencies with an interface with the Programme for gaining approval for studies/pilots, and provides some transparency in the Programme's decision-making.

For some pilot studies, the partner has a broader programme in which they wish to engage the LHW in providing services, as it will further the objectives of that programme; e.g. the Sprinkles project by the Micronutrient Initiative. In other cases, it might be the Programme seeking a sponsor for a new activity that they wish to trial; e.g. the use of counselling cards for maternal health sessions.

Of the 13 pilot studies identified by the FPIU as having been implemented between 2004 and 2008, only three were rolled out to the whole country as refresher trainings.<sup>40</sup>

#### **5.4.2 Development of refresher training**

From 2004, the Programme has had the target of all LHWs attending 15 days of refresher training each year. The aim was to use refresher training to increase professional knowledge and skills. As reported in the Systems Review and the Quantitative Report, the LHWs are now attending a broad range of refresher trainings.

Six refresher trainings were developed and implemented throughout the Programme (Table 5.3). All of these were in collaboration with an external agency with the exception of the module on nutrition, which was developed in partnership with the Nutrition Wing of the MoH.

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<sup>39</sup> This risk is increased when districts send LHWs on training programmes that are not authorised by the Programme. The results of the survey found that the Programme had only approved half of the trainings LHWs had listed.

<sup>40</sup> See Annex D.

**Table 5.3 Development of refresher trainings, 2004–08<sup>41</sup>**

Refreshers	Pilot area	Year of pilot	Duration	New skill introduced at the training	Status of trainings
Injectable contraceptives	10 UNFPA districts	2005/06	6 days' training of LHW and trainers	I/m Injection	Disseminated all over the country
Child health (CSD)	UNFPA and UNICEF districts	2004/05	6 days' training of LHW and trainers	Use of laminated picture cards for childhood diseases	Disseminated all over the country
Optimal birth spacing interval (OBSI)	10 districts by CATALYST Consortium	2004/05	5 days' training of LHW and 3 days' trainers	Use of counselling cards	Disseminated all over the country
Counselling cards on maternal and newborn health	Save the Children districts	2003/04	5 days' training of LHW and trainers	Use of counselling cards and counselling skills	Disseminated all over the country in 2005
Revised MIS tools	UNICEF districts	2004/05	4 days' training of LHWs	Revised LHW reporting system	Disseminated mostly all over the country, except some parts of Sindh (at the time of survey)
Module on nutrition	Not piloted. Funded by Nutrition Wing, MoH	No pilot	4 days' training of LHW and trainers	Use of counselling cards	Disseminated all over the country

Source: LHWP, MoH.

The quantitative survey found that a high percentage of LHWs had attended refresher trainings in past year (Table 5.4).

<sup>41</sup> UNFPA districts: Chakwal; Muzaffargarh, Thatta, Jacobabad, Manshera, Kohat, Nushki (?), Killa Saifullah, Muzaffarabad, Kotli and Rahim Yar Khan.

UNICEF districts: Kasur, Nankana, Sheikpura, Karachi, Hyderabad, Matiary (?), Tando Allah Yar, Tando M. Khan, Sanghar, Mardan, Kalat, Muzaffarabad and Islamabad Capital Territory (ICT).

Districts for Sprinkles Project: Narowal, Gwader, Noshero Feroz (?) and Swabi.

PAIMAN districts: Jhelum, Rawalpindi, DG Khan, Khanawal, Upper Dir, Benair (?), Lasbella, Jaffarabad, Sukhar and Dadu.

**Table 5.4 Type of refresher training received by LHW in the previous year, by province/region**

	Punjab	Sindh	NWFP	Balochistan	AJK/FANA	Overall
Child health	83	85	88	59	38	81
Injectable contraceptives	71	57	55	35	68	63
Revised MIS tools	44	51	49	17	50	45
OBSI/family planning	70	71	76	69	69	71
Counselling cards	70	82	77	72	37	73
Food and nutrition	18	15	26	17	2	18

Source: OPM LHWP 4th Independent Evaluation, Quantitative Survey Data (2008).

However, in addition to the refresher trainings planned and organised by the Programme, there are more than 30 percent of LHWs across the country that have attended additional trainings. More than half of these trainings are without the approval of the LHWP at the national or provincial level.

## 5.5 Findings

1. Planned innovations and quality improvements happen when the solution is under the Programme management's direct control, and particularly when that solution is deemed to be training or conducting a pilot study.
2. While most initiatives planned during the period under review were not implemented, those designed for improving the performance of the LHW were, and had the desired result.
3. The processes for addressing the range of services of the LHW, as described in the Strategic Plan and the PC-1, were not utilised. The Programme Review Committee that was to give approval for involvement of LHWs in new areas did not meet. Policy guidelines on clinical priorities and efficacy were not developed.
4. The TCI was formed to give authority for pilot testing and evaluation of proposals for new services. It is unclear why the Programme management delegated this authority to a committee with external stakeholder membership.
5. Most pilot studies were conducted in collaboration with development partners and a few with other health programmes. However, it is not obvious that these were selected on the basis of the priorities of the Strategic Plan. Several initiatives were adopted that initially were pilot studies; e.g. injectable contraceptives, counselling cards and child health cards.
6. Additional refresher trainings were developed and implemented in the period covered by the PC-1. They focused on maternal and child health, counselling skills, and nutrition – all core skill areas of the current LHW curriculum. The evaluation has proven the success of refresher training in improving the knowledge and performance of LHWs, particularly the training in counselling cards, food and nutrition, and MIS tools.
7. In addition to the refresher trainings planned and organised by the Programme, there is a significant number of LHWs attending additional trainings, many of which have not been approved by the Programme at the national or provincial level. It is important that the Programme maintain quality control of the LHWs' knowledge and skills through approving training programmes to be attended by LHWs. The process for approval needs to be responsive to the needs of the districts where it is wished to strengthen the LHW within her defined role.



## 6 Implementation of the Programme across different levels of government

**Key question: How well has the Programme been implemented across the different levels of government?**

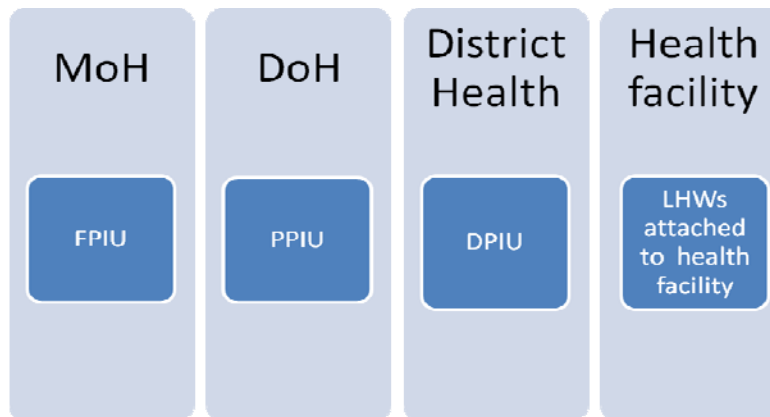
While the LHWP is a federally funded primary health care programme, it is dependent on the provincial and district governments for implementation. Without their cooperation and collaboration, the Programme could not exist.

This chapter describes how the Programme's organisational structure, planning, systems and management are implemented across the federal, provincial and district governments. The chapter also includes a discussion on the contracting-out of basic health units.

### 6.1 Organisational structure

The formal integration of the Programme with each level of government occurs through the implementation units (Figure 6.1).<sup>42</sup> The management of these units is staffed by public servants who are delegated the duties of Programme management. These public servants are a part of the management teams in the Ministry and Departments of Health and the District Health Offices. LHWs are generally attached to first level care facilities (FLCFs), either rural health centres (RHCs) or basic health units (BHUs). They receive their training at these facilities, their monthly meeting is held there, and it is from their facility that they replenish their supplies for their medicine kits.

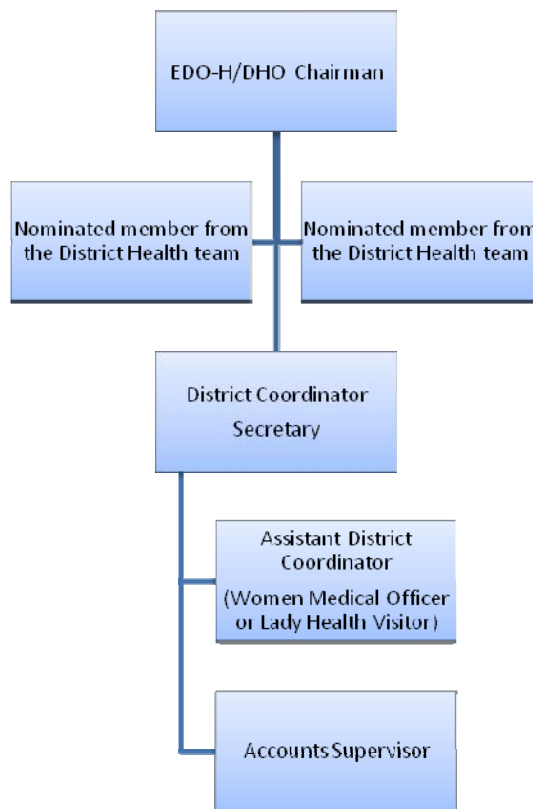
**Figure 6.1 Organizational structure of LHWP and linkages with health system at different levels of government (federal, provincial, and district)**



The EDO-H, or the District Health Officer (DHO) is the chairman of the Programme's implementation unit at the district level, the DPIU (Figure 6.2). The EDO-H is accountable to the district government and also to the Department and the MoH for adherence to Programme policies and performance standards, and for expenditure. The DPIU manages the large workforce of LHWs through the DC supported by the ADC.

<sup>42</sup> The list of functions of the implementation units is provided in Annex B. These have not changed from the previous evaluation.

Figure 6.2 Organisation chart of the DPIU



Source: PC-1 (2003–08), LHWP, MoH.

There is evidence from the quantitative survey that the EDO-H, the DC, the LHS and the LHW have a very clear understanding of their roles, and a common understanding of the priorities of service delivery.<sup>43</sup>

The Programme planned that, after 2005, alternative models of operation of the LHWP would be piloted in selected areas. From this experience, alternative strategies for implementation could be developed, resulting in changes to the functions of the implementation units. This did not happen.

## 6.2 Planning process

The Strategic Plan and the PC-1 are integrating mechanisms. The Strategic Plan was produced after extensive consultation across all levels of the Programme. Each year, the district produces a micro-plan that is provided to the PPIU to ensure access to resources for implementation, including recruitment and training of LHWs.

There was an annual national plan of action for the period 2002/3 to 2004/05. However, this process stopped after 2005.

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<sup>43</sup> Although there is a tendency in health facilities for the LHS to be used for collating management information that is the responsibility of the facility manager, and in facilitating training of LHWs.

### **6.3 Organisational systems**

The Programme's systems are uniform throughout the country, enabling quality standards of key inputs to be established and monitored. By their very nature, the systems ensure integration between the different units. This includes the financial, recruitment, training, management information, supplies, and transportation systems (see Systems Review). When there is a failure to meet standards, there are mechanisms in place (both formal and informal) that report the failure and trigger action; for example, the Field Programme Officer (FPO) monthly meeting at the PPIU, where reports are filed on all districts and issues identified with actions. These reports are sent to the FPIU, which typically has representatives at the provincial meeting. In addition, there are monthly reports that are sent from the DPIU to the PPIU. The survey found that most districts had delivered their reports for the previous six months.

There are some vacancies for FPOs but, typically, districts had received a visit from an FPO for most months of the previous year.

### **6.4 Management linkages**

In addition to the FPO monthly meeting, there are meetings at the PPIU of all the DCs. These are supposed to happen quarterly. Half of the districts had had three or four of these meetings in the previous year, and 40 percent of them had attended two. Typically, the district should present a report or a presentation to the meeting: 70 percent of districts had two or more reports on file for the previous year.

### **6.5 Leadership**

Benefits of integration are weakened if overall leadership is weak. Stress arises where there are difficult problems that cannot be resolved by the implementation units at various levels. These have included: recruitment of drivers, condemning of vehicles, dealing with political control that is against Programme rules. At any point, there are examples of non-compliance or actions being taken that are not in line with Programme policy. In the past year:

- Non-residency of LHWs in Sindh. This is a problem that has had considerable attention, and yet the Programme and the government have failed to take definitive action;
- Recruitment of LHWs in urban areas, against Programme policy;
- LHWs being used on the MICS survey in the Punjab, away from their main jobs;
- LHWs working outside their catchment area on NIDS; and
- The National Commission for Human Development (NCHD) in the Punjab claiming Programme LHSs to work on their programme to undertake baseline surveys and work with reduced number of LHWs.

For difficult issues, the Programme needs to rely on the authority of the MoH and Departments of Health. Frequent changes in leadership increase the vulnerability of the Programme. In any organisation, new senior managers can be expected to take a year to be effective. After a long period of stability, the position of National Coordinator of the Programme was turned over three times in three years. This vulnerability is increased when

there are frequent changes in the senior management of the Ministry and Departments of Health.<sup>44</sup>

## **6.6 EDO-H and delegation**

In the Quantitative Survey, the EDO-Hs were asked what additional duties, responsibilities, powers or authorities could be delegated to the district level. Their responses were:

- Greater budget provision;
- For EDO-Hs in the Punjab to have drawing and disbursement powers;
- For the payment of LHW salaries to be transferred to district management;
- Spot verification of LHW recruitment to be undertaken within the district rather than by the PPIU;
- Power to punish and reward LHWs and supervisors;
- A vehicle and POL for the EDO-Hs;
- Reinstatement of the Project Allowance; and
- Training provided to EDO-Hs.

These requests need response from the Programme. In some cases, the EDO-H might require further information as to the purpose of a control or the rationale for a system. For example:

- the request for an increased budget allocation at the district level is in line with the intention in the Strategic Plan and the PC-1 to increase the levels of delegation, particularly to districts that were assessed as capable;
- the salary system of paying the LHW directly to her bank account was instituted to increase efficiency and to ensure she received her full payment;
- spot verification of the LHWs by the PPIU is an external control from the district recruitment process that serves to ensure compliance with selection criteria. The system is working well, with the exception of non-compliance with residency criteria in Sindh;
- the question of the EDO-H or the DPIU, in general, having the capability to sanction non-performance is important and is discussed later; and
- the Auditor General has objected to the payment of a project allowance. The Programme continues to request that it be reinstated.

## **6.7 Issues on integration with contracted out BHUs**

During the period of this PC-1, provincial governments began a process of contracting the management of the BHUs to NGOs. These facilities are the training organisations of many LHWs, and are the main institution to which the LHW refers her clients. The survey results found that there are more high-performing LHWs where a health facility has an individual person with overall responsibility for overseeing the LHWP's activities. Essentially, the outreach service that the Programme provides is linked to this health facility.

