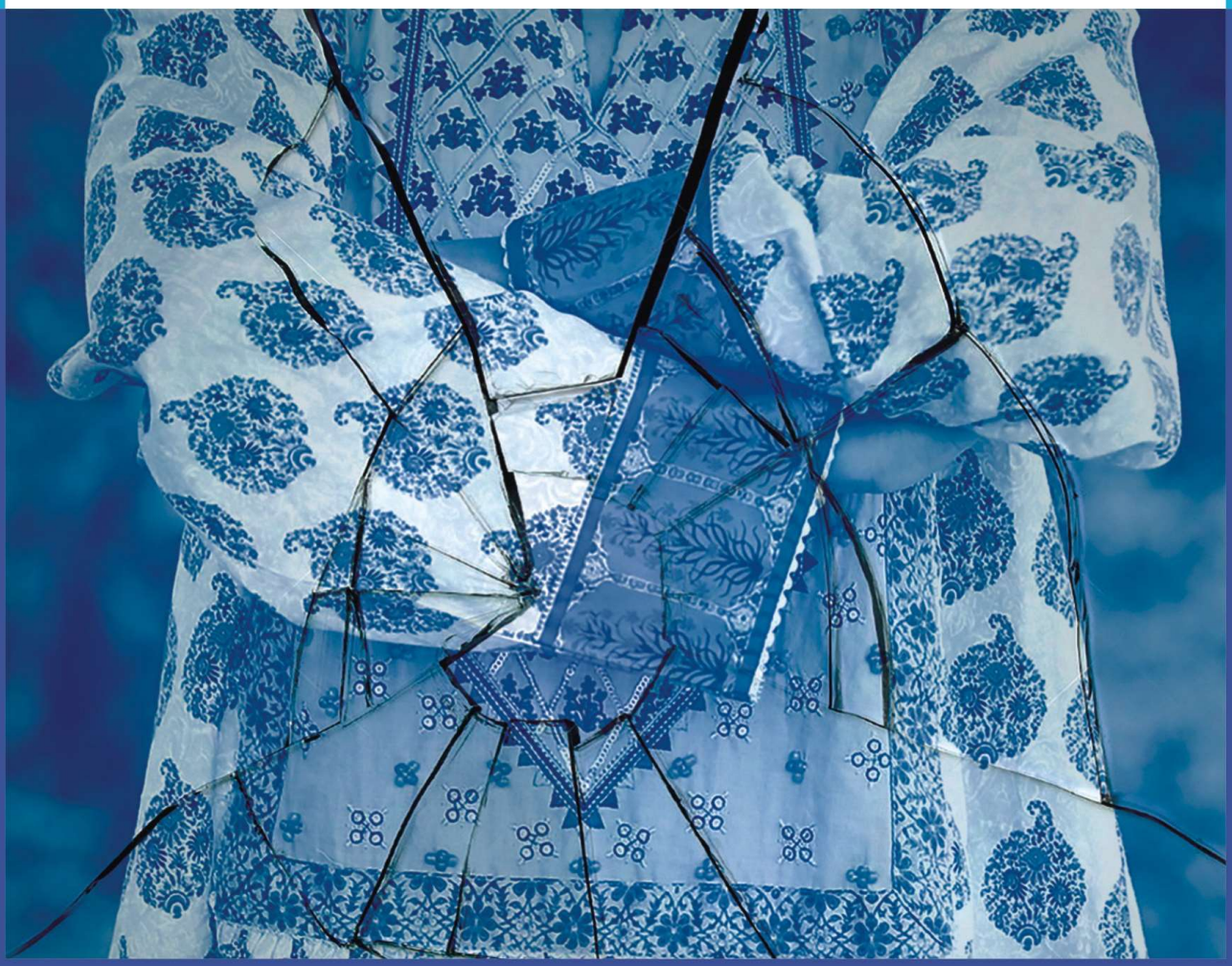
Non-Standard Work in the Healthcare Sector in South Asia

BREAKING THE SILENCE: SEXUAL HARASSMENT OF COMMUNITY HEALTH WORKERS IN PAKISTAN

Moniza Inam



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NON STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA

BREAKING THE SILENCE: SEXUAL HARASSMENT OF COMMUNITY HEALTH WORKERS IN PAKISTAN

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Contents

Abbreviations

AIHS	Assistant Inspector Health Services
ADC	Assistant District Coordinator
ASLHWA	All Sindh Lady Health Workers Association
BHU	Basic Health Unit
CBR	Crude Birth Rate
CDR	Crude Death Rate
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
DC	District Coordinator
Dias	Traditional Birth Attendants
DHO	District Health Officer
DHQ	District Headquarters Hospital
ECNEC	Executive Committee of National Economic Council
EDO (H)	Executive District Officer (Health)
EPI	Expanded Program on Immunization
FPO	Field Program Officer
FP&PHC	Family Planning and Primary Healthcare
FWC	Family Welfare Centre
HEO	Health Education Officer
IMR	Infant Mortality Rate

LHS	Lady Health Supervisor
LHV	Lady Health Visitor
LHW	Lady Health Worker
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MO	Medical Officer
OPV	Oral Polio Vaccine
PC -1	Planning Commission – Performa 1
PHC	Primary Health care
PSI	Public Services International
RHC	Rural Health Clinic
SDG	Sustainable Development Goals
SH	Sexual Harassment
TB	Tuberculosis
TBA	Traditional Birth Attendant
THQH	Tehsil Headquarter Hospital
UNICEF	The United Nations Children's Fund
UC	Union Council
WAF	Women's Action Forum
WB	World Bank
WERO	Workers Education and Research Organization
WHO	World Health Organization
WMO	Woman Medical Officer

NON-STANDARD WORK IN THE HEALTHCARE SECTOR IN SOUTH ASIA SERIES

The current set of publications under this series include the following:

Breaking the Silence: Sexual Harassment of Community Health Workers in Pakistan delves into the forms and causes of violence against women in Pakistan's Lady Health Workers Programme with a focus on the under studies trends of sexual harassment of this highly vulnerable workforce.

Impact of Stolen Wages on Community Health Workers in Pakistan, based on an explanatory survey in the province of Sindh, provides a detailed understanding of the consequences of long delays in wage payments to women engaged in Pakistan's Lady Health Workers Programme.

Informalisation of Work: A Regional Overview covering the trends in informalisation of employment in the public healthcare sector in India, Nepal and Sri Lanka.

Informalisation and Trade Union Movement: A Case Study of Delhi exploring the evolution of the trade union movement in the sector against the backdrop of the continuous neglect of the public health sector.

Non-Standard Work and Quality of Healthcare Services providing a framework to understand the multiple paths through which growing informalisation of employment leads to the deterioration of the quality of services in the public healthcare sector, giving a stern warning against leaving this practice unchecked.

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Employment in Healthcare MNCs: A Case Study of Apollo Hospital, Dhaka which gives a compelling narrative of the exploitative working conditions in the sector, even amongst the most profitable companies in the sector.

