January 2002

Strengthening primary health care and family planning services in Pakistan: some critical issues

A Islam
Aga Khan University

F A. Malik

S Basaria

Strengthening Primary Health Care and Family Planning Services in Pakistan: Some Critical Issues

A. Islam,F. A. Malik,S. Basaria (Department of Community Health Sciences, The Aga Khan University, Karachi.)

Abstract

Objective: The Lady Health Workers (LHWs) under the Ministry of Health and the Village-based Family Planning Workers (VBFPWs) under the Ministry of Population Welfare are mandated to bring services to the people and are often the only health care resource available particularly for women. This study was conducted to understand the problems faced by the LHWs and VBFPWs in their routine work.
Study Design: A situational analysis followed by focus group discussions conducted with a cross-section of LHWs and VBFPWs in four districts, one from each province.
Results: Findings reveal that LHWs and VBFPWs are faced with a number of problems that severely limit their effectiveness. Findings suggest that the population/health worker ratios vary considerably from one district to another. Moreover, these two categories of workers differ considerably in terms of level of education, training and skills. There is lack of well-designed client record cards, proper training and backup support, including emergency obstetric care, to cover the range of essential services demanded by the consumers and a lack of information feedback.
Conclusion: These issues need to be recognized and addressed to further strengthen primary health care and family planning services in the country.
The paper presents some of the important findings of the survey and focus group discussions conducted by the Community Health Sciences Department of the Aga Khan University as part of a broader study funded by the United Nations Population Fund. These findings have serious implications for future primary health care and family planning policies in Pakistan (JPMA 52:2,2002).

Introduction

Following the 1978 Alma-Ata Declaration1, Pakistan, like many other developing countries, initiated numerous programs to bolster its primary health care services. The development of Basic Health Units (BHU) and Rural Health Centers (RHC) was perhaps the most significant initiative of the Government of Pakistan (GOP) to make primary health care services available to its growing population, particularly those living in rural areas. Undoubtedly, these initiatives, made primary health care services available to the people. For example, between 1960 and 1990, the percentage of population with “access” to primary health care increased from under 20% to over 60%2. However, despite these attempts, some of the major health status indicators in Pakistan did not register much improvement over the years.
Most importantly, maternal and child mortality and morbidity remained high. The maternal mortality rate (340 per 100,000 live births in 1998) and the infant mortality rate

(95 per 1,000 live births in 1998) remain unacceptably high3. On the other hand, as the use Qf contraceptives remains extremely low (only about 17% of married women of reproductive age use any family planning method), the population of Pakistan continued to grow at a rate of 2.8% during much of 1990s4'5, At this rate, the population of Pakistan would double within 24 years6.

In response to these persistent problems, the Government of Pakistan in 1994 introduced what is now called the National Program on Primary Health Care and Family Planning. The purpose of this Program was to take essential primary health care to the homes of the clients, in villages and towns across Pakistan. A new cadre of service providers - Lady Health Workers - was created to serve as the backbone of the Program. Recruited from within the communities, the LHW÷ were t÷ained ty provid— essential maternal and child health care and family planning services. With a target of I LHW per 1,000 population, by 1998 the Program recruited about 44,000 Lady Health Workers. For the Ministry of Health (MOH), the National Program is the only direct service provision venture. The Village-based Family Planning Workers managed by the Ministry of Population Welfare (MOPW) also provide family planning services. By 1998, there were approximately 14,000 VBFPWs throughout the country. VBFPWs, however, are functionally limited to the provision of family planning services, although in reality they do encounter demands for various maternal and child health care.

The Study

In 1999, the Department of Community Health Sciences (CHS) of the Aga Khan University (AKU) undertook a study aimed at (a) developing and field-testing. a user-friendly Client Record Card (CRC) that can be used by both the LHWs and the VBFPWs and (b) developing a Management Information System (MIS) that would make it possible to use CRC generated information for monitoring and decision making purposes at the district level. The Project, funded by the United Nations Population Fund (UNFPA) in Islamabad, would field-test the CRC in four districts, one from each province. These districts are Faisalabad in Punjab, Peshawar in the North-West Frontier Province, Quetta in Balochistan, and Mirpurkhas in Sindh. In each district, 30 LHWs and 20 VBFPWs and their supervisors have received training in field-testing the new CRC. This implementation phase is of three months duration. As part of this on-going project, CHS conducted a situation analysis in each of the selected districts and carried out focus group discussions with a cross-section of LHWs, VBFPWs and their supervisors. The situation analysis identified numerous structural issues pertaining to these two Programs, while the focus group discussions (FGDs) helped identify some of the practical problems faced by the LHWs and VBFPWs in carrying out their functions.

