

**THE NATION'S CAREGIVERS:
WORK EXPERIENCES, PROFESSIONAL IDENTITIES AND GENDER POLITICS OF
PAKISTAN'S LADY HEALTH WORKERS**

By

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ABSTRACT

Lady Health Workers (LHWs) are community health workers who work under the Pakistani government's *National Programme for Family Planning and Primary Health Care*, and provide basic medication, contraceptives, and nutrition and prenatal advice to expectant mothers. LHWs are a pivotal bridge between mothers, especially those who live in traditional households, and medical practitioners and policymakers. Several studies indicate that LHWs have been instrumental in decreasing maternal and infant mortality rates, lowering the incidence of tuberculosis in urban and rural populations, and treating depression among patients. In addition, they conduct vaccination campaigns including the WHO-supervised polio campaign.

Since 2007 tensions have emerged between LHWs and the government regarding pay and working conditions. The LHWs have staged sit-ins, demonstrations as well as a march to the capital to highlight their plight and demand better working conditions from the government. This has resulted in disruptions in vaccination and awareness campaigns. Reports suggest that a higher morale amongst workers translates to higher productivity and more effective work results. Thus, understanding the issues affecting LHWs is essential to a more productive health care work force. By analyzing the dynamics underpinning the relationship between LHWs, the Pakistani government, and the community, policymakers can obtain a better understanding of how the intersecting influences of gender, culture and spaces impact the implementation of health care policies. This analysis could also shed light on the issue of worker retention in the medical field.

Drawing from a series of semi-structured interviews conducted over a four-month period in the Pakistani city of Karachi, I analyse how LHWs view their work in relation to gender,

agency, self-worth and human security in an urban setting. In addition, I locate the workers' experiences within neocolonial and postcolonial systems.

Findings indicate that while LHWs are extremely devoted to their work, a lack of security, compounded by irregular pay and gender discrimination, has contributed to low morale. The masculine and hierarchal systems LHWs operate within have contributed to the workers' struggle to be recognised professionally. In addition, international development organisations' agendas and government policies have had unintended and often negative consequences on LHWs' morale and experiences.

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GLOSSARY

APLHWA All Pakistan Lady Health Workers Association

CAD Canadian Dollars

CIA Central Intelligence Agency

CHW Community Health Worker

DFID Department for International Development

KP Khyber-Pakhtunkhwa

LHWs Lady Health Workers

LHS Lady Health Supervisors

GPEI Global Polio Eradication Initiative

UCWs Unlicensed Care Workers

UN United Nations

UNICEF The United Nations Children's Fund

USAID United States Agency for International Development

WHO World Health Organisation

CHAPTER ONE: INTRODUCTION

THE NATION'S CAREGIVERS: WORK EXPERIENCES, PROFESSIONAL IDENTITIES AND GENDER POLITICS OF PAKISTAN'S LADY HEALTH WORKERS

1.1 INTRODUCTION

At a protest rally outside the governor's house in the Pakistani city of Lahore, a government-employed community health worker¹, or Lady Health Worker (LHW), states "we were intimidated with sticks and weapons...we help the world but we should not be given anything in return. Why aren't we given any money?" Another LHW says, "we are told we are being dramatic...we are hungry, orphaned, poor, widowed but we are still not being given regular pay"². These workers are two among at least a 100,000 LHWs who have been protesting regularly since 2010 against the government. The health workers' demands are the regularisation³ of their jobs and timely payment of their salaries⁴ but the Pakistani state has yet to realise these demands⁵.

What has driven the LHWs to protest are their poor working conditions and job dissatisfaction⁶. In this regard, their experiences are similar to other low-wage health workers

¹ A Community Health Worker provides basic medical and health care to communities and neighbourhoods that are underserved by more educated health care practitioners such as doctors and nurses.

² Fiza Noor, "Lady Health Workers Protest Rally against their Rights Pkg by Fiza Noor," YouTube video, 3:09, posted by citynewsLahore, October 18, 2011, <http://www.youtube.com/watch?v=k7Tc9f9Jrw8.html>.

³ 'Regularised' or 'Regularisation' refers to the demands of the LHWs to make their jobs permanent work positions with benefits. Currently all LHWs are employed by the state on a contract basis.

⁴ Asma Kundi, "Factors making LHWs say enough is enough," *Dawn*, April 22, 2012, accessed May 5, 2012, <http://dawn.com/2012/04/22/factors-making-lhws-say-enough-is-enough.html>.

⁵ "A long struggle," *Dawn*, 22, January 2013, accessed February 15, 2013, <http://dawn.com/2013/01/22/a-long-struggle.html>.

