Bridging the Gap between Lady Health Workers and Traditional Birth Attendants for Reducing Maternal Mortality in Rural Pakistan

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Abstract

Background
A woman’s social status affects her mortality; Pakistani women have one of the highest maternal mortality rates in the world. Due to rural and urban divides along with difficulties in access to health services, it is not surprising that maternal health of rural Pakistani women suffers greatly. In fact, 82.5% of all hospital beds exist in urban hospitals, while 70% of the population lives in rural areas. In this context, the role of the Lady Health Worker (LHW) and traditional birth attendants (TBAs) become crucial for providing health promotion and delivery services, respectively. However, there are tensions between these two cadres of health providers which hinder the improvement of maternal mortality.

Objectives
- Analyze the underlying tensions between LHWs and TBAs and their impact of delivering maternal services
- Prescribe a framework to resolve tensions and promote harmony between LHWs and TBAs

Methods
The literature review is based on studies and reports.

Results
LHWs and TBAs have expressed great frustration over their job dissatisfaction; interestingly, each health practitioner complains of what the other has. Both compete to get community support and prestige for their professions and also undermine the other’s work without realizing that their skills set and areas of influence are different but complementary.

Conclusions
There is a need to clarify the role and responsibilities for both cadres to generate a mutual understanding which will further improve their social status and consequently reduce maternal mortality.
Abbreviations

BHU – Basic Health Units

DFID – UK Department for International Development

GDP – Gross Domestic Product

GoP – Government of Pakistan

LHV – Lady Health Visitor

LHW – Lady Health Worker

MAP – Midwifery Association of Pakistan

MMR – Maternal Mortality Ratio

MoH – Ministry of Health

NGO – Non-governmental Organization

OPM – Oxford Policy Management

PMP-FP&PHC - Prime Minister’s Program for Family Planning and Primary Health Care

RHC – Rural Health Centers

SBA – Skilled Birth Attendant

TBA – Traditional Birth Attendant

UNICEF – United Nations International Children’s Fund

USAID – United States Agency for International Development

WHO – World Health Organization
Introduction

The status of Pakistani women as citizens of Pakistan is much lower than of those women residing in countries with similar levels of development (Table A). Yet, as Pakistan has continued to flourish and life expectancy has grown, greater disparities in health practices and services have become apparent, most specifically between rural and urban Pakistan (Human Development Report, 2011). In fact, 82.5% of all hospital beds in the country exist in urban hospitals whereas only 17.5% are dispersed throughout rural Pakistan (Burki, 1999; Jaffar et al., 2010). Similar statistics follow in terms of doctor to patient ratios as well as in maternal and infant mortality rates (Jaffar et al, 2010). With such disparities between the urban and rural health sectors coupled with women’s low status in the nation, it is understandable why maternal health suffers greatly in rural Pakistan.

<table>
<thead>
<tr>
<th></th>
<th>Gil value</th>
<th>Gil Rank</th>
<th>Maternal mortality ratio</th>
<th>Adolescent fertility rate</th>
<th>Female seats in parliament (%)</th>
<th>Population with at least secondary education (%)</th>
<th>Labour force participation rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistan</td>
<td>0.573</td>
<td>115</td>
<td>260</td>
<td>31.6</td>
<td>21.0</td>
<td>23.5</td>
<td>46.8</td>
</tr>
<tr>
<td>India</td>
<td>0.617</td>
<td>129</td>
<td>230</td>
<td>86.3</td>
<td>10.7</td>
<td>26.6</td>
<td>50.4</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>0.550</td>
<td>112</td>
<td>340</td>
<td>78.9</td>
<td>18.6</td>
<td>30.8</td>
<td>39.3</td>
</tr>
<tr>
<td>South Asia</td>
<td>0.601</td>
<td>—</td>
<td>252</td>
<td>77.4</td>
<td>12.5</td>
<td>27.3</td>
<td>49.2</td>
</tr>
<tr>
<td>Low HDI</td>
<td>0.606</td>
<td>—</td>
<td>532</td>
<td>98.2</td>
<td>18.2</td>
<td>18.7</td>
<td>32.4</td>
</tr>
</tbody>
</table>

The Gender Inequality Index (GII) reflects gender-based inequalities in three dimensions—reproductive health, empowerment, and economic activity. Reproductive health is measured by maternal mortality and adolescent fertility rates; empowerment is measured by the share of parliamentary seats held by each gender and attainment at secondary and higher education by each gender; and economic activity is measured by the labour market participation rate for each gender.

Source: Human Development Report, 2011
Presently, an estimated 260 maternal deaths per 100,000 live births and 61.27 infant deaths per 100,000 live births are reported for Pakistan; of these maternal deaths, 70% occur in rural Pakistan (Central Intelligence Agency, 2012; Jaffar et al, 2005; Siddiqi, 2001). To counter maternal and infant mortality, the Pakistani government implemented the Lady Health Worker (LHW) Program in 1994 which recruited women from city slums and rural communities and trained them on acting as liaisons between the formal health system and the community and as educators on best health practices, hygiene, and sanitation (Ministry of Health 2004). While the LHW program has been successful on many accounts, tensions between the LHW and pre-existing health workers, such as traditional birth attendants (TBAs), have surfaced and created a divide within the rural communities due to the conflict between modern vs. traditional medicinal practices (Hafeez, 2010). While different in their practices, LHWs and midwives have been crucial in improving maternal health care by providing their own methods of primary and maternal health care (Ministry of Health, 2004). However, little initiative has been taken to bridge the gap between the two different modes of improving maternal health care.

At the same time, there are many problems within each paradigm of health care in that both practionnars feel some job dissatisfaction and frustration in their inability to move upwards within their respective fields. Furthermore, TBAs and community midwives hold a lower status than their LHW counterparts within the medical realm because of the lack of their relation to the formal health system; interestingly, the different levels of midwifery are not taken into account and as a result, all midwives are pooled together and regarded as uneducated village maasi’s (aunts) who deliver babies (Kamal 2010). While this paper explores midwifery as a whole in
Pakistan, emphasis on bridging the gap will be placed between TBAs with LHWs in rural settings as that is where the conflict lies.