CHAPTER 1

INTRODUCTION

The Lady Health Workers (LHWs) Program was started in 1994 by the late Pakistan premier Benazir Bhutto with a staff of nearly 30,000 women. Over the years, the program has expanded to more than 125,000 employees deployed in all districts. It has led to the development of a very well-placed cadre that links first-level care facilities to communities. Apart from revitalizing the primary healthcare system, it has also helped overcome the gendered division of public and private space which was a major obstacle in women's access to basic services including education and employment opportunities; it is now also a major employer of women in the non-agricultural formal sector in rural areas. The program's care objective is to improve health indicators by providing essential primary maternal, neonatal and child healthcare services, family planning services, and integrating other vertical health promotion programs. Almost 60 percent of Pakistan's population, mostly rural, is covered by the program across the country.[1]

The Program was cited as a game changer in the country as it hired the services of a large number of women from different communities to serve women and children. There is a lot of literature and research studies which bring to light the benefits of this program on women and children's health in their catchment areas.

A third-party evaluation conducted in 2000-01 by Oxford Policy Management (OPM) found that the population served by LHWs had substantially better health indicators than other areas.[2]

The program got a boost when the federal government regularized its services in January 2013 and subsequently, all the provinces also regularized its services.[3]

1. http://www.pide.org.pk/pdf/PSDPS/PSDPS%20Paper-7.pdf.
2. http://tns.thenews.com.pk/lady-health-workers-courageous-women/#.VIwhddKUfXA.
3. http://www.who.int/workforcealliance/knowledge/case_studies/Pakistan.pdf.

The LHWP functions as a de facto social security net which has helped poor women across the country and given them mobility, space and financial security.[4]

LHWs have had a social impact as well. They are developing into community leaders, particularly in rural areas, in a context that offers few spaces to women in the public domain. If universal coverage is achieved, every community in the country will have at least one LHW, that is, one working woman and potential leader, who could serve as a catalyst for positive changes for women in her community.[5]

The LHWs do, however, confront some challenges. Apart from irregular salaries, uncertain job conditions, long hours, daily visits to other women's homes and being forced to go to 'uncovered areas' (that are not covered by the LHWP), the women in the program also face many other problems including no clear job description. They are expected to execute any assigned task; they face unsupportive management structures in the public sector and oppressive use of power by senior officials where the managers use many tactics to assert their authority such as talking down, excluding them from decision-making, and sending them to other Union Councils (UCs) for campaigns as punishment.

None of the reports address a very common problem which these workers face during the course of their work, sexual harassment and domestic violence.

Because of their public interactions, these women also become the target of domestic violence as their male family members think that their job is against their notion of honor and they bring disgrace to their families. This results in domestic violence, mental torture and emotional abuse which affects their professional life as well as family relations.

Sexual harassment is rampant and these women have to face it on multiple levels. Due to their public interactions, these women are considered soft targets and "available". From senior officers to community members no one wants to lose an opportunity to harass them.

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4. http://www.dawn.com/news/780257/100000-lady-health-workers-get-their-service-regularised.
5. http://www.researchcollective.org/Documents/lady_health_workers_in_pakistan.pdf.

The Government of Pakistan passed The Protection against Harassment of Women at the Workplace Act, 2010 which made sexual harassment of women in the workplace and in public spaces a criminal offense. However, its implementation has not been satisfactory.

This report was commissioned by the Workers Education and Research Organization (WERO) with active support from Public Service International (PSI) to fill the existing gap on the issue of violence and harassment faced by women in the LHW Program. We hope that this report will help in addressing the problems faced by these women and enable them to serve their communities with dignity and respect.

CHAPTER 2

METHODOLOGY

This is a qualitative study based on interviews with key informants and Focus Group Discussions (FGDs) with nearly 100 women working in LHWP in Karachi, Sukkur, Hyderabad, Thatta, Tando Allahyar, Mirpurkhas, Shadadpur and with the participants from Mithi. The FGDs were held in private settings, providing the women a confidential and supportive environment to discuss their problems. The result was an amazing collection of personal stories, collective sharing and sisterhood bonding between all the participants in the research. The women in the program are a very vocal group of professional women who believe that the government, society, communities and families have not given them the status and respect that they deserve despite all the hard work, long hours and extensive travelling that they put in to serve their communities.

As mentioned earlier, this is the first report of its kind which discusses problems which have always been swept under the carpet due to a patriarchal set-up. Hence, it was important to interview women rights' activists and feminist thinkers, such as Afiya Shehrbano Zia, a feminist scholar and analyst; Hilda Saeed, a seasoned development worker and activist; Uzma Noorani, a council member of the Human Rights Commission of Pakistan, Managing Trustee of Pannah Shelter Homes, former member of the National Commission on the Status of Women (NCSW) Sindh, and Women Action Forum (WAF); Sheikh Tanveer Ahmed, Chief Executive of HANDS; and Anis Haroon, Human Rights Commissioner, Member Sindh, National Commission of Human Rights and WAF member.

Many government officials from different departments such as health, finance, planning and development as well as doctors working in the National Program for Family Planning and Primary Healthcare (FP&PHC) were also included in the study. However, all of them agreed to talk on condition of anonymity.

2.1 Background: the Lady Health Workers Program

Pakistan's annual public expenditure on health of $9.31 per person remains well below the recommended international level of $60 per person. Pakistan's health expenditure only covers 21.92 percent of its population. Since most of Pakistan's population lives below $2 a day, tax revenue collected by the government is not adequate to fund quality state healthcare among a broader population. As such, expenditure on certain inputs necessary for basic health coverage is well below the requisite funding to sustain a quality healthcare program. Additionally, certain segments of the population, particularly those employed by the military and the government receive far better government provided healthcare than the rest of the population.

Lack of funding is an important reason why, despite making some gains in maternal and child health, Pakistan continues to lag behind in its Millennium Development Goals' (MDGs) targets and has the third highest number of newborn deaths in the world. Currently, half of Pakistan's population is undernourished and up to a million and a half children are believed to be malnourished. It is in this context that the LHW Program has proven to be innovative and efficient in delivering positive health outcomes.

The LHW Program, officially titled the "National Program for Family Planning and Primary Healthcare" (FP&PHC) was started in 1994. It had its roots in the Alma Ata declaration adopted in September 1978 at a conference on primary health care (PHC) convened by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in collaboration with non-governmental organizations (NGOs) that aimed to reset the international health agenda. The Alma Ata declaration noted that PHCs must, 'evolve from the economic conditions and socio-cultural and political characteristics of the country and its communities.'[6]

The Alma-Ata declaration states that primary healthcare "relies, at local and regional levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

6. http://www.who.int/publications/almaata_declaration_en.pdf?ua=1.

Most of the signatories to the declaration decided to establish community health workers' programs in line with the PHC approach. However, the conception and activities of the community health workers differed from one state to another depending on their local objectives and financial capacities.

Like other developing countries, Pakistan also had low health indicators especially for maternal and child health in the 1970s and 1980s.[7] There was a lack of communication between the communities and the health system and a major part of the resources was spent on tertiary care at the cost of primary healthcare and the rural population.[8]

In 1994, the Government of Pakistan, with support from WHO, launched FP&PHC. Popularly known as the "Lady Health Workers Program" (LHWP), it aimed to foster community participation and bring changes in societal attitudes towards basic health issues and family planning through a cadre of community health workers.

