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Capacity Building Training Interventions and Lady Health Worker's Outcomes: Evidence from district Lahore, Pakistan

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***Abstract*:** Community Health Workers (CHWs) by acting as a liaison between the community and the healthcare system, significantly enhance the well-being of people at community level. Community Health Workers, generally known as Lady Health Workers (LHWs) in Pakistan, are females who provide pediatric and maternity healthcare in communities. A diversified group of healthcare providers known as "Lady Health Workers" perform in communities outside of formal healthcare facilities. Lady Health Workers (LHWs) are vital components of the health system, not only for the provision of primary healthcare but also for the improvement of individual, family, and community health. Their training has been limited, leaving them unprepared for the difficult work they have ahead of them. Keeping in consideration the importance of LHWs capacity building, researchers tries to understand the impacts of training interventions on the outcomes. For the purpose of this evaluative study applied cross-sectional survey design to collect primary data from the participants. The data collected from the Lady Health Workers of district Lahore with the help of interview schedule as tool of data collection. Total 262 participants approached through simple random sampling techniques and findings of the study revealed significant association among capacity building training interventions and the positive outcomes of Lady Health Worker. Results also indicate these training programs enhance skills, professional productivity and satisfaction among Lady Health Workers. On the basis of results of current study it is recommended that to upgrade the knowledge and competence of LHWs time to time training opportunities should be provided.

Key words: Lady Health Workers, Capacity Building, Health Professional, Primary Health, Care Providers, Community Health Workers

1. Introduction

A strong health system must include comprehensive primary care, and the Community Health Workers (CHWS) model may be one way to deliver it (Mor et al., 2023). CHWs are reliable members of the community who offer healthcare and health-related information (Harries et al., 2023). Community Health Workers (CHWs) are an essential part of the healthcare profession due to their work with the most disadvantaged populations (Salve et al., 2023). Community Health Workers (CHWs) are an integral element of the public health workforce because they improve the quality of healthcare, advocate for communities facing racial and health inequities, and connect the people they serve with resources (Smithwick et al., 2023). Due to their close connection to communities both

geographically and socially, Community Health Workers (CHWs) find themselves in a position to offer a range of basic healthcare services (Perry et al., 2013). In addition to being low-level members of the health workforce, community-based health professionals' unique ties to the community—sometimes known as social capital—also contribute to their efficacy (Mohajer & Singh, 2018). It has been proved that recent CHW projects improve infant and newborn health outcomes, and there is growing support for paid CHWs to become a crucial part of healthcare systems, furthermore the use of Community Health Workers (CHWs) has been proposed as a way to bridge healthcare delivery gaps in rural areas (Singh et al., 2015). A vital component of marginalized communities' health care delivery methods in the context of a global health worker shortage are community health workers (CHWs). In addition to sharing personal experiences with the people they assist, CHWs act as a crucial conduit between public health and healthcare services and underprivileged communities. They possess a deep grasp of the causes and consequences of health disparities (Knowles et al., 2023). Even though there is growing evidence of the challenges faced by community health workers (CHWs), such as those related to training, supportive supervision, and remuneration, it is still necessary to look at problems from their perspective (Musoke et al., 2022). Expanding CHW programs to increase population-level coverage of life-saving interventions is one especially promising strategy for attaining universal health care and ending avoidable mother and child death by 2030s (Chou et al., 2017). Furthermore, in addition to giving basic first aid and in-home care, CHWs' responsibilities in health promotion also included helping patients get into medical facilities, altering their behavior with health education, and facilitating their access (Seutloali et al., 2018). A scarcity of trained healthcare workers is a major obstacle to reducing maternal, neonatal, and under-five mortality in many low-resource countries, while the evidence shows that community health workers (CHWs) are effective at providing primary healthcare services; however, because it can be challenging to determine an appropriate package of services for CHWs and to avoid overstuffing the cadre, tasks that were previously assigned to providers with advanced training have generally been transferred cautiously to CHWs (Haver et al.,2015). Moreover, the reputation of Community Health Workers (CHWs) as change agents who inspire community members to lead better lifestyles is well-established (Kohli & Chadha, 2017). Moreover, it is possible to prevent epidemics from spreading into pandemics and continue to provide healthcare by utilizing community health workers who are properly equipped, trained and acknowledged as members of an effective healthcare system (Ballard et al., 2022). It is evident that community health workers (CHWs) have been successful participants in addressing public health and healthcare-related challenges, however, CHWs, like other health professionals, need support in order to contribute to health programs and achieve health equity (Allen et al., 2022; Raven et al., 2020). Furthermore, CHW experiences are shaped by gender norms and relationships at all levels of the health system. In order to address gender disparities and restrictive gender norms for this crucial interaction cadre, health systems must devise gender transformational management initiatives (Raven et al., 2022).

