A young woman with a bright smile, wearing a black headscarf with a teal border and a green top, is sitting on a large haystack. She is holding a yellow notebook and pointing at it with her right index finger. The background shows a green field and a clear sky.

Enhancing reproductive health services use by married adolescent girls and young women: Role of Community Volunteers

Executive Summary - 2021

Nur Center for Research and Policy (NCRP), Lahore, Pakistan was established in 2006 by the Nur Foundation-Fatima Memorial System complex to generate and collate policy-relevant research and advocate for its use in policy and decision-making. NCRP received the US National Academies – USAID Partnership for Enhanced Engagement in Research (PEER) Cycle 7 grant for its research proposal titled, '*Enhancing Reproductive Health Services Use by Married Adolescent Girls and Young Women – Role of Community Women Volunteers*' in 2018.

The study was aimed at testing the effectiveness of Community Women Volunteers (CWVs) in enhancing the utilization of LHW-provided FPRH services by married adolescent girls and young women aged 15- 25 years.

Owing to the Covid-19 pandemic, the sequential mix methods intervention testing study could not be completed. However, a number of activities under the project had been undertaken before the discontinuation of the intervention testing phase. These included:



24 Focus Group Discussions with **145** community groups participants



Baseline survey of **5000** married adolescent girls and young women in the age range of **15 to 24** years before the pandemic lockdowns and after the lifting of lockdowns



Survey of **500** Community Women Volunteers (CWVs) who had been recruited by Lady Health Workers (LHWs) for the project and of



Interviews with **201** Lady Health Workers participating in the study and their **14** Lady Health Supervisors (LHSs)

The project was, therefore, able to collect a large observational data set with quantitative and qualitative data from four sources:



Community groups on their perspectives on the Family Planning and Reproductive Health needs of adolescent girls and young women and knowledge about LHW-provided services



Married adolescent girls and young women on their knowledge of FPRH and available services, their FPRH practices and utilization of services and use of contraceptives;



CWV on their reasons and motivation for volunteering to work without pay and their experience of volunteering during the project and



LHWs and LHSs on their own FPRH practices and views on their felt need for volunteers for support and facilitation of their work and the effectiveness of the volunteers during the project

Full reports of all the four studies mentioned above are available. Summaries are given below.

Project Rationale and Objectives

Despite being a priority area in the policies of all governments since the 1960s, population growth control remains a challenge for Pakistan's government. Since the early 1990s, Primary Health Care (PHC), Family Planning and Reproductive Health (FPRH), and Maternal Newborn and Child Health (MNCH) services strengthening and coverage expansion have been areas of special focus. In Punjab, many initiatives have been taken in recent years to strengthen PHC and its FPRH and MNCH components and enhance their coverage. Despite these efforts,

Millennium Development Goals (MDGs) have been missed, the country's commitment to increase Contraceptive Prevalence Rate (CPR) to 50 by 2020 has not been fulfilled, and FPRH indicators are improving sluggishly. FPRH related Sustainable Development Goals (SDGs) are unlikely to be achieved if the current situation doesn't improve.



Available evidence suggests that: **a)** critical shortage of Human Resources for Health (HRH), **b)** continuing low investments in PHC, **c)** Pakistan's demographic youth bulge, **d)** the resulting increasing proportion of adolescent girls and young women keeping birth rates high, and **e)** women's low utilization of FPRH services are barriers in the way to fulfilling the country's FPRH goals and international commitments. The many tasks assigned to Lady Health Workers (LHWs), who are the main providers of PHC and FPRH services for the poor and marginalized communities, hinder them from performing their primary duties, and prevent programs like Integrated Maternal, Neonatal, Child Health and Nutrition (IRMNCH&N) from fully achieving their goals and objectives.

On the other hand, the increasing proportion of the highly marginalized married adolescent girls and young women population which currently constitutes 20% of married women of child bearing age, demands special attention. The CPR among this group is half that of all women of child bearing age. If special focus is not brought on to the FPRH needs of this age group in programs like IRMNCH&N, Pakistan and the Punjab province are unlikely to achieve national goals and realize the many international commitments the country has made.

Original Objectives

- i. Increasing access of LHWs to young women for the provision of FPRH services
- ii. Pursuing solution-testing research to inform policies and implementation of the IRMNCH&N program
- iii. Promoting community mobilization to address gaps in family planning and reproductive health awareness
- iv. Increasing inter-sectoral collaboration

Although the study intervention-testing could not be completed due to the Covid-19 pandemic, useful data was collected through the baseline survey of the study in the pre-pandemic period. Therefore, the objectives were revised.

Revised Objectives

- i. Observing FPRH awareness and access among young married women between the ages of 15 and 25
- ii. Providing feedback to the Punjab Health and Population Welfare Departments' policy, decision-makers, and program managers on the current state of FPRH knowledge and practices among married adolescent girls and young women and their utilization of PHC and FPRH services provided by LHWs to emphasize the need for mobilizing community support for the LHWs to facilitate their work and enhance the impact of the services they provide

Project Outputs and Outcomes

While the original objective of experimentally testing the effectiveness of the Community Women Volunteers (CWVs) in enhancing the FPRH knowledge and practices of married young women and increasing their use of contraceptives was not achieved, we were able to collect a large observational data set on the community perceptions of FPRH needs of married adolescent girls and young women, the FPRH knowledge and practices, and utilization of services by this age group of women, the potential of CWVs in providing support and facilitation to LHWs in reaching out to the community and creating awareness about the FPRH services the LHWs provide and the views of LHWs and their supervisors on the contribution of volunteers and the acceptability of volunteers to them.

The data is presented in the following reports:



01

Focus Group Discussions Paper for Publication

"Married Adolescent Girls Reproductive Health Needs: Community Perceptions and Awareness about Available FPRH Services"

02

Baseline Survey Report

"Underutilization of LHWs' Family Planning and Reproductive Health Services by Married Adolescent Girls and Young Women in Lahore District."

03

Community Women Volunteers Survey Report

"Potential of Community Women Volunteers for Filling Services Delivery Gaps in Family Planning and Reproductive Health Services Delivery in the Community."










04

Lady Health Workers and Lady Health Supervisors Survey Report




"Lady Health Workers and Lady Health Supervisors Experience with and Views on the Role of Community Women Volunteers in Enhancing FPRH Services Utilization."



Key Findings:

-  Disempowerment and low social status of married adolescent girls and young women was found responsible for their low age at marriage and first childbirth and marginalization from access to and use of FPRH services
-  Low age at marriage and first childbirth attributable to disempowerment of young women
-  Low knowledge among community about the FPRH needs of married women
-  No sources of FPRH information for husbands
-  Little knowledge and utilization of FPRH and LHW services among young women
-  Control of family over LHW access of young women
-  Community Women Volunteers successful in creating awareness about LHW services, facilitating access to FPRH services, and conveying counseling messages to those disinclined towards LHWs
-  CWVs motivated by respect for LHWs and admiration for their work
-  Generally positive feedback from LHWs on the value of CWVs

Secondary Findings:

-  Primary care and LHW-provided FPRH services bypassed for secondary and tertiary care services even by economically challenged families
-  Little value of general education of girls among the community; appreciation for skill-based education
-  Financial independence, decision-making authority, and increased mobility of LHSs and LHWs thanks to the empowerment provided by their jobs



Summaries of Project Reports



1

Focus Group Discussions Paper for Publication
Married Adolescent Girls' Reproductive Health Needs:
Community Perceptions and Awareness about
Available FPRH Services

06

2

Baseline Survey Report:
Underutilization of LHWs' Family Planning and
Reproductive Health Services by Married Adolescent
Girls and Young Women in Lahore District

13

3

Community Women Volunteers Survey:
Potential of Community Women Volunteers for
Filling Services Delivery Gaps in Family Planning
and Reproductive Health Services Delivery in
the Community

19

4

Lady Health Workers and Lady Health Supervisors Survey:
Lady Health Workers and Lady Health Supervisors
experience with and views on the role of Community
Women Volunteers in enhancing FPRH services utilization

25

1

**Focus Group Discussions Paper for Publication:
Married Adolescent Girls' Reproductive Health Needs:
Community Perceptions and Awareness about
Available FPRH Services**

1.1. Background:

Pakistan's reproductive health indicators are improving sluggishly and Contraceptive Prevalence Rate is stagnating. Lack of attention to the specific reproductive health needs of married adolescent girls and young women below the age of 24 years is contributing to the suboptimal performance of the country's Maternal, Newborn and Child Health and FPRH Programs. This age group of women constitutes 20% of the women of childbearing age population in the country. They have specific Family Planning and Reproductive Health (FPRH) needs which demand special attention in policies and interventions being undertaken to improve reproductive health indicators and contain population growth rate. This age group of women is the most disempowered in the country and is victim of entrenched socio-cultural beliefs and FPRH practices in the community. An understanding of the community beliefs and practices and their awareness and opinions about available services is necessary for fine-tuning policies, focusing interventions and developing new initiatives.