The Pakistan People's Party was at the helm of affairs at the time when LHWP was launched and the then Prime Minister, Benazir Bhutto, termed it as the fulfilment of her party's election manifesto of creating jobs and opportunities for women from the grassroots level.

Almost 10,000 women were inducted in the initial phase of the program and after its success 20,000 more were employed.[9] After 22 years, there are about 125,000 LHWs in the country serving the communities and in Sindh their number is around 22,576. However, this surge in numbers has not decreased their problems and LHWs are still facing myriad problems including irregular wages, salaries not in accordance with their seniority and qualifications, security issues, sexual harassment, lack of security during polio campaigns, denial of maternity leave and medical facilities.

Major changes have occurred in the structure of the program since it was last evaluated in 2009. The most important of these include the program's transition from central to provincial management, as a result of the 18th constitutional

7. https://www.unicef.org/sowc97/download/sow1of2.pdf.

8. http://121.52.153.178:8080/xmlui/handle/123456789/6634.

9. http://www.brecorder.com/editorials/single/600/0/1246943:the-plight-of-lady-health-workers/?-date=2011-10-30.

amendment, and induction of LHWs – who were originally recruited as paid volunteers – to become regular government employees.

In pursuance of the Supreme Court's decision, LHWs, Lady Health Supervisors (LHSs), drivers, account supervisors and program management unit (PMU) staff members of the National Program for FP&PHC have been regularized. The program continues to be funded through the federal Public Sector Development Program (PSDP). Funding for LHWP was capped at PSDP's allocation in 2010 as per the Council of Common Interest's decision dated April 28, 2011. The Government of Sindh set out a health strategy for 2012-20 pledging continued support to LHWs, LHSs and staff members of the basic health units (BHUs) to which they are attached.

The LHWP design originally aimed to:

- address the primary healthcare problems of the community,
- bring about community participation through creating awareness, changing attitudes, and supporting mobilization,
- bridge the gap between the community and health services,
- expand the availability of family planning services in urban slums and rural areas, and
- gradually integrate existing healthcare delivery programs (immunization, malaria control, nutrition, and maternal health) into the Prime Minister's program.[10]

Currently, each LHW has a catchment area of about 1,000 people and her responsibilities include doing field work and engaging with maternal and child health services. Responsibilities for field work include broadening awareness and education on reproductive health and nutrition, facilitating registration of births within the assigned area, and distribution of key public health medication for family planning and immunization. Responsibilities in maternal and child health services include educating people about preventive medical care including how to maintain healthier reproductive health and lifestyles, family planning, education and care about HIV/AIDS, basic curative care and medical treatment for

10. http://www.researchcollective.org/Documents/Final_LHW_Paper.pdf.

certain conditions, including diarrhea, malaria, acute respiratory tract infections, intestinal worms, and offering contraceptives as part of family planning.[11]

2.2 THE NEED FOR THE PROGRAM

Many health professionals and government officers have raised a question about the need for such an extensive program. However, evaluations of the program have proved its efficiency and utility as these record that maternal and child mortality rates have decreased in LHW covered areas. A recent comprehensive review of the program found that as compared to other areas, the LHW served households were 11 percent more likely to use modern family planning methods, 13 percent more were likely to have had a tetanus vaccination, 15 percent more were likely to have received a medical check-up within 24 hours of a birth, and 15 percent more were likely to have immunized children below three years of age. It has also been proven all over the world that maternal and child health are deeply connected and all the initiatives taken to improve maternal health result in benefitting newborns and children, thereby creating the foundations of a healthy life.[12, 13]

Pakistan has the eighth highest newborn mortality rate in the world and the third highest under 5 mortality rate in Asia. Health experts, who associate artificial feeding of infants with higher risks of gastrointestinal and lower respiratory tract infections, say that initiating exclusive breastfeeding within the first hour of birth and continuing it for six months could reduce the neonatal mortality rate by 22 percent.[14]

Through LHWP, which is one of the largest health workers programs in the world, Pakistan tried to meet its MDGs and is now trying to meet the Sustainable Development Goals (SDGs) in the health sector, demonstrating a successful phased scale-up of LHWP with clear policy planning, integration of the health system and implementation of the health policy in letter and spirit.[15, 16]

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11. https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH-Pakistan5.pdf.
12. http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-10-319.
13. http://thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961140-9/abstract.
14. https://www.dawn.com/news/520386.
15. Macro International Inc, National institution of Population Studies Islamabad: Pakistan Demographic and Health Survey (PDHS) 2006 <http://www.healthnwfp.gov.pk/downloads/PDHS>.
16. http://peersforprogress.org/wp-content/uploads/2013/09/20130923_pakistans_lady_health_workers.pdf.

The latest National Nutrition Survey (NNS) of 2011 (report released in 2013), presents a very depressing picture of women's health in Pakistan. Nearly 51 percent of pregnant women were anemic, 46 percent suffered from vitamin A deficiency, 47.6 percent suffered from zinc deficiency and 68.9 percent from vitamin D deficiency. Malnutrition was only slightly lower among non-pregnant women 50.4 percent of whom were anemic; 41.3 percent had vitamin A deficiency, and 66.8 percent had vitamin D deficiency. A significant number of households (58.1 percent of the families surveyed) were food insecure and only 3 percent children received a diet that met the minimum standards of dietary diversity.[17]

There are various reasons for the poor health of women, the most important of which are societal bias, gender roles and collective customs that lead to early marriages and childbearing, repeated pregnancies and malnutrition all of which take a toll on children's health as well.

This shows the importance of enhancing knowledge about the nutritional needs of mothers and children and providing information about birth spacing.

17. http://www.dawn.com/news/1232897.

CHAPTER 3

GENDER ANALYSIS OF LHWS' PROBLEMS

Many of the problems faced by the women in the LHWP come out of the reality that higher officials and the concerned authorities are oblivious to their gender needs. They have adopted a foreign program but not modified it to local needs. Explaining this, Hilda Saeed, a seasoned development worker and activist, said, "Our officials are gender blind and have not incorporated the gender needs of these women. The LHW program lacks gender budgeting and a gender analysis which is vital for the success of any program pertaining to women. For instance, when developing the program, they forgot to take into account the health workers' specific needs and also ignored the ILO Conventions which safeguard workers' interests and provide social security according to international parameters. They were hired on contract and their service structure lacks job security, medical cover such as paid maternity leave, paid holidays, pension and gratuity and other benefits enjoyed by government servants. Moreover, their salaries are not commensurate with their expertise and even their salaries are not given regularly which undermines their decision-making status at home."

When it comes to societal attitudes, these workers are looked down upon in their communities due to the nature of their work, they have to face domestic violence and abuse, their salaries are taken by male family members and above all they are victims of sexual harassment in their line of work, added Saeed.