Methodology

A survey questionnaire was prepared to carry out the situation analysis. A panel of scholars knowledgeable about the subject reviewed the questionnaire. The panel consisted of selected faculty and staff of the CHS Department at the AKU, senior officials of the National Program (Ministry of Health), the Ministry of Population Welfare and the UNFPA in Islamabad. With input from these panel members, the questionnaire was revised. Trained research officers administered the questionnaire to both type of workers, their supervisors and the technical staff responsible for MIS at the offices of District Health Officer (DHO) and District Population Welfare Officer in all four pilot districts.

Following this activity in 2000, focus group discussions (FGDs) were carried out with the same people except the MIS technical staff. The objective of these FGDs was to discern information about the tasks and skill level of the two types of workers and to identify the health issues that the workers come across while working with the community. This information contributed towards devising a Client Record Card in the light of the reproductive health package. This was useful in designing the training programs for the LHWs, VPFPWs and their supervisors. A total of 32 FGDs was conducted by trained community development workers and research officers with the overall supervision of the Project Director. This was made possible with the support and facilitation of district officials from the Departments of Health and Population Welfare. The framework used for the analysis of FGDs was also reviewed by the same panel and revised with its input.

Study Sites

The four districts surveyed were Mirpurkhas, Faisalabad, Peshawar, and Quetta. One hundred fifty one LHWs and their supervisors and 94 VBFPWs and their supervisors particypated iy the fo÷us group discussions. A total of 24 FGDs were conducted. Table 1 presents detailed breakdown of the FOD participants.

Table 1. Districts and number of focus groups/participants.

District	Number of LHWs	Number of Supervisors	Number of VBFPWs	Number of Supervisors	Number. of FGDs
Mirpurkhas	30	8	20	4	8
Faisalabad	30	2	20	4	8
Peshawar	30	9	20	4	8
Quetta	30	12	20	2	8
Total	120	31	80	14	32

Selected districts varied substantially in terms of their population size and available LHWs and VBFPWs. Faisalabad was the biggest district with a population of over 5.3 million, followed by Peshawar with a population of about 2.04 million. Mirpurkhas and Quetta, on the other hand, had a population of under 1 million each7. The total population of the four districts was almost 9.04 million. There were 1,864 LHWs and 937 VBFPWs in these four districts. The population/LHW or VBFPW ratio varied substantially among the districts (Table-2). However, district official noted that these workers were not serving the entire population; they served only 1.8 million or 20 percent of the population. With this lower target population, the population/LHW ratio is much favorable and more evenly distributed; while in case of VBFPWs, the uneven distribution persists.

planning services, attending to minor ailments and maternal and child health (MCH) services. LHWs receive 15 months of basic training, comprising 3-month classroom instructions and 12 months of practical training. Although these two programs have similar selection criteria, the workers hired by them differ sharply in terms of educational and some other social and demographic characteristics.

According to the eligibility criteria developed by the MOPW, VPFPWs are required to be married females between the age of 18-50 years and residing in the villages of their work. They must also possess matriculation certificate (middle pass in exceptional cases). However, it was found that a majority of the VBFPWs had only five years or less of schooling. Some of them cannot even read or write. Matriculation is an exception. High level of female illiteracy throughout the country, especially in rural areas,