Tensions between TBAs and LHWs exist because LHWs look down upon TBAs due to the lack of their formal training and education (Hafeez et al., 2010). However, what both cadres forget to acknowledge is that each works on separate issues from each other but both are required in order to ensure a safe pregnancy and delivery. Yet, with the fear that LHWs are infringing upon the territory of TBAs, frustrated interactions between the two groups result in a large disconnect and a lack of collaboration (Hafeez et al., 2010).

Unfortunately, little has been done to evaluate and promote positive and symbiotic relations between TBAs and LHWs. This paper will attempt to explore maternal health and maternal health policy, LHWs and midwifery in Pakistan as well as understand the reproductive rights movement and accessibility to maternal health care. Furthermore, this paper will go on to propose a framework that integrates LHWs with TBAs so as to increase program efficiencies, job satisfaction of both sets of professions, and improve the overall maternal health in rural Pakistan.

Understanding Accessibility to Reproductive Rights

While much of this paper is focused on program and literature review, it is still necessary to situate Pakistan within the discourse around reproductive rights and the right to maternal health. By commonly used expressions to indicate a complex set of human development indictors, Pakistan is considered a “third world country”, “a developing nation”, or a “low-income country.” The status of woman in Pakistan is not equal to a man and within the
patriarchal culture which follows an honor system, a woman often finds herself in a difficult position. From education to mobility to reproductive rights, Pakistani women lag behind other comparable nations, especially since no active movements to ascertain such rights have occurred within Pakistan (Rahman 1995). Thus, a Pakistani woman, and especially one living in rural Pakistan, is subject to many more restrictions and difficulties when accessing reproductive or maternal health care. In fact, in rural Pakistan, an unmarried woman is not supported in seeking medical help unless absolutely necessary, whereas married women are more often than not accompanied by a male relative when accessing health care services (Rahman 1995). As a result, rural Pakistani woman do not have access to their reproductive rights due to the culture, and when they are afforded them through LHWs, it is in controlled environments where only married women give and receive information on sexual health and reproduction. So, while the Pakistani government has policies to support reproductive rights and reduce maternal mortality rate, it does not follow what reproductive rights are considered to be as Correa et al., explain:

For reproductive decisions to be in any real sense “free,” rather than compelled by circumstance or desperation, requires the presence of certain enabling conditions. There conditions constitute the foundation of reproductive and sexual rights and are what feminist mean when they speak of women’s “empowerment.” Thy include material and infrastructural factors, such as reliable transportation, child care, financial subsidies, or income supports, as well as comprehensive health services that are accessible, humane, and well-staffed. The absence of adequate transportation alone can be a significant contributor to higher maternal mortality, (Correa et al., 1994).

Thus, while policies are in place to improve maternal mortality and empower women to access their reproductive rights, Pakistan still has much ground to cover so as to ensure that every woman can access her own personhood and body.

At the same time, because culture dictates daily life of rural Pakistani women, it is unreasonable to assume that a revolution will enable women to be more self-sufficient and
empowered over their bodies. Instead, initiatives such as the LHW Program are useful in that they begin the dialogues necessary to raise the awareness needed about a woman’s body. At the same time, by further educating TBAs on such conversations and creating a relationship between LHWs and TBAs based on mutual respect, stronger messages can be shared within rural communities. As a girl gains more information about her body, she can then make better decisions when she is married and not only protect herself, but also her child, and her community.

Organization of the Pakistani Health Care System

The Pakistani government spends 2.9% of its GDP on the healthcare system (WHO, 2010). This system is made up of three distinct parts that work together to provide for the 91,108,205 million women and 95,874,516 million men – the governmental, military, and private health systems (Figure 1) (Central Intelligence Agency, 2012). The Ministry of Health (MoH) focuses on initiating, supporting, and overseeing various public health programs including the Family Planning & Primary Health Care system which conducts the LHW Program, but is not directly involved with running the medical system. Instead, it is the Federal Health system which coordinates seven hospitals, one tuberculosis clinic, four maternal and child health (MCH) clinics, three rural health centers (RCHs), 39 dispensaries, and 14 Basic Health Units (BHUs). Although the government directly supports the aforementioned number of clinics and hospitals through its own funds, it should be noted that there are 500 RHCs in place in Pakistan under which 3,500 BHUs are accommodated and all are financed through a combination of government lobbying of international donors and international organizations such as the USAID and DFID.
(Rahman, 1994). In addition, the military health system, which is run by the Department of Defense and focused largely on military personnel, also provides general curative care to the public at large, especially in areas where there are no governmental health centers. Lastly, there is the private health system which focuses on all levels of medicine from preventative to curative health care. It should be noted that the private health care system includes private hospitals, individually run by bio-medical providers or allopaths, homeopaths, hakeems, tabibs, and other practitioners of traditional medicine, other clinics based on partnerships, ambulatory services, and health care facilities supported by NGOs and philanthropic organizations.

Figure 1. Overview of the health care system in Pakistan.

The health system is further divided into three levels that focus on the same type of health services throughout all the health systems: primary care which includes preventative care and is managed through BHUs and RHCs; secondary care which encompasses first and second level of curative care with ambulatory and inpatient care at the district level; and tertiary care which focuses on specialized care, such as cancer treatments, eye care, and cardiology, among many others.

Insurance in Pakistan is also divided into two parts between social protection and private insurance. Social protection has further separation between social assistance and social insurance. Social insurance is supported through social security but only provides for less than 27% of the population. Most people are covered by employers or through self-obtained insurance. The remaining persons obtain medical support through philanthropic organizations (National Health Assessment 2009).

Maternal Health in Pakistan

Clearly a country that focuses on the biomedical model than on preventative care as witnessed by the limited national fiscal support of public health initiatives, Pakistan is a developing country with a low GDP as well as a high maternal mortality ratio (MMR) of 260 deaths per 100,000 live births (Aqil, 2011; UNICEF, 2011; Choudry, 2005). While many programs have been implemented to decrease this avoidable statistic through various initiatives by both the Pakistani government and international and local NGOs, much work remains to be done. For example, the MMR fell from 490 deaths in 1990 to 340 deaths in 2000 to the present number of 260 deaths per 100,000 live births; however it still remains high as compared to other
neighboring countries such as Indonesia, India, and Malaysia, among others (The World Bank, 2012; Index Mundi, 2009).