During key informant interviews, many prominent human rights workers and feminists candidly talked about the issue. As a feminist researcher and analyst Afiya Shehrbano Zia said, the harassment faced by women in LHWP should be seen in the context of a patriarchal society and its policies and politics on women's health, their sexuality, the urge to control their bodies, their mobility and agency and enforcing gendered roles.

Similarly, Uzma Noorani, a council member of the Human Rights Commission of Pakistan, Managing Trustee of Pannah Shelter Homes, former member of the National Commission on the Status of Women (NCSW) Sindh, and the Women Action Forum (WAF) said that sexual harassment was an issue which all working women faced across the board. To eradicate this problem, there was an urgent need to create conducive conditions for women working in the formal sector. The Government of Pakistan passed the Protection against Harassment of Women at the Workplace Act in 2010 to deal with the problem in work places and public spaces. Now the government, civil society and human rights' and women rights' activists should struggle for its effective implementation. There is a need for active advocacy and creating awareness among the masses through media campaigns using the print and broadcast media. As far as LHWs are concerned, the program officials should work closely with the community to give them their due respect and status.

Sheikh Tanveer Ahmed, Chief Executive of HANDS, said that it was important to make LHWs' village committees. These committees should comprise elected and non-elected male and female members. One of the members should accompany LHWs while going out of the village or whenever they felt insecure. The government should also start mass media campaigns to give dignity to LHWs. LHWs should have a uniform to make them more visible and prominent. All these measures will help enhance their status in the community.

According to Anis Haroon, Human Rights Commissioner, Member Sindh, National Commission of Human Rights, LHWs are a vital part of our health system. These women are given the responsibility of administering polio vaccines to children, while commuting from door-to-door addressing women's health issues in different communities. The nature of their work – visiting different communities makes them more vulnerable to violence and sexual harassment. They are more at risk than women who are confined to homes or move and work in a safe community setting. To minimize these risks, they need awareness, ample security and counselling services. The Health Department should ensure that the Anti- Harassment Act of 2010 is enforced. The male staff members working with LHWs should be gender sensitized.

Like for many other women, LHWs' salaries are not commensurate with their expertise, which is a structural and not an individual problem and contributes to the gap between the incomes of men and women in society, explained Hilda

Saeed. Further, their salaries are not paid regularly, which undermines their decision making status at home. Their salaries are also taken by their male family members.

Afiya Shehrbano Zia said that the harassment faced by LHWs should be seen in the context of a patriarchal society and its policies and politics on women's health, their sexuality, the urge to control their bodies, their mobility and agency and enforcing gendered roles. Regarding societal attitudes, these workers are looked down upon in their communities due to the nature of their work. As a consequence, they are more susceptible to domestic violence, humiliation, abuse and above all, they are victims of sexual harassment, added Saeed.

CHAPTER 4

VIOLENCE AND SEXUAL HARASSMENT

In a series of meetings with LHWs in Karachi, Hyderabad, Sukkur, Thatta, Tando Allayar, Mirpurkhas, Shadadpur, and with participants from Mithi, an attempt was made to cover the extent of the harassment, violence, intimidation and problems faced by these workers. The meetings were held in a confidential and friendly atmosphere where they could narrate their stories without fear. In these meetings, the community workers talked about their fears and problems very openly.

The first issue that came up in the meetings was that their line of work was different from other professions, such as teaching, domestic work, agriculture and industrial work and working in the public and private sectors in different capacities which has set timings and did not require any field work. In these professions, there was also less interaction with men and the duty hours were also less.

Due to a patriarchal set-up, working in the public sphere is already frowned upon and the combination became more lethal when the work needs frequent travelling, home visits, going to hospitals and liasioning with the community. This interaction made these jobs more stigmatized and these workers were considered easy prey and 'available.'

Almost all the community workers interviewed said that they faced resistance from their families and community and, to make matters worse, their own families found it difficult to accept their interactions and mobility. However, the only saving grace was the financial aspect as, by and large, the health workers come from lower or lower middle-class families where the additional income is always welcome to make ends meet.

4.1 THE FACTORS

Harassment has many types, forms and faces (see Box 1). Women in LHWP face multiple types of harassment in their line of duty. In many cases women and girls are the first ones in their families, communities and villages to acquire education up to the matric level and get paid jobs in the public sphere. They have broken the glass ceiling and become agents of change in their communities. In a deeply patriarchal society such women are always viewed with deep suspicion and misogynist mindsets never lose an opportunity to disgrace them. Sometimes, they are victims of domestic violence, or acid attacks. Other times they are raped, molested and killed on charges of having a 'loose character' and accused of infidelity. However, economic compulsions due to rising costs of living and market forces compel them to supplement their family incomes. Their families, husbands and in-laws need their money to make ends meet but, at the same time, they also want to control their mobility and career growth.

Many of the women who were interviewed came up with horror stories. They were the breadwinners of their families as their husbands were unemployed, drug addicts, or gamblers and they lived under very stressful conditions with lots of physical, emotional and mental abuse. There were endless tales of extreme violence by brothers, fathers, husbands, brothers-in-law and in-laws.

4.2 DOMESTIC VIOLENCE

A community worker said that her mother-in-law instigated her husband to beat her up on different pretexts and take all her salary. She was not allowed to keep

Box 1: Forms of discrimination and harassment experienced by women

At home: discriminating against and demeaning the girl child, deriding the women working at home, not allowing women to take decisions and being violent.

On the streets: catcalling, touching, teasing and intimidating.

On public transportation: touching, pushing, and using vulgar language.

In public places: staring, touching, intimidating, behaving aggressively, chasing and being violent.

At the workplace: leering, staring, making passes, discriminating, abusing authority for sexual favors, flirting, and inflicting violence.

the money. If she bought new clothes for her children, her mother-in-law made a lot of fuss and asked her to bring clothes for her sister-in-law and her children as well. On the other hand, if she argued with her husband on anything, her mother-in-law told her husband that she had become very independent as she went out with other men and needed to be fixed which resulted in severe beating and threats of a divorce.

"Balancing work and family life is like walking on a right rope " added another women. "We are constantly living in danger of being divorced, and thrown out of the house. The only saving grace is the salary which helps keep tempers down. However, even the salary is not given on a monthly basis and sometimes it comes after two or three months. So, we are again dependent on our husbands for financial support" she explained.

Many of the women complained that their husbands took their cheques and drew their salaries from the bank and spent the money. The women had no control over their own income. Many of them were not even in a position to buy new clothes or a bag. If they were unmarried their fathers took their earning for household expenses.

One worker echoed a common sentiment when she said that a husband usually loved his wives when it was time for her salaries to come and when the money came he sometimes took it away not leaving anything for the woman to meet her daily expenses. If she refused she was beaten. However, the health workers cherished those brief moments of love and caring.

A senior supervisor talked about a very tragic story of her team member who lost a hand in an accident but was very confident and continued working. One of her distant cousins who saw her participating in a program decided to marry her and sent a proposal which was happily accepted. However, after marriage he showed his true character, he was a drug addict and a gambler and had married her for money. Now she has become a money-making machine for him and also has to support their two children.

Explaining the common ordeal, a young worker said that due to her income her family was reluctant to marry her and she was now in her middle age and had lost hope of ever getting married.