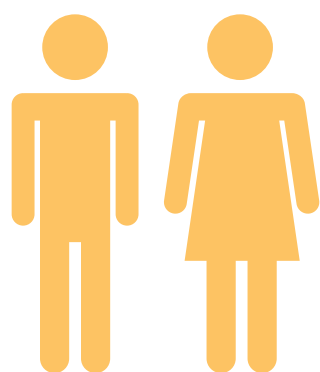
For the development of our interventional research study to test the effectiveness of Community Women Volunteers in supporting and facilitating the work of LHWs, we undertook Focus Group Discussions with Lady Health Workers (LHWs), the husbands of our study's target women population, their family members, and community members in six peri-urban sites of the city of Lahore, Pakistan, to record their views on FPRH needs of married women, particularly women aged less than 24 years and their knowledge and awareness about FPRH services provided by LHWs.



FGDs were undertaken in six peri-urban areas of Lahore city from January 24 to February 17, 2019. The areas included Gajumata, Lakhodair, Hazrat Esha, Kaahna, Malikpur and Nainsukh. These FGDs were conducted with the collaboration of Nur Community Outreach Program (NCOP), which assisted us in identifying locations where FGDs would be conducted and in identifying and selecting study participants. NCOP also provided community assistants to facilitate the organization of the FGDs.

FGD participants included families and husbands of married adolescent girls and young women, as well as community members and LHWs providing services in the area. Among family members, most were mothers-in-law but mothers and older sisters-in-law also participated. Furthermore, among community members were influential women including wives of landlords (Chaudhries), politicians, and religious and spiritual leaders. The four categories of participants (Family Members, Community Members, Husbands and LHWs) were recruited from each study site and four FGDs, one for each category, were undertaken at each site. The number of participants varied from **4-8**, with Hazrat Esha having the the lowest number of participants in its LHW group.

A total of 24 FGDs with 145 participants were completed. These included 41 family members, 38 community members, 30 husbands of married adolescent girls and young women, and 36 LHWs. A two-member team comprising a moderator and a note-taker conducted the discussions. Two teams were constituted, one each for women and men (husbands' group) participants. The checklists for the discussions were written in Urdu; however, the FGD data collectors (moderators and note-takers) were Punjabi-speaking and were able to translate the Urdu into Punjabi.



24

Focused Group Discussion

145

Participants

Husbands

30

Family
Members

41

Community
Members

38

LHWs

36

1.3. Key Findings

1.3.1 Married adolescent girls and young women are not empowered to make decisions about themselves and their reproductive health related matters.

Marrying off their daughters was considered a parental duty and parents wanted to fulfill this responsibility as quickly as possible



Women should be married off at a young age and marriage takes precedence over girls' education

*"She should get married by 18-19 so that she can give birth to 2-3 babies at a younger age."
(FGD, Community Members)*



Husbands and in-laws have the right to take women's earnings

*"Female elders of the household, mothers-in-law, or male elders, fathers-in-law, and husbands should have control over the women's earnings. They are the elders and they should make the decisions. She should give her money to her in-laws so that they are happy with her."
(FGD, Community Members)*



Women cannot take employment without their husband's permission and only for their families

*"My daughters are well-educated but their in-laws never allowed them to pursue a career or anything. They are only supposed to produce children."
(FGD, Family Members)*



The mother-in-law is the main decision-maker in her daughter-in-law's utilization of FPRH services

*"The mother-in-law is everything, we first need to gain her trust by making conversation with her. We cannot approach the girl directly before involving the mother-in-law. Once we have taken the mother-in-law in confidence, then it becomes easier to talk to the daughter-in-law."
(FGD, LHWs)*

1.3.2 Negative views on use of Family Planning in the early years of marriage and on modern contraceptives are pervasive

Most PGD participants were averse to family planning in the early years after marriage. According to them, a gap in conception after marriage gives rise to doubts about the woman's ability to bear children and may have adverse social consequences for her.



The first child should be born within a year of marriage and there should be no spacing until at least two children are born

*"If there is a gap in having your first baby after marriage, men and their families will start searching for other avenues e.g. husband cheating with another woman or marrying another woman. People start judging whether you can have a baby at all."
(FGD, Family Members)*



There were fears about the adverse effects of modern contraceptives

*Participants reported that bleeding problems could result from contraceptives and expressed the fear that they could cause infertility.
(FGD, Family Members)*



Ideal of a small family was 3-4 children

Four children, with a gap of 2-3 years between each, was considered a small and ideal family.

1.3.3 There are no sources of FPRH information for husbands, resulting in lack of knowledge and negative perceptions about family planning.

Husbands are ultimate decision-makers for their wives' access to and utilization of FPRH services. They reported that they had no sources of information other than the messages conveyed to them by their wives and friends. Most were not familiar with LHWs and others said they avoided them when they visited their houses.



Many husbands considered family planning a sin

*"One should not use family planning methods. The more children you give birth to, the more rewards you get from God. If you do family planning, you are committing a sin."
(FGD, Husbands)*



Some had heard that contraceptives cause cancer

*"One of my friends told me that the use of family planning pills causes cancer and also ruins the uterus."
(FGD, Husbands)*

1.3.4. There were low levels of knowledge about FPRH needs of married women and lack of trust in community-based services



Knowledge of RH needs and services requirement of adolescent girls and young women was limited to the need for rest and good diet during pregnancy

"During pregnancy, the girl should have a good diet, iron, calcium, vitamins and other minerals, good mental health and should stay active and work properly (so the baby's position remains the right side up) to deliver a normal baby."

(FGD, Community Members)



None of the FGD participants mentioned antenatal care, skilled birth attendance at delivery, postnatal care or checkups as needs

Some participants expressed a lack of confidence and trust in community-based providers, and preferred gynecologists

"Women shouldn't go to a Dai or LHW but to a gynecologist. Nowadays girls suffer from many weaknesses and Dais or LHWs neither guide them properly and nor do they have proper instruments so consulting a gynecologist is the best option."

(FGD, Community Members)



Doctor-provided services and facilities were preferred over those provided by LHWs

"LHWs should do their work more effectively. We should have doctors and other facilities for childbirth because LHWs don't know how to deliver babies and we should have government facilities."

(FGDs, Family Members)



While those who knew LHWs and had used their FPRH services were satisfied with them, there were some concerns about their education and knowledge as well as dissatisfaction over the unavailability of medications with LHWs



There was lack of awareness about available reproductive health services in their areas of residence: LHWs were recognized primarily as polio workers

1.3.5. Perspectives and experiences of LHWs: Mixed levels of motivation and valuing of their work

LHWs were satisfied with their relationship with the community



"It was hard to gain this level of respect. People miss us now when we do not visit frequently. Even my daughter gets annoyed that I stop to talk to every woman that I come across."

(FGD, LHWs)

The LHWs also faced certain barriers including:

- Negative attitudes of the community towards working women and the pressure on them from their husbands and some community members to quit their jobs
- Irregular supplies of medicines and contraceptives as barriers to their smooth interaction with the community.
- Cultural barriers to their interaction with male members of families
- Control of mothers-in-law over young women's access to FPRH counseling
- Annoyance of families over frequent visits



Some people do not like women going out to work. People with outdated cultural values used to come to my family and say that this does not suit our family.

Even my husband once told me to leave this work, but I told him not to worry about it. They don't like working women. Sometimes they get irritated by frequent visits.

(FGD, LHWs)

1.3.6. LHWs had mixed feelings about the usefulness of Community Women Volunteers' help and facilitation of their work

Previous experience of working with volunteers



Some LHWs had worked with community volunteers before, namely members of Sehat Committees (with influential male members), Women Committees (with active and influential female members), and school committees (with teachers and influential people as members).