Findings

The situation analysis identified numerous structural issues pertaining to these two Programs, while the focus group discussions (FGDs) helped identify some of the practical problems faced by the LHWs and VBFPWs in carrying out their functions. The situation analysis points to a mismatch between the job description, the training received, and the actual issues faced by these frontline health workers. This mismatch seems to affect the sense of responsibility these workers feel as health providers for their community. VPFPWs job description states that they would deal with minor ailments of their clients and promote family planning along with dispensation of various types of contraceptives. In reality, their scope of work is limited to dispensation of contraceptives. VBFPWs receive 7 months of basic training, which includes 4-month classroom course work and 3 months of practical fieldwork. There is provision for a further 2-week refresher training course if, while working in the field, either the supervisors or VBFPWs experience any deficiency in their original training. The job description of LHWs is much wider is scope. It includes family might have contributed to this low level of education among the VBFPWs. The educational status varies by geographical area. While an overwhelming majority of the VBFPWs in Sindh province had under five years of schooling, a majority of their counterparts in the Punjab were matriculates. Perhaps due to the requirement of being married, most of the VBFPWs are middle-aged women with a rather fixed mindset. They seem to have less inclination and time or resources to acquire new knowledge and skills from the media and/or other sources. The simultaneous burden of family and job responsibilities seems to overwhelm most of these middle-aged VBFPWs. Their work reporting procedure is quite simple as they submit, on a monthly basis, a one-page report comprising of basic information pertaining to family planning services to the District Population Welfare Office (DPWO) through their supervisors. The VBFPWs receive their monthly quota of contraceptives from the Tehsil Population Welfare Office. The monthly report, as noted earlier, does not include any other reproductive health care issues and/or or needs the VBFPWs come across in the field. In short, the monthly reports are exclusively concerned with family planning services (or, better still, contraceptive distribution activities). This narrow focus of the monthly reports makes the information less useful for diverse policy making decisions. Clearly this seems to be a missed opportunity.

The LHW Program requires females preferably married, resident of the same area as posted, between the age of 20-45 years, preferably with a matriculation certificate or with eight years of schooling in exceptional cases. Previous experience of working in the community is preferred. Unlike the VBFPW Program, the LHW Program seems to adhere to these selection criteria. Most of the LHWs have at least 8 years of education. The new recruits of the LHW Program are better educated with more years of schooling than their earlier colleagues. Since being married is not a condition for hiring, the LHW Program is able to attract young, energetic and educated females. Compared to the VBFPWs, the LHWs use much more complex and numerous reporting tools. However, these multiple reporting tools not only contain duplication in terms of information collected, but also include rather redundant items. Such duplication and redundancy make the LHWs ‘waste’ considerable amount of their time that could otherwise be utilized in the field. Eveiy month the LHWs are required to submit a monthly report to the Health Facility through their supervisors and receive their monthly supplies from the Health Facility.

The salary structure of these two levels of frontline workers is also different. Although LHWs are better trained and perform more diverse and complex functions, their monthly salary is a little lower than that of the VBFPWs. However, salary disbursements seem to be irregular. At the focus group discussions both the LHWs and VBFPWs complained of not receiving a salary for the 'last three months'. Clearly this irregularity in salary disbursement acts as a disincentive for these frontline workers.

The Lady Health Workers also noted the difficulty of having a qualified female health professional looking after a client once she is referred to the Basic Health Unit or the Rural Health Centre. In most cases, female health professionals are not available and often their schedule of working hours does not make them easily accessible to women sent for emergency attention. In most cases, women are taken to the health centres for Emergency Obstetric Care. The health centres, sadly, lack proper facilities to provide such Emergency Obstetric Care. Rural women, therefore, are reluctant to go to public health centres. LHWs, as a result, are faced with increasing, and often incompatible, demands on their services.

The uneven distribution of LHWs and VBFPWs is also an important issue. The population/LHW ratio varies from a low of 2,045 in Mirpurkhas to a high of 7,480 in Faisalabad. On the other hand, the population/VBFPW ratio varies from 5,732 in Mirpurkhas to 11,816 in Faisalabad (Table 2).

Table 2. Population Size and LHWs/VBFPWs in the selected districts.