A supervisor said that a young worker was torn between her family and husband as they both wanted to take her money. When payday approached her mother

invited her to come and stay with her and took her salary and when she went back to her husband he also wanted her money and beat her up for giving it to her mother.

At times a husband can be very irrational as we saw in the case of one of the health workers whose husband insisted on visiting homes with her and wanted to go inside to give drops. People objected to this and he was refused entry. His argument was that when "she (health worker) goes inside the male family members of the house see her. I will also go inside and see their women." The assistant health coordinator controlled him with great difficulty.

Sometimes the women want to spend their salaries on themselves like buying a new dress or sandals or something for the children, and for that they have to tell lies.

These women also faced domestic violence due to irregular timings as during different campaigns they have to travel across UCs and for training they have to go to a different city which is very annoying for their families, especially husbands. Many workers said that on their return their husbands beat them and threatened to divorce them. But this is something which was not in their control and they had to bear it.

Describing her ordeal, one supervisor said that her husband beat her so much that he fractured her arm. Unfortunately, this is not an isolated incident (see Box 2).

Another woman said, "once, I went for a polio campaign to an uncovered area in another (UC) and reached home late. My husband got furious and beat me in front of our home. The entire neighborhood watched but no one interfered and he broke my arm and fractured my ribs. When he was tired of beating me, he said, "I don't want to keep you as you are a woman with a loose character and go out with men and I will marry someone else". This wasn't a threat as he married another girl and as a punishment he didn't divorce her. Now she is living with her mother.

One worker said that her husband had a serious issue with the seating arrangement in the van when they went out as they had to sit with the driver on the front seat as pickups do not have seats at the back. "He always says that you are a brazen woman and travel with the driver. Whenever I come back from a campaign he doesn't lose any opportunity to beat me" she added. Such insecurity among husbands has in one instance resulted in the tragic death of a LHW (see Box 3).

Box 2: Case of Societal Violence

'T' narrated her story. She is a married woman with two children and eight years of work experience. During the polio campaign two years ago, some of her relatives asked her not to go to the neighboring village as they had a tribal feud with that village. But she refused and said that she had to cover it. This infuriated them and they beat her with sticks which resulted in a head injury with 12 stitches, broken teeth and a swollen eye. The department supported her and reported the incident to the police but the community elders asked them to patch up and withdraw the case. Though her family supported her, the rest of the community insisted on withdrawing the case.

However, 'T' refused to bow down and went for the polio campaign and also covered the village. In the beginning, the people from that village were hostile to her but after some time they accepted her. After two years she is still angry with her community for letting her down and forgiving her tormentors.

Box 3: Extreme Case of Domestic Violence

There was a very famous case of domestic violence faced by a lady health worker who lost her life. The case made headlines in print and broadcast media in the country.

Naseem Akhtar, 38, mother of four children, was a supervisor and an active union leader of women health workers. Due to the frequent polio campaigns, she returned home late in evenings about which her husband had serious reservations. She often tried to explain but he was not ready to believe her and was convinced that she was using it as a pretext. After many fights, she went to her parents' home in Sukkur. Her FPO called her and asked her to come back to Karachi for an upcoming polio campaign. She told him about her domestic problems. The FPO also knew her husband and said that he would talk to him. When the FPO tried to talk to her husband, he became further convinced that his wife was involved with him. The husband apologized and asked her to come back. When she came back to their house he shot her dead.

4.3. SEXUAL HARASSMENT IN THE FIELD

Many workers complained that when they visited households, the behavior of the men in the families was highly inappropriate. Sometimes they stared at them unabashedly and when they (community workers) explained the benefits of birth spacing and family planning the men asked embarrassing questions.

A lady health worker narrated her experience, "When I entered a house the person who answered the door took me to a room where boys from the family were watching porn movies and no woman was present in the house. I immediately left the house and made a hue and cry about it. People from the neighborhood gathered but those boys unabashedly said, why are you making a fuss as you have no honor and go door to door". However, they were admonished by their neighbors and their landlord also punished them.

In many cases, women are scared of the consequences if they were to speak of their experience of sexual assessment, especially in the case of molestation or rape (see Box 4).

Box 4: Breaking the Silence

"L" told her story in these words: "We went to an 'uncovered area' for the door-to-door polio campaign. In one house, a man was standing with a child at the door. We asked him if we could go inside and give drops to the kids and he said yes. We were two women. However, when we went inside, there was no one in the house and meanwhile the man locked the door and started molesting me. My assistant just ran outside and started shouting. People gathered and he fled from the scene.

The place turned out to be a bachelors' accommodation and people blamed us for going inside the house in the first place. I tried to explain that the man had a child in his arms who he claimed to be his offspring. My assistant also called our seniors who reached promptly. My husband belonged to the tribal society and I knew he would get very annoyed and even divorce me, so I didn't pursue the case and no one from my family and my village knows about it as that village is very far from my house. But thinking about what happened still gives me the shudders to say the least."

'M' narrated her story which she had not discussed so far as her sexual harassment was concealed in the name of family honor and saving her house. 'M'

is a very good-looking girl in her mid-20s with a sweet and melodious voice. Two years ago she was going for polio campaign with her colleagues — her assistant, a vaccinator and a driver. Walking along the canal her assistant suggested that they take a brief walk and the driver would bring the vehicle there. On the way, three men attacked them and beat them. She was very surprised and told them that they were government employees and their team was also with them. Then the vaccinator and the driver arrived and the attackers kidnapped all of them and took them to a large house in a deserted area. There were women in the house too who were also very rude and violent towards them and snatched their personal belongings including cell phones and locked them separately. The women from the family scared them saying that their men would kill them and that this would be the last meal of their lives. Then they took 'M' to another room where two men raped her. By that time a farmer who had seen them going to the house became alarmed and informed the local zamindar (landlord) who came with the police

to rescue them. At that time, the culprits were planning to shift them to another vehicle and take them to another place.

However, 'M' was so scared that she did not report her rape and the culprits were only booked on kidnapping charges. People were sceptical of her account and everyone probed her but she never disclosed the details. Her husband also asked her but she denied it vehemently as she wanted to save her house. She believed that if she disclosed the truth her husband would leave her.

'M' still goes to that village for polio campaigns as the department has asked her to cover the village but she does not go to that house. Like most rape victims she is very depressed but she can't share her ordeal with anyone except with some trusted friends.

However, there are many women workers who raise their voice. For instance, a supervisor said that once a boy taunted a young worker about vaccination and made a suggestive remark, on which she went to the police station and lodged a complaint. Her male family members also reached there and the police had to register a case as the family knew the DIG who made the boy apologize to the girl. Such cases work as a deterrent and people think twice before teasing them again.

Explaining the attitude of the people in the villages, a young worker said that one day it was very hot and she was walking slowly so some boys in the lane taunted her saying, "Why are you are so tired and where are you coming from?"

A senior supervisor said that once they went with the DC, Mukhtiarkar and other officials to a village from where many cases of refusal had been reported. There were nearly 10-12 people in the team. The notable of the area asked why they had brought this woman (the supervisor) with them as the temptation was too much. "None of the officials said anything but I answered him back," she added.