Most thought volunteers would be helpful: They felt that CWVs would reduce their work burden, connect them with new people, and help them when they are over-worked.



"They can help us to connect with new people; They can help us register more people/ new people, and when sometimes number of pregnant women increase at once and we can't to provide all the services, we need help." (FGD, LHWs)

Overall, the idea of CWVs facilitating and promoting their work was acceptable to the LHWs and considered effective for bridging the FPRH knowledge gap and enhancing outreach.



Some of them ask for monetary incentives when we ask for their help, but if they are doing it voluntarily, they don't need any incentive. However, if we give incentives, they will perform more effectively. (FGD, LHWs)

1.3.7. Research team feedback on the FGDs

The main issue the research team encountered during the FDGs was the time constraint of the participants. Some participants would get restless and want to leave, citing a list of chores they had to do. This impacted the completeness and depth of the discussions. To address this issue, the moderator took up the more relevant questions early during the discussions.

In the FGDs with LHWs, the research team sensed that LHWs were reluctant to openly discuss issues and challenges they faced in delivering services. They generally portrayed a perfect relationship with the community and reported no problems in their work. The team interpreted this as a fear among the LHWs of being considered incompetent and not fit for their jobs if they acknowledged having problems and needing help. The association of the district IRMNCH&N office with the study may also have contributed to this lack of openness of the LHWs.

1.4. Discussion and Conclusions

Pakistan was unable to achieve the Millennium Development Goals (MDGs). Many of these MDG targets — including increased skilled birth attendance, increase in Contraceptive Prevalence Rate (CPR) and antenatal care, and reduction in fertility rate — were dependent, to a large extent, on the performance of the LHW program 2. Therefore, a critical appraisal of the LHW program is needed to identify the gaps that can be plugged to enhance its performance.

Our study indicates that adverse FPRH socio-cultural ideas and practices are preventing the program from achieving its objectives. Women overall, and especially those less than 24 years of age, are highly marginalized and disempowered and their access to and use of FPRH services are controlled by husbands and other authority figures in their families. Their low socioeconomic status and dependence on others to choose for them result in early marriages and childbearing with resultant high birthrates and maternal and newborn morbidity and mortality. Without understanding these issues and community behaviors, the program will be unable to perform optimally. Further behavioral research must be undertaken to understand the beliefs and perceptions about FPRH prevalent in the target communities. Such research would inform the development of new initiatives and interventions to promote the utilization of LHW-provided FPRH services and achieve the objectives of the LHW program.

Our study has also brought attention to the low level of knowledge of the community about the FPRH needs of women and available FPRH services provided by LHWs. The community has yet to recognize and trust LHWs as health professionals and providers of FPRH services. A finding of concern is that the community prefers doctor-provided FPRH services over community-based services that are made available to them to reduce their healthcare costs. For Pakistan, which has a crisis-level shortage of health human resources, LHWs are a precious health human resource. It is imperative to enhance the impact of their services by addressing the gaps and barriers in their recognition and utilization. One well-documented reason for the lack of recognition and low utilization of the LHW-provided FPRH services is their multitasking and diversion of their time from their primary functions of providing Primary Health Care (PHC) and FPRH services. A cost intervention, tested intervention, for creating awareness about their services and reducing their work burden is the mobilization of volunteers from the community. The Care Group Model – which we have adopted and adapted to the Pakistani context – has been tested in many developing countries and found to be effective. Its integrated model, tested in Burundi, has proven to be cost-effective, scalable, and sustainable.



² Planning Commission of Pakistan & UNDP, 2013. Pakistan Millennium Development Goals Report. [Online]

Available at:

<https://www.undp.org/content/undp/en/home/presscenter/pressreleases/2014/01/22/pakistan-makes-progress-on-millennium-development-goals.html>

<https://www.undp.org/content/undp/en/home/presscenter/pressreleases/2014/01/22/pakistan-makes-progress-on-millennium-development-goals.html>

2

Baseline Survey Report:

Underutilization of LHWs' Family Planning and
Reproductive Health Services by Married Adolescent
Girls and Young Women in Lahore District

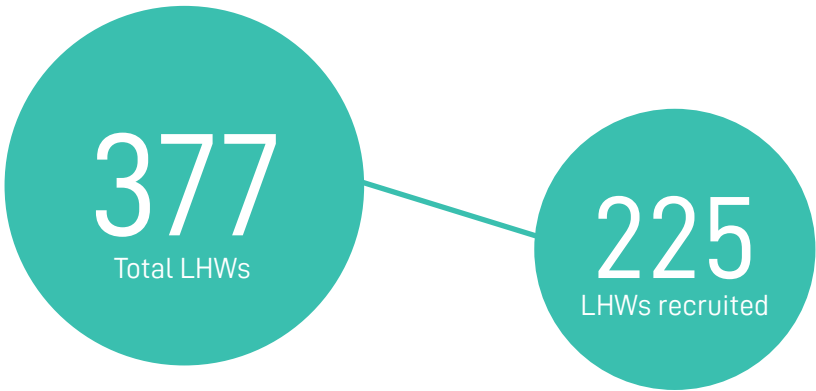
2.1. Introduction

The baseline survey was undertaken as a part of the 'before and after' study component of the project to document the baseline data on the following indicators.

- Respondents' Socio-Demographic Data and Empowerment Status
 - Reproductive Health Knowledge and Practice
- Family Planning Knowledge and Practice
 - Knowledge of and Utilization of LHW Services

2.2. Participants and Methods

The study was undertaken in Nishtar Town, Lahore District with the permission of and in regular consultation with district IRMNCH&N Office. From among the **377** LHWs working in the area, **225** were recruited with their informed consent. From among the households served by the participating LHWs, a total of **5249** married adolescent girls and young women **in the age range 15-25 years** were selected (using the snowball sampling technique) and administered a semi-structured interview. After cleaning and filtering for completeness and consistency, **4635** interviews were analyzed.



2.3. Key Findings

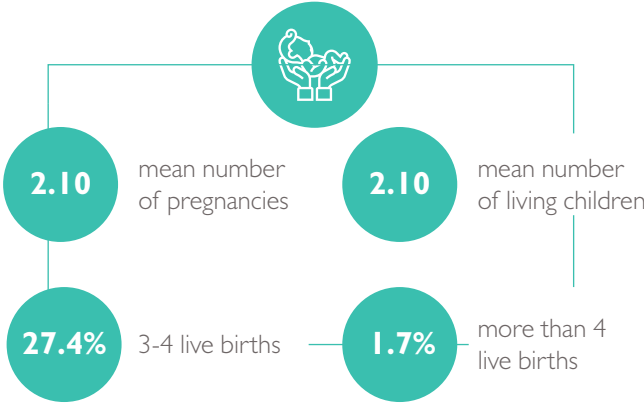
Education and Employment Status

The respondents of the study had a **higher average literacy rate than that of women of child bearing age** in Pakistan and the Punjab province as reported by PDHS 2017-18. Their literacy rate and secondary education status was better than their husbands unlike that reported for females and males by PDHS 2017-18.

Their employment rate was **93%**, with majority working as domestic servants. Despite their equal or slightly better education status, their monthly income was, on average, less than that of their husbands. The maximum monthly household income was **PKR 40,000**.

Marriage and Pregnancy

The mean age at marriage of the respondents was **18.56** years and age at first delivery **19.48** years, both lower than the median ages of all married women of childbearing age reported by PDHS 2017-18. The mean number of pregnancies was **2.10** and mean number of living children was **2.03** in the group, with **27.4%** having had 3-4 live births and **1.7%** more than 4 live births.