In these initial stages of the contracting process, it appears from our interviews that there has been a number of cases where the contracted health facility staff were being refused the opportunity to be trained as LHW trainers; were refusing to provide ongoing training and refresher training to LHWs and to collate the necessary management information, distribute

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<sup>44</sup> See Annex G, on management changes at the FPIU (2001–09) and the Ministry of Health for the Secretary of Health and the Director General of Health, 2002–09.



supplies and run the monthly meeting. These issues have, reportedly, been resolved in some districts. It is important that the integration of the LHWP with the facility remains safeguarded, and that the performance of the LHW and her professional competence are not undermined by different service delivery models.

## **6.8 Findings**

1. The Programme design of implementation units, and the means by which they are integrated into the Ministry and Departments of Health and district government, have proven successful in establishing a grass-roots community service.
2. The government and the managers of the implementation units know the procedures, policies and standards of the Programme even if, at times, there is a lack of authority to enforce compliance and to deliver sanctions for non-compliance. One solution to this weakness is the functioning of oversight committees of senior people with influence to promote the benefits of compliance in order to support the resolution of difficult problems. Another solution is for senior management to be able to deliver more effective sanctions to non-compliant districts and provinces.
3. The Programme did not pilot different models for Programme operation in different districts, as it had planned to do after 2005.
4. Different service delivery models implemented by the provincial or district governments can have an impact on the integration of the Programme as an outreach service delivering public health services – for example, the contracting out of BHUs. It is important that different service delivery models allow for the benefits of integration to be retained.



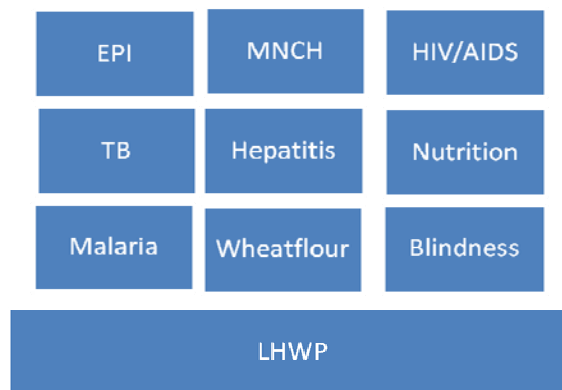
## 7 Integration with other public health programmes

**Key question: What integrating mechanisms are there, between the LHWP and other public health programmes?**

### 7.1 Introduction

The LHWP is one of 10 priority development programmes of the MoH designed to address difficult national public health challenges (Figure 7.1).<sup>45</sup> The programmes are all operating under the umbrella of the National Health Policy, and are part of the Public Sector Development Programme (PDSP). Each programme has a PC-1. The funding mechanisms for the programmes are at the federal and provincial levels of government. This chapter describes the mechanisms that integrate the LHWP with other public health programmes.

**Figure 7.1 List of health programmes located in the federal MoH**



Source: Ministry of Health (2009).

### 7.2 Primary health care programmes and the LHW service delivery

The LHWP delivers services at the community level that contribute to the operation of a number of the other programmes (Figure 7.2). The scope of work of the LHW defined in the PC-1 lists her duties, clearly indicating that priority be given to mother and child health, including training LHWs as vaccinators and providing close support to skilled midwives, as they were trained under the MNCH Programme. The role of the LHW in stimulating community participation and being a linkage to health facilities and other providers was also emphasised.

<sup>45</sup> (1) Expanded Programme of Immunisation (EPI), (2) National Programme for Family Planning and Primary Health Care (LHW Programme), (3) National Maternal, Neo-natal and Child Health (MNCH Programme), (4) National AIDS Control Programme, (5) National Tuberculosis Programme, (6) National Programme for Prevention of Blindness, (7) National Nutrition Programme, (8) National Wheat Flour Fortification Programme, (9) National Malaria Control Programme, (10) National Programme for Prevention and Control of Hepatitis.

**Figure 7.2 Contribution by LHW to other primary health care/public health programmes and family planning**



Source: Strategic Plan (2003–11), and PC-1 (2003–08), LHWP, MoH.

### 7.3 Policy development

Each primary health care programme has its own PC-1. Each programme has the goal of achieving the targets agreed in the National Health Policy. However, the PC-1s are formulated in different years, and it can be difficult for a programme to seek variations that will enable, for example, increased integration of its policy with another programme.

This planning process encourages silos with vertical decision making and management, and makes difficult the introduction of new initiatives that would maximise benefits of integration between primary health care initiatives. Even when the policy is incorporated into the PC-1 (as with the EPI initiative), it remains difficult to overcome the barriers to implementation at the federal level.<sup>46</sup> Another example of planned integration was the development of

<sup>46</sup> The PC-1 has attached, as Annex XV11, the policy for strengthening EPI services through LHWs that had been approved in 2001–02. The policy was to have LHWs initially working as a team with the vaccinators from the EPI programme, and then to be trained as vaccinators – following which, initially, they would vaccinate mothers against TT and, subsequently, vaccinate children against DPT, measles and BCG.

objectives to support the new Maternal and Child Health programme (MNCH). These included: providing supervisory support for activities in the MNCH programme, using funds for drugs and training from the LHWP budget to strengthen the MNCH programme, and providing additional training in Safe Motherhood to LHWs.<sup>47</sup> The PC-1 for the MNCH programme also reflected these linkages.<sup>48</sup> Unfortunately, there were teething problems with the introduction of the MNCH programme.

## **7.4 Management arrangements**

The policy for the primary health care programmes is developed at the national level, and the federal government provides significant funding. The operational planning and coordination of the services of these programmes at the district level is the responsibility of the EDO-H. Members of the EDO-H management team, include the primary health care coordinators for the LHWP, the EPI, the TB DOTS, Malaria, and MNCH. The Family Planning Officer of the Ministry of Population Welfare should also liaise with the EDO-H. Typically, the staff in these positions are medical doctors that are not necessarily trained or experienced in public health or management.

Districts should have an Annual District Health Plan, coordinating efforts towards improved primary health care in their district. The EDO-H reported that the LHWP fitted best with the district health priorities of mother and child health care, family planning, and NIDs.

DCs were asked to rank nine services provided by the LHWP in order of priority. LHSs and LHWs were asked to choose the three top priority services from the list of nine.<sup>49</sup> Across the country, there was consensus that the Programme's top priority was maternal health, child health and family planning. In addition, a high priority, in terms of time allocated by the LHWP, is given to NIDs. All these services require coordination with other public health programmes to maximise health impacts. The EDO-H has an important management role in this respect.

## **7.5 Development partners and other agencies**

Development partners provide or contribute to health initiatives in the MoH, the Departments of Health and the districts (Table 7.1). Often, they work across programmes. For example: UNFPA partners with the MoH, the Ministry of Population Welfare, Women's Development, Ministry of Education, the Federal Bureau of Statistics and the Census Organisation and NGOs. Certainly, there is the potential for such relationships to foster collaboration.

Delivery is through a number of mechanisms including: budget support (National Health Facility), direct support to the health programmes (e.g. provision of technical advisors), and direct support to districts. For management purposes, there are protocols in place to guard against distortion of the Programme's purposes. Tensions can exist between the goals, funding mechanisms, and management and accounting practices of the development partners and those of the government.

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<sup>47</sup> PC-1: p. 21.

<sup>48</sup> See Annex C.

<sup>49</sup> The nine services included: TB DOTS; Village Health Committee meetings; Nutrition; National Immunisation Days; Health education, hygiene and sanitation; Accurate recording of MIS data; Child Health; Family Planning (including OBSI); and Maternal Health.

**Table 7.1 Examples of key development partners contributing to primary health care outcomes**

Target	Government agency/programme	Government agency	Development partner
IMR	MNCH programme and Nutrition Wing	MoH	UNICEF, USAID, SCF- US, SCF-UK,
MMR	MNCH programme	MoH	USAID, DIFD, CIDA, UNFPA, ADB
CPR	MoPW	Ministry of Population and Welfare	UNFPA, DFID
Immunisation	EPI programme and Hepatitis programme	MoH	UNICEF, WHO
TT	EPI programme	MoH	UNICEF, WHO
Exclusive breastfeeding	MNCH programme and Nutrition Wing	MoH	USAID, UNICEF
Assisted births	MNCH	MoH	UNFPA, USAID, Norwegian government, DFID

## 7.6 Review

1. The DPIU is a part of the District Health Department. The EDO-H is the chairman and, typically, he spends some time each week on DPIU responsibilities. He has staff members, the DC and the ADC, basically delegated full time to implementing the Programme. In addition, he has team members that have responsibilities for managing other key programmes. In nearly 90 percent of districts, there is a District Health Management team, which had generally held a recent meeting attended by the coordinators of the primary health care programmes. Of the EDO-Hs, 80 percent reported holding monthly meetings.
2. Over 80 percent of EDO-Hs reported visits to the field to visit the LHWP, typically including visits to other programmes as well.
3. The LHWP is considered one of the ways of delivering outreach health services in the district. Of the districts surveyed, 70 percent have an annual district health plan in which over 90 percent of them cover the activities of the LHWP. The EDO-Hs thought that the services of the LHWP that were the best fit with district health priorities were: mother and child health care; family planning and NIDs. Mention was made of EPI, TB DOTS, and health education.
4. In most districts, the EDO-H reported that the District Assembly had reviewed the District Health Plan.
5. The most frequently reported contributions that the EDO-H thought the LHWs services made to the district were: family planning; improvement of immunisation, general health education; MNCH services, TB DOTS, polio eradication, and increasing community awareness for primary health care.
6. To run the Programme, the district needs to provide offices, training and meeting rooms for the LHWs, together with warehouse space for medicines. The district receives fully paid LHWs and their supervisors, their vehicles (and POL), and their supplies from the MoH. They receive some vehicles for supervision. They also receive training allowances and training materials. In return, they must agree on the number of LHWs they require, manage recruitment, train them in the core curriculum, and ensure they are providing a reasonable level of service delivery.

7. The LHWs and their supervisors provide a link to the community for many of the activities that EDO-Hs manage. Through the monthly meetings, the LHSs provide feedback on how the Programme is running and on implementation issues. Over half of the EDO-Hs had attended the previous LHS meeting.

## **7.7 Findings**

1. Federally funded primary health care programmes are designed to address issues that are of national priority. It is not possible to implement these programmes without the collaboration of the provincial Departments of Health and the district health offices.
2. It is, reportedly, difficult to achieve policy coordination amongst the MoH's public health programmes. The PC-1 planning process – which essentially locks in activities – does not support collaboration, and inhibits flexibility and responsiveness. In addition, Programme managers report spending a great deal of their management time attempting to obtain permission from higher authorities for initiatives that appear to be already within the framework and intent of the PC-1.
3. Coordinating public health services at the district level is the responsibility of the EDO-H: the day-to-day operation of the public health programmes is managed by his management team members, with whom he holds regular meetings. Where there is a District Health Plan, then the LHWP is typically included in it, and the District Assembly will have reviewed the plan.
4. The EDO-H reported that the LHWP fits best with district health priorities of mother and child health care, family planning and NIDs. Across the country, there was consensus between DCs, LHWs and LHWs that the Programme's top priority was maternal health, child health and family planning.
5. LHWs are spending a significant amount of time on NIDs in collaboration with the EPI programme. This activity is the result of commitments made by the government to the World Health Organization to participate in the international goal of polio eradication. Working on NIDs does not have a negative impact on the LHW's performance; however, nearly half of all LHWs are working outside their catchment area on this activity, which is against Programme policy. The high commitment in time required by LHW for NIDs needs to be monitored to ensure that other core priorities are not displaced.
6. The EDO-H and his DC of the Programme manage the LHWP. Many of the EDO-Hs attend, even if briefly, the monthly LHS meetings chaired by the DC.
7. There will always be a tension between the prescribed solutions that address national health priorities and the need to have some flexibility in service delivery to cater for district priorities. However, there appears to be consensus between the district health management and the LHS and LHWs that the focus on service delivery should be on maternal and child health, and family planning. While district managers would like an increase in budget allocation and salary incentives, there does not appear to be a conflict between district health primary health care strategies and the Programme.





## 8 Coverage

**Key question: Has expansion led to greater coverage in remote areas and to poorer families?**

### 8.1 Introduction

At the time of the 3rd Evaluation, the reliance of the LHWP on functioning health facilities<sup>50</sup> and requirement that LHWs have at least eight years' education meant that some very impoverished and remote areas were not covered in the first decade. The need to rationalise scarce supervisory resources has also been important in determining coverage within a district.

The expansion of the Programme to those who most needed the services was of utmost importance to the Programme in 2003. The intention was strongly reflected in the Strategic Plan and the PC-1.

With the planned expansion of the Programme to 100,000, priority was to be given to: communities that are predominantly poor, and either unserved or under-served by primary health care services; households that are under-served, despite being in LHW-serviced communities; and non-expansion in urban areas, where the impact is lower.<sup>51</sup>

The objective was to 'expand the number of Lady Health Workers in the Programme using equity based principles to ensure that priority was given to the under-served and poor rural areas'.<sup>52</sup>

This chapter begins with the list of the performance indicators for coverage and expansion of the Programme from the Strategic Plan and PC-1. The chapter then describes the planned strategies, followed by a review.

### 8.2 Performance measures

The following performance measures were listed in the Strategic Plan and PC-1:

1. 100,000 LHWs working by 2005;
2. All LHWs continue to fulfil the Programme selection criteria;
3. The LHW provides services to 50 percent of the poor;
4. All registered households regularly visited by the LHW;
5. No new recruitments in urban areas.<sup>53</sup>

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<sup>50</sup> Typically called 'First Level Care Facilities' (FLCFs), here, they are referred to as 'health facilities'.

<sup>51</sup> Strategic Plan: p. 8.

<sup>52</sup> Strategic Plan: p. 18.

<sup>53</sup> PC-1: p. 40. While, initially, the Programme was planned for rural areas, in 1995 it expanded into urban slums following a decision of the Social Sector Committee of the cabinet. Only urban slums where the health facilities and health indicators were comparable to rural areas were to be covered.

In the current PC-1 based on findings of the 3rd Evaluation, it was decided that further recruitment in urban areas would be stopped. The policy was that LHWs and their supervisors already working would continue to be supported, but that there would be no further recruitment in urban areas.