4.4 SEXUAL HARASSMENT BY COLLEAGUES

The workers spoke about the attitude of the officials in the department and said that sometimes they openly talked about recruiting young and beautiful girls. When younger persons join, the field program officers (FPOs) call them to their offices for no reason and try to attach them to their teams and in case of non-compliance, they threaten to sack them or terminate their services.

The health workers added that they faced harassment from DCs and DHOs who usually tried to intimidate them through official procedures and sometimes also issued show cause notices or warning letters to intimidate them and break their will. Usually the women workers in LHWP did not report this harassment to senior officials as they were afraid that if their families came to know about it, they will ask them to leave their jobs. It is a classic case of a double whammy where the victims can't access justice due to societal constraints.

Additionally, they also complained that due to the polio campaigns and other such drives the role of the bureaucracy had increased. Now besides going to the hospital on the first and second of every month to report about last month's performance they also had to deal with District Collectors assigned to look after these campaigns. Moreover, the Monitoring Officers (MOs) are also male doctors.

The women questioned the logic of having so many male officers in the hierarchy. They said that to make the profession more gender-friendly and gender-equal, the government should appoint female DCs and DHOs. This will have two advantages: first, the women will feel more secure, and secondly, there will be upward career mobility from the cadres. If it was not possible to implement this right now, the government should implement rules more strictly which forbid men to travel alone with the workers. Many workers complained that sometimes the DC and DHO came to their homes to pick them up with no female staff members which upset their families and resulted in physical violence and threats of divorce.

Another woman said that the DC came to her house which also served as a 'health house' with the Assistant District Coordinator (ADC) and asked her to bring some files. When she left the room to bring the files, he followed her and tried to molest her as there was no one else in the house. Suddenly the ADC came out of the room and he ran outside. They wanted to take the issue to the higher authorities but couldn't do that as the health worker was afraid that if her family came to know about it they would ask her to leave her job.

Narrating her experience, a supervisor said, "our DHO told us not to go out after 5pm even if a senior official asked, but one day he asked me to come to the hospital after 6pm to give a tour to a team of doctors. When I reminded him of his own advice he lightly asked why was I trying to become very pious or purdah observing."

A senior supervisor added, "When I was young, about 14 years ago, a DHO asked me to go to Karachi with him. When I asked him the reason he said 'just for fun.' When I refused he said that he would terminate my services, but I told him that he could go ahead and do what he wanted. I considered myself very bold and now think that if it can happen with me it can happen with anyone. At that time we didn't have any union to fight for our rights. And the most unfortunate part is that after so many years it is still happening." Many workers endorsed this view and said that they faced similar problems on a daily basis.

Another supervisor said that things had not changed and field program officers still wanted young beautiful workers to accompany them. The women who did not cooperate with them were victimized in different ways. Either their salaries were withheld or they were given show cause notices. They were asked to report to the office just to pressurize them and break their will. Those health workers who did not comply with their demands had to leave their jobs.

Sometimes the officials flaunted the rules openly as according to the regulations even the FPO, DHO and other officials are not allowed to visit the women workers' homes; they have to be accompanied by the ADC. One FPO went to a worker's house directly and her brother beat him and the driver. The case was also reported in the media.

As if community members and officials were not enough to make their lives miserable, the women also have to face discrimination from an unexpected quarter.

Sometimes the wives of the FPOs, EDOs and other senior officials become very insecure if the women text their plans to the officers. The wives say that these women are trying to trap their husbands and sending messages to them.

Technically for immunization campaigns the officers have to go with a vaccinator and their families are upset about this. A supervisor said that to accommodate the young girls they often asked an elderly female worker to accompany them just to pacify the girls' families.

4.5 HUMILIATION BY COMMUNITY MEMBERS

Another worker said that when they went to the community for antenatal sessions they also had to include mothers-in-law and husbands as the real power rested with them. "They are offended by our sessions and the husbands say openly, 'Our mothers and grandmothers have lived the same life and given birth through dias (traditional birth attendants). Now you have come to spoil our wives'."

"We have to face a lot of humiliation in our line of work" said a lady health worker. "We have to listen to nasty things as sometimes the families and communities do not allow us to enter their homes. Sometimes they say that despite so much humiliation you have come again and we tell them that we come to serve you and save your children," she added.

One worker who belongs to the minority community said that she used to wear black clothes on field trips and some people thought that she was trying to convert them, so she changed the color of her clothes to gain their confidence. "Once I went to a madrassa and greeted the prayer leader (mullah) but he didn't answer my salam. I said that if you don't want to talk to me it is okay but you have to get the children vaccinated" she said.

Many women said that sometimes when they went out for routine work for antenatal and postnatal care, people refused to cooperate with them and said things such as, "don't listen to them as they roam around every day" and made other such derogatory comments.

It was reported that during antenatal sessions where husbands are involved, they took a keen interest in family planning and use of contraceptive sessions. They asked embarrassing questions and in some instances went to the women workers' homes and ask for a contraceptive which was very irritating for their families.

Another important problem faced by these women is the dosage of TB tablets as according to the laws the LHWs have to go to the patients' house twice a day and give them the tablet and also talk to them as it is a very painful medicine and sometimes the patients spit it out. If the patient is a male it makes some wives jealous and they object to their talking to their husbands. "So now it has been decided that the LHWs will visit the house but the wife will give the tablets" added a senior woman health worker.

A woman worker complained that during immunization campaigns they were even sent to transgender houses and bachelors' accommodations by vaccinators who insisted that they should cover these houses too.

A woman explained that sometimes people became violent and abusive if their children became ill after a vaccination as they thought that the women had given him/her some expired or poisonous medicines. Though the immunization program has been running for three decades, parents still had doubts about it. "A child became ill with high fever after the immunization. His father came to my house to beat me up as he believed that I had poisoned him. No matter how hard I tried to explain to him, he was not convinced and was not ready to listen. The matter was finally resolved with the intervention of community elders," she said.

Almost all the health workers who were interviewed narrated similar incidents. Polio vaccination is another problem for these women as people, by and large, are not ready to allow them to administer the drops. They have serious reservations about it as they believe that it is against the teachings of Islam. Some also believe that it can stunt the growth of their children and others believe that it is an international conspiracy to cause sterility in the Muslim population. The more the government tries to eliminate the disease, the more people resist it and in this tussle the LHWs are caught between a rock and a hard place.

A worker explained that they have to go to administer polio drops in the "uncovered areas" where they have no contacts. "Whenever we go to these villages and communities, people are very hostile to us, they close their doors on us, don't allow us to enter their homes and forbid their womenfolk from talking to us. The more we insist on giving drops, the more they seem to be convinced of some conspiracy theory. However, we make concerted efforts and involve the notables of the area like landlords and government officials to access their homes.

But this conflict consumes our energies and time and by the end of the day we are exhausted. But the story doesn't end here. When we reach home late in the evening our family members (especially husbands/brothers/fathers) are furious as we have to travel long distances and they don't like our staying out late. They question our character and curse our job and sometimes demand that we should leave this profession" she said.