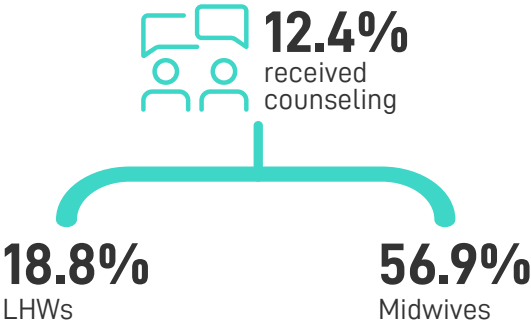
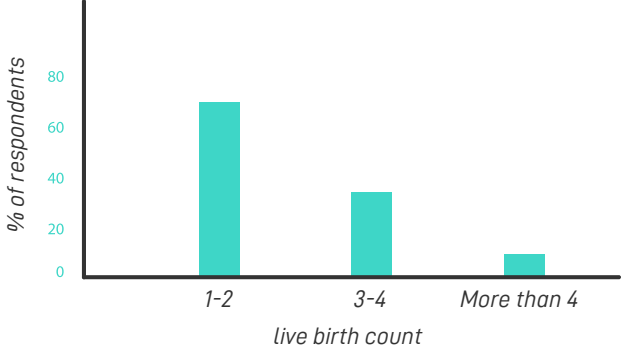
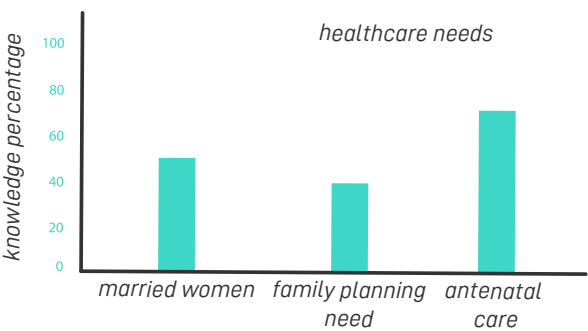




Knowledge and Utilization of FPRH Services

Three out of four respondents to our survey were ignorant about the availability of FPRH services at the household level and **87.6%** had never received any FPRH counseling. Among the ones who had received counseling, LHWs had provided the counseling to **18.8%** and midwives to **56.9%**.

Furthermore, they had mixed knowledge about the healthcare needs of married women with **50.90%** acknowledging the need for skilled birth attendants, **40.84%** recognizing family planning services as a need, and **76.79%** being aware of antenatal care.



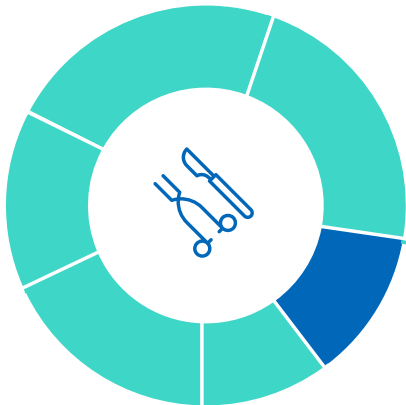
Positive findings of our study include high rates of antenatal care during the last pregnancy (with **81%** having gotten antenatal checkups, of whom **76.53%** had had 4-8 antenatal checkups), skilled birth attendant delivery (**84.8%**), and deliveries in hospitals (**87%**). However, these findings have negative connotations, as well. LHW services and PHC facilities were bypassed and secondary and tertiary care level services were accessed directly. Doctors had provided antenatal care to **95.4%** of the respondents and had attended the deliveries of 84.81%. Another negative finding was the **25.99%** rate of caesarian section delivery. Lastly, two out of three women had not received postnatal checkups after their last delivery.



Antenatal care during the last pregnancy

- 81% got their antenatal checkups, of whom,
- 76.53% had had 4-8 antenatal checkups
- 84.8% had skilled birth attendant delivery
- 87% deliveries in hospitals

negative connotations



95.4%

of the respondents were provided with antenatal care by doctors

25.99%

rate of caesarian section delivery

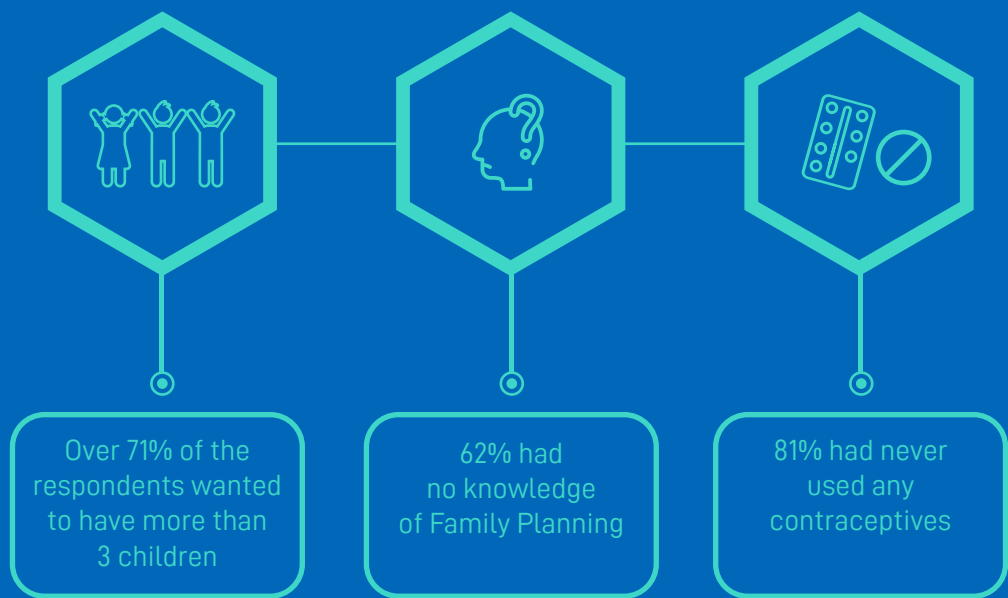


2 out of 3 women

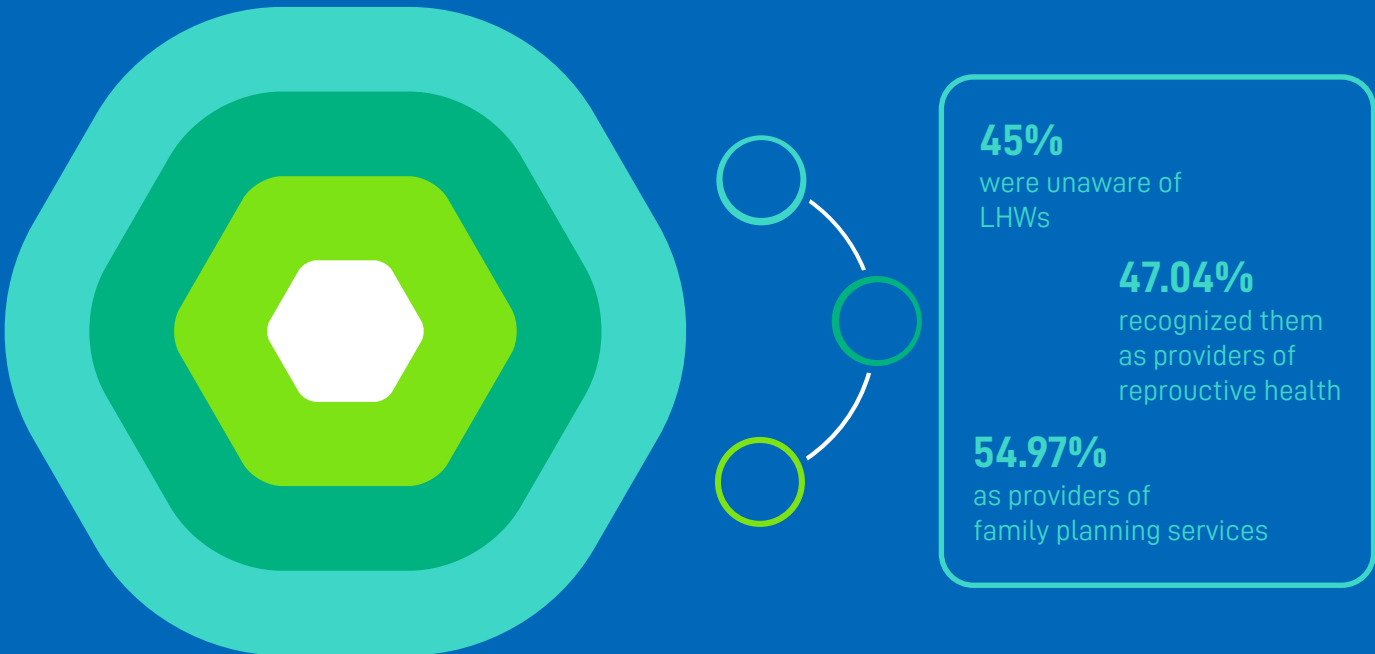
had not recieved postnatal checkups after delivery

Low utilization of Primary Healthcare and LHW-provided antenatal services is evident in the study results. LHWs had advised antenatal care to **16%** of the respondents and provided care to **3.56%**. They had provided supplements to **10.08%** during their last pregnancy, advised vaccination to **22.2%** and had provided **7.79%** referrals for delivery. **Two out of three** respondents had not received postnatal checkups after their last delivery.