## 8.3 Strategies

**Strategic Plan** The Strategic Plan lists three strategies for achieving the objective of expanding coverage to under-served and poor areas:<sup>54</sup>

1. Prioritising recruitment of under-served and poor areas through:
  - supporting implementation units in the identification of under-served areas by developing principles for allocation of LHWs to these areas; training the managers on these principles and then monitoring that they had been applied;<sup>55</sup>
  - supporting implementation units in the identification of poor families within existing communities, and developing approaches to ensure they were provided with services; and
  - developing capacity and incentives at the district level to allocate posts according to criteria set by the Programme;
2. Expanding the numbers of LHW candidates through community mobilisation and education by:
  - providing scholarships, adult literacy programmes, or condensed education courses for primary pass to women in poor rural areas for education; and
  - involving community leaders, including religious leaders and NGOs, in mobilising and motivating the community to encourage girls to achieve selection criteria;
3. Developing alternative approaches/models for LHW support in under-served rural areas by:
  - conducting a review of national and international best practice;
  - reviewing NGO and departmental capacity to support Programme development in under-served areas; and
  - costing and piloting alternative models especially: options for mobile training units, and options for supervision and systems support in locations with non-functioning health facilities and weak infrastructure.

The issues these strategies were designed to address were: that Programme capabilities, including management, might be weakest in under-served areas; non-availability of suitable candidates for selection as LHWs in the poorest and under-served areas; and, potentially, the lack of functioning health facilities.

**PC-1** A number of the implementation strategies in the PC-1 reflected those in the Strategic Plan.<sup>56</sup>

- prioritising recruitment to under-served and poor rural areas; and
- mobilising effective support of opinion leaders, youth, women groups, teachers, religious leaders (particularly at the local level);
- reviewing the role of partnership arrangements with NGOs, CBOs, Citizens Community Boards, and Women's groups.

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<sup>54</sup> Strategic Plan: p. 19.

<sup>55</sup> The DPIU develops an annual 'micro plan', which is submitted to the PPIU, proposing the number of posts to be filled within their allocated positions. They determine, in consultation with health facilities, where these posts will be allocated, and have to ensure that each LHW post has a catchment area of a minimum of 700 people.

<sup>56</sup> PC-1: p. 24.

Further elaboration for supporting these strategies in the PC-1 included:

- no new recruitment in urban areas;<sup>57</sup> and
- collaboration with the Education Department, NGOs and donors for designing and implementing condensed educational courses.<sup>58</sup> These courses would be of 6 months' to one year's duration, supported by government and NGOs, and designed to provide middle-school competency to girls in remote rural areas who only had primary education. This strategy would expand the pool of potential LHWs;<sup>59</sup>
- to expand the main criteria for allocating LHWs to different catchment areas. This was traditionally based on population and literacy rates. Under the new PC-1, additional factors to be included were maternal and infant mortality rates, and the state of the health facilities.<sup>60</sup>

## 8.4 Review

### 8.4.1 100,000 LHWs and adherence to selection criteria

Essentially, the Programme did not achieve the target of 100,000 LHWs by 2005, and none of the provinces had fulfilled its actual allocation, as had been planned, by June 2005, or by June 2008 (Figure 8.1).

However, the Programme did undergo significant expansion and has generally adhered to selection criteria, with the exception of Sindh, where the Quantitative Survey found over 10 percent of LHWs were non-resident.

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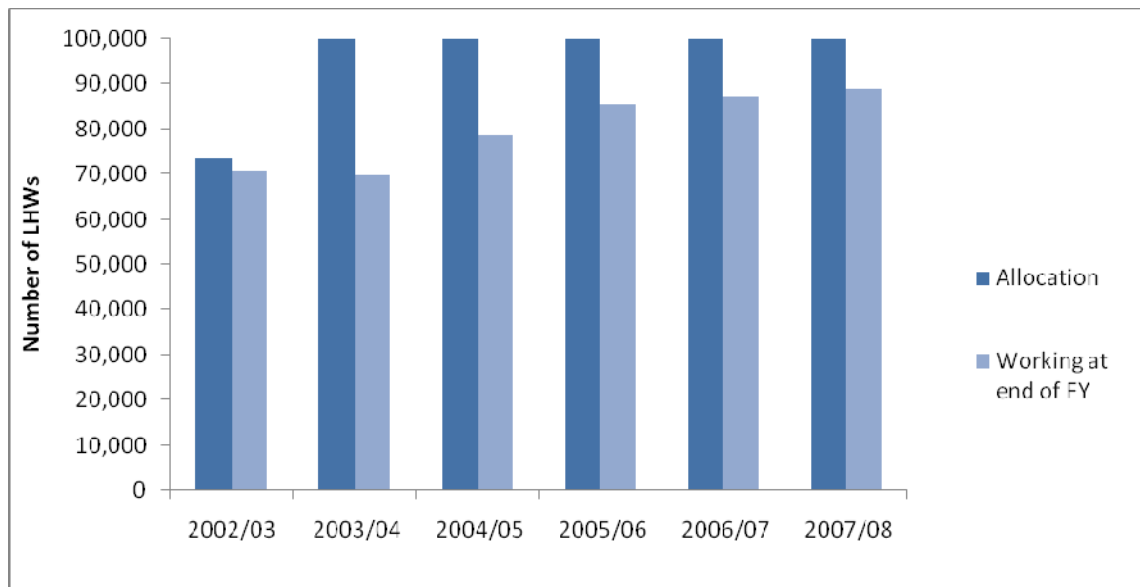
<sup>57</sup> PC-1: p. 40.

<sup>58</sup> PC-1: p. 17.

<sup>59</sup> PC-1: p. 28.

<sup>60</sup> PC-1: p. 28.

**Figure 8.1 The number of working LHWs at the end of the financial year compared with the allocated posts**



Source: PC-1 for the allocations and the PSP database (January 2009), LHWP, MoH for working LHWs.

#### 8.4.2 The allocation of LHW posts

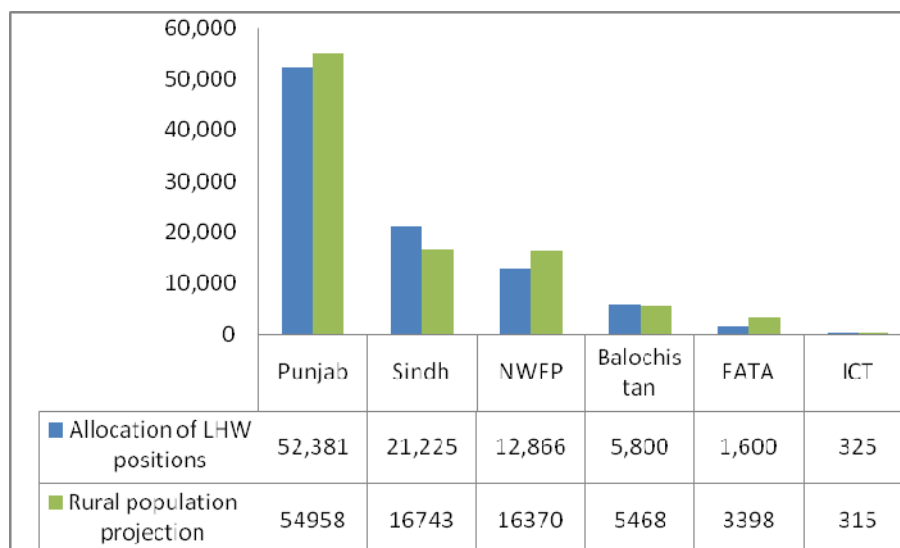
**Decision-making process** The allocation of LHW posts, which essentially is the decision on the level of LHW services to be provided to each province, was determined at the beginning of the PC-1 through consultation between federal and provincial units of the Programme. The allocation is tailored within provinces, in consultation and as a trade-off process between districts. Only one district of those sampled for the survey reported not having been consulted on the allocation of LHW posts.

The districts determine which health facilities in their district are allocated LHWs. They should take into account the Programme criteria: coverage of the rural poor; a functioning health facility, the availability of staff as trainers, and supervision coverage by the Programme.

**Allocations based on rural population** The provincial allocations determined by the Programme for the period of the PC-1 were based on rural population projections (Figure 8.2).<sup>61</sup>

<sup>61</sup> Annex E, Allocations of LHWs by province/area, 2002–08.

**Figure 8.2 Allocation of LHW positions in PC-1 (2003–08), by province/region, compared with the distribution of the rural population**



Note: AJK/FANA are excluded from GoP population projections.

Source: Allocation of LHW positions from the FPIU, LHWP. The rural population projections are from the National Institute of Population Studies (NIPS).

**District allocations** If a district has been given a particular allocation against which they can recruit, then they can build this into their health strategy, and plan accordingly. If allocations are a moving target, then it is difficult to achieve the optimum structure. If the reason for re-allocation of positions is political/self-interest, rather than according to rational criteria, then it undermines the professionalism within the health service and the reputation of the Programme.

Allocation of LHW posts to the districts is the responsibility of the PPIU.<sup>62</sup> In reality, this is undertaken in consultation with districts. If re-allocations are made without discussion with the EDO-H, then it undermines their relationship with the Programme. However, if allocations are moved due to the inability of the district to absorb more LHWs, or a lack of desire by the district to have more LHWs as a part of their strategy, then this is more acceptable.

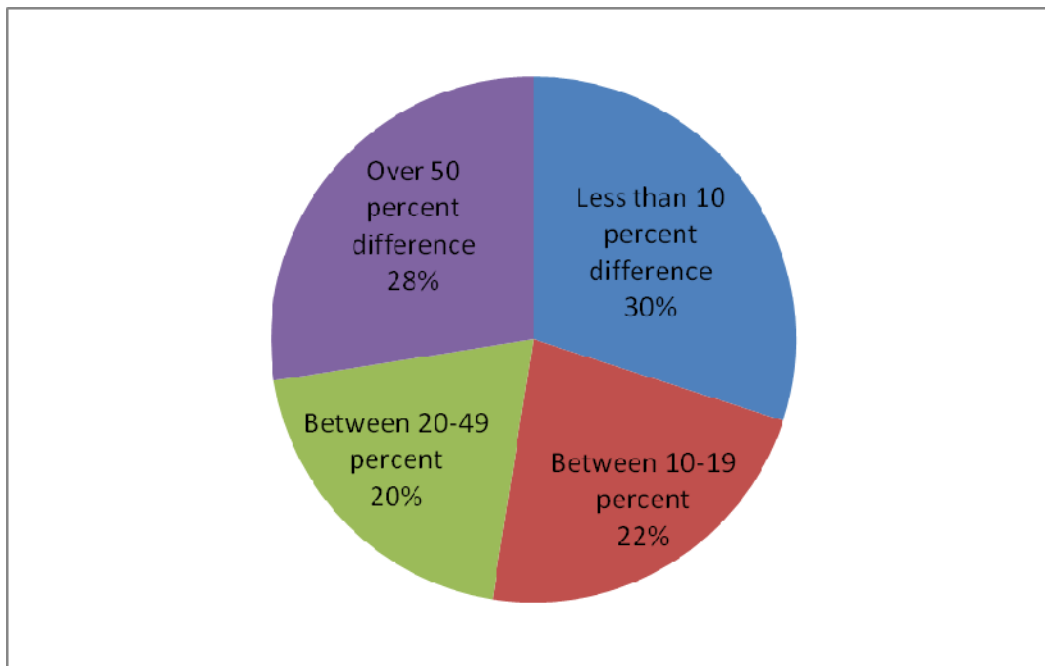
There is a wide variation between the records on the PSP database (June 2008) of the number of allocated positions for each district, compared with the number reported by the sample districts at the time of the survey.

No formal reallocation process occurred between June 2008 and the survey timetable of July–November 2008. Only 30 percent of the sample districts reported an allocation of LHWs that was equivalent to the PSP database. Nearly 30 percent of sample districts had over 50 percent difference (Figure 8.3). As the overall number of allocated posts for the province remains the same, this indicates redistribution in the allocation of posts between the districts within a province, as well as outdated information in the PSP database.

While there are reports of re-allocations occurring due to political/self interest, the EDO-Hs reported that they were consulted on the number of positions being allocated.

<sup>62</sup> PC-1: p. 42.

**Figure 8.3 Difference between the recorded allocation of LHW posts, by district, in the PSP database (June 2008) and the districts’ report of their allocation of LHW posts**



Source: PSP Database, FPIU (June 2008) and OPM LHWP 4th Independent Evaluation, Quantitative Survey Data (2008).

### 8.4.3 LHW registration of clients and households

**Coverage** By mid-2008, with nearly 90,000 working LHWs, population coverage by the Programme was around 77,000,000. This is assuming 89,125 LHWs providing services, on average, to 863 people.<sup>63</sup> If the LHWs had registered the target of 1,000 people each, then coverage would have been closer to 90,000,000. Registrations per LHW were lower in 2008 than in the previous evaluation of 2000. The average number of clients registered has dropped from 980 to 919, and the number of households registered from 145 to 131. This reduction in the size of the LHW’s average catchment area is an issue. It would only be justified if the reduction were due to LHWs being recruited in remote areas, but this is not the case.<sup>64</sup>

**Programme management information on catchment area** The Programme Status Proforma (PSP), which is entered into the Management Information System (MIS), provides information on the population coverage of the Programme, by urban and rural area. This information can be used by managers to indicate whether there is a problem with insufficient household and client registrations, on average, by LHWs within districts and at the provincial level. There are examples of where this information triggered action in the form of instructions to the relevant districts to ensure that catchment areas were increased. Programme management needs to take action to ensure catchment areas are maintained.

<sup>63</sup> This is the average number of people ‘effectively’ registered on average per LHW, as identified by the quantitative survey. ‘Effectively’ means the household/client knew that they were covered by the LHW.

<sup>64</sup> See Quantitative Survey Report.

#### 8.4.4 Expansion to cover additional health facilities and poorer areas

**PSP database information** The PSP records the number of health facilities covered by the Programme each year (Table 8.1). In each province/region, with the exception of ICT, there has been an increase in the number of health facilities covered.

**Table 8.1** Number of health facilities with LHWs, by province/region, by year

Year	Punjab	Sindh	NWFP	Balochistan	AJK	FANA	FATA	ICT	Total
2003	2,079	793	638	149	118	49	35	19	3,880
2004	2,243	814	682	149	118	56	35	19	4,116
2005	2,449	808	710	164	118	56	35	19	4,359
2006	2,520	828	725	214	99	56	66	20	4,528
2007	2,581	845	721	193	118	59	65	19	4,601
2008	2,628	846	743	200	126	94	65	19	4,721

Source: PSP database (January 2009), LHWP, MoH.

There has been a significant increase in the number of health facilities that have LHWs attached to them, (Figure 8.4). However, the information on the database does not allow for analysis of whether the additional health facilities are serving populations that are poor, or in remote areas.