'Sometimes they set their dogs on us and we have to run and take shelter in other houses,' said another woman.

In some communities especially the upper class or landowners the LHWs are not allowed to enter the houses as they believe that they will influence and corrupt their women who are being kept in total seclusion and purdah. "It is even more difficult to work with these classes" added a woman.

Another worker said that once she and her Assistant District Coordinator were locked in a house because the husband was furious that they had entered without is permission. "We contacted our seniors through cell phone and they came to rescue us," she added.

"Sometimes people say very malicious and obnoxious things to us; however, over time we have learned to take this in our stride and deal politely with them which compels them to change their opinion about us and allow us to enter their houses," added an experienced worker.

Another supervisor said that while refusal and use of foul language were not uncommon she had experienced an extremely uncomfortable situation. There was a prayer leader in a UC who had two kids but he was constantly refusing polio drops for them. Then the district health officer (DHO) and district coordinator (DC) along with other officials accompanied the vaccinator to a mosque. The women health workers also went with them. "The mullah said before the whole village that he had no objections about the drops but had serious reservations about the women (read LHWs) who visited his house with other men *(nameh-rum)*. We were very embarrassed and a young woman worker left the job on that very day" she added.

4.6 VIOLENCE BY EXTREMIST GROUPS

Apart from regular discrimination, sexual harassment and domestic violence, the women health workers also face violence and intimidation from a very different segment of society, religious fundamentalists, commonly known as the Taliban. The Islamic warriors are against the institution of health workers and think that the women health workers are breaking the norms of society by venturing out in the public sphere and interacting with families, communities and the local administration. Taliban consider all the services that these women provide against the teachings of Islam, such as practicing family planning, birth spacing, the immunization program officially called the Expanded Program on Immunization (EPI) and polio vaccinations. Taliban have their reasons to hate the polio campaign as they believe that it is being used for their surveillance and for spying on them. They give the example of Osama Bin Laden when his identity was revealed from a DNA sample of his family taken during a fake campaign.[18]

The women health workers interviewed in the BMJ study cited specific examples of beheadings as well as public beatings and firing on their houses and murders of their colleagues' family members. The study notes that providing family planning services has become "an ideological target."

This is very similar to the campaigns and political positions taken by some mainstream Islamists who argue that family planning, contraception and sex education promotes "vulgarity", "obscenity" and encourages extramarital sex. Maulana Fazlullah argued that "LHWs want to promote prostitution and sins in our society."[19]

However, there is no official record of women health workers being killed by the Taliban over the years. According to press reports, in January 2013 the Islamist terror group shot and killed 16 health aid workers for administering polio vaccines to children.[20]

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18. http://www.academia.edu/12802687/Conflicts_in_International_Health_Care_A_Case_Study_of_Pakistani_Polio_Workers.
19. https://www.theguardian.com/commentisfree/2013/jan/03/pakistan-war-polio-workers.
20. http://www.frontpagemag.com/fpm/172818/talibans-jihad-polio-vaccines-frank-crimi.

According to a Dawn report, "Two polio workers and a police guard were shot dead in the mountainous Danna area of Mansehra district in March 2015."[21]

Sometimes the attacks and threats are so severe that the government is forced to restrict the mobility of the women health workers to their own areas. The Health Department also does not want to depute LHWs for anti-polio vaccinations to enable them to continue their basic duty of providing primary healthcare services to mothers and children at the community level.[22]

According to the 'Conflicts in International Health Care: A Case Study of Pakistani Polio Workers' report, nearly 22 polio workers (LHWs) have been killed in deliberate and orchestrated plots since 2012.[23]

4.7 WORK ENVIRONMENT FOR WOMEN IN PAKISTAN

The work environment for women, in a male-dominated society like Pakistan is often hostile and antagonistic hindering their contribution to the country's development as well as their right to employment. Various studies have found that social constraints and an aggressive work environment discourage women from seeking employment. To encourage women to join the labor force the government has set a quota for women but often even this minimum quota of 10 percent remains unfilled. Though women have been working in senior positions and running businesses in the private sector, these have been few in number. However, in recent years, there has been a gradual increase in the number of women working in the government and the private sector despite the obstacles that they face.

21. http://www.dawn.com/news/1170300.
22. http://www.dawn.com/news/1095842.
23. http://www.academia.edu/12802687/Conflicts_in_International_Health_Care_A_Case_Study_of_Pakistani_Polio_Workers.

CHAPTER 5

AWARENESS ABOUT SEXUAL HARASSMENT LAWS AMONG LHWS

5.1 THE PROTECTION AGAINST HARASSMENT OF WOMEN AT THE WORKPLACE ACT

The Government of Pakistan passed the Protection Against Harassment of Women at the Workplace Act, 2010 to control the problem of women being harassed in workplaces and public spaces. Now the government, civil society and human rights and women rights activists should struggle for its effective implementation. There is a need for active advocacy and for creating awareness among the masses through media campaigns in the print and broadcast media. As far as women health workers are concerned, the program officials should work closely with the community to give them due respect and status.

As mentioned earlier, the women health workers' job is by definition a field job and they have multiple workplaces. All these factors — field visits and home visits, liaison with communities, reporting to hospitals, interaction with doctors and other staff, going for various campaigns to covered and uncovered areas — make their job very susceptible to sexual harassment.

While asked about experiences of sexual harassment, all the women who were interviewed had many instances to share. However, when asked whether they knew about redressal mechanisms, they did not know anything and were shocked as they didn't know that such a law had been passed by the Government of Pakistan.

It is worrying that a workforce of nearly 125,000 women has no knowledge about the law meant to provide them protection against an offense they confront on a regular basis.

The government should try to raise awareness about the Protection Against Harassment of Women at the Workplace Act, 2010 in its rank and file and in the public at large (see Box 5).

Box 5: The Protection against Harassment of Women at the Workplace Act, 2010

The Protection Against Harassment of Women at the Workplace Act was passed in March 2010. It makes sexual harassment of women in the workplace and in public spaces a criminal offence.

Objective

The objective of this act is to create a safe working environment for women, which is free from harassment, abuse and intimidation to facilitate their right to work with dignity. This will enable higher productivity and a better quality of life at work.

This law is not only restricted to workplaces, it is applicable to all public spheres.

Sexual Harassment

Unwelcome sexual advances, requests for sexual favors or other verbal or physical conduct of a sexual nature that interferes with work, which is made a condition of employment or which creates an intimidating, hostile or offensive work environment constitutes sexual harassment.

The significant types of sexual harassment at the workplace are:

- Abuse of authority
- Creating a hostile environment
- Retaliation
- Unwelcome sexual advances
- Demanding sexual favors in exchange for job security
- Verbal or physical conduct of a sexual nature
- Rumor spreading and malicious gossip in the workplace
- Obstructing performance and/or advancement upon refusal to comply

Code of Conduct and Inquiry Committee

The law requires all public and private organizations to adopt an internal Code of Conduct aimed at establishing a safe working environment, free of intimidation and abuse, for all working women. This law obligates employers to set up an Inquiry Committee to investigate a harassment related complaint. The committee

has to have three members, at least one of whom is a woman.