A number of factors influence maternal mortality; a primary one appears to be the nutritional status of mothers which is observed through the high proportion of underweight mothers, particularly in rural areas (Arif, 2006). Studies attribute such poor nutritional status to repeated pregnancies, inadequate food intake due to poverty, and poor dietary habits which are reflective of women’s gender status within Pakistan. As a result, anemia is high within many rural Pakistani women. Other problems with maternal health arise due to complicated pregnancies that often occur at home and rarely have trained technicians, TBAs, trained midwives, or LHWs in attendance to support the ailing mother (Golding et al., 2009). Overall, a rural mother’s status in Pakistan is so clearly neglected that it is not a surprise that her maternal health outcomes are poor.

Understanding Maternal Mortality

The MMR in rural Pakistan is 319 deaths per 100,000 live births compared to the 175 deaths per 100,000 live births in urban Pakistan (Golding et al., 2009). These drastic statistics are attributed to the lack of health care, trained staff, adequate medical supplies, poor access especially for women, and little national funding to rural areas. In fact, Pakistan is one of the lowest social investors in its own country with an expenditure of approximately 2% from its annual GDP that is allocated to health and health services (Golding et al., 2009). However, the high MMR cannot solely be associated with difficulties in accessing adequate healthcare; culture also plays a significant role.
Many socio-cultural barriers exist to maintain the lower status-quo of women which in return adversely affects their maternal health. Women in rural Pakistan are not given priority in terms of education or employment; they have little to no say over income and assert they have limited mobility, low levels of participation in public life, and high levels of violence against them (Golding et al., 2009 & Burki 1999). Furthermore, very little focus is paid towards single women when it comes to discussing reproductive health which often results in a great lack of knowledge of best health practices (Appel et al., 1995). Appel elaborates:

Reproductive health services have tended to focus on married women who, because of their biological function of childbearing, are more vulnerable in terms of their reproductive health. In doing so, these health services tend to perpetuate existing gender disparities. In many countries, family planning programs concentrate on convincing married women of the need for family planning and offer most services to them. Men’s concerns in this field are neglected although they are influential in couples’ decision concerning reproduction and fertility control…Mother and child health and family planning programs have tended not only to ignore men, but also unmarried and childless women, (Appel et al., 1995).

Appel raises two important points here which significantly impact maternal health: the role of the man within the family and the ignorance of an unmarried woman. While this paper does not focus on men’s participation in the reproductive sphere, other than take for granted that a man often permits his woman (read: wife, daughter, sister) to partake in any activity, it does acknowledge the heavy focus of maternal education only on married women. Such a focus is largely attributed to the conservative Pakistani society where discussing reproductive and maternal health with those women and girls who are unmarried is strongly discouraged so as to ensure that sexuality is maintained and policed – this is characteristic of the Pakistani culture which is based on the honor code and Islamic law, two components which work together to hide sexuality and sexual desires (Aqil et al., 2010).
Another key issue prevalent in affecting the health status of rural women is the freedom of mobility. Due to Pakistan’s conservative nature along with the significance placed on family honor, rural women are not afforded large freedoms in movement when contrasted to their urban counterparts. As a result, women from rural areas often find it difficult to access healthcare services, especially when questions regarding maternal or women’s health are concerned. This is further problematized with the ratio of male doctors to female doctors of 3 to 1, which makes it exceptionally difficult to achieve social approval and doctor-patient comfort levels if the gender of the patient and doctor are not the same (Pakistani Foreign Medical Students & Graduates, 2011).

In addition, because women are not permitted to travel alone, rural women are often accompanied by male relatives into the clinic. Mumtaz et al., studied different mobility patterns of rural women with respect to their education and socio-economic as well as their professional and marriage statuses in correlation to accessing health services. While there were no significant findings in regards to age, some key findings were highlighted: it was noted that women who worked in the field had greater movement in terms of travelling unaccompanied to health clinics than housewives; other professional women, mostly LHWs or those who had to travel for work, were found to have greater mobility as well; on the other hand, education was found to have no correlation with unaccompanied access to health clinics; and that married women were also more free to travel than single women (Mumtaz et al., 2005). While these results suggest that most women are restricted in their movement, many social factors affect how a rural Pakistani woman interacts with the healthcare system and these need to be taken into account. Because of the honor system and insecurities in traveling alone, women are less likely to attempt accessing
healthcare, at which point having health services come to them results in more successful overall health practices. Thus, maternal health is not just affected by the poor and invisible status of rural women but also cultural practices and fears that have made best maternal health practices difficult to access.

*Steps taken to improve Maternal Health in Pakistan*

In order to account for and provide for the varying female populations in Pakistan, many governmental programs were initiated (Table B). However, the most successful program to date has been the Lady Health Worker Program. Founded under the National Program for Family Planning and Primary Health, the LHW Program is perhaps most successful for its design and practice, which will be discussed in greater detail further on.

In addition to the various programs, many Acts regarding women’s safety and autonomy were passed between the years 2000-2008 so as to improve women’s status which would thereby improve their maternal health (Table C). While the aims of the laws, Acts, and current legislation is to support women’s security both in the private and public sphere, it has yet to be implemented at a cultural level. However, the hope is that as women begin to take more responsibility of their own agency, they will begin to negotiate the terms of their reproductive health which will in turn have significant effects of their maternal health.
Table B – National Policies Advocating Improved Maternal Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>National Health Policy</td>
<td>Envisioned universal health coverage through skilled and trained providers</td>
</tr>
<tr>
<td>2000</td>
<td>National Reproductive Health Services Package</td>
<td>Joint efforts of the Ministry of Health with the Ministry of Population Welfare and Health</td>
</tr>
<tr>
<td>2001</td>
<td>National Health Policy</td>
<td>Focused on poverty alleviation along through strengthening secondary and tertiary tiers of health services</td>
</tr>
<tr>
<td>2001-2011</td>
<td>Ten Year Perspective Development Plan</td>
<td>A 10-year plan to shift towards a preventative rather than a biomedical model of medicine</td>
</tr>
<tr>
<td>2002</td>
<td>Population Policy</td>
<td>Large focus on sexual and reproductive health inclusion to family planning initiatives along with educating men on issues of women’s health and violence against women</td>
</tr>
<tr>
<td>2005</td>
<td>National Maternal, Newborn, and Child Health Strategic Framework</td>
<td>Focuses on improving district level programs in the rural areas with emphasis on midwives</td>
</tr>
</tbody>
</table>