**Survey results on expansion and coverage** The Quantitative Survey analysis found that expansion has occurred through extending coverage to uncovered health facilities, as well as by increasing the number of households served in the catchment areas that were already served in 2000. Their results showed that the Programme has expanded to serve populations that are somewhat more disadvantaged, on average, than were being served at the time of the last evaluation. This is an important achievement.

After 1997, the pattern of expansion has been towards BHUs, facilities with a smaller catchment population and in relatively more remote areas. While opening hours are similar, the newer health facilities are, on average, less well equipped, have poorer stocks of medicines, and have fewer qualified medical staff. Not only is the average number of doctors in post lower (which could be due to the smaller catchment population), but also the efficiency in filling sanctioned posts is lower.

However, the population that now remains unserved is even more disadvantaged, and will require collaboration between the provincial and District Health Departments to increase coverage.

**The unserved health facilities** Of the districts, 25 percent reported having more than 50 health facilities that were not served by the Programme; 40 percent of districts had between 21 and 50 of these health facilities. In total, in rural areas about one quarter of existing health facilities are still uncovered by the Programme.

There were a number of reasons given as to why facilities remained unserved. These included: lack of educated women;<sup>65</sup> more than one facility/union council; the facilities are actually mother and child health centres or dispensaries, and are therefore not suitable; trainers not available; and the facilities were in remote areas. The facilities' catchment area is served by LHWs attached to another facility. Of the districts reported, 80 percent had

<sup>65</sup> The LHWP has, so far, managed to maintain the educational criteria for selection of LHWs. In fact, the educational level has increased with time, reflecting general trends in women's access to education. It might, however, become a problem with further expansion into remote areas.

around eight unserved health facilities where the facilities' catchment areas is served by LHWs attached to another facility.

#### **8.4.5 Planned initiatives for expansion into unserved areas**

**Condensed education courses** The Programme did not facilitate the implementation of condensed education courses during the period under review. There is no systematic collection of information to enable assessment as to whether problems with expansion are due to a lack of suitable applicants, though some PPIUs and DPIUs report this to be the case.

**Development of criteria for allocation purposes** There was no development of additional criteria for the allocation of LHWs to different catchment areas, and no development of incentives to ensure under-served areas were covered. The provincial allocations remained proportionate to the rural population. However, there were re-allocations within districts, but these were, reportedly, due either to reassessments of a district's capacity to manage LHWs or political requests. There does not appear to have been any costing or piloting of alternative models for providing services to under-served areas.

**Identification of poor families** There was no identifiable activity to support districts in the identification of poor families, or the development of approaches to provide them with services. It could be assumed that the increased positive response from the community should aid in the LHW visiting poorer households.<sup>66</sup>

#### **8.4.6 LHW recruitment in urban areas**

While the overall number of LHWs working in urban areas reduced slightly, according to the Programme's database, recruitment in urban areas continued in some districts, even though it was contrary to Programme policy.

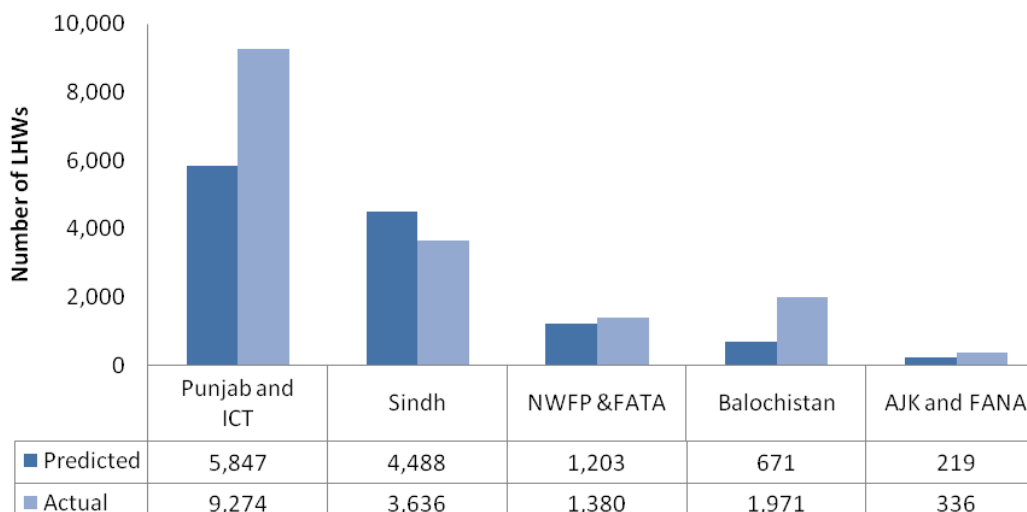
The Programme has an assumed attrition rate of 5 percent. Attrition, together with no recruitment in urban areas, would have resulted in over 13,000 urban LHWs remaining in 2008. In fact, there were over 16,500. In the Punjab and Balochistan, there was an increase in urban LHWs (Figure 8.4). There are two explanations: one is the official changing of designations of rural areas to urban; the other is that districts in these provinces found it easier to recruit into urban areas, and the ban on urban recruitments was not reinforced. In Quetta, Balochistan in 2005, there were 15 health facilities in the Programme. According to the PSP database, this had increased to 29 by June 2008.

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<sup>66</sup> Results from the Community Survey were very positive, with over 90 percent of respondents saying that there had been improvements in health due to the LHW's work; that she had generally improved people's lives in the community and that women were usually respected after becoming LHWs.



**Figure 8.4 Number of urban LHWs, predicted and actual, 2008, by province/region**



Source: PSP database (January 2009), LHWP, MoH.

## 8.5 Findings

1. Through the Strategic Plan and the PC-1, the Programme is explicit in its intention to extend coverage to under-served areas and to poorer families.
2. Recruitment targets were not met. None of the provinces had fulfilled their actual allocation, as had been planned, by June 2005, or by June 2008. Registrations per LHW were lower in 2008 than in the previous evaluation of 2000. The average number of clients registered per LHW has dropped from 980 to 929, and the number of households registered from 145 to 133. The number of clients who knew their LHW was even lower, at 863.
3. There has been a significant increase in the number of health facilities that have LHWs attached to them. The survey found that the Programme has expanded over the past 10 years to serve populations that are somewhat more disadvantaged, on average, than those that they were serving at the time of the last evaluation. This is an important achievement. However, the population that remains unserved is significantly more disadvantaged still, and efforts must be made to cover those areas.
4. Implementation strategies designed to increase coverage to under-served areas and to poorer households were not implemented in the life of the PC-1. This includes the plan for condensed education courses for areas with a shortage of educated applicants for the post of LHW, and the development of incentives to ensure under-served areas are covered. The sheer increase of numbers of LHWs in some districts has probably been the main force in expanding into under-served areas.
5. Districts provided a number of reasons as to why facilities remain unserved that include: lack of educated women, there is more than one facility/union council, the facilities are actually MCH centres or dispensaries, there are no trainers available, the health facility accommodation is not appropriate, the area is remote, and the catchment area is served by LHWs attached to another facility. Four out of five districts reported that they had unserved health facilities where this was happening.

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6. While in accordance with Programme policy, there has been a reduction in the overall number of LHWs working in urban areas. However, Punjab and Balochistan recorded an increase in the number of urban LHWs.
7. There is a wide variation between the PSP database record of the number of allocated positions for each district as of June 2008 and those reported by the districts. Nearly 30 percent of sample districts had over 50 percent difference. As the overall number of allocated posts for the province remains the same, this could indicate a great deal of fluidity in the allocation of posts between districts and within provinces, as well as outdated information in the PSP database.
8. Micro-planning by districts is the mechanism for determining allocation of LHW positions and planning how to resource the necessary monitoring and supervision. This annual process provides the opportunity for the Programme to ensure that the district is acknowledged for extending the Programme into difficult areas. The main incentive on districts is to recruit to their targeted allocation of posts, which results in a tendency to recruit LHWs to those health facilities already engaged in the Programme. Additional resources need to be provided to support districts in expanding into difficult areas.
9. The LHW now has a positive reputation in many of her communities, which should support her gaining access, with community support, to poorer families. She should be given further support to cover poorer families in her catchment area. The Programme is able to communicate key priorities for services. It will also be able to use its communication channels, backed up by supervision, to provide the message that poor families need greater support.
10. Increased collaboration with other organisations that provide basic safety nets would enable the LHW to provide services to the very poor.

## 9 Benefits and tensions of expansion

**Key question: What have been the benefits and tensions of expansion from 38,000 LHW to 90,000 LHWs?**

### 9.1 Introduction

The LHWP has expanded considerably since 2000. This has resulted in an increase in public health services to the poor of Pakistan, particularly in rural areas. However, any expansion of this size will have both benefits and associated tensions. This chapter describes:

- aspects of expansion, including the overall rate, variations between districts, rate of growth of LHWs to LHSs, and the ratio of supervisors to health facilities;
- the factors that drive expansion; and
- the benefits and tensions of expansion; followed by findings.

### 9.2 Aspects of expansion

**Allocation of LHWs posts** The allocation of 100,000 LHW posts to both the provinces and the districts was agreed at a workshop in July 2002, attended by the federal and provincial implementation units and selected district implementation units. Allocation in districts was based on: population-based needs (urban/rural), the literacy rate, availability of health infrastructure, and trainers (especially female). As mentioned, when considering coverage of the Programme, the provincial allocations have remained unchanged, but there was considerable fluctuation in district allocations.

**Rate of expansion** In 2001, the evaluation of the LHWP provided an estimate of 38,000 working LHWs. The Programme's database records 70,738 LHWs working in June 2003 and 89,125 in June 2008 (Table 9.1).

**Table 9.1 End of financial year status of LHWs working for the Programme**

June	Punjab	Sindh	NWFP	Balochistan	AJK	FANA	FATA	ICT	Total
2002	29,496	14,795	9,246	4,443	1,952	1,056	477	299	61,764
2003	33,662	17,657	10,889	4,130	2,256	1,112	716	316	70,738
2004	32,789	17,995	10,260	4,140	2,287	1,130	777	312	69,690
2005	39,983	17,393	11,478	4,892	2,342	1,214	1,016	277	78,595
2006	43,492	19,060	12,530	5,485	2,310	1,214	1,297	232	85,620
2007	44,704	19,084	12,566	5,481	2,413	1,166	1,414	291	87,119
2008	45,757	19,446	13,044	5,510	2,556	1,146	1,377	289	89,125

Note: This includes LHWs funded through the PC-1, the RHP and the WHP.

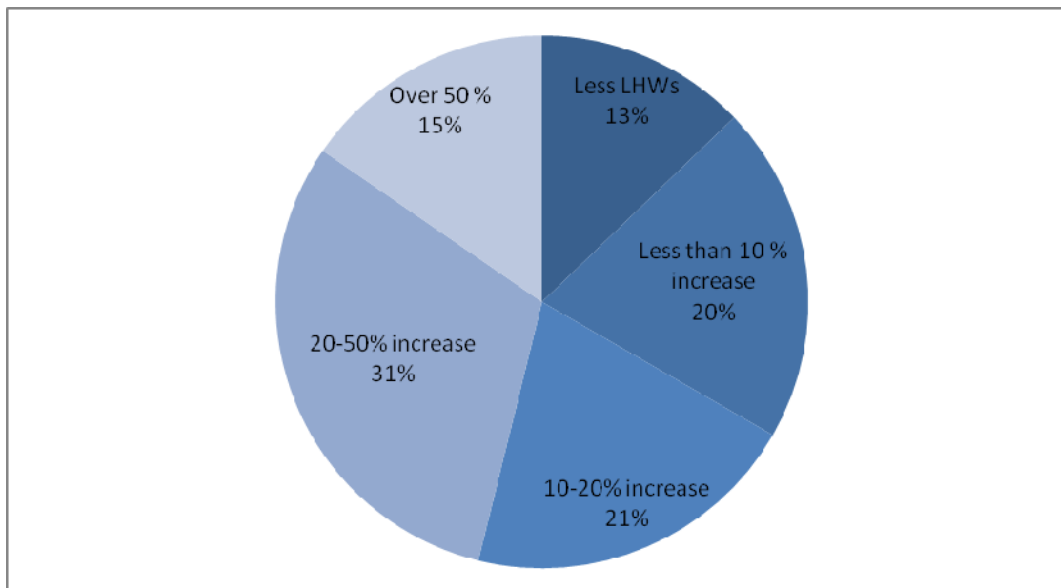
Source: PSP database (January 2009), LHWP, MoH.

The greatest period of expansion was between 2001 and 2003. The rate of expansion since then has slowed considerably. Turnover during the period 2003–08 was, on average, 4 percent, average annual recruitment would have therefore been around 7,125 LHWs. With

120 districts, that would indicate, on average, only 60 new LHWs per district recruited per year.<sup>67</sup>

**Variation between districts** However, the survey information from districts shows an uneven pattern of expansion: 13 percent of districts had fewer LHWs in 2008 than in 2003 (Figure 9.1). A further 20 percent had increases of fewer than 10 percent. In 15 percent of districts, expansion was over 50 percent.

**Figure 9.1 Percentage of districts where the Programme expanded between 2003–08**



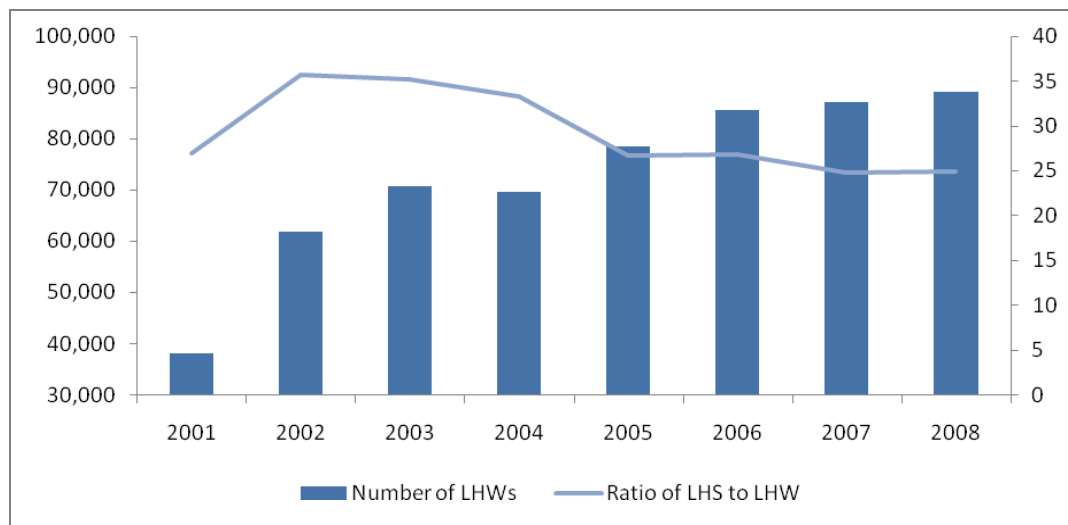
Source: PSP database (January 2009), LHWP, MoH.