District	1998 Census Population	LHW	VBFPW	LHW/ Pop	VBFPW/ Pop		Population Served
Mirpurkhas	899,947	440	157	2,045	5,732		393,210
Faisalabad	5,340,771	714	452	7,480	11,816		800,703
Peshawar	2,038,629	390	290	5,227	7,030		385,000
Quetta	757,245	320	38	2,366	19,928		250,543
Total	9,036,592	1,864	937	17,118	44,506		1,829,456

However, based on population served, as noted by the district officials, the distribution pattern is much better for LHWs, but not for VBFPWs. The population served/LHW ratio varies from a low of 783 in Quetta to a high of 1,121 in Faisalabad. While the population servedIVBFPW ratio varies from a low of 1,328 in Peshawar to a high of 6,593 in Quetta (not shown in the table). These disparities in the distribution of frontline health workers need to be effectively addressed by policy makers.

Discussion

These fmdings need to be further analyzed and reviewed. The study fmdings assume greater significance in the context of the government's impending move to amalgamate the VBFPW and LHW Programs into one with a view to further strengthen the PHC services. The findings of this situation analysis and FGDs have important policy implications.

One of the key factors in strengthening primary health care services is to improve the quality of services which, in turn, depends on the skills and training of available personnel. A mismatch between training and job requirements can lead to qualitative imbalances. Such imbalances occur when more highly trained health personnel are used

to perform tasks that lesser trained health personnel could do and vice versa8.
These two cadres (LHWs and VBFPWs) of community based health workers represent the lowest and yet perhaps the most important component of the human health resource hierarchy in the country. These health workers almost exclusively have a rural background, speak an indigenous language, understand and relate to the local culture and have a strong appreciation for community involvement, and preventive programs. These characteristics make them natural backbone of the health care system9. Although they have limited training, VBFPWs and LHWs define/perceive their role as health care providers to be broad. Since the community recognizes them as health workers, they develop a sense of responsibility and use their training to the highest degree to respond to the needs of their clients. They try to meet community expectations. Consequently, they feel inadequate when they cannot provide proper information on issues like adolescent health, infertility, menopause, and STDs. The list is longer for VBFPWs. Often the advice that they provide is not based on sound professional knowledge, but on experimental observation and learning. Clients, therefore, often ignore their referral because they cannot provide satisfactory information that can adequately establish or explain the seriousness of the issue at hand. They feel that their training did not cover such important topics as health education, information and communication and, therefore, they are unable to effectively play their role in promoting health. In short, this real and/or perceived inadequacy of their training seriously limits the ability of the LHWs and VBFPWs to provide effective health promotion and health education services. Most LHW and VBFPWs felt that their training curricula should be revised to address this shortcoming.
More significant is the neglect accorded to adolescent health both in the training curricula and in information collection tools that feeds into the Health Management Information System (HMIS). In HMIS forms, adolescents are lumped as “others”, which makes the information collected of little value. Often adolescents are submerged within the categories of child or women10. In short, the invisibility of adolescent health is apparent from the very beginning and LHWs and VBFPWs are aware of this important drawback. Adolescents comprise a significant proportion of the population and it is important that accurate, relevant and reliable information is collected on services provided to them. It should be recognized that in rural areas early marriages are still quite common and that a girl of 13-16 years of age often go through the experience of motherhood and other aspects of reproductive health. These frontline workers frequently come across problems of adolescent girls, both married and unmarried; but cannot provide sufficient information and professional advice. HMIS should include reliable information on adolescent health and researchers and policy• makers should have access to such data. Planners and policy makers could use information on adolescent health in developing appropriate programs and services specifically targeted to this group.
Clearly there is a mismatch between the training provided to the frontline workers and their actual work/job responsibilities. This is more so in case of the VBFPWs. They strongly felt that their training curricula should include adolescent health and wellbeing. A discrepancy is also evident between assigned job responsibilities and actual demands placed on them in the field. The health care workers face much more demands in the communities than their job description outlines. Both LHWs and VBFPWs are aware of these discrepancies and felt that the training curricula must be revised to address these

issues. The job descriptions also need to be updated to reflect ground realities.

In focus group discussions, LHWs and VBFPWs also identified another problem - lack of continuing contact and liaison among themselves and with the RHCs and BHUs. These two programs, managed by two different ministries, seem to operate independently of one another. There is no formal mechanism for the LHWs and VBFPWs to contact each other on a regular basis to coordinate their seryices. On the other hand, the federal government administers these two programs, while the rest of the health care system at the district level is within the jurisdiction of the provincial governments. This structural separation makes it difficult for the LHWs and VBFPWs to maintain continuing contact with the provincially administered health care system. In other words, there is a lack of integration of services. This structural issue also needs to be reviewed and seriously addressed by the policy makers.