The findings of real concern are low demand, and poor knowledge and practice of **Family Planning (FP)**.



Overall, utilization of LHW-provided FPRH services by the respondents was found to be low. **45%** of the respondents who had ever been pregnant were unaware of LHWs. Of those who were aware of LHWs, **47.04%** recognized them as providers of reproductive health services and **54.97%** as providers of family planning services.



2.4. Discussion, Conclusions, and Recommendations

The survey confirms the poor knowledge and underutilization of PHC and LHW-provided FPRH services by married adolescent girls and young women. While antenatal care and safe delivery practices of the group were found to be better than those of all women of childbearing age reported by PDHS 2017-18, it is a matter of concern that these are being sought at secondary and tertiary care facilities in preference to PHC and LHW-provided services. This trend increases healthcare costs for families and wastes government investments in PHC. It also reduces the prospects of protecting families from impoverishment through Universal Health Coverage (UHC)⁴. In addition, preference for deliveries in hospitals appears to be increasing the rate of cesarean section deliveries, which is another cause of increase of delivery costs and financial burden on families. These trends need to be taken notice of and measures must be introduced to create awareness about PHC and LHW-provided services to increase the utilization of these services at the grassroots and household levels.

Our study has recorded low mean ages at marriage of **18.56** years and first birth of **19.48** years as compared to the median ages of **20.4** years and **22.8** years, respectively, reported by PDHS 2017-18 for married women of 25-49 years. The low utilization of FP services by the group of married women below 24 years of age and their uncontrolled high fertility and birth rate will keep the Contraceptive Prevalence Rate (CPR) low and birth rate high if the issue is not recognized and specific approaches are not introduced in programs like IRMNCH&N to address it. This age group is currently lumped with all women of childbearing age and its specific needs are being ignored.

After about three decades of service, LHWs have yet to be recognized as providers of FPRH services at the community level. This finding demands serious consideration since LHWs are the lynchpin for the achievement of PHC and FP goals and objectives as well as UHC. Hence, two main recommendations to increase awareness and utilization of LHW-provided FPRH services are depicted in the figure below.

RECOMMENDATIONS

- Further research is needed to understand the reasons for LHWs' lack of recognition by the communities in which they operate.
- If tasks entrusted to LHWs (currently 22) cannot be reduced owing to the shortage of health workers, then community support for them may be mobilized in the form of volunteers to create awareness about their services and facilitate their work by spreading their FP counselling messages in the community. Volunteer women groups called Care Groups (Care Group Model) were found to be effective in rural Mozambique and Cambodia in reducing under-5 mortality rate by **45% and 47%** respectively when paid Community Health Workers (CHWs), like our LHWs, recruited them to help them in the dissemination of health messages.⁶

³ National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. 2017-18 Pakistan Demographic and Health Survey Key Findings. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

⁴ Universal Health Coverage for Inclusive and Sustainable Development. World Bank 2014
<http://dx.doi.org/10.1596/978-1-4648-0297-3>

⁵ World Fertility 2019. Early and later childbearing among adolescent women. United Nations New York, 2020

⁶ Perry, H., Morrow, M., Borger, S., Weiss, J., DeCoster, M., Davis, T., & Ernst, P. (2015). Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings. *Global health, science and practice*, 3(3), 358-369.
<https://doi.org/10.9745/GHSP-D-15-00051>

3

Community Women Volunteers Survey:

Potential of Community Women Volunteers for Filling
Services Delivery Gaps in Family Planning and
Reproductive Health Services Delivery in the Community

3.1. Introduction

Underutilization of Pakistan's Primary Healthcare (PHC) and Family Planning and Reproductive Health (FPRH) services is a cause for immense concern since the achievement of the country's health goals and international health commitments are firmly tied to the performance of these services. PHC was the strategy for achieving the 'Health for All' goal and is now the main approach for achieving Universal Health Coverage (UHC). The Lady Health Workers (LHWs) Program, which takes the provision of PHC and FPRH services to the household level, is especially of critical importance since it has the potential to not only enhance health through provision of services but also by positively changing thinking and behaviors through counseling and sustained interaction with the community.

Our baseline survey has documented the underutilization of PHC and LHW services by young married women under the age of 24 years and their low FPRH knowledge and poor practices. This age group constitutes **20%** of women of childbearing age in Pakistan. If their knowledge and practices are not improved and CPR not increased, Pakistan will continue to struggle to improve its health indicators and control its population growth rate. Major hurdles to the adequate performance of these services are low financial allocation and severe human resources shortage. LHWs have been assigned 22 tasks to perform in addition to their primary responsibility of providing PHC and FPRH services. Irregular supply of medicines and contraceptives result in undermining the credibility of the program and service providers, and disruption of their efforts to gain the community's trust and respect.

New initiatives are needed to boost the performance of the service providers and mitigate the adverse effects of both the human resources and commodities shortages in the currently implemented PHC and FPRH programs.

We developed our interventional research study to test the effectiveness of Community Women Volunteers (CWVs) in helping LHWs reach married women between the ages of 15 and 24.



The CWVs were recruited to supplement the FPRH counselling provided by LHWs and create awareness in the community about the FPRH services the LHWs can provide. We developed a modified concept of peer volunteers based on the Care Groups Model, which was found to be effective in helping community health workers in reducing under-5 mortality rates in Mozambique and Cambodia by **43%** and **47%**, respectively.

The term "volunteer" is currently used across a wide range of settings to denote unpaid and un-coerced service. As compared to paid employees, volunteers have been reported to be more motivated by social interaction with others and by the opportunity to contribute towards achieving the missions of their recruiting organizations. Volunteers are increasingly being found necessary and helpful for building healthy communities.

As mentioned in the Baseline Survey Report section above, the interventional study could not be completed due to the COVID-19 pandemic. To compensate for the uncollected data, we modified our methodology and replaced the Endline Survey of the intervention phase of the study with interviews with the recruited CWVs and participating LHWs and LHSs. A summary of the findings of the CWV survey is given below. Details are provided in the Survey Report.

3.2. Survey Purpose and Objectives

The overall purpose of the survey was to generate evidence to advocate for the need and feasibility of mobilizing the services of volunteers to address the human resource shortages and negative socio-cultural beliefs that limit the impact of FPRH and MNCH services being provided by community-based programs.

OBJECTIVES

- i. To document the demographic data and FPRH knowledge, beliefs and practices of CWVs
- ii. To record the CWVs' reasons for volunteering and their experiences of working with the LHWs and the community for promoting FPRH and the LHW-provided FPRH services.

3.3. Study Participants and Methods

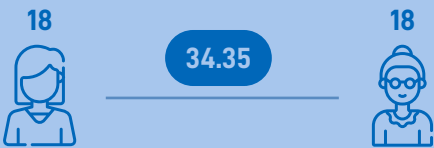
The participating LHWs selected **900** Community Women Volunteers (CWVs) from among their family members, friends, social circles, and clients, and trained them on Family Planning and Reproductive Health counseling in informal interactions. The CWVs then went out into the community to create awareness about the services the LHWs provide and delivered FP messages – such as delaying of the first birth and practicing adequate birth spacing – to families of married adolescent girls and young women. All volunteers were unpaid and no incentives of any sort were given to them. A team of three trained interviewers administered semi-structured questionnaires to the CWVs. Qualitative data software MaxQDA was used for the entry, coding, and analysis of the large qualitative data component of the interviews.



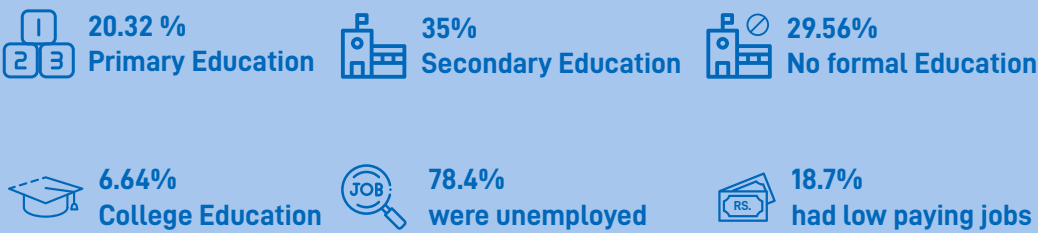
3.4. Study Key Findings

3.4.1 CWV Profiles

The age of the volunteers ranged from **18** to **65** years with the mean age of **34.35 ± 8.4** years.