**Rate of growth of LHSs compared to LHWs** There was delayed recruitment of LHSs. Delayed recruitment results in lower levels of supervision at the time that newly recruited LHWs started working.

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<sup>67</sup> By mid-2008, there were 135 districts in Pakistan.

**Figure 9.2** Number of LHWs working in June each year, and the ratio of LHSs to LHWs



Source: PSP database (January 2009), LHWP, MoH.

**Ratio of supervisors to health facilities** The LHS is now covering fewer health facilities; half of all LHSs are now covering only one facility (Table 9.2). In the 2000, this was closer to a third. There are on average more LHWs per facility than previously and also the LHS is supervising a smaller number of LHWs. The ratio has dropped from 1:27 to 1:23.

**Table 9.2** Comparison of the percentage of LHSs covering this number of health facilities between 2000 and 2008

	2000	2008
One	31.0	50.0
Two	28.0	44.0
Three	25.0	5.0
Four	11.0	1.0
Five or more health facilities	7.0	0.4

Source: OPM LHWP 4th Independent Evaluation, Quantitative Survey Data (2008).

### 9.3 What drives expansion?

The 3rd Evaluation recommended an immediate focus on improving the quality of services, rather than further expansion. Decisions for expansion are made at senior levels of government, and not necessarily on the advice of the Programme.

In outlining the targets for the National Health Policy, the Strategic Plan commented that ‘if the Programme is to make a major contribution to achieving these national level targets then the Programme will need to expand significantly’.<sup>68</sup> While recognizing the difficulty of calculating population figures, it refers to the original target of the LHWP to cover 70 percent of the population in rural and urban slum areas.

<sup>68</sup> Strategic Plan: p. 12.

However, the Plan then raised the issue of financing and management capacity that would be needed to address this level of expansion, and proposed that major options that needed to be reviewed were:

- reducing the target number of LHWs employed by the Programme;
- allocating more resources; and
- modifying the level and package of services being provided by LHWs.<sup>69</sup>

Essentially, the Programme was allocated more resources and duly expanded.

## **9.4 Benefits and tensions of expansion**

The Programme does not lack confidence in managing a process of expansion; since its inception, it has been geared to produce working LHWs. As it has some districts with many thousands of LHWs, it knows that these systems, for all their weaknesses, will operate on a larger scale at the district level. However, just because it can be done does not mean it should be done. Benefits need to be weighed against the tensions and costs of expansion.

### **The benefits of expansion**

The benefits of expansion include:

- **increased coverage** The opportunity to provide a service to a larger number of the rural poor (coverage) and improve their health status;
- **more of the same** Increasing primary health care services using a known and proven model. In expanding the LHWP, the MoH expanded a programme it knew was operational and provided services. This is a lower risk than a new venture. The organizational structure is in place, with all provinces and districts having implementation units and LHWs attached to health facilities.

#### **9.4.1 The tensions of an expanded or expanding Programme**

The tensions of an expanded or expanding Programme include:

- **Management attention diverted** Recruitment and training absorb the management attention of the Programme and divert it from resolving costly issues; e.g. dealing with non-performing LHWs, developing alternative models of operation, developing criteria for determining the scope or work for LHWs, and so on. The initial increase would have required intensive effort by the Programme to recruit and train LHWs and their supervisors, as well as to strengthen the systems to support them. However, by 2007 the extra effort associated with recruitment and initial training should have been considerably reduced.
- **Funding** The LHWP is still operating under a financing gap, despite being better funded than in 2000. There are insufficient medicines, a lack of transport for supervision, and delays in payments of stipends, salaries and allowances.
- **Administrative problems become magnified** These include: insufficient storage space for a larger amount supply of medicines; paper systems that become unwieldy as numbers increase; where the district is computerized, the more LHWs, the greater the dependence on efficient data processing.

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<sup>69</sup> Strategic Plan: p. 13.

- **Performance management** can become more difficult. The larger the workforce, the greater the actual number of human resources issues that will have to be managed. For example, dealing with five non-performing LHWs in a year might be manageable for one DC with a supportive EDO-H; dealing with 25 might not.
- **Vacancies in key positions** will also be a problem as the Programme become larger within a district. Between 10–15 percent of districts in the survey had vacancies for EDO-H, DC and Field Programme Officer positions. About 43 percent of districts had vacant posts for second account supervisors, and two districts did not have a single accounts supervisor in post at the time of the survey.
- **Management capacity and resources**, particularly at the district level, have not increased to match the increase in staff numbers. There is no additional funding for organisational development.

Essentially, the ADC has the responsibility of managing the LHS's daily supervisory concerns.<sup>70</sup> It would be reasonable for the ADC to have control over 20 LHS. In a district with over 1,000, the ADC has 44 or more LHSs to manage. Over half of the districts in our sample had more than 400 LHWs. In these districts, there will be more than 20 LHSs for the DPIU to manage.

Over 60 percent of ADCs reported working between 36 to 50 hours per week, and nearly 10 percent are working more than 50 hours per week. Half the districts now have two or more sessions for the monthly meeting in order to accommodate the number of supervisors. This results in additional workload for the management and administrative staff of the DPIU.

In addition, there are some administrative posts vacant; on average, one quarter of the vehicles are not working; there are problems with delayed delivery of supplies and ongoing issues with performance management of LHWs.<sup>71</sup>

It is not surprising the survey results show that the districts operating the larger size of Programme are finding it difficult to produce high-performing LHWs.

## 9.5 Findings

1. Given concerns about financing and management capacity being insufficient for Programme expansion, the Strategic Plan proposed a review that would include the options of reducing the target number of LHWs or allocating more resources, or modifying the level and package of services being provided by LHWs. It is not clear whether these options were, in fact, reviewed. Rather, it appears that the target of 100,000 LHWs was simply retained and more resources were allocated.
2. Proposals for expansion of the Programme by government need to consider the implications with regard to funding and sustainability, the opportunities for increasing coverage into remote areas, the functioning of health facilities, and the organizational capability of the Programme.
3. The greatest period of expansion was between 2001 and 2003. The rate of expansion since then has slowed considerably.
4. While provincial allocations remain fairly constant, there is an uneven pattern of expansion between districts. In comparison with 2003, 13 percent of districts had fewer LHWs in 2008. A further 20 percent of districts had only increased by within 10 percent. In 15 percent of districts, expansion was over 50 percent.

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<sup>70</sup> There was provision in the PC-1 for an additional accounts supervisor for districts with more than 800 LHWs.

<sup>71</sup> See Chapter 10 and the Systems Review.

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5. Expansion has resulted in LHWs now having to cover fewer health facilities, due to health facilities increasing the number of LHWs per facility and, in addition, the ratio of LHWs to LHWs has reduced.
6. Expansion has resulted in greater coverage, although there are still poorer areas where there is no, or very limited, coverage.
7. The Programme has also managed to upscale using the same mode of operation. It is a credit to the original designers of the Programme that this has been possible.
8. However, there are tensions associated with expansion, in particular for larger districts. These can be resolved. Essentially, there needs to be an increase in the number of managers responsible for the LHWs. There also needs to be an increase in resources at the district level that support good human resource management and organizational development.



## 10 Dealing with non-performance

**Key question: Has the Programme managed to deal effectively with non-performing LHWs?**

### 10.1 Introduction

Since 2000, the Programme has expanded from 37,000 LHWs to 90,000 LHWs. If the strategies to deal with non-performance have not worked, then this is a costly problem.

The 3rd Evaluation provided a benchmark of LHW performance. The 4th Evaluation provides a similar set of measures and, in addition, through its design, considered whether district management made a difference to LHW performance.

This chapter provides an assessment of the level of non-performance, together with factors that are under the Programme's control that contribute to high performance. It also identifies and reviews the strategies from the strategic plan and PC-1 that were designed to address non-performance.

### 10.2 Assessment of the level of non-performance

**Measuring LHW performance** LHWs provide a range of services to clients. These include the provision of health education and health promotion, informing and motivating clients to improve their health status. They provide some preventive and simple curative health services. They also refer individuals to higher levels of the health systems for a wider range of services.<sup>72</sup>

Both this evaluation and the previous evaluation addressed the question: Do LHWs provide the services that they are supposed to? The conclusion is that many individuals in the LHWs' populations are being provided with appropriate preventive and promotive services. Also, often around 40–50 percent of eligible groups have received the service, and levels are generally similar in urban and rural areas.

For a wide range of services, LHWs are providing many services to a higher proportion of their clients than they were in 2000. The use of their curative services by adults appears to have declined slightly, but not those for children.

The mean LHW performance score, which measures the extent of service delivery to eligible clients for preventive and promotive health services, has increased from 42 percent to 52 percent. For those serving in the same areas as the previous evaluation, the score has increased even further, to 55 percent. However, around half the clients are still not being provided with services that they are supposed to receive (Table 10.1).

**Benchmarks for service delivery** The performance measure of LHW service delivery uses 10 preventive and promotive services (Table 10.1). These cover LHW activities in: hygiene education, vaccination promotion, family planning, pregnancy and birth, and child nutrition and growth monitoring. The measure is a simple percentage of all the people who were eligible, receiving a specified service. On average 52 percent of eligible individuals received the selected services.

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<sup>72</sup> Quantitative Survey Report, Oxford Policy Management, March 2002: p. 28.

The LHWs are then divided into four groups of equal size (quartiles) on the basis of the level of services they provided overall.<sup>73</sup> The four groups; (1) poor, (2) below average, (3) good and (4) high performers provided strikingly different levels of service. The high performers covered at least nearly 70 percent of their clients and often well above this, for all services except growth monitoring. At the other extreme, the worst performing 25 percent of LHWs provide service to only around a quarter of their clients.

**Table 10.1 Levels of service provision by performance score quartile for services included in the performance score**

Measure	Poor performers	Below average performers	Good performers	High performers
	(25%)	(25%)	(25%)	(25%)
Mean summary performance score	26	49	63	78
Households who report that LHW talked about ways to improve cleanliness of water (%)	33	62	74	87
Households who report that LHW talked about ways to improve hygiene (%)	32	61	76	88
Women aged 15–49 who are non-users of modern contraceptives, who report that LHW discussed family planning (%)	25	36	49	66
Women aged 15–49 who are users of modern contraceptives, who report that LHW supplied them or referred them to a health centre (%)	27	44	47	61
Mothers who gave birth since 2004, who report that LHW gave advice on which foods to eat during pregnancy (%)	17	40	65	79
Mothers who gave birth since 2004, who report that the LHW saw mother at birth or within a week (%)	23	40	52	76
Children < 3 years old whose mothers report that the LHW talked about vaccination (%)	44	74	88	99
Children < 3 years old whose mothers report that the LHW encouraged vaccination at the correct age (%)	31	56	70	84
Children < 3 years old whose mothers report that the LHW gave advice on feeding the child (%)	17	41	61	81
Children < 3 years old whose mothers report that the LHW weighed the child within the last three months (%)	2	7	12	28

Source: OPM LHWP 4th Independent Evaluation, Quantitative Survey Data (2008).

As seen in the previous evaluation there is an unambiguous gulf between high performing and poorly performing LHWs

**Busy at work** Though they are serving fewer households, LHWs are working longer hours than they were in 2000. They report an average of 30 hours per week of work, compared

<sup>73</sup> See Quantitative Report, for further description of quartile analysis.

with 20 hours per week in 2000. A large part of the increase is due to time spent on NIDs. The survey found an average of 131 households registered per LHW, compared with 145 in 2000. However, there is significant variation across provinces, with only 86 households per LHW in Balochistan, compared with 150 in Punjab/ICT.<sup>74</sup>

High-performing LHWs increase the impact of the Programme's services. More knowledgeable LHWs (who tend to be high performing in any case) have an impact on the health knowledge of their households, including the household's knowledge of the proper treatment of basic illnesses, and are more persuasive in improving hygiene and sanitation practices.

**Explaining LHW Performance** As the poor-performing LHWs were not randomly scattered throughout the Programme, the evaluators looked for factors that might be contributing to performance. They found that LHW performance showed a strong relationship with a number of variables that were under the Programme's control. Higher-performing LHWs had higher levels of knowledge, were better supervised, and better supplied with drugs and equipment. They worked longer hours than poor-performing LHWs. Their supervisors also had higher levels of knowledge. The size of the Programme of the district is also a factor in the performance of LHWs. Larger districts (greater than 1,000 LHWs) are finding it harder to produce high-performing LHWs.

### **10.3 Addressing non-performance: Strategic Plan and PC-1**

**Strategic Plan** One of the four priority areas in the Strategic Plan was to improve the quality and the level of services delivered by the LHW.

Key performance indicators (KPIs) were developed that covered: LHW knowledge, supplies of medicines and contraceptives, regularity of salary payments, and supervision. Other measures were for functional health committees, and for the implementation units to have strategic plans and be compliant with procedures. These measures would reflect the management environment of the Programme and the governance function by the community of the LHWP.<sup>75</sup>

Activities were also listed that aimed at strengthening management and accountability,<sup>76</sup> improving service quality and service levels through improved support systems, reviewing the remuneration, and further decentralising decision-making based in district capabilities.<sup>77</sup>

**PC-1 (2003–08)** The PC-1 defines the scope of work for the LHS.<sup>78</sup> Under a section on supervisory functions it lists:

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<sup>74</sup> The PC-1 and the Strategic Plan clarify the role of the LHW and the services she is to deliver. The initial standard was that the LHW should visit each of her registered households once a month. The new PC-1 (p. 33) set a standard for visiting 5–7 households every working day and ensuring a revisit every two months.

<sup>75</sup> Strategic Plan: p. 21.

<sup>76</sup> Strategic Plan: p. 22: (1) Clarify the roles of managers in the Programme, especially at the district level in the light of expansion and quality improvements, (2) develop the District Team Problem Solving (DTPS) approach, (3) support development of management capabilities to address expansion and service quality, (4) enhance accountability through district and programme level mechanisms, (4) a review of the role of the FPO (supervisors or independent inspectors), (5) improved programme awareness and accountability to Nazims, councillors, and members of Citizens' Boards and at the provincial level, (6) a system for making district-level managers accountable for Programme performance, (7) review and develop role of health committees.

<sup>77</sup> Strategic Plan: p. 22.

<sup>78</sup> PC-1: p. 33.