Before the Barefoot Doctors, there were farmers who trained in China in the 1930s as the first Community Health Workers (CHWs). Afterwards, small CHW initiatives began to emerge in several countries in the 1960s and 1970s, and in several low-income countries in the 1980s. Another set of very successful programs emerged in the 1980s and 1990s and Pakistan's Lady Health Workers Program (LHWP) was one of them in 1994 (Perry et al., 2013). Because LHWs enter women's homes and provide them with access to services that would otherwise be unavailable to them, especially during their childbearing years, the LHW Program helps underprivileged populations access health care by bringing essential services that are provided in the public domain (Khan, 2008). Through Pakistan's Lady Health Workers program, 100000 women have received training to offer community health care in remote locations. In addition to reviving the primary health care system, the program has helped eliminate gender inequality, a major obstacle preventing women from accessing essential services like employment and education (Haq & Hafeez, 2009). Reproductive health services are provided by the LHWP to women who find it difficult to walk outside of their houses to seek health care (Wazir et al. 2013). First-level health care providers, known as Lady Health Workers, are residents of the community in which they serve. Furthermore, they provide healthcare services to underprivileged women and children. In an average catchment area of about 1000 individuals, each LHW roughly covers a geographical area with 100–150 homes (Rabbani et al. 2016). Every LHW receives 15 months of training in the identification, management, and prevention of common illnesses. There are two parts to the fifteen months of training. Basic healthcare training is offered for the first three months, followed by on-the-job training for the final twelve months (WHO, 2006). According to Pakistan's Essential Package of Health Services (EPHS), the training equips LHWs to offer care in five key areas: Preventive services (health education, motivation and counseling), to create awareness on methods of family planning, vaccination and immunization, nutritional

awareness, counseling and to make referrals for the use of contraceptives (Wright et al. 2015). The program is successful, according to the evaluations, but there are differences in the quality of the services. It is necessary to explore about the LHWs' perspectives about their job duties, challenges, and needs to facilitate LHWs for better healthcare delivery at community level especially for underserved communities (Haq et al. 2008). Along with efficiently addressing women's unmet health needs, the LHWP was designed to provide women with the means they need to overcome abuse and poverty. Women gain from the LHWP at both ends of this service: on the one hand, by offering preventative and promotional healthcare services, it improves the health of low-income and rural women; conversely, by hiring women, primarily from rural regions with little formal education, it gives women job chances (UNICEF 2019).

1.1 Objectives of this Study

a) To understand the impacts of socio-demographic and economic conditions on Lady Health Workers productivity and outcomes.
b) To assess the impacts of capacity building training interventions on the professional outcomes of Lady Health Workers.

2. Research Methodology

Researchers applied cross-sectional survey design to collect primary data from the participants. The target populations were the Lady Health Workers (LHWs) who perform their duties in district Lahore at least one year. This research applied simple random sampling to draw the sample of 262 respondents from the list of all Lady Health Workers providing services in the rural areas of Lahore. The research was carried out in the rural areas of district Lahore where the communities were receiving reproductive and primary health care from Lady Health Workers. The study's geographical universe was the Lahore district, and its human universe comprised of Lady Health Workers of rural areas of Lahore.

There were 1046 Lady Health Workers in all, offering services in the rural areas of District Lahore. Simple random sampling was employed to choose the sample because the geographical universe was so dispersed and it was not feasible to gather data from the whole population in the time and resources available. One-fourth of the population, or 262 respondents, made up the sample. Instrument of gathering data was the interview schedule. Information was gathered through interviews as the respondents were not highly qualified, and the possibility for in-person communication with the respondents helped to ensure that the necessary data was correctly gathered.

The purpose of the structured data collection tool was information gathering because the study was quantitative in nature. In accordance with the study's objectives, the interview schedule helped in explaining the respondents the specific elements of the instrument used for data collection. After talking to Lady Health Supervisors and examining relevant literature, the instrument was developed. The data was gathered with the assistance of lady health supervisors as they were the contact persons and facilitated to access the lady health workers who were under their supervision. Pretesting was done to see whether the data collecting tool was adequate before actual data was collected. Twenty interviews were done in order to pretest the interview schedule. First, the office of EDO Health Lahore provided a list of lady health workers and supervisors who were serving in the rural parts of the Lahore district. Each lady health supervisor was in charge of 20–25 lady health workers. The lady health supervisors contacted the lady health workers under their supervision to be interviewed for data collection.

Following data collection, analysis was done on the collected information. Statistical techniques were used to compute averages and percentages. The mean was calculated with the help of measures of central tendency. In order to make comparisons, percentages were computed and included in the tables. The following formula was utilized to calculate percentages:

$$\mathbf{F / N \times 100}$$

Where F is the frequency of the class and N is the total number of respondents. For the purpose of tabulating the data, the arithmetic mean or average was determined.

$$\text{A.M or Average} = \sum xn / n$$

Where $\sum$ = Total or Sum
Xn = Variables Used in Analysis.
n = No. of Observations.

3. Results and Major Findings

Various descriptive and inferential analysis were applied on collected data and findings presented in the form numbers and percentages for better understanding of various areas related to trainings received by respondents and need of further trainings of Lady Heath Workers rendering services in district Lahore.