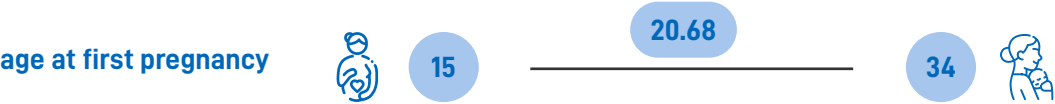


- Of the volunteers, **20.32%** had received primary education, **35%** secondary school level education, and **29.56%** had no formal education. In addition, **8.45%** had received secondary education and **6.64%** college education. Furthermore, **78.4%** were unemployed, while **18.7%** had low paying jobs.



3.4.2. CWVs' Reproductive Health Knowledge and Practice

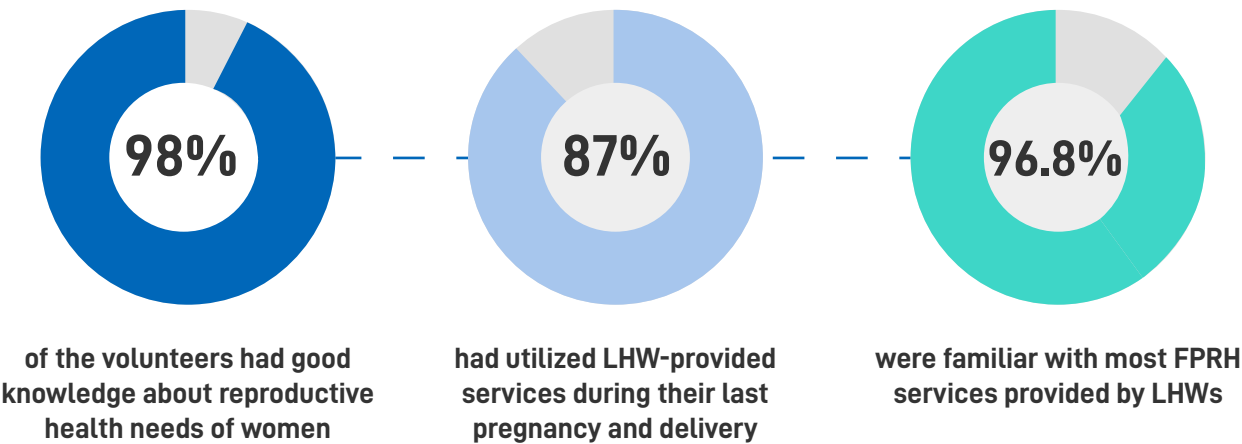
The age at first pregnancy of the volunteers ranged from 15 to 34 years with a mean of 20.68 years.



Their number of pregnancies ranged from 1 to 14 with a mean of 4.15. Their number of live children ranged from 1 to 10 with a mean of 3.5.



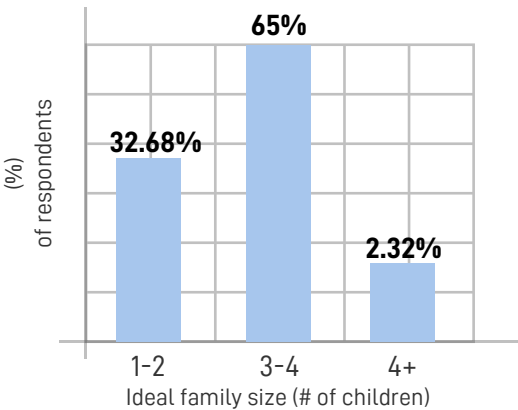
98% of the volunteers had good knowledge about reproductive health needs of women and available reproductive health services, while 96.8% were familiar with most FPRH services provided by LHWs. Over 87% had utilized LHW-provided services during their last pregnancy and delivery.



3.4.3. CWVs' Family Planning Knowledge and Practice

Almost all the CWVs (99.6%) believed in planned families.

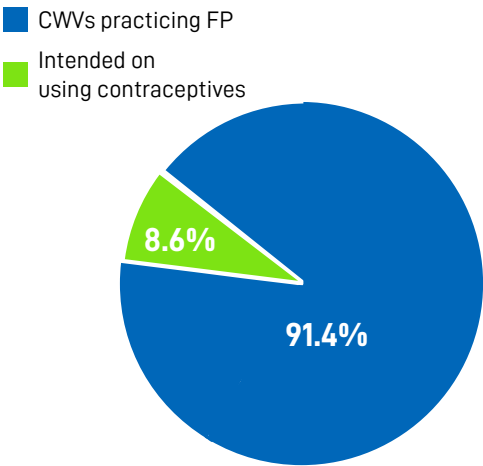
- Ideal family size**
1-2 children for 32.68%, 3-4 children for 65%, and 4+ children for 2.32%
- Contraceptive preference**
86.69% favored the use of modern contraceptives, 11.5% preferred traditional methods



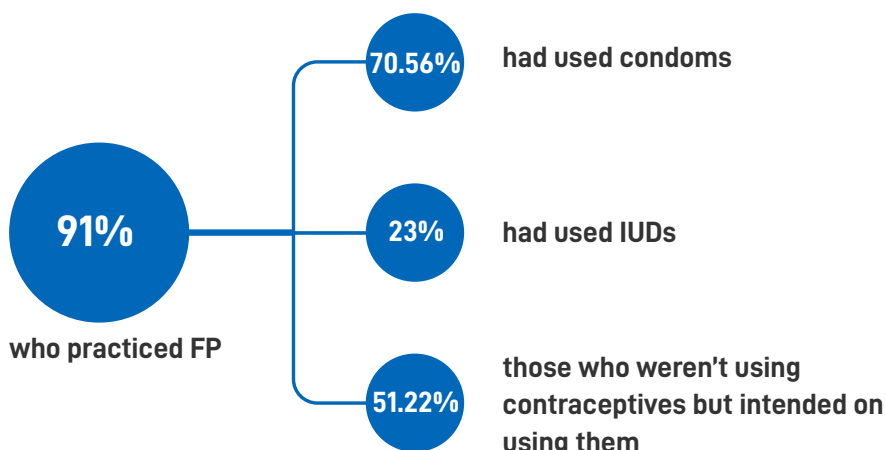
Modern contraceptive preference

80.67% preferred condoms and 28.44% IUDs

- Of the CWVs surveyed, 91.4% had practiced family planning themselves. Among these 70.56% had used condoms and 23% IUDs. Of those who were not using contraceptives at the time of interview, 51.22% intended to use them.



Modern contraceptives preference



3.4.4. CWVs' Reasons for Volunteering



High regard for LHWs and an appreciation for their work



Previous volunteer work with LHWs as vaccinators and polio workers



To please Allah



To fruitfully spend spare time



To increase interaction with their communities



To benefit their communities



To increase their knowledge of FPRH



In expectation for a job

3.4.5. Knowledge Gained by CWVs

- Some volunteers were unaware of the range of services the LHW provided other than contraceptives before working for the project.
- Others gained knowledge about birth spacing, and the adverse health impacts of inadequate birth spacing.
- Many respondents learned about contraceptive implants that are inserted in the arm.

3.4.6. CWVs' Perception about Community Acceptance of Their Services and Their Satisfaction with Their Own Service

- Most CWVs were happy with the response of the community to their outreach.
- Some reported being subjected to rude behavior from mothers-in-law and some being made fun of because they had not borne any children themselves.

A remark made by one CWV sums up the experience of the volunteers with the community:



Yes, I faced some problems. Like in some houses, women didn't cooperate because of their regressive mentality, and in some houses, mothers-in-law and husbands didn't allow them to interact with us. But there are still some people who appreciate our work and follow our advice.

3.5. Discussion

Most CWVs were happy with the response of the community to their outreach.

Our study has demonstrated that volunteers are available for the promotion of LHW-provided services and for spreading FPRH counseling messages in the community, even in impoverished communities. Mobilizing volunteers from the community is likely to fill the inter-sectoral cooperation and collaboration gaps in family planning programs.