Source: Golding et al., 2009

Table C – Acts Passed Post-2005 to Support Women’s Security

<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>The Women Protection Act</td>
<td>This Act protected women from being unlawfully accused of adultery and calls for punishment to those who wrongfully accuse a woman.</td>
</tr>
<tr>
<td>2008</td>
<td>The Anti-Women Practices Bill</td>
<td>This intended Act will work to criminalize discrimination against women and work towards curtailing the use of women as commodities.</td>
</tr>
<tr>
<td>2009</td>
<td>Domestic Violence (Prevention and Protection) Bill</td>
<td>Currently on hold, this Act would provide a safe-space and community for abused women along with criminal charges against the perpetrators of violence</td>
</tr>
<tr>
<td>2009</td>
<td>The Reproductive Healthcare and Rights Bill</td>
<td>The passing of this bill would ensure greater funding be placed in the training of reproductive health care givers which include LHWs, midwives, and traditional birth attendants</td>
</tr>
<tr>
<td>2010</td>
<td>The Protection Against Harassment of Women at the Workplace</td>
<td>This law imposes punishment for anyone who harasses a man or a woman in the workplace</td>
</tr>
</tbody>
</table>

Source: Golding et al., 2009.
Midwifery in Pakistan

While practices of midwifery vary largely within Pakistan, the official definition according to the Midwife Association of Pakistan (MAP) is:

A midwife is a person who having been regularly admitted to a midwifery education program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice as a specialist in normal obstetrics, (Kamal, 2010).

Due to the longstanding practice of traditional birthing and ease in access especially in the rural sphere, this official definition of midwives does not apply to the large number of midwives dispersed throughout Pakistan. In fact, there are five main categories of midwives which include: the Nurse Midwife, Lady Health Visitors (LHVs), Direct Midwives, Community Midwives, and Traditional Birth Attendants (TBAs). Each group, except TBAs, access different educational and training routes as well as function at different levels of a society.

The Nurse midwife undergoes three years of nursing education with a follow up of one year of midwife training; she is most usually found in hospitals and clinics. LHVs, on the other hand, receive one year of midwifery training along with one year of public health education; they are found to be more focused on teaching and preventative health care than in active medicine.

The Direct Midwife partakes in one year of midwifery training while the Community Midwife undergoes a training of 18 months and is largely a hybrid between the Direct Midwife and a LHV. TBAs are the fifth type of midwife; however, they receive no formal education and are largely trained through familial lineages or undertake apprenticeships with other TBAs (Kamal 2010).
History of Midwifery

Midwifery is an integral part of Pakistan and its history, even though it was not considered a medical profession until recently. Even before statehood, the first School of Midwifery was opened in 1882 in Lahore, Punjab, as an initiative of the British government during the colonization of India. After partition between India and Pakistan in 1947, only a handful of trained Pakistani midwives and nurses remained. This is most attributed to the little movement afforded to Muslim women in comparison to the Hindu and Christian women before partition. Because Hindi and Christian women moved more freely, they accessed more education and jobs than their Muslim counterparts. However, after partition, the practice of keeping Muslim women behind the screen in purdah changed drastically and necessitated the training and recruitment for more midwives and nurses so that the health care system of newly founded Pakistan could flourish. To support this, Begum Ranna Liaqat Ali Khan, wife of the Pakistani Prime Minister in 1948, campaigned for approximately fifty women to be sent to the United Kingdom to gain professional midwifery skills, which could then be taught to other Pakistani women upon their return. Unfortunately, while the women sent to the U.K. did gain the necessary skills, all but one was ill-equipped to teach the information they had garnered because they did not have the tools or the knowledge necessary to pass on the skill of midwifery. As a result, no formal form of teaching midwifery skills was enacted until 1955 (Kamal, 2009).

In 1955, when Mrs. Imtiaz Kamal returned from her training in the UK to Pakistan, she embarked on her “one-woman crusade for the promotion of midwifery as a modality separate from nursing” (Midwifery Today 2011). Now known as the grandmother of midwifery in Pakistan, she has not only gained midwifery an official and internationally approved professional
status, but she has also brought in large funds to support midwifery training for both rural and urban Pakistan; the Family Health Project (FHP) was one of the many programs guided by Mrs. Kamal’s efforts.

However, in 1955, there were no formalized curriculums or midwifery-only schools in place in Pakistan. Whatever programs of midwifery did exist functioned without curriculums and without future expectations of what a midwife could do. In short, there was no career structure or a regulatory mechanism for midwives and in turn the programs existed only as an entity to provide cheap labor for already-trained midwives. In addition, the situation of midwives was exacerbated by constant degradation of a midwife within the medical realm, especially from other nurses. As a result, midwives were ignored and taken away from the Nursing Association of Pakistan as well as denied any practical opportunities unless they were certified nurses (Kamal, 2009). All the while, TBAs within the rural areas continued to exist as dais, without any formal training and the high rates of maternal mortality in rural Pakistan saw no hope for reducing.

It was not until the 1990s when Pakistan’s high maternal mortality rate began to receive a considerable amount of attention that midwifery began to be acknowledged as a necessary advent to improve maternal health in Pakistan. Since then, international support from the WHO and UNICEF has heavily supported midwife training programs all over the country, with special attention to rural Pakistan. In conjunction with Mrs. Kamal, the GoP, and international support, the Midwifery Association of Pakistan (MAP) was established in 2005 with aims to establish the identity of midwives as healthcare professionals and to improve maternal health care in Pakistan (Midwifery Association of Pakistan 2011). In addition, MAP also works on creating midwifery
teaching curricula and implementing training missions throughout the country, with a special focus on rural Pakistan (Kamal, 2009).

*Traditional Birth Attendants*

TBAs have been involved in maternal and reproductive healthcare since before Pakistan achieved its independence (Kamal, 1998). While TBAs are not directly involved in providing reproductive and maternal healthcare, they are the health workers who conduct the delivery in most rural households for three main reasons: a) there is a scarcity of hospitals in rural Pakistan; b) accessibility to these hospitals is difficult; and c) TBAs are a more economically sound and trusted form of medicine for rural households (Jokhio et al., 2005). At the same time, many of these cadres of midwives are untrained in comparison to LHWs or professional midwives which create tension between traditional medicinal practices and those who follow the biomedical format; in addition, maternal mortality is also higher due to the poor sanitation practices or difficulty in addressing complicated pregnancies. To counter the tensions as well as to improve the high maternal mortality statistics, many initiatives have taken place to assess, train, and improve TBAs in rural Pakistan.