The survey questionnaire and the focus group discussions that followed identified a number of important issues pertaining to the Lady Health Workers and the Village Based Family Planning Workers Programs. Some of the key issues are:

(a) LHWs and VBFPWs act as the backbone of the primary health care system in Pakistan. Recruited from villages, they are culturally attuned to the needs of their clients.

(b) LHWs, overall, are higher educated, trained and skilled than the VBFPWs. LHWs also have more broader job responsibilities.

(c) Since placed in villages where there is a lack of other health care resources, community expectations of these frontline workers are much higher than their job descriptions. However, they lack skills and training to respond to these diverse demands. This is particularly the case with the VBFPWs.

(d) VBFPWs would require substantial additional training to perform the services currently provided by LHWs. Without such extensive additional training for VBFPWs, these two cadres of workers cannot be merged.

(e) The recruitment policies pertaining to these frontline workers, especially the VBFPWs, need to be reviewed and revised. The VBFPW Program has not consistently followed its existing recruitment standards.

(f) The Basic Health Units and Rural Health Centres lack female health professionals and appropriate facilities for Emergency Obstetric Care. These deficiencies are seriously affecting the quality of health care services available to rural women.

(g) The current system largely ignores the health care needs of the adolescents.

(h) There is substantial disparity in the distribution of LHWs and VBFPWs across districts and regions. Such disparity adversely affects effective service provision.

(i) The LHW and VBFPW Programs are vertical in nature and lacks horizontal contact and coordination. Moreover, these two programs, being administered by the federal government, lack integration and coordination with the broader health care system managed by the provinces.

(j) In the context of the planned merger of LHWs and VBFPWs, planners and policy makers should seriously review these. findings.

The planned merger of these two categories of frontline health workers presents an opportunity to address the issues raised. Priority must be placed on clearly defining the role of the new cadre of health workers once the merger is implemented. This clearly defined role should guide the work of revising/improving the training curricula. At the same time, it should be recognized that a work force would not be able to perform its

responsibilities without proper support and infrastructure and facilities. Continuing on-the-job training and periodic refresher courses could prove to be very effective in keeping the knowledge and skills of the workers updated. The infrastructure and facilities available in primary health care centres also need to be improved and strengthened. It is apparent that most Basic Health Units and/or Rural Health Centre lack adequate facilities and human resources to effectively cater to the health care needs of women. Concerted efforts must be made to make women health professionals available in health centres. At the same time, facilities for emergency obstetric services must be made available in health centres. Availability of proper emergency obstetric care is essential to ensure that the referral system is efficient and responsive to the critical needs of women. It is imperative that there is continuing coordination among the LHW and VBFPW Programs and, at the same time, between these programs and the broader health care system. Structural issues that impede such coordination and collaboration need to be forcefully addressed.

References

1.World Health Organization. Evaluation of the Strategy for health for all by the year 2000: Seventh report on the world health situation. Vol. 1: Global review. Geneva: WHO.,1987.
2.World Bank. The World Development Report: investing in health. Washington: Oxford University Press, 1993.
3.Mahbub ul Haq. Human Development in South Asia 2000. Islamabad: Human Development Centre, 2000.
4.UNDP. Human Development Report 2000. New York, Oxford University Press, 1997.
5.World Health Organization. World Health Report 2000. World Health Organization, Geneva, 2000.
6.Population Reference Bureau, Washington DC. World Population Data Sheets 1996.
7.Population Census Organization, Pakistan. Census of Pakistan-l998, Bulletin 1.1998.
8.Mejia A, Pizurki H. Royston E. International migration of physicians and nurses: analysis of the phenomenon study of its political implications. Cath. Soc. Demogr. Med., 1978; 18:105-96.
9.Perry B, Gesler W. Physical access to primary health care in Andean Bolivia Soc. Sci. Med., 2000; 50: 1177-88.
10.UNICEF Pakistan, Government of Pakistan. Situation analysis of children & women in Pakistan: Islamabad, Pictorial Printers,1992.