- providing support and guidance;
- ensuring adequate performance of LHWs regarding delivery of primary health care and family planning services; and
- carrying out corrective measures for improving the performance of LHWs in accordance with given guidelines.<sup>79</sup>

**Other measures** There were other measures in the Strategic Plan and PC-1 that might have increased performance, but were not aimed at dealing with non-performance. These include the: remuneration review, improving management performance through providing a project allowance,<sup>80</sup> improving monitoring and supervision by decreasing the ratio of LHSs to LHWs from 1:30 to 1:25,<sup>81</sup> providing greater access to vehicles for supervision and inspection for both LHSs and Field Programme Officers, and encouraging LHSs to provide supportive supervision.

## **10.4 Review**

**Focus on success** The emphasis in both the Strategic Plan and the PC-1 was on developing an environment in which the LHW could succeed at her job.<sup>82</sup> The Programme succeeded in increasing the performance and knowledge scores of LHWs through providing: refresher trainings and monthly training at the health facility to improve knowledge and skills, giving greater mobility to the Field Programme Officers through the provision of vehicles, and increasing LHSs mobility with increased access to vehicles.

There was a reduction in the ratio of LHSs to LHWs from 1:30 in 2000 to 1:23; however, as was shown in the previous evaluation, this does not make a difference to performance, is more costly to the Programme, and increases the workload at the district level.

**Additional measures** in the Strategic Plan and PC-1 that might have impacted on performance and were not implemented were the:

- remuneration review, though the salary of the LHW did increase in real terms, by around 30 percent, between June 2003 and June 2008;<sup>83</sup> and
- project allowance of 20 percent of base pay for management staff on deputation to the PPIUs and DPIUS was not reinstated, despite being approved in the PC-1. However, DCs are working hard, spending more than seven days in the field per month, with over 60 percent of them working more than 36 hours on the Programme per week.

**Dealing with poor performance** However, apart from the reference to carrying out corrective measures in the PC-1 (and, even then, these are mainly focused on supportive supervision and training) and the existence of a Programme policy, there has been no major

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<sup>79</sup> PC-1: p. 39.

<sup>80</sup> The purpose of the allowance was to ensure that the Health Department staff would devote the necessary time and effort to ensure the success of the Programme. These staff are essential for: selection of the LHW, spot verification resulting in termination if the criteria have not been met, training of the LHWs and LHSs, firing of non-performing LHWs and Supervisors, supervision and monitoring of performance, providing performance feedback to non-performing FLCFs, ensuring the smooth delivery of supplies to the field, accounting for expenditure in the programme, improving the quality of HMIS information.

<sup>81</sup> Although the previous evaluation had found that the number of LHWs supervised was not a contributing factor to high performance.

<sup>82</sup> The LHW is monitored by the LHS according to a checklist. This results in a score that, if it is below 65 percent, should trigger training from the LHS. If the score continues to be low, then the LHS is to report the LHW to the DPIU, who will issue a warning. After three warnings, the LHW's employment is terminated.

<sup>83</sup> See Finance and Economic Analysis Report, OPM (August 2009).

initiative designed to tackle this problem. In 2008, there remained a substantial group of under-performing LHWs. Low-performing LHWs deliver relatively low levels of service across all their services. The level of employment terminations is very low compared with the number of non-performing LHWs. It is also difficult to assess, using the Programme records, whether an LHW's employment has been terminated due to the LHW being non-resident or for her non-performance.

**The LHS and non-performing LHWs** The LHSs are using their checklists and report discussing poor performance with LHWs that have low scores. If this is not followed by improvement, the LHS then reports the problem to the DC/ADC and, sometimes, the Field Programme Officer. However, this course of action does not seem to result in the level of expected terminations of employment.

**Terminations** Districts have the authority to terminate the employment of non-performing LHWs, and there was consensus on the definition of non-performance. DCs reported it was: not visiting households, not recording and updating MIS information, and non-attendance at the monthly meeting. The performance score was recognized as an important measure by a significant number of DCs. DCs reported asking non-performing LHWs for written explanations, and sending out warning letters (part of the discipline process).

**Ability to apply sanctions** It appears that the Programme is limited in the amount of leverage it has in applying sanctions for non-performance.

This issue is also apparent when considering other non-compliance issues. For example, it was recognised by the Programme that there were governance issues in Balochistan and, in 2004, an advisor was appointed to facilitate a development plan for improvement. This plan was agreed with the PPIU but was unable to be implemented due to lack of support by the government.

The Programme has also been unable to deal with the non-residency issue in Sindh, or with some districts recruiting in urban areas. There are non-approved training programmes being conducted, and LHWs are working outside their catchment areas for NIDs and working for other organisations (e.g. the MICS survey in the Punjab). There is an increase in charging for services by LHWs, which is also unacceptable.<sup>84</sup>

However, an area of compliance that has improved is the number of LHWs with an additional paid job. This has reduced significantly in all provinces and regions since 2000. It is unclear whether this is attributable to a reinforcement of the policy of LHWs not having other paid work, or is a result of the LHW now working more hours.

**Increasing community participation** The community reports having respect for the LHW and valuing her role. In particular, the women's health committees are more active than in the previous evaluation. Almost all women's health committees in the Punjab have met in the past month and have undertaken some activity in the past year. The community plays an important role in the operation of the LHWP. Without its acceptance, it would not be possible for the Programme to function. It might be that, in future, the community will not accept non-performing LHWs.

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<sup>84</sup> The National Health policy is to provide the Programme services free of charge. Of households reporting, 9 percent had paid LHWs for treatment of diarrhoeal disease. This has increased since 2000. The regulations on charging need to be enforced. This needs to be communicated to clearly LHWs, particularly as, in future, they are to work closely with community midwives who are able to charge for services.

## **10.5 Findings**

1. While the Programme has made a significant effort with strengthening positive incentives for LHW performance, the number of non-performing LHWs is significant. The benchmark used for service provision in the survey shows that the bottom 25 percent of LHWs are only delivering one third of the level of service provided by the top 25 percent, the high-performers.
2. These high-performers are making a significantly higher impact on health in their communities. Communities with non-performing LHWs are not receiving the services that they deserve and for which the Programme is paying. The Programme needs to strengthen its ability to manage non-performance by terminating the employment of those LHWs that do not wish to provide a service.
3. To do this, the Programme could provide more accountability and support to the district. This might include additional managers for the teams of LHSs and, in particular, increasing the number of ADCs in order to ensure that one-to-one support and supervision is available. A maximum span of control needs to be established of one manager (in particular, the ADC role) to around 15–20 LHWs. This would allow for an increase in focus on supervision, and on the training and management of human resource issues.
4. As the community becomes increasingly aware of the role and value of the LHW, she, in turn, becomes accountable to the community. In future, it might be that communities will no accept non-performing LHWs.
5. The Programme must increase its ability to gain compliance on core Programme policies and performance standards, including dealing with non-performing LHWs.

## 11 Conclusion

The Programme entered this five-year period with a Strategic Plan (2003–11) and a PC-1 (2003–08) with clear directions for the future.<sup>85</sup> The main challenges were to:

- improve the quality (knowledge and skills) and the level of services delivered by LHWs;
- expand from 40,000 to 100,000 LHWs into under-served poor rural areas;
- gain assurance of a sufficient level of funding; and
- strengthen and develop the organisation for the future.

The Programme now has 90,000 working LHWs in all districts of Pakistan. The LHWs are working harder and are more knowledgeable than in the 3rd evaluation (2000). While the full allocation of funds was not received, the level of funding was significantly higher.

However, while the Programme has made significant progress, there was a failure of governance to drive the strategy and to command accountability, and there was a management failure to implement Phase 2 of the PC-1. Phase 1 (mid-2003 to mid-2005) was to be a time of consolidation and expansion; Phase 2 (mid-2005 to mid-2008) was to develop a sustainable programme.

By the end of Phase 1, there were to be 100,000 fully-trained LHWs and 4,000 LHSs. Systems and procedures for training, implementation, monitoring and supervision were all to have been improved.

By the end of Phase 2, a capacity-building process at the provincial and district levels was to have been conducted, along with the trialling of different models for the development of a sustainable and viable structure for the LHWP. This included exploring, through pilots, the transfer of management functions to the provinces and districts. This did not take place.

The Programme has also failed to implement a number of initiatives and systems developments outlined in the PC-1 and the Strategic Plan. These are that:

- the external evaluation planned for 2005 did not take place, though there was an internal assessment conducted in 2007 and an external evaluation in 2008;
- while there was expansion, 50 percent of the expansion occurred in only 15 districts;
- the Programme did not consistently prevent recruitment in urban areas;
- while there was expansion into poorer areas, the incentive remained to increase LHWs at health facilities where the Programme was already established;
- a mechanism was established to explore options for decentralization, but it was never utilized. The Inter-Provincial Committee for Decentralisation never met. Government did not pursue decentralization for this Programme during this period;
- the building of partnerships with NGOs has been limited, including at the national level. Individual units of the Programme are not authorised to initiate projects and partnerships. However, we can use training programmes as an indicator of other activity. From the results of the survey of LHWs, it is clear that reasonable numbers of them have attended training courses that have not been authorised by the Programme. This presents risks, both in a lack of control of the quality of the training and of the LHW becoming confused as to her priorities in service delivery;

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<sup>85</sup> The PC-1 for the period 2003–08 was approved by ECNEC (the Economic Cabinet Committee) on 08 January 2004 at a cost of Rs. 21.534 billion.

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- the EPI policy of administering various childhood vaccines, by LHWs, nationally, was not fully implemented;
- the planned reviews in areas of high expenditure (salary policy; development of a fleet management system; improvement of the logistics management system.) did not occur; and
- in addition, the Programme failed to address some difficult problems. These include: the significant number of LHWs in Sindh being non-resident in the area served; the lack of sanction on non-performing LHWs; the write-off, disposal and replacement of outdated vehicles; and the on-time procurement of drugs.

Any organisation has limits on the amount of management attention available. In a bureaucracy working in a challenging environment, such as rural Pakistan, this attention is quickly absorbed by day-to-day operations. And so it is with the Programme. The governance arrangements of the Programme are there to allow management (both internal and within the Ministry and Departments of Health) to provide leadership, and to make and implement the necessary strategic decisions. That they have generally failed to do so became evident as we addressed the seven questions of the management review. Some of the issues that were not addressed are: options for decentralisation, non-compliance with residency criteria in Sindh, issues of integration with BHUs that have been contracted out to non-governmental organisations, and further expansion in urban areas at the expense of development of the Programme into poorer rural areas. These are issues that needed to be exposed by the National Coordinator of the Programme, addressed through the governance committees, and on which decisions needed to be taken to resolve the issues by the Secretary of Health and the central agencies.

The Programme managers must now plan for the future. There are emerging risks that must be managed by the Programme. These include:

- tolerating non-compliance; for example, by the 25 percent of LHWs providing a low level of service, LHWs not maintaining the residency criteria in Sindh, LHWs working outside their catchment area and/or for other organisations, and LHWs charging for services. The Programme needs support from government to apply sanctions for non-compliance;
- the lack of accountability of the Programme to the government for full implementation of the Strategic Plan and the PC-1 between June 2003 and June 2008. There needs to be a more formal system of reporting against key performance indicators. The Programme also needs support from government to implement initiatives that will ensure development and risk management;
- rapid turnover in management positions at all levels in the Programme presenting a risk that managers are not in position for sufficiently long periods to provide leadership. In addition, there is a shortage of expertise in the management of the fleet, procurement, and logistics management at senior levels.

There are also issues that Programme managers need to address in order to ensure that the Programme can expand successfully into more disadvantaged areas and to improve the level and quality of services provided by LHWs. These are that:

- Programme expansion has occurred both through the LHWP extending coverage to previously unserved health facilities in more disadvantaged areas and through recruiting more LHWs to health facilities that were already a part of the Programme. Future expansion is going to require working with provincial and district governments to ensure functioning health facilities that take responsibility for the success of their outreach services;



- compliance with Programme policies and performance standards must be achieved in order to be able to introduce greater delegation to the provincial and district levels;
- district management that has a proven record of supporting Programme performance should be given increased responsibility as soon as accountability mechanisms are in place. There will need to be a strengthening the Programme's capability in monitoring and the provision of management information. As the community becomes increasingly aware of the role and value of the LHW, she, in turn, becomes accountable to the community. In future, it might be that communities will not accept non-performing LHWs;
- the factors under the Programme's control that have been shown to improve LHW performance need to be strengthened. These will include: further management and administrative resources to all districts, but particularly those that have large programmes; initiatives targeted at encouraging effective supervision by the LHS; ensuring health facilities have a person who is responsible for the Programme; and refresher training.
- the budgets for management, monitoring and training are only a small percentage of the unit cost of the Programme, yet they are important for increasing the quality of the services and should not be under-utilised; and
- collection of high-quality information to use for policy development and decision-making.

The Programme's vision of providing a service to the doorstep of the community has been retained over the past five years. The LHW is now established as a community service provider who is recognised by the community for the services that she is able to deliver. The LHWP is able to provide services to the community, and in all provinces and regions of the country. The goal now must to improve LHW performance and expand into even poorer areas, so as to maximise the impact on health.



## **Annexes**



## Annex A The service providers: the LHW

The LHW provides frontline services, immunisation provision and liaison, and simple curative care with a focus on maternal and child health. The scope of work of the LHW is specified in the PC-1, as follows:

- **Frontline services** The LHW is responsible for establishing direct contact with families, ensuring accessibility of the Programme to all primary health care target groups in the community. The LHWs deliver family planning services and carry out MCH activities such as ante-natal care, the giving of advice on natal and post-natal services, increasing immunisation coverage against major infectious diseases, the promotion of health education, giving advice on nutrition and basic sanitation, the prevention and control of local endemic diseases, and educating people about the prevention of AIDS and STIs.
- **Immunisation provision** Immunisations against the seven vaccine-preventable diseases are primarily carried out by designated vaccinators. By 2003, half of the LHWs had been trained in giving vaccines and had vaccinated more than five million women of child-bearing age against tetanus toxoid. The plan in this PC-1 was to increase the number of LHWs giving vaccines. The LHW also participates in various campaigns for immunisation against EPI target diseases; e.g. polio, MNT.
- **Simple curative care** In accordance with guidelines, the LHW refers cases to the nearest medical centres. However, from a limited monthly supply of essential drugs the LHW is able to treat simple illnesses, such as diarrhoea and minor cases of upper respiratory infections, which constitute more than 60 percent of the cause of mortality of children under five years old. Common illnesses managed by the LHW include: fever, malaria, eye infections, intestinal parasites and anaemia. In areas where iodine deficiency is endemic, the tasks of the LHW include the provision of IDD Programme services. The LHWs are also involved in the management of TB patients through the DOTS strategy of the National TB control programme and in the control of malaria.



## Annex B Functions of the implementation units

While strategy, evaluation, standard setting, purchasing and cost-control are the responsibility of the federal MoH through the FPIU, operational management, recruitment, training delivery and monitoring are the responsibility of the provincial Health Departments and District Health Offices through their provincial and district implementation units and their governing bodies.