One of the most prominent and long-running projects was the Family Health Project (FHP) in rural Sindh which conducted a TBA training mission over a period of seven years and focused on creating a relationship between LHWs and TBAs. The program was geared towards providing best health practices education to TBAs using LHWs as teachers and monitors of the program implementation. Follow up research and evaluation of the FHP found that not only were TBAs crucial in deliveries within the rural sphere but more respected and permitted in the
households than LHWs or professional midwives. The research also uncovered that the criticism involving TBA sanitation practices were not as well founded and that TBAs had their own methods of ensuring clean deliveries that worked in tangent with the available resources; however, the biggest problem noted was the lack of an effective referral system and the lack of knowledge during complicated deliveries. While LHWs are the bridge between the community and more professional services, it was interesting to observe that regardless of the formal training TBAs received, without a proper referral system, the high rates of maternal mortality did not change. Instead, the most crucial finding of the FHP was the tension and discord between LHWs and TBAs which inadvertently negatively impacted maternal mortality and health (Jokhio et al., 2005).

Drawbacks of Midwifery in Pakistan

Midwifery, like in other parts of the world, suffers significantly in Pakistan because it is not a profession dictated by the biomedical model. While the basic formal education system of midwives includes one year of training and one year of internship, it is still not appreciated by doctors and nurses alike. In fact, midwifery was not considered its own entity until Mrs. Kamal helped found MAP in 2005; to this day, out of the 36 midwifery educational programs, only one program is dedicated to midwifery training that is independent of a nursing school (Kamal, 2010).

Many problems exist that affect both the perception of and enrollment into midwifery programs. Midwives are considered out of the medical realm because of the lack of their association with traditional medicine. In addition, because midwifery, like gynecology, deals
with a woman’s vagina and acknowledges woman’s sexuality, many young women as well as their families, are afraid and uncomfortable allowing young girls to enter into this profession, unless it is a family tradition as observed in TBAs (Rukannudin, 2007). Interestingly, because midwifery exists outside hospitals and the biomedical model, the lack of professionalism reinforces the idea of the crudity of midwifery (Jan et al., 2011). In addition, formal midwifery training requires students who have had at least eight-ten years of study before enrolling into a midwifery program; this is often difficult for women who have not had accessibility to schools or a formal education system, as is observed in rural areas (UNFPA, 2010).

The Lady Health Worker Program

Overview

On September 12, 1978, the GoP committed itself to the goals of the 1978 Declaration of the Alma Ata, which focused on achieving “Health for All” through a Primary Health Care Approach. As a direct result of the Alma Ata, the GoP initiated the Prime Minister’s Program for Family Planning and Primary Health Care (PMP-FP&PHC) through the MoH in 1994. The goals of the PMP-FP&PHC included “preventing and treating common ailments at the community level in a cost effective matter,” (Ministry of Health, 2004). In order to meet the aims of the PMP-FP&PHC, the LHW Program was created with the main focus to provide primary healthcare to the rural districts of Pakistan as well as urban slums. More specifically, the LHWs

…provide health education and promote improved health behavior, including the use of basic preventive health services. They supply some types of family planning and provide some basic curative care. They are trained to identify and refer more serious cases (Oxford Policy Management 2009).
LHWs are normally recruited from their own communities in which they eventually serve. Since its inception, the LHW Program has not only improved health outcomes, especially in comparison to other countries with community health workers, but has also significantly improved women’s roles within their communities and homes by creating job opportunities along with increasing their knowledge about better health practices (Khan 2011; Oxford Management Review, 2009).

The Lady Health Worker

Characteristics of the LHWs recruited and trained are based upon four main features: 1) eight years of formal education; 2) local residency; 3) minimum age of 18; and 4) recommended and accepted by the community; additionally, preference is given to married women as sexual information is socially only acceptable to married women due to the conservative Pakistani society (Khan et al., 2006). A quantitative survey report by Oxford Policy Management (OPM), conducted in 2009, examined the finer details of the requirements as well as the characteristics of a LHW.

LHWs are preferred to be between the ages of 20-50 years, although women of ages 18-19 years are allowed to partake in the program if they are married. Currently, demographics show that most of the LHWs were under the age of 35 years and married (Figure 2). While it is interesting that married women are encouraged to work, it should be noted that married women are preferred for two reasons: 1) married women have more personal experience and are better able to relate to their community, especially with mothers and wives; 2) there is less risk with married women as their sexuality is not threatened therefore they are afforded greater mobility.
Even though the program requires for workers to live in the village they serve, 3% of the LHWs were found to not be a part of the community which they served whereas the majority had been raised within the community they served (Oxford Policy Management, 2009). Such a distinction was explained through a minority of LHWs having the ability and autonomy to travel greater distances than in comparison to other women. However, just as seen with married women, local women were highly preferred because of their knowledge of their local culture and traditions as well as ease of access to the community.

Eight years of minimum education was required for LHWs to qualify entrance into the training program but a spectrum of education levels still existed. Even though less than 1% of the LHWs reported receiving fewer than eight years of education, 36% reported receiving up to ten years of education, where as another 10% reported matriculation from high school. At the same time, only 70% of those with more than eight years of formal education could provide records (Oxford Policy Management, 2009).