Scalability and sustainability are key concerns in all new initiatives. In our study, we focused on scalability and sustainability in conceptualizing the CWV program. LHWs and other community-based workers (CBWs) are widely deployed in Pakistan and no new cadres are proposed to be introduced. In this initiative, LHWs/CBWs have been empowered to recruit volunteers with no interferences from officials. No qualifications or other specific particulars are required in recruitment. No specific time duration is needed for the volunteers to serve. Perhaps most importantly, there are no monetary incentives to be paid to the volunteers, which could have burdened government-funded cash-strapped programs or lead to other complications like political influence and favoritism in recruitment.

There is, however, a need for replicating our study in rural areas since it was conducted in a highly urbanized area of Lahore district. In the replication of the program, program managers and supervisors must monitor and supervise the volunteers and perform trouble shooting when required. The Lady Health Supervisors are well placed to undertake this responsibility. Furthermore, to ensure sustainability, CWVs can be awarded certificates for providing services beyond a specified period of time (for example, 3 months) and to the LHWs for the number and diversity of volunteers they recruit.

3.6. Conclusions

LHWs can mobilize volunteers to facilitate them in the delivery of counseling services and spreading awareness about LHW-provided FPRH services.

Volunteers have the potential to fill the long-standing gaps of community participation and inter-sectoral collaboration in the delivery of community-based services. Volunteers are available in economically challenged communities to provide services without cash incentives.

The volunteers' intervention is scalable and sustainable where LHWs or other community-based workers are deployed. Further research is needed in rural and far-flung areas to study the applicability of the model in those areas and to adapt the model for those areas



4

Lady Health Workers and Lady Health Supervisors Survey:

Lady Health Workers and Lady Health Supervisors
experience with and views on the role of Community
Women Volunteers in enhancing FPRH services utilization

The country's national health programs are underperforming as is evident from its stagnating health indicators and failure to achieve national and international health goals.⁷ The Lady Health Workers (LHWs) program has immense potential to mobilize communities, enable them to understand their health needs, and motivate them to take ownership of the programs working for their health and social wellbeing. A significant reason for the underperformance of the programs is shortage of health human resources (HHR). While over 100,000 LHWs have been trained and deployed to provide PHC and FPRH services in the underserved and marginalized communities, owing to the shortage of HHR, they are performing 22 other tasks in addition to their two primary responsibilities.^{8,9}

Fresh initiatives are needed to invigorate the programs and enhance their impact. The health programs have as yet not explored the role of volunteers in overcoming barriers they face. The primary healthcare and reproductive health programs have a special need for volunteers mobilized from within the community to support and facilitate the work of their services providers. Volunteers have the potential of multiplying their voice and increasing its reach to distant and inaccessible corners of the communities they serve.

Nur Center for Research and Policy (NCRP), Lahore in collaboration with George Washington University Milken Institute of Public Health, undertook a study to test an innovative strategy of enhancing access of LHWs to married adolescent girls and young women (aged 15-24 years) for family planning and reproductive health counseling through community-based women volunteers. Our study concept was derived from the Care Group model of peer volunteers who were able to help community health workers in Mozambique and Cambodia in reducing under-5 mortality rates. The peer volunteers in our study, namely Community Women Volunteers, are recommended for motivating mothers to adopt key Maternal and Child Health (MCH) behaviors.¹⁰

A2. Objectives

(i) To document the demographic data and FPRH knowledge, beliefs, and practices of LHWs and LHSs participating in the project.

(ii) To record what the LHWs and LHSs learnt from working with the volunteers, and their views on the potential of volunteers to facilitate the FPRH services they are providing to married adolescent girls and young women.

The purpose of the surveys was to generate evidence to advocate for mobilizing Community Women Volunteers to address the human resources shortages and mitigate the effects of socio-cultural beliefs that limit the impact of FPRH and MNCH services being provided by community-based programs like the Integrated Reproductive Maternal, Newborn and Child Health & Nutrition (IRMNCH&N) program.

A3. Participants and Methods

We selected the quasi-experimental before and after study design to test our peer-to-peer health promotion approach. This included **a)** the selection of Community Women Volunteers (CWVs) by LHWs from among their family members, friends and social circles and clients, **b)** setting a manageable workload for the volunteers, and **c)** at least monthly contact between the LHW and her selected group of volunteers for feedback on how their work was going and any issues they were facing. During these meetings, the messages the volunteers were passing on to the target age group women and their families were re-evaluated and new messages were added. The LHWs provided monthly feedback on the progress of the intervention-testing to our study Field Monitoring and Supervisory Teams (FMST). Our intervention-testing phase was interrupted by the COVID-19 Pandemic. We had completed a baseline survey, and the 225 participating LHWs had selected and trained 900 CWVs who had started conveying the messages given to them by the LHWs. While we were unable to complete our intervention testing, in our revised study methodology, we undertook a survey of the recruited CWVs and the participating LHWs and their supervisors (LHSs) to record the profiles of the volunteers and their motivation for volunteering, and received feedback from the LHWs and LHSs on their experience mobilizing volunteers and the latter's contribution to the facilitation of their work.

⁷ Pakistan MDGs Report

⁸ Z Mumtaz, S Salway, C Nykiforuk, A Bhatti, A Ataullahjan, B Ayyalasomayajula. The role of social geography on lady health workers' mobility and effectiveness in Pakistan. *Soc Sci Med*, 91 (2013), pp. 48-57

⁹ Rose Zulliger, PAKISTAN'S LADY HEALTH WORKER PROGRAM. <https://chwcentral.org/pakistans-lady-health-worker-program>

¹⁰ Perry H., Morrow M., Borger S., Weiss J., De Coster M., Davis T., & Ernst P. (2015). Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings. *Global health, science and practice*, 3(3), 358-369. <https://doi.org/10.9745/GHSP-D-15-00051> the study participating 225

A4. Key Findings

A4.1. LHW Socio-Demographic Profiles

- The age of the **201** LHWs interviewed for the survey ranged from **26** to **63** years with a mean age of **43** years.
- **84%** were currently married, **11.4%** were widows, and **2.5%** separated or divorced.
- All had secondary level education with **13.93%** with higher secondary and **8.49%** with college level education.
- Husbands of about **10%** of respondents were unemployed and **71%** had low paying jobs.

Age range	●	26 – 63
Mean age	●	43
Currently married	●	84%
Widows	●	11.4%
Secondary education	●	100%
Higher secondary	●	13.93%
College education	●	8.49%

About **48%** were married off in adolescence. For the **24%** who were in school at the time of their marriage and wanted to continue their education after marriage, it was not possible to do so owing to the usual reasons of looking after the home and children and the refusal of the in-laws to give permission.



My husband allowed me to study further but my in-laws did not want me to study more. They said ‘pay attention to your husband and your home. What will you do by educating yourself?’

A4.2. Empowerment of LHWs through their jobs

- **Family dependence on LHWs' income:** With **10%** husbands un-employed and over **70%** working in low-paying jobs, the LHWs' families were highly dependent on their salary. For **13%**, it was the only source of income and for **53%**, it paid for some critical needs of the family.
- **LHWs jobs are valued:** The interesting finding is that the very same families who were adverse to the continuing of their education after marriage had no problem allowing them to take the training and jobs of LHWs.
- **High husband and family support:** In fact, for **50%** of the LHWs their husbands made the decision that they would work as LHWs. It is, therefore, not surprising that **90%** of the LHWs reported their husbands to be supportive or highly supportive. Only about **6%** reported their in-laws to be discouraging, the rest said they were either supportive or highly supportive, while **15%** said they were neutral.
- **Enhanced respect within the family:** The LHWs reported that their jobs had enabled them to contribute to their families' income, give better education to their children, and meet their children's other needs. This has increased respect for them within the family.
- **Increased independence and decision-making status:** According to the LHWs, their employment had also increased their mobility, given them independence, and a decision-making status within the family.
- **Change in community perception:** Some LHWs reported facing criticism and negative remarks from the community but they felt that over time and with better understanding of the work they do, the negative perceptions have changed and there is more respect for and acceptance of their services.
- **Increased trust and enhanced status in the community:** LHWs were especially pleased about their increased mobility and interaction with the community and their enhanced status in the community. They believed they had gained the trust of the community and people shared intimate matters with them.