**FPIU** The FPIU is headed by the National Coordinator. According to the PC-1, the National Coordinator should be the Deputy Director General of Primary Health Care from the MoH, in order to ensure integration of Primary Health Care activities. In 2006, these responsibilities were separated out to form a separate position that is to be filled on contract. In addition to Deputy Coordinators who support the management of the programme, there is also provision for a National Programme Advisor to be hired on contract. This is a mechanism for attracting personnel with extensive public health experience to support coordinating activities with the provinces, and planning and piloting strategies.

**PPIU** Provincial Programme Implementation Units are established in the Punjab, Sindh, NWFP, Balochistan, AJK, FANA, FATA, and ICT (these latter four areas are called RPIUs). The Director General, Health Services is the Chairman of the PPIU and is responsible for overseeing the performance of the PPIU. The PPIU is headed by the Provincial/Regional Coordinator, is a member of their respective health department with the delegated powers similar to a medical superintendent or an EDO-H. The Provincial/Regional Coordinator is responsible for all operational matters, and the day-to-day functions of the PPIU and the activities of the Programme in their province/region.

**DPIU** The District Programme Implementation Unit (DPIU) is defined in the PC-1 as the most important field-level functional unit, and is chaired by the head of the district health office (i.e. the EDO-H or the DHO). The DC is an officer of the District Health Office nominated by the EDO-H/DHO in consultation with the PPIU. The EDO-H/DHO may nominate two other members of the District Health team to be part of the DPIU. These members are actively involved in the day-to-day functions of the DPIU, and are supposed to be paid an additional 20 percent of their basic pay each month (however, this did not take place during the course of this PC-1). The DPIU may also co-opt other related staff to be members of the DPIU; however, they will not be entitled to the payment of the 20 percent allowance.

**Table B.1 Functions of the implementation units**

FPIU	PPIU	DPIU	Health facilities
Policy development within the context of government policies and in consultation with the MoH, Planning and Development Division, Ministry of Finance and the relevant departments in the provinces and districts	Planning and implementation of provincial Programme activities under the guidance of the FPIU, including preparation of an annual operational plan	Planning and implementation of district Programme activities under the guidance of the PPIU, including the preparation of an annual operational plan	
Management of the budgeting and accounting processes, including distribution of funds to the PPIUs	Management of the provincial budget and accounting processes, including payroll	Management of the district budget and accounting processes, including payroll	

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<b>FPIU</b>	<b>PPIU</b>	<b>DPIU</b>	<b>Health facilities</b>
Management of strategic and annual planning processes, and national reporting on targets and activities	Reporting on provincial targets and activities	Reporting on district targets and activities	Organize LHW monthly meeting
Management of monitoring and evaluation, including internal audit	Management of the monitoring/inspection system for the province, including recruitment of FPOs	Supervision and quality control of all district Programme activities	Oversight of the LHWP at the community level
Management of the recruitment system, including allocation of posts to provinces	Allocation of LHWs, LHSs, drivers and vehicles to the districts Responsibilities in the selection process for LHSs, accounts supervisors, and drivers	Allocation and selection of LHWs at health facilities	Selection of LHWs
Management of development of professional skills and knowledge, including curriculum development ensuring uniformity across the country	Planning and organizing the delivery of training, including providing provincial master trainers Quality control of the training system	Planning and organizing the delivery of training, including providing district master trainers Quality control of training provided in the district.	Training of LHWs
Management of the MIS system	MIS and HMIS data collation and reporting to the FPIU	MIS and HMIS data collation and reporting to the PPIU	Collate the HMIS data from the LHWs and submit to the DPIU
Procurement of supplies and distribution to PPIUs with active involvement of provincial governments and bodies at the federal level	Logistics management for the province, including distribution and monitoring of supplies to the districts	Logistics management for the districts, including distribution and monitoring of supplies to the facilities	Replenish the LHWs' supplies from LHWP stocks
Fleet management, including a national database, and maintenance and repair of FPIU vehicles	Fleet management, including a provincial database, and maintenance and repair of PPIU vehicles	Fleet management, including a district database, and maintenance and repair of vehicles and equipment	Parking space for LHSs' vehicles
Resource mobilisation from government and development partners			
Development and implementation of media campaigns for mass awareness			
Intersect oral collaboration with other governmental and non-governmental organizations	Intersect oral collaboration with other governmental and non-governmental organizations where this is Programme policy	Intersect oral collaboration with other governmental and non-governmental organizations where this is Programme policy	Intersect oral collaboration with other governmental and non-governmental organizations for service delivery where this is Programme policy

Source: PC-1 (2003–08), LHWP, MoH



## Annex C Levels of decision-making in the LHWP

Essentially, the most important decision in terms of fulfilling Programme objectives and incurring budgetary expenditure is the number of LHWs employed. This decision is taken by the Secretary of Health (SoH) with the concurrence of the Planning and Development Division. Decisions on policy matters within the PC-1 guidelines or operational initiatives that do not incur expenditure are taken within the FPIU.

While most of the decision-making power is held at federal level, the major exceptions are the responsibility of the PPIUs and DPIUs for:

- most provincial staff appointments, including the hiring and firing of LHWs and LHSs; and
- decisions on which district and health facility receives coverage by the Programme.

The PC-1 proposes the Programme be given authority to:

- hire and fire staff (in accordance with the PC-1);
- call quotations/tenders (in accordance with requirements) and to place orders up to a value of Rs. 40,000;
- transfer funds to districts from Programme accounts, every quarter;
- establish PIUs with adequate office and storage space;
- acquire computers, fax, Internet access and telephones, and connect all offices by means of the Internet; and
- have a special ceiling for telephone and fax bills;
- hire drivers for, and pay for POL and maintenance on, donated vehicles.

Table C.1 was first constructed in 2002. The fact that it does not require modification, in 2008, demonstrates that decision-making has not been further delegated within the Programme.

**Table C.1 Decision-making within the Programme**

Where is the decision taken?	Example of decisions
GoP, Cabinet	To continue the Programme until 2011, and to include it in the 10-year Perspective Development Plan with an allocation of Rs. 23,100 million Revision of PC-1 Programme decentralisation (most probably would go to Cabinet) Vehicle purchases The increase from 33,000 LHWs to 100,000 LHWs (1995) Expansion of Programme from rural areas to urban slums in 1995
Specifications in PC-1, approved by Federal Secretary of Health	Services to be provided by the LHWP Goals and objectives of the Programme, including coverage and policies such as discontinuing recruitment in urban slums Organisational arrangements for implementation including oversight committees Monitoring and supervision arrangements, including ratio of LHSs to LHWs, staffing levels of the implementation units, and numbers of FPOs Selection criteria for LHWs and LHSs Annual budget for inputs, including salaries, training, project allowances, Type of vehicles to be purchased Organisational policies; e.g. on office renting for the PPIU, procurement of supplies, policy on transfers (which was to not transfer federal, provincial and district Programme coordinators – presently working against regular posts – for three years)

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Where is the decision taken?	Example of decisions
Central agencies: Finance, Prime Minister's Office, Planning and Development Division (P&D)	<p>Programme creation            Programme approval for continuation prior to going to Cabinet            Increase in salaries/stipends            Strategic Plan clearance            Release of budgeted GoP funds            Changes in disbursement procedures (2000 for payroll)            Programme included in SAP            Travel allowance for supervisors who do not have access to a vehicle (1999)</p>
MoH	<p>Policy for partnerships with NGOs            Programme extended to urban slums            Increase in POL allowance            Change in contents of LHW kits            Pay increase for LHW/LHS (concurrence with MoF)            Creation of Accounts Supervisor role (concurrence with P&amp;D)            Targets for programme expansion (concurrence with P&amp;D)            Transfers at the higher levels (SoH and Director General (DG))            Appointments in the FPIU (DG)            Procurement of drugs/non-drug items (procurement committee headed by the Federal Director General of Health)            Donor agreements ( to include Economic Affairs Division and MoF)            Expenditure over Rs. 25,000</p>
National Coordinator- FPIU	<p>Allocations to districts in collaboration with PPIUs            Budget allocation within line items at federal level (with SoH concurrence)            Partnerships; e.g. Medicin du Monde, AKHS,            Select provincial master trainers from provincial coordinator nominees            Replenishment policy for LHW kits            Additional tasks included in LHW job description; e.g. AIDS education, TB DOTs therapy            Job descriptions of DCs, Assistant Provincial Coordinators, and Field Programme Officers            Programme meetings policy; e.g. monthly LHS meeting at the DPIU            Strengthening of the LHWIS reporting system            Introducing the diary for LHWs            Verification process for LHWs selection criteria            Curriculum review            Development in core training and professional standards of LHWs and LHSs (within revised PC-1 boundaries)            Training delivery channel            Rationing of vehicle distribution            Content of continuing education programme            Review of training manual            LHS training in IUCD insertion</p>
Provincial Department of Health	<p>Director General of Health, Chairman of PPIU            Appointment and termination of employment of Provincial Coordinator (SoH)            Verification of supplies            Approval of expenditure over Rs. 25,000</p>
Provincial Coordinator	<p>Allocations of LHWs to districts within the province            Appointments and termination of employment of staff in PPIU            Selecting office space            Supply contract for transportation of supplies from provincial level out to districts            Budget allocation to line items (provincial level)            Release of salaries to LHWs</p>
Executive District Officer of Health	<p>Coverage (which health facilities and villages will have LHWs)            Selection of LHSs            Selection of district-level trainers            Terminations of employment of LHWs and LHSs            Appointments in the DPIU (with concurrence of the PPIU)            Budget allocation amongst line items (district-level – with PPIU concurrence)</p>
FLCFs	<p>Selection of LHWs with approval of EDO-H</p>

## Annex D An example of planned integration between the MNCH programme and the LHWP, and others

Table D.1 shows the planned integration between the MNCH and the LHWP, as expressed in the MNCH PC-1.

Key informant interviews, conducted in early 2008, revealed some of the issues in implementation:

**Re-litigation** ‘With the mid-wives, once they were trained and back in their catchment area we planned that monitoring would be a joint responsibility between the two programmes. The LHS would monitor their activities (not their professional competence; that would be done by tutors hired by the MNCH programme). However, when the Programme was finally approved, this same debate started again. It seemed like the LHWP was against it on the basis that it would require additional POL.’

**Delays in functioning** ‘The MNCH Programme needed the LHW to be the contact point for referral to the midwife. Unfortunately, the MCNH programme is not functional yet. We have been training the midwives. The linkage will come up when we put them in the field.’

**Flow of funds** ‘A mechanism like the LHWP was proposed, but Punjab Secretary of Planning and Development was adamant on not having this. He said “Give us the money and the targets and evaluate us on the targets and monitoring.” The rest of the provinces then wanted to follow them. They wanted a tied grant to give to the districts. In this system, it is not possible to trace the money down to the districts. The provinces are now having the problem of not being able to secure their money from the provincial account as it involves dealing with the Department of Health, Finance and Planning. Now, all the PIUS in the MCH programme are saying “We would like the same funding mechanism as the LHW.”’

**District level expertise** ‘At the district level, we envisaged that within the existing managers we would provide them with a public health specialist. But our primary contact is the EDO-H, not a member of the Programme.’

**Table D.1 Examples of planned linkages between the MNCH programme and other programmes**

Government programmes with direct impact on MNCH	Mode of delivery	Proposed MNCH linkage
National Programme for FP and PHC	Ongoing service delivery managed at the district level, supervised by LHSs	LHWP will provide supervision of the CMWs, and LHWP officers will assist in supervision of training activities.
National EPI Programme, including polio, NIDs and MNT- Special Immunisation Activities	Ongoing service delivery to the community from the district level. Field days organized quarterly and delivered through the District Health Services (including the LHWP)	Reinforce message for vaccination, including support for TT vaccination of pregnant women through CMWs, and provision of vaccination through fixed sites at BHUs. Polio vaccinations and surveillance of AFP
Integrated management of newborn and childhood diseases (IMNCI) strategy (1998–ongoing)	Community component delivered by the LHWP	Provide training and support to health facilities
Acute Respiratory Infections Control Project	Integrated into the IMNCI strategy	
National Programme for Control of Diarrhoeal Diseases (CDD)	Integrated into the IMNCI strategy	

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<b>Government programmes with direct impact on MNCH</b>	<b>Mode of delivery</b>	<b>Proposed MNCH linkage</b>
Maternal and newborn health related special activities		
Nutrition project		Integrate district nutrition officer (focal person) with MNCH activities, and support implementation through CMWs
Hepatitis programme	Provides/installs incinerators at all DHQ hospitals, nationwide	

## Annex E Training conducted for pilot initiatives, 2003-08

**Table E.1 Training conducted for pilot initiatives, 2003–08**

Pilot/study	Sponsor	Year of pilot and current status	Duration of training	Any new skill introduced	Districts involved	Whether approved by committee
Injectable contra-ceptives	UNFPA	Became a refresher training course and a new service. However, there are problems with the Programme supplying injectable contraceptives	6 days' training of LHWs and trainers	Intra-muscular injection?	10 districts	No
Training on support group methodology	PAIMAN	Became a refresher training course	3 days' training of LHW and trainers	Use of counselling cards and counselling skills	10 districts	No
Child health (CSD)	UNFPA	Became a refresher training course	6 days' training of LHW and trainers	Use of laminated picture cards for childhood diseases	10 districts	No
TB DOTs	CIDA	Completed in pilot area	3 days' training of LHWs and trainers	Sputum collection Filling out of cards	14 districts	No
Use of Sprinkles by LHWs	Micro Nutrient Initiative, Nutrition Wing, MoH	Completed in pilot area, July 2007	1 day's training of LHWs and trainers	Use of Sprinkles counselling skills on child nutrition	4 districts	Yes
Hifazati Teeka Jat	EPI Programme, MoH					No
Maternal and newborn health trainings	UNFPA and UNICEF	Completed in 10 UNFPA districts and in 13 UNICEF districts	7 days' training of LHWs (6 days' training of trainers)	Use of bathroom scale for women Use of plastic cards for children	23 districts	No
Use of zinc in connection with diarrhoea	Aga Khan University	Not known			1 district (Hala)	Yes
Social mobilisation (Qualitative Study, 2007)	USAID to Green star and Green star to Save the Children UK				4 districts (around 300 LHW)	No

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<b>Pilot/study</b>	<b>Sponsor</b>	<b>Year of pilot and current status</b>	<b>Duration of training</b>	<b>Any new skill introduced</b>	<b>Districts involved</b>	<b>Whether approved by committee</b>
Non-communicable diseases	Heart file	Only the section on heart disease was conducted at Lodhran district	3 days' training of LHWs and trainers	Counselling skills	Was supposed to commence in July 2007 in 4 districts but conducted in 1 district)	No
SMART (Safe Motherhood Applied Research and Training Project)	European Union	2003–06	158 LHWs and LHS had CCA training; 170 LHWs and LHSs had technical training		DG Khan – two sites. District Layyah was a control site.	No
Birth registration with Plan International						No
Community IMCI						No
NCHD						No

Source: LHWP, MoH, (2009).