Other characteristics of LHWs surveyed included access to mass media, application of knowledge on self, and other employments opportunities. It was shown that while the program discourages LHWs to undertake second jobs, those few who did choose to have second employments did not show a negative impact on their duties as a LHW. In addition, having exposure to media, such as television and news, was not as prevalent, an occurrence attributed to working in rural areas. Lastly, it was found that the majority of married LHWs utilized modern methods of contraceptives and desired lower family sizes for both themselves and the communities they served (Oxford Policy Management, 2009).
Figure 2. Characteristics of Lady Health Workers Surveyed in 2000 and 2008

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>2000</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age distribution (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>20–24</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>25–29</td>
<td>41</td>
<td>25</td>
</tr>
<tr>
<td>30–34</td>
<td>15</td>
<td>27</td>
</tr>
<tr>
<td>35–39</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>40–44</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>45+</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Mean age</td>
<td>29.6</td>
<td>32.4</td>
</tr>
<tr>
<td>Mean age when recruited</td>
<td>24.5</td>
<td>25.3</td>
</tr>
<tr>
<td><strong>Marital status (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Currently married</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td>Widow/divorced/separated</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td><strong>Years LHW has resided in village/mohalla (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>3–4</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>5–20</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>More than 20</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Since birth</td>
<td>53</td>
<td>52</td>
</tr>
<tr>
<td>Mean years resided</td>
<td>–</td>
<td>21.78</td>
</tr>
</tbody>
</table>


Education and Training of LHWs

Having a minimum of eight years of formal education on average, LHWs are further trained over a course of 15 months with both in and out of classroom instruction. The first three months of LHW training include practical learning through videos, charts, and medical professionals, consisting of doctors, nurses, and LHVs who operate most commonly at the closest BHU. The remaining nine months include task-based learning which includes four days of in service training with an additional in class reflection session. Furthermore, refresher courses are annually provided with Lady Health Supervisors (LHS) attending, teaching, and following up on the LHWs (Figure 3) (Oxford Policy Management, 2009).
Figure 3. Education Received by Lady Health Workers

<table>
<thead>
<tr>
<th>Training was imparted by:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctor (male)</td>
<td>87</td>
<td>88</td>
</tr>
<tr>
<td>Medical doctor (female)</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Lady health visitor</td>
<td>70</td>
<td>67</td>
</tr>
<tr>
<td>Dispenser</td>
<td>48</td>
<td>25</td>
</tr>
<tr>
<td>Male medical health technician</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Female medical health technician</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LHW training was given by any female trainers:</th>
<th>n/a</th>
<th>82</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one female trainer</td>
<td>n/a</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of LHWs who attended task-based training of one week per month:</th>
<th>94</th>
<th>95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean months of part-time training attended</td>
<td>12.4</td>
<td>11.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of LHWs who received refresher/additional training courses in the past year:</th>
<th>95</th>
<th>97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any additional training (including refresher)</td>
<td>n/a</td>
<td>96</td>
</tr>
<tr>
<td>Any refresher training courses (counselling cards; child health; injection contraceptives; revised MIS manuals; OBSi)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Mean number of refresher trainings attended</td>
<td>n/a</td>
<td>3</td>
</tr>
</tbody>
</table>


LHWs are trained as educators on various health topics which include family planning, HIV/AIDS, and treatment of minor illnesses. More specifically, they work on issues such as breastfeeding and nutrition, IUDs (a form of contraceptive), birth control pills, injectable contraceptives, and manage the vaccination schedules for both mother and child. In addition, they attend to providing preliminary analysis of malaria, diarrhea, and tuberculosis, growth rate of a child, respiratory illnesses, and pregnancies (World Health Organization, 2008). When complications arise, the LHW is the liaison between the community member and a medical practionnar. Overall, LHWs are well-equipped to handle and refer their patients and presently, current LHWs have higher knowledge levels when compared to LHWs in prior years.

Once LHWs have matriculated from the Program, they work from their homes, where one room in their house is designated as the “Health House.” From this room, the LHW sees community members, holds meetings, stores contraceptives, medicines, and educational
materials, and maintains community records. On average, one LHW is required to cover 200 households or about 1000 persons per capita.

*LHW Activities:*

The LHW Program is based upon providing primary healthcare to underserved communities through Pakistan. Their role includes: 1) registering the population of the community they serve; 2) organize the community by developing women’s and health groups within the community; 3) discuss better health, hygiene, nutrition, sanitation, and family planning with their communities; 4) act as liaisons between the formal health system and the community; 5) educate their communities on hygiene and sanitation; 6) provide essential drugs; 7) strengthen vaccination programs; 8) provide support and motivation to mothers to receive antenatal, safe delivery, and postnatal care; 9) coordinate TBAs and Skilled Birth Attendants (SBAs), including midwives (Table D) (Ministry of Health, 2004).

*Monitoring & Evaluation*

The LHW Program is monitored on a multi-tiered system. The LHW is directly supervised by the Lady Health Worker Supervisor (LHS) who conducts monthly meetings of LHWs for evaluations and to monitor performance. The LHS then reports to the Field Program Officers (FPOs) at the District Health Office who coordinate LHSs along with the allocation of LHWs within the district. The FPOs further report to the Provincial Health Department (PPIU) which focuses largely on internal regulation and program design. The PPIU further answers to the Federal Ministry of Health which publishes the work that LHWs accomplish and report on the health statuses of the communities served (Oxford Policy Management, 2009).
Table D – Activities carried out by LHWs

- Register all family members
  - Special focus on married couples and women between the ages of 15-49 years
  - Maintain up-to-date information
- Visit 5-7 households every working day
  - Re-visit households every two months
- Connect with influential women of the community
  - Includes TBAs, lady teachers, and satisfied clients
- Motivate and encourage family members on adopting and practicing family planning methods
- Provide methods of contraception to eligible couples as well as inform them of possible side effects of:
  - Condoms
  - Oral pills
  - IUD insertions
  - Contraceptive surgery
- Coordinate with local TBAs, or SBAs to ensure appropriate antenatal, natal, and postnatal care
- Monitor nutrition and undertake any interventions such as:
  - Anemia control
  - Growth monitoring
  - Assessing risk factors that cause malnutrition
  - Nutritional counseling
- Treat iron deficiencies, especially in pregnant or lactating women and anemic children
- Promote nutrition education
  - Emphasize breast feeding and weaning practices
  - Attend to maternal nutrition
- Coordinate immunizations
  - Include tetanus shots for mothers and children
  - Vaccinate for six preventable diseases
  - Participate in awareness campaigns regarding immunizations
- Carry out prevention and treatment of common ailments such as
  - Malaria
  - Diarrhea diseases
  - Acute respiratory infections
  - Tuberculosis
  - Intestinal parasites
  - Primary eye care
  - Scabies
  - Snake bites
  - Other minor injuries
- Disseminate health education with emphasis on hygiene and sanitation
- Provide information on preventative measures against AIDS
- Submit monthly reports to in charge health center detailing work conducted