The Inquiry Committee shall:

- Launch an investigation against the accused
- Recommend the imposition of penalties if the accused is found guilty
- Forward recommendation to the Competent Authority which will implement the decision.

Punishment can range from censure, stopping promotion, compulsory retirement and removal/dismissal from service and imposition of fine payable to the complainant. Amendment to Section 509 of the Pakistan Penal Code, 1860, clearly defines harassment and recognizes it as a crime. This section has increased the maximum punishment for this offence to imprisonment which may extend to three years or a fine of up to PKR 500,000 or both.

The act also provides for the appointment of an Ombudsman both at the federal and provincial levels to listen to appeals filed by the aggrieved party. The victim can also appeal to the President or the Governor if dissatisfied by the decision of the Ombudsman.

More information intended to help organizations ensure compliance with the act is available at: www.aasha.org.pk

Source: : http://pcsw.punjab.gov.pk/protection_against_harrassment

5.2 THE PROVINCIAL OMBUDSMAN

The Protection Against Harassment of Women at the Workplace Act IV of 2010, provides for the appointment of an Ombudsman both at the federal and provincial levels to listen to appeals filed by the aggrieved party under the Act.

The Provincial Government of Sindh promotes the role of the Provincial Ombudsman on its website. Key information is reproduced below.

As per the Act, Syed Pir Ali Shah, a former judge of Sindh High Court was appointed as its First Ombudsman which was established at 7th Floor, New Sindh Secretariat Building No-1, Karachi, vide Sindh Government notification dated 05-07-2012. The Sindh government thus took a massive step towards effective implementation of the anti-sexual harassment legislation and there has been consistent effort by the Sindh government to provide a common platform for women's development.

The Ombudsman has to act as a legal, impartial intermediary between the employees and the management. As many as 130 complaints lodged till now have been investigated with confidentiality and resolved on the basis of evidence and also through mediation with necessary recommendations.

The office of the Provincial Ombudsman provides relief to working women suffering from sexual harassment by carrying out investigations while maintaining the confidentiality of the complainants, takes stern action against the accused as prescribed by the law if the accused are proved guilty. The aim is to redress the grievances of the complainants and to ensure provision of a safe and secure environment for a woman at her workplace.

As such, the institution of the Provincial Ombudsman is considered to be an ideal solution for providing justice at one's doorstep without adopting lengthy procedures and requirements of the judicial system and, without payment of any cost or court fee. Relief has been provided, either directly or indirectly, to a large number of complainants belonging to urban as well as interior Sindh.

CHAPTER 6

RECOMMENDATIONS

- The foremost problem which has come out of various consultations is the irregular salary structure of the women health workers. The Government of Sindh should take immediate steps to initiate the 'Statement of New Expenditure' (SNE) in its budget proposals for the financial year 2017-18 and beyond. SNE could help the government to allocate enough resources to pay salaries on time and also the smooth running of the program.
- The program should pay salaries to health workers which are commensurate with their educational qualifications; other perks and privileges given to regular government employees should also be extended to them.
- To raise awareness about the benefits of the program, the Government of Sindh and the National Program for Family Planning and Primary Healthcare should launch advocacy and awareness campaigns in print and broadcast media and FM radio stations, leaflets, handbills and posters should be displayed in public spaces and in their offices. The campaign should highlight women health workers' contribution in providing preventive health facilities, combating maternal deaths, nutrition screening and family planning services at the doorstep. The government should also highlight the fact that women health workers' contribution is vital for meeting international development targets such as the just MDGs and the on-going SDGs. This will bring a level of acceptability and dignity to their work.
- The women health workers should only be assigned to do the duties which were part of the original PC1 of the program as using them for other services has affected their performance.
- The Protection Against Harassment of Women at the Workplace Act, 2010 should be part of their curriculum and an integral part of their training. The health workers should have a clear understanding of the bill. It should be

displayed prominently in their secretariat, hospitals and other work places to discourage people from taking advantage of them.

- There should be widespread awareness about the implementation mechanism of the Protection against Harassment of Women at the Workplace Act, 2010 and how to access redressal mechanisms via the Ombudsperson's Office as per law in all districts. Committees should be formed in all districts to monitor sexual harassment cases and a female member should be included in them.
- Threats and attacks on or harassment of women health workers should be investigated and action against the perpetrators should be taken to deter perpetuators.
- LHWs' union should be strengthened in all the provinces and there should be a network at the national level. The All Sindh Lady Health Workers Association (ASLHWA) should be emulated in all the provinces.
- To highlight the problem studies focusing on sexual harassment and domestic violence should be conducted on the national level and in all the provinces.
- The government should monetarily compensate the families of the women health workers that were killed or injured during their duty.
- To make the profession more gender-friendly and gender-equal, the government should appoint female DCs and DHOs.
- The LHWs' village committee should be formed and these committees should comprise elected and non-elected male and female members. One of the members should accompany the women health workers while going out of the village or whenever they feel insecure.
- The government should also start mass media campaigns to give dignity to the women health workers who should have a uniform to make them more visible and prominent. All these measures will help enhance their status in the communities.

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ANNEXURE 1

Participating Organizations

All Sindh Lady Health Workers Association

All Sindh Lady Health Workers Association (ASLHWA) is a trade union of the workers of the National Program for Family Planning and Primary Health Care (FP&PHC) created to collectively fight for their rights in the province of Sindh. ASLHWA includes members in most districts of Sindh and aims to fight against injustices and unite all workers and employees of the program. In 2016, ASLHEWA launched a Campaign against Stolen Wages to highlight the impacts of delayed payment of wages and demand fair remuneration and decent working conditions for LHWs.

Public Services International

Public Services International (PSI) is a global trade union federation representing 20 million working women and men who deliver vital public services in 154 countries. It champions human rights, advocates for social justice and promotes universal access to quality public services. PSI works with the United Nations system and in partnership with labor, civil society and other organizations.

Workers Education and Research Organization

Workers Education and Research Organization (WERO) works on labour and citizens issues including labor, education, peace and child rights, provides basic utilities to the working class and also works for good governance. It also works with marginalized sections of society that include women, minorities and youth. WERO consists of dedicated experts in development work in various fields dealing with labor, women, peace, minorities, media, education, and community health.

ANNEXURE 2

Comparison of Exchange Rates in South Asia

As of 1 May 2017

	BDT	INR	LKR	NPR	PKR
1 US$	81.19	64.16	149.63	101.75	103.69
1 Euro	88.43	69.88	162.97	110.82	112.93

Source: Onanda currency converter, https://www.oanda.com/currency/converter

Non-Standard Work in the Healthcare Sector in South Asia is a series of publications aimed at disseminating information on the challenges facing the health workforce in the region, both in the public and private sector. Overall, we hope that the booklets published under the series will provide a window into the issues of interest of Public Services International, South Asia and areas of possible collaboration with existing and future allies in the struggle for Health for All with Decent Work around the world. For more information visit the PSI website (given below).

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