Table 1: Length of Service of Respondents

Length of Service (in years)	**N**	**%**
3-6	73	28
7-10	63	24
11-14	44	17
15-18	82	31
Total	**262**	**100**

Table 1 contains information regarding the length of service of the respondents and indicated that 31 percent respondent's length of service was 15-18 years, while 28 percent respondents had 3-6 years of experience as lady health workers. The length of service reported by 24 percent respondents was 7-10 years, while 17 percent respondents reported that their length of service was 11-14 years.

Table 2: Capacity Building Training Interventions for Lady Health Workers

Nature of trainings	**Responses**	**N**	**%**
Capacity building training interventions	Yes	262	100
	No	0	0
	Total	**262**	**100**
Duration of training before joining	15 months	256	98
	17 months	06	02
	Total	**262**	**100**
Types of training received during last one year	Mother & child health care	262	27
	Health & nutrition	164	17
	Cleanliness & hygiene	111	11
	Community development	114	12
	Eye treatment	112	11
	HIV/AIDS	92	09
	T.B DOTS	54	06
	HMIS	46	05
	Measles	22	02
	Total	**977***	**100**
Relevance of training with the job description	To great extent	260	99
	To some extent	02	01
	Total	**262**	**100**
Priority areas for further trainings	EPI/Vaccination	163	36
	To check blood pressure	136	30
	Antenatal care	94	20
	Midwifery	55	12
	To check blood sugar level	08	02
	Total	**456***	**100**

*Multiple responses of 262 respondents.

Table 2 contains information related to the availability of on job training. The table depicts that 100 percent respondents reported that on job training was available to them. The responses related to the duration of training received by respondents before joining their duties. According to data 98 percent respondents reported that their duration of training was 15 months, while 2 percent respondents reported that they had training of 17 months before joining their duties. There were multiple responses of 262 respondents regarding the trainings received during the last one year. It depicts that 27 percent responses fall in the category of mother & child health care, while 17

percent responses were related to the training on health & hygiene. Training on community development was reported by 12 percent LHWs, while 11 percent responses were related to the training on eye treatment and 11 percent responses were that the respondents got training on cleanliness & hygiene. The training on HIV/AIDS was also received by respondents as indicated by 9 percent responses, while training on T.B DOTS was also another area on which respondents had training showed by 6 percent responses. Training on HMIS was reported by 5 percent responses, while training on measles was reported by 2 percent responses. Table 2 also contains data regarding the relevance of trainings received by the respondents with the tasks of their job description. According to data 99 percent respondents reported that the trainings were relevant to great extent with the tasks of their job description, while 1 percent respondents reported that the trainings were relevant to some extent with the tasks of their job description. The information regarding priority areas for further training purpose of the respondents showed that training on E.P.I/vaccination was one of the priority areas for training purpose, reported by 36 percent responses, while the second priority area was training to check blood pressure reported by 30 percent responses. Other areas were training on antenatal care as shown by 20 percent responses, while 12 percent responses reflect midwifery as priority areas for training purpose. Training to check blood sugar level was reported by 2 percent responses as a priority area for training purpose of the respondents.

3.1 Discussion

According to findings of the current study Lady Health Workers (LHWs) reported that they received trainings to provide primary health care and reproductive health services to build their capacity for rendering services at community level before joining as well as in-service training. Majority respondents reported that the trainings received were very much relevant to enhance their abilities to provide services according to the duties of their job description, while the respondents also identified priority areas for further trainings in order to build their capacity. These findings are in accordance with the study by Bechange et al. (2021) which found that a wide range of community-based activities are under the purview of LHWs, who possess a comprehensive grasp of basic healthcare. As a result of their primary care training, LHWs believed they were able to recognize and refer patients. Similar was also found by Khan et al. (2006) in their study that the knowledge of LHWs exceeded 36%, the attitude score above 88%, and the skill evaluation score exceeded 86% because of the trainings received by them. Moreover a study by ul Momina et al. (2024) discovered the same that LHWs who have received training were more productive. The current study findings are also in accordance with the study of Shah and Jariko (2021) which discovered that the services rendered by trained Lady Health Workers in communities have positively influenced the uptake of maternal health services, as indicated by variables such as pregnant mothers' prenatal visits to the closest medical facilities and their receipt of a tetanus toxoid injection. The current study indicated the priority areas identified by the respondents for further training to build their capacity and another study by Khalil et al. (2016) also found that in order to eradicate knowledge gaps, clarify myths, and deliver accurate information in a manner that is relevant to Pakistani women's reproductive health, it is essential that LHWs time to time participate in frequent advocacy workshops and trainings.

4. Conclusion

It is concluded on the basis of the results of current study that Lady Health Workers (LHWs) found the trainings received from their Department very relevant in rendering services according to their job description. Although the respondents identified many priority areas for further trainings to build up their capacity in order to provide reproductive and primary health care at community level. It is essential to provide opportunities for further trainings relevant to the tasks assigned to LHWs, so that they could be able to carry out their tasks efficiently.

4.1 Recommendations

1. To enable LHWs to carry out their duties effectively, it is crucial to offer chances for further training pertinent to the activities they are assigned.
2. Surveys should be carried out periodically to assess how well LHWs' trainings relate to their activities to develop their competence.

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