Source: Bhutta et al., 2010
Criticisms of LHWs by LHWs

While the LHW Program is commended for its effective on the ground approach along with women’s empowerment, there is a significant divide between job satisfaction and job necessity. Studies have found that there is a great deal of job dissatisfaction among LHWs due to distress in obtaining their salaries on time and ensuring that they are given adequate health supplies. The OPM study found that LHWs had to wait 6-12 weeks to be paid for their services as the money was allocated through the government (Oxford Policy Management 2009). In addition, LHWs also struggle with having enough supplies as it is often too few supplies sent to the BHUs for the large number of persons that they are required to serve (Haq et al., 2008 & Hafeez et al., 2011). Coupled to this is the strong sense of stagnation with the professional sphere as a majority of LHWs feel that there is neither upward mobilization nor further opportunities to improve their status as medical professionals. The second largest concern was based upon being looked down upon by the department which included nurses, and doctors. More specifically,

The low salary and lack of career path was highlighted by Asfar et al., as a reason for job dissatisfaction among LHWs. Mumtaz et al., reported abusive hierarchical management structure, disrespect from male colleagues, lack of sensitivity to women’s gender-based cultural constrains, conflict between domestic and work responsibility and poor infrastructural support as the important problems faced by primary health care workers…., (Haq et al., 2008).

Overall, LHWs find themselves in difficult predicaments as not only do they have to fight against their employer to receive their salary and supplies, but they also have to deal with the knowledge that their position is stagnant and it is difficult to achieve more than the status of being a LHW.
LHW Program as a tool of Empowerment

The LHW Program employs over 100,000 women across Pakistan and directly accesses as well as assesses women’s reproductive health needs and health in general. Ayesha Khan conducted her fieldwork on the empowerment of LHWs within Pakistan and found that not only did women’s autonomy increase in general but their status within their societies and households was also positively influenced. Khan defined autonomy “in terms of indicators such as domestic decision-making, financial decision-making, access to household resources, type of mobility, and even communication with the husband” (Khan, 2011). By becoming earning members of the families, Khan found that instead of facing repercussions from traditional and conservative households, LHWs instead were viewed positively because of the status their job signified. In addition, the LHW is not only empowering herself but also the community in which she works because she presents the opportunities and possibilities that younger women can follow.

Khan presents various stories of LHWs which highlight various themes that are pervasive and indicative of how the Program has become a vehicle for empowerment. Poverty is pervasive in rural Pakistan and job security a rarity. However, having the credentials of an LHW provides women with the tools necessary to not only find employment but also to gain status within their communities. As Khan discusses, husbands and in-laws increase their emotional support of a wife and daughter-in-law once she matriculates from the LHW Program. Such respect is founded upon the woman’s ability to be a contributing member of the family. On the other hand, Khan also discovered that more often than not, the husband or the family-in-law forced the daughter-in-law to undertake LHW as a profession so as to becoming an earning member of the family. Making the woman a financially important part of the family also aids in alleviating the family’s
poverty status, especially in rural settings, and furthers her status in her husband’s family’s home.

Other LHWs assert interest in their work because of the expanded mobility they are afforded by being able to travel further distances to meet their cases. In fact, LHWs successfully challenge gendered spaces because they are regarded as non-gendered medical professionals and their opinion takes precedence over the patriarchs of the household. In short, her status as an LHW elevates her from many social norms such as purdah, segregation of the sexes, and izzat (honor). Lastly, LHWs seem to have gained the confidence to demand change and to mobilize against a cause. In 2001, when many LHWs had not received their salaries, they came together and protested as a collective body which not only increased their visibility but marked them as social agents who were more than just health educators within their respective societies (Oxford Policy Management 2009). In addition, LHWs become role models for other women in their communities, including their daughters, an offer an avenue which these young women can embark upon to work towards being more autonomous.

Understanding Empowerment

While the LHW program has provided avenues through which many women have gained some facets of autonomy, it has not improved gender roles within Pakistan’s often conservative and traditional rural society. In fact, many LHWs expressed concern with balancing their domestic workload and child care responsibilities while working outside the home. Upon further examination, it was found that push factors, which included inflation, need to support her family and personal needs, male unemployment, widowhood, divorce, too many children, and poverty,
dominated why women chose to enter the workforce as LHWs as opposed to the pull factors, which include: desire for independence, to work, to stay busy, to utilize their education, to gain respect, honor, confidence, and knowledge, and to increase their awareness as well as their level of income. Thus, while LHW is commended on being a tool of empowerment for Pakistani women who are not afforded easy access to autonomy, it does not directly challenge gender roles as the woman, especially those working due to Pull factors, has to return home and give her salary to her husband or father (Oxford Policy Management, 2009).

Bridging the Gap

Midwifery is a multi-level profession that is based upon the level of education and training each woman has undergone. While community midwives and other certified midwives are gaining popularity in urban Pakistan, TBAs are still more prevalent in rural Pakistan as they hold a strong cultural place within the rural household (Byrne et al., 2011). However, LHWs are also gaining prominence within the rural sphere, but only as advocates and practitioners of primary prevention. In short, while LHWs are required to create links with TBAs, each health provider exists in their distinct spaces and does not interact.

Virtually no initiatives have been taken to increase the interaction between TBAs and LHWs which would not only reduce the feelings of territorial hostility or inferiority between the two groups but also improve maternal health as a whole. In fact, the solution often given to improving maternal mortality is to eradicate TBAs and replace them with SBAs (Jaffar et al., 2010). While this mechanism may prove fruitful, it is more feasible to use the existing health
providers and create a coalition that would encourage a partnership and sharing of knowledge of the mothers of the community.

In addition, both the LHW and TBA fill in the gaps left by each provider’s health care practices. The LHW is most involved with the prenatal and postnatal care while the TBA is only needed during the birth process. However, a clear problem arises as the TBA is less likely to be mindful of the mother’s health history and not be aware of any complications that may occur. The LHW, on the other hand, has full knowledge of the mother’s physical and social health and environment and therefore is more likely to be privy to potential problems that may occur during the child birth process. Ideally, by connecting the LHW and TBA, mothers can receive a more comprehensive care package where their health history is accounted for and risks are better planned for, especially since LHWs are the liaisons that connect the community with surrounding health clinics and hospitals. Overall, by working together, TBAs and LHWs can be better prepared to serve an expecting mother and ensure her health and needs are safely and most appropriately provided for.