## Annex F Allocations of LHWs, by province/area, 2002-08

The allocation of LHWs for the Programme was 100,000 in the PC-1. This PSP data provided to the Evaluation team shows a slight increase on this number to 102,008 in 2008. However, the Programme reports that this is an error in the database, as the allocation remained at 100,000 (the figure decided on when the PC-1 was developed; see Table F.1).

**Table F.1 Allocations of LHWs by province/area, 2002–08**

Province	2002 <sup>86</sup>	2003	2004	2005	2006	2007	2008
Punjab	36,484	52,381	52,381	52,432	52,434	52,381	52,381
Sindh	18,008	21,225	21,225	21,225	21,225	21,225	21,225
NWFP	10,263	12,866	12,866	12,762	12,762	14,465	14,469
Balochistan	4,305	5,800	5,800	5,871	5,871	6,030	6,000
AJK	2,250	2,500	2,500	2,800	2,800	2,800	2,800
FATA	545	1,600	1,600	1,600	1,600	1,600	1,600
FANA	1,268	1,267	1,267	1,318	1,318	1,265	1,200
ICT	325	325	325	325	325	325	325
Total	73,448	99,967	99,968	100,338	100,341	102,098	102,008

Source: PSP database (January 2009), LHWP, MoH.

Table F.2 shows the allocation of LHWs by province in 2003, together with the population prediction provided by the National Institute of Population Studies (NIPS). It is clear that the Programme criteria for the allocation of LHW positions are based on the rural population in each province or area. Sindh has a slightly higher percentage of LHWs allocated in proportion to the rural area, due to urban allocation for LHWs in *katchi abadis* (urban slums). In the FPIU database, Sindh had 17,657 LHWs allocated in 2003, with 6,737 of those being allocated to urban areas.

**Table F.2 Comparison of the allocation of LHW posts by province/area, 2003–04, with rural population predictions**

Province	2003–04 LHW allocations	Share of the total (1) (%)	Rural population prediction 2003 (NIPS) (000s)	Share of total population (%)
Punjab	52,381	55.61	54,958	56.51
Sindh	21,225	22.53	16,743	17.22
NWFP	12,866	13.66	16,370	16.83
Balochistan	5,800	6.16	5,468	5.62
FATA	1,600	1.70	3,398	3.49
ICT	325	0.35	315	0.32
Total	99,967	100.00	97,252	100.00

Source: PC-1 (2003–08), LHWP, MoH for LHW allocations, and National Institute of Population Studies (NIPS) for rural population projections.

<sup>86</sup> Figures for 2002 are from the National Plan of Action, Year 2002–03, FPIU, NPFP&PHC.





## Annex G Management change at the FPIU of the LHWP, 2001-09

**Table G.1 Management change at the FPIU of the LHWP, 2001–09**

	2001	2002	2003	2004	2005	2006	2007	2008	2009
<b>Federal Programme Implementation Unit</b>									
National Coordinator + Deputy Director General (Primary Health Care)	Dr Zahid Larik	Dr Zahid Larik	Dr Zahid Larik	Dr Zahid Larik	Dr Zahid Larik	Dr Haroon Jehangir Khan	Dr Haroon Jehangir Khan	-	-
National Coordinator	-	-	-	-	-	-	-	Dr Asad Hafiz/ Dr Hakroo/ Dr Baseer Achakzai/ Dr Iqbal Lehri	Dr Iqbal Lehri
Deputy Director General (Primary Health Care)	-	-	-	-	-	-	-	Dr Tahir Sajjad	
ADG (PHC)							Dr Farrukh Lodhi	Dr Farrukh Lodhi	Dr Farrukh Lodhi
Deputy National Coordinator 1	Dr Zaidi	Dr Zaidi	Dr Zaidi		Dr Zareef-u-din Khan	Dr Zareef-u-din Khan	Dr Moham mad Safi	Dr Moham mad Safi	Dr Farah Sabih
Deputy National Coordinator 2	Dr Moham mad Kazi	Dr Moham mad Kazi	Dr Fazle Molah						Dr Naseer Jomezai
DNC R&I/Monitoring officer				Dr Rashid Zar					
M&E Officer				Dr Moham mad Safi	Dr Moham mad Safi	Dr Anjum	Dr Anjum	Dr Anjum	
Deputy National Coordinator SMT				Dr Sherbaz Khan	Dr Moham mad Safi	Dr Moham mad Safi	Dr Moham mad Safi		
Deputy National Coordinator MS				Dr Fazle Molah	Dr Zareef-u-din Khan	Dr Zareef-u-din Khan	Dr Anjum	Dr Naseer Jomezai	
Deputy National Coordinator RHP				Dr Zareef-u-din Khan	Dr Samra (brief)	Dr Farah Sabih	Dr Farah Sabih	RH project merged with LHWP after the project expired	
Finance Officer	Mr. Zulfiqar	Mr Zulfiqar	Khawaja sahib	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq
Logistics Officer	Inam-ullah	Inam-ullah	Inam-ullah	Fazle Subhan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan
Monitoring and Evaluation Officer	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi

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	2001	2002	2003	2004	2005	2006	2007	2008	2009
Training Specialist	Dr Ayub Sulariya								
Training Coordinator (UNICEF)		Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel
MIS Coordinator	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman			Shehzad	Shehzad
Health Education Officer							Mr Aslam	Mr Aslam	Mr Aslam
MIS Officer	-	-	-	-	-	Imran Ahmad	Imran Ahmad	Imran Ahmad	Imran Ahmad
Research Officer	Dr Fazle Mohah	Dr Fazle Mohah		Dr Sofia Furqan	Dr Sofia Furqan			Dr Farhat Nazir	Dr Farhat Nazir
BCC Advisor				Asma Akbar	Asma Akbar			Dr Zaheen (PAIMAN)	Dr Zaheen (PAIMAN)
National Advisor		Dr Zulfiqar Ali	Dr Zulfiqar Ali	Dr Imtiaz Malang	Dr Imtiaz Malang	Dr Imtiaz Malang			
Finance Advisor		Fareed Khokhar	Fareed Khokhar	Fareed Khokhar	Fareed Khokhar	Fareed Khokhar	Fareed Khokhar	Fareed Khokhar	
Logistics Advisor	Tanvir Opal	Tanvir Opal	Tanvir Opal	Inam-ullah Khan	Inam-ullah Khan	Inam-ullah Khan			
M&D Advisor				Dr Mushtaq Sulariya	Dr Fawad Khan				
<b>Management Advisor</b>									
Training Coordinator (Govt)							Dr Zia ullah	Dr Zia ullah	Dr Zia ullah
MIS Advisor DFID		Anwar Hussain	Anwar Hussain	Anwar Hussain					
Media Officer				Uzma	Uzma				

**Table G.2 Management changes at the FPIU, LHWP, 2001–09 (cont'd)**

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Finance Officer	Mr Zulfiqar	Mr Zulfiqar	Khawaja sahib	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq	Qazi Farooq
Logistics Officer	Inam-ullah	Inam-ullah	Inam-ullah	Fazle Subhan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan	Tahir Akbar Awan
Monitoring and Evaluation Officer	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi	Dr Baqir Jaferi
Training Specialist	Dr Ayub Sulariya								
Training Coordinator (UNICEF)		Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel	Dr Fouzia Aqeel
MIS Coordinator	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman	Bashir-Ur-Rahman			Shehzad	Shehzad
Health Education Officer							Mr Aslam	Mr Aslam	Mr Aslam
MIS Officer	–	–	–	–	–	Imran	Imran	Imran	Imran
Research officer	Dr Fazle Mohah	Dr Fazle Mohah		Dr Sofia Furqan	Dr Sofia Furqan			Dr Farhat Nazir	Dr Farhat Nazir
BCC Advisor				Asma Akbar	Asma Akbar			Dr Zaheen (PAIMAN)	Dr Zaheen (PAIMAN)
National Advisor		Dr Zulfiqar Ali	Dr Zulfiqar Ali	Dr Imtiaz Malang	Dr Imtiaz Malang	Dr Imtiaz Malang			
Finance Advisor		Khokhar sahib	Khokhar sahib	Khokhar sahib	Khokhar sahib	Khokhar sahib	Khokhar sahib	Khokhar sahib	
Logistics Advisor	Tanvir Opal	Tanvir Opal	Tanvir Opal	Inam-ullah	Inam-ullah	Inam-ullah			
M&D advisor				Dr Mushtaq Sulrya	Dr Fawad				
Management Advisor									
Training Coordinator (Govt)							Dr Zia ullah	Dr Zia ullah	Dr Zia ullah
MIS Advisor DFID		Anwar Hussain	Anwar Hussain	Anwar Hussain					
Media Officer				Uzma	Uzma				

**Table G.3 Changes in Health Management at MoH, 2002–09**

	2002	2003	2004	2005	2006	2007	2008	2009
Secretary of Health	Mr Ejaz Rahim	Mr Ejaz Rahim	Mr Tariq Farooq	Mr. Anwar Mehmood	Mr. Anwar Mehmood	Mr. Anwar Mehmood	Mr Khushnood Lashari	Mr Mehmood Salim Mehmood/Mr Khushnood Lashari/Mr Khushnood Lashari
Director General Health	General Aslam	General Aslam	Dr Majid Rajput	Dr Majid Rajput	General Dr Shahida	General Dr Shahida	Dr Rashid Jooma	Dr Rashid Jooma

Source: LHWP, MoH, 2009.

## Annex H List of people interviewed

1. Dr Anjum (Monitoring and Evaluation Officer, FPIU, NP FP&PHC)
2. Dr Fauzia Aqeel (UNICEF Training Coordinator for the FPIU, NP FP&PHC)
3. Dr Khawaja Maqsood Ahmad (Logistic Officer, RPIU, NP FP&PHC, AJK)
4. Dr Nabeela Ali (PAIMAN Pakistan)
5. Dr Syed Zulfiqar Ali (Former Deputy National Co-ordinator and former National Advisor NP FP&PHC)
6. Dr Mohammad Atif (Assistant Provincial Co-ordinator, NP FP&PHC, NWFP)
7. Dr Khalif Bile (WR, WHO, Pakistan)
8. Mr Farasat (Internal Auditor, FPIU, NP FP&PHC)
9. Mr Qazi Farooq (Finance Officer, FPIU, NP FP&PHC)
10. Dr Asad Hafeez (National Coordinator, NP FP&PHC)
11. Dr Rehan Hafeez (National Manager, EPI Programme, MoH)
12. Dr Fazle-Hakeem Khattak (Planning Commission)
13. Mr Mohammad Imran (MIS Officer, FPIU, NP FP&PHC)
14. Dr Inam-ullah (Provincial Coordinator, NP FP&PHC, NWFP)
15. Mr Inam-ullah (USAID) (Former Logistic Advisor, FPIU, NP FP&PHC)
16. Dr Baqer Jaferi (Programme Monitoring Officer, FPIU, NP FP&PHC)
17. Dr Masood Jomezai (Deputy National Coordinator, FPIU, NP FP&PHC)
18. Mr Ali Asghar Khan (MIS coordinator, PPIU, NWFP, NP FP&PHC)
19. Dr Aman ullah Khan (Director Health, Save the Children Fund, UK; Former Provincial Coordinator, NP FP&PHC, NWFP)
20. Mr Jehangir Khan, (Finance Officer, PPIU, NWFP, NP FP&PHC)
21. Malik Ahmad Khan (Logistic Officer, UNFPA)
22. Dr Mushtaq A. Khan (Chief, Health Policy Unit), Pakistan
23. Dr Saleem Wali Khan (Technical Advisor, UNFPA, for MNCH Programme, FPIU, NP FP&PHC)
24. Dr Zareef u-din Khan (National Manager IYCF, UNICEF, Former Deputy National Co-ordinator, FPIU, NP FP&PHC)
25. Mr Fareed Khokhar (Financial Advisor, FPIU, NP FP&PHC)
26. Dr Zahid Larik (DDG, Nutrition; Former National Coordinator, NP FP&PHC and DDG of PHC)
27. Dr Farrukh Lodhi (ADG, NP FP&PHC)
28. Dr Imtiaz Malang (Former National Advisor NP FP&PHC)
29. Dr Mobashir Malik, (National Officer Reproductive Health, UNFPA)
30. Dr Naeem u-din Mian (CONTECT Consortium), Lahore
31. Dr Tahir Nadeem Khan (Former Provincial Coordinator, NP FP&PHC, NWFP)
32. Ms Nadia (LHS, Usterzai, District Kohat, NWFP, NP FP&PHC)
33. Dr Sadiq Paryal (DPC, Punjab, NP FP&PHC)
34. Dr Abdul Rehman (WHO) (Former DPC, NWFP) NP FP&PHC)
35. Mr Bashir-u-Rehman (UNICEF, Former MIS Coordinator, FPIU, NP FP&PHC)
36. Dr Farah Sabih (Deputy National Coordinator, Reproductive Health Project, NP FP&PHC)
37. Dr Malik Mohammad Safi (Deputy National Coordinator, NP FP&PHC)
38. Dr Naeem Shah (District Co-ordinator, District Kohat, NP FP&PHC, NWFP)
39. Dr Tanvir (Provincial Coordinator, Punjab, NP FP&PHC)
40. Dr Raza Zaidi (DFID, Former Deputy National Co-ordinator, NP FP&PHC, Former Technical Advisor, NP FP&PHC)
41. Dr Nabeela Zaka (National Officer Reproductive Health, UNICEF)
42. Dr Zia ullah (Training Coordinator, FPIU, NP FP&PHC).

## ***LHWP – Management Review***

Comments were received on the draft reports from:

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45. Dr Asad Hafeez
46. Dr Syed Zulfiqar Ali
47. Dr Amanullah Khan
48. Mr Fareed Khokhar
49. Mr Inam-ullah Khan
50. The Management of National Programme for Family Planning and Primary health Care.

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All reports were reviewed by the peer reviewers designated by the National Programme for Family Planning and Primary Health Care:

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2. Dr Shakila Zaman (Health Services Academy)
3. Dr Raza Mohammad Zaidi (DFID, Pakistan)
4. Dr Fazal Hakeem Khattak (Planning Commission)
5. Dr Inam UI Haq (World Bank)
6. Sadia Ahmad (CIDA).