A4.3. LHWs' Family Planning and Reproductive Health practices

- We documented the FPRH practices of the LHWs to assess their belief in and commitment to the services they are providing and promoting in the community.
- Average age at marriage, age at first pregnancy and number of children of LHWs were the same as all women of child-bearing age reported by PDHS 2017/18.
- **48%** were married off in adolescence.
- Average age at first pregnancy was **21.25** years.
- **71%** had more than **4** pregnancies and **60%** had more than **4** live children.

A4.4. LHWs' FPRH services utilization

- Comparison of utilization of reproductive health services by the LHWs in their first and last pregnancies showed an increase but no difference in the providers of services was found.
- Doctors provided services to the overwhelming majority both in their first and last pregnancies. This finding is the same as in other women groups of childbearing age and has negative implications for the development and utilization of primary health care services and achievement of universal health coverage (UHC).

A4.5. LHWs' views on and practice of Family Planning

- For **71.64%** of the LHWs, the ideal number of children for a couple is 3-4 and for **24.38%**, 1-2. All except **6.47%** believed in modern contraceptives for FP. Condoms were the preferred modern contraceptives of **85%** and IUDs of **31.8%**.
- Adverse side effects of pills were mentioned as a reason for their infrequent use.

A4.6. LHWs Experience and Views as FPRH Services Provider

- **LHWs' assessment of the effectiveness of services provided by them:** When asked to provide their own assessment of the effectiveness of their FPRH counseling and other services provided by them, only **1.4%** said they were disappointed, **14%** were satisfied and the rest considered themselves successful or very successful.



- **LHWs assessment of FPRH services utilization in their coverage communities:** 60% thought contraceptive prevalence in their area was more than 40% with 35% claiming that it was more than 50%. The age group of 25-30 years was the most frequent user of services according to 58.2%, while 32% of LHWs thought that the age group of less than 24 years had the most frequent users.

Average age at marriage, age at first pregnancy and number of children were the same as of all women of childbearing age

The FPRH services utilization of LHWs was similar to that of all women of childbearing age with doctors and secondary and tertiary care hospitals providing services

A4.7. Issues and barriers faced by LHWs in the delivery of services

- **Negative attitude to FP in the community:** A number of LHWs said that they had faced a hostile response from the community, especially from mothers-in-law, to FP counseling in the early years of their employment. However, they felt that with the passage of time, communities are becoming more aware about the need for family planning and their attitude towards LHWs and FPRH is improving.
- **Shortages of contraceptives and medicines:** According to the LHWs, along with counseling, supply of recommended commodities enables them to develop and maintain good rapport with their clients and their families, and enables them to perform their duties. A shortage of contraceptives and medicines, then, creates issues in the delivery of services.

A4.8. Views on working with CWVs

- **Reasons for reluctance of some LHWs to recruit volunteers included:**
 - People need money. Nobody works without money *"People know us, we don't need volunteers to promote our work"*
 - Doubt about volunteers understanding their work
 - Instead of help, volunteers will become an added responsibility
- **Experience of the LHWs in recruiting volunteers**

The 225 LHWs were able to recruit 900 volunteers, which clarified the doubt among most LHWs about the willingness of women to work without pay.
- **Reasons for success of recruitment were:**
 - Recruited relatives as volunteers.
 - Personal friendships with families of CWVs
 - Good standing and trust in the community
 - Return of favor for the services, for instance, supply of contraceptives and medicines by the LHW to some of the volunteers and their families

- **Approaches used by some LHWs to mobilize volunteers included:**
 - Invoked women's desire to please Allah
 - Informed women that it would increase their knowledge of FPRH
 - Told women that it would increase knowledge in the community
- **LHWs' feedback on the work of the volunteers they had recruited:**
 - After working with the volunteers, a number of the LHWs said there was a positive change in their earlier views
 - Most of them said that volunteers helped make their job easier
- **Volunteers were able to convey the FP message to a greater audience**
 - Working with volunteers had helped LHWs build confidence in their work
- **LHWs felt that volunteers would step in for them if they were busy when needed by someone or unable to reach some place.**

In quantitative terms, a mixed picture emerged but the encouraging part was that despite the difficulties some faced finding volunteers to work without payment and in training the volunteers. For instance:

- 68% of the LHWs admitted that the volunteers had made a difference
- 92% said that they will continue working with their volunteers
- 96% were of the opinion that this initiative could be implemented all over the Punjab province

Section-B: Lady Health Supervisors' (LHSs') Views on Volunteers

B4.1. Introduction:

LHSs are hired to monitor and supervise the work of the LHWs. They are required to have passed 12th grade and are given 3 months of full-time basic training at the District Health Office, followed by 1 week per month of classes for the next 9 months.

All the **14** LHSs who were supervising the **225** LHWs participating in our study were interviewed. They had no direct interaction with the Community Women Volunteers (CWVs) recruited by the LHWs but were well aware of the initiative.

B4.2. Socio-demographic Profiles

On average, LHSs were higher in age, education, and income than the LHWs. Their reproductive health history and utilization of FPRH services was similar to the LHWs except that their mean age at marriage was higher, and the age at first birth of **76%** was more than 30 years.

B4.3. LHSs' empowerment due to their job

All the LHSs were full of praise for the support and facilitation provided by their husbands and families to them in undertaking their jobs. Like the LHWs, they felt empowered, respected, and valued by the community.

B4.4. LHSs' FPRH practices and utilization of services

The practice and utilization of FPRH services by LHSs was comparable to that of LHWs. PHC and LHWs services were bypassed in favor of secondary and tertiary care services. There was a high prevalence of modern contraceptives but **77%** had had more than 4 pregnancies.

B4.5. LHSs' views on CWVs' support for LHWs and themselves

Most LHSs were happy with the work the volunteers had done. They were also impressed with the LHWs ability to recruit volunteers. Some said they had helped the LHWs in identifying and convincing volunteers to work with them.

The LHSs who were not in favor of volunteers' support for LHWs saw little need for it. According to them, the LHWs had been working for many years by themselves and were doing a good job. They were convinced that nobody works without money and recruiting unpaid volunteers will neither benefit the volunteers nor the LHWs.

Despite the mixed views about the availability of unpaid volunteers and the need of LHWs for their help, **71%** said they would encourage LHWs to continue working with the volunteers they had recruited for the project and all were in favor of testing the initiative in the whole of Punjab.

B5. Discussion and Conclusions

Our interviews with the LHWs and LHSs provided insights on the providers' perspective on the delivery of FPRH services to the community.

Overall, they had positive feelings about their own performance and the effectiveness of services provided by them.

Their own FPRH practices show that 'they practice what they preach,' but their number of children and use of secondary and tertiary care services have negative implications for the stagnation of the population growth rate, development of PHC, and the achievement of the goal of UHC through the PHC approach. Furthermore, most were of the opinion that CWVs played an important role in supporting the LHWs. Some of those who had concerns about finding volunteers willing to work without pay admitted that it was not impossible, and they were able to recruit them from among their families, friends, and client families satisfied with their services.

They also expressed satisfaction with the work the volunteers had performed before the project was stopped with some even calling them their 'right hand.'

The ones who were not supportive of the idea of volunteers were mainly concerned about the unavailability of people willing to work without pay. A small number also believed that the LHWs did not need any help or support.

Nevertheless, majority of LHSs and LHWs was happy with the work the volunteers had done during the project and said that they would continue working with the volunteers they had recruited. They were also not averse to the idea of scaling up the initiative to the whole of the Punjab.

Two findings of the project which were not among the primary objectives of our study are related to the socio-cultural values of the communities in which LHWs and LHSs provide services. First, while girls' families, more specifically families they are married into, do not allow them to continue their general education after marriage, they readily allow them to take training for skilled jobs like LHWs and LHSs. This gives a clear message that women's empowerment can be achieved through skills development-based education rather than general education in isolation.

Second, LHWs and LHSs are empowered owing to their jobs. Almost all respondents expressed personal satisfaction with their jobs, and expressed pride and increased self-esteem thanks to the way the community gives them respect and trust. Besides financial independence, their job allows them increased mobility and interaction with the community. Even the unpaid volunteers informed us that the community gave them respect because of the health-related services they provided to them during the project. Hence, more such jobs need to be created for women.