_Bridging TBAs and LHWs – Evidence and Benefits_

Before TBAs can begin to work in conjunction with LHWs, their presence within the healthcare system has to be recognized. While TBAs conduct 70% of the births in rural Pakistan, they are not afforded credit by the government and other health professionals because of the lack of their formal training and education. However, in the early 2000s, a randomized-control trial was conducted in the province of Sindh to assess how TBAs would function with a short period of training and further inclusiveness within the health care system through the LHW Program.
The study recruited 7,460 TBAs and used LHWs to train them for a course of two weeks on how to recognize serious complications as well as encouraged them to access hospitals and clinics when faced with more complicated births. The two week training session resulted in a large number of TBAs refining their techniques to better serve their patients. At the same time, however, the TBAs found difficulty in working with LHWs who were acting as overseers and managers rather than as health care providers working alongside with the TBAs (Jokhio et al, 2005).

This study, a first of its kind, brought forth the tension that exists between TBAs and LHWs. While the researchers found that TBAs were open and willing to reevaluate their practices and work with LHWs, they stated their preference to work alongside LHWs than below them as that created an obvious hierarchy. That hierarchy assumed TBAs to be less knowledgeable than the LHWs due to the differences in the levels of education and training. Yet, even with the hierarchy present, the researchers found that their partnership resulted in a reduction of maternal mortality more than having the TBAs refine their techniques. They attributed the success to the partnership between TBAs and LHWs because they found that TBAs accessed LHWs more frequently when faced with complicated births. This further allows LHWs to connect the mother with more advanced medical support and ultimately, save the mother and her child. Overall, the TBAs were more aware of the mother due to prior knowledge obtained by the LHW and then more agreeable to accessing more advanced health services. Additionally, the authors hypothesized that if LHWs and TBAs were given a larger space to interact without difficulty, then this partnership would prove more fruitful and successful in reducing maternal mortality (Jokhio et al., 2005).
In order to assess this theory, authors Bhutta et al., conducted a case-control pilot study which prepared an intervention package that trained LHWs and TBAs on newborn care. The LHWs and TBAs then collaborated together to educate the community on newborn care and ways to access emergency care as well. Their results indicated a marked improvement in maternal mortality and newborn care in those communities where TBAs worked alongside LHWs than in those communities where they did not interact with each other (Bhutta et al., 2008).

Overall, the little insight into the coupling of LHWs with TBAs to increase the knowledge and provide better health care and services to the mother suggest that it there is more benefit to have collaboration between the two cadres of healthcare providers.

**Framing the Bridging Dialogue**

While Bhutta et al., implemented a pilot project, no further work has been done to encourage LHW and TBA partnership. In addition, the pilot project included an objective third party that coordinated the LHWs and TBAs; in daily life, there is no mediator. Therefore, before a partnership can be assumed, dialogue between the two groups needs to be fostered. This dialogue can be fostered by integrating TBAs within the LHW training program. This would include:

1) TBAs attending LHW trainings and taking part in workshops that enable the two providers to work together;
2) TBAs receiving training from LHSs or other health care providers on better health practices;
3) Both groups receiving education on basic newborn care;
4) and workshops establishing the need for LHWs and TBAs as independent but partnered health care providers
Through working together and learning together, the expectation would be that an alliance forms between TBAs and LHWs. From here, the next step would encompass creating a ‘buddy system’ which would partner a TBA and LHW from a specific community together. The ‘buddy system’ would further include:

1) Monthly meetings to evaluate the health status of pregnant women;
2) Joint TBA and LHW visitations to expecting mothers closer to the due date;
3) Joint TBA and LHW collaboration with nearby clinics or hospitals to ensure the safety of the mother when necessary;
4) and joint presence at the birth where TBA aids in the birth and the LHW is close by to offer assistance and connection with advanced health care providers when necessary

Lastly, in order to ensure the success of this partnership, it is crucial for the government to acknowledge TBAs and provide monetary compensation for their work. One of the largest reasons for tensions between the two groups is the LHW being a salaried-worker while the TBAs depend solely on the families they serve. If the TBAs are provided slight compensation, they are more likely to attend and work with LHWs.

Overall, in order to implement a TBA-LHW partnership, trust between the two groups needs to be fostered through dialogue, active participation in the expecting mothers’ lives needs to occur, and monetary compensation needs to be provided. Through acknowledgement and visibility, both groups of women can then further their goals to reduce the rates of maternal mortality and improve overall community health.

Conclusion

Maternal mortality is a problem in rural Pakistan and is affected largely by social and cultural factors. However, the LHW Program has been successful in providing basic care to a number of households and has significantly helped reduce the mortality rate of mothers. In
addition to increasing the knowledge of married women regarding their reproductive and maternal health, LHWs are also a symbol of empowerment and change in the rural sphere. At the same time, their job dissatisfaction leaves much to be questioned about the longevity of such a program.

TBAs are also successful in cultivating a relationship within the houses they serve and gaining the trust from their communities. However, their lack of education puts them in difficult positions with trained midwives, LHWs, and the larger body of healthcare providers. Yet, both the LHWs and TBAs are crucial to alleviating the maternal mortality rate in rural Pakistan. Yet, complications during pregnancy are still a hurdle that needs to be overcome and will only be possible by TBAs and LHWs working in tandem with each other.

In order to begin working to counter maternal mortality, it is crucial that TBAs and LHWs come together and understand the role each other plays within the healthcare paradigm. In addition to assisting the dialogue between the two healthcare providers, it is also essential that TBAs and LHWs be required to work together so that not only does each gain knowledge and skills, but also so that pre-conception, pre-natal, and post-natal care can be handled by the LHW while the birth process is taken care of by the TBA. By ensuring that the different parts of maternal health are attended to, LHWs and TBAs can aid in the revolutionizing of the MMR in rural Pakistan. Lastly, by providing economic incentives to TBAs as well as due payment to LHWs, the government can guarantee the progress of this partnership as well as its dedication to reducing maternal mortality.

Overall, this paper aimed to provide suggestions upon which LHWs and TBAs can collaborate to provide better healthcare to mothers in rural Pakistan. Through these short
recommendations, I hope to establish the rhetoric through which newer and more community
specific paradigms can be initiated, designed, and implemented to both ensure the reproductive
right of a rural Pakistani woman and her safe health.
Bibliography