⁶ Based on interviews conducted with the author, September-December 2012.

across the globe. For instance, the high turnover of unlicensed care workers (UCWs)⁷ in the US is due to extremely low pay and a lack of opportunity for career advancement. Since UCWs mostly serve people aged 65 and over, an aging population in the US will increase the demand for such workers⁸. The prevalent job dissatisfaction among UCWs and the low pay, however, has led to a lack of labour retention and an undersupply of workers⁹. In addition, LHWs, midwives and UCWs provide more intimate health care that patients seek but which nurses and doctors cannot or are unable to deliver. For instance, a 2007 Statistics Canada study indicated that 71 percent of mothers who gave birth with the assistance of a midwife stated their experience was “very positive” compared to 53 percent of women who had an obstetrician-aided birth. Many expectant mothers state they prefer midwives as these healthcare providers spent more time on their patients and provide one-on-one care¹⁰. There is certainly an unmet demand for such services as 40 percent of pregnant women in Ontario in 2011 wanted to deliver with the assistance of a midwife but only 10 percent were able to do so¹¹. As of 2010, there were 900 midwives practicing in Canada¹² but more are needed to meet the demand.

⁷ UCWs are the largest category of workers in the healthcare industry and work in hospitals, nursing homes and health homes. They assist patients with daily activities such as feeding, dressing and bathing. See Julie Anne Whitaker, “Seeking Compassionate Women: The Crisis in Low-Wage Health Care Work,” (PhD diss., University of Wisconsin-Madison, 2003), 1-3.

⁸ Robyn I. Stone and Joshua M. Weiner, “The Long-Term Care Frontline Workforce” in *Who will Care for us? Addressing the Long-Term Care Workforce Crisis*, ed. Robyn I. Stone and Joshua M. Weiner, (Washington D.C.: Urban Institute and the American Association of Homes and Services for the Aging, 2001), 10-12.

⁹ Whitaker, “Seeking Compassionate Women.”

¹⁰ Lianne George, “A midwife crisis: Not enough doctors, not enough midwives: it’s a bad time to have a baby in Canada,” *MacLean’s*, November 20, 2008, accessed May 15, 2013, <http://www2.macleans.ca/2008/11/20/a-midwife-crisis.html>.

¹¹ Jenn Hardy, “How Canada’s midwife shortage forces healthy mothers into hospitals,” *this Magazine*, January 7, 2011, accessed May 15, 2013, <http://this.org/magazine/2011/01/07/canada-midwife-shortage/.html>.

¹² “News & Announcement – International Day of the Midwife: CAM Press Release,” Canadian Association of Midwives, updated May 5, 2010, accessed May 20, 2013 <http://www.canadianmidwives.org/2-news/International-Day-of-the-Midwife-CAM-Press-Release.html>.

Given that highly educated healthcare professionals such as doctors and nurses cannot meet every health need of the population, the retention of the labour pool of LHWs, midwives and UCWs is essential to fill in a gap between the supply and demand for health services. Research suggests that a higher morale amongst health workers translates to better patient care and greater worker retention¹³. Thus, understanding the issues affecting health workers such as LHWs is essential to a productive work force and improved healthcare for patients. In addition, an analysis of the job experiences of health workers could shed light on the issue of worker retention in the medical field.

Most research on LHWs has focused on the effectiveness of their health delivery services or on expanding the scope of their job duties. For example, studies indicate that healthcare workers are effective at decreasing still births and neonatal mortality rates¹⁴, lowering the incidence of pneumonia in urban and rural populations¹⁵, treating depression among patients¹⁶ and eye health issues such as conjunctivitis¹⁷. Other studies have established the reasons for LHWs' job-related stress such as a high workload, unsupportive supervisors, sexual harassment,

¹³ Francis A. Adzei and Roger A. Atinga, "Motivation and retention of health workers in Ghana's district hospitals," *Journal of Health Organization and Management* 26, no. 4 (2012): 467-485; Michael P. Leiter, Phyllis Harvie and Cindy Frizzell, "The Correspondence of Patient Satisfaction and Nurse Burnout," *Soc. Sci. Med.* 47, no. 10 (1998): 1611-1617.

¹⁴ Zahid A. Memon et al., "Implementing community-based perinatal care: results from a pilot study in rural Pakistan," *Bulletin of the World Health Organization* 86, no.6 (2008): 452-9 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647462/pdf/07-045849.pdf>

¹⁵ "Pakistan: Lady Health Workers take on child pneumonia – and win," IRIN, November 2011, accessed January 25, 2011, <http://www.irinnews.org/report.aspx?ReportId=94200>; Abdul Bari et al., "Community case management of severe pneumonia with oral amoxicillin in children aged 2–59 months in Haripur district, Pakistan: a cluster randomised trial," *Lancet* 378(2011): 1796–803.

¹⁶ Farooq Naeem et al., "Screening for Depression in the Community by Lady Health Worker," *Interdisciplinary Journal Of Contemporary Research In Business* 3, no. 1(2011): 180-188.

¹⁷ Asad Aslam Khan, Haroon R. Awan and Niaz Ullah Khan, "Women Health Workers: Improving Eye Care in Pakistan," *Community Eye Health Journal* 22 no. 70 (2009):1-2.

lack of transport to and from work, and low pay¹⁸. What is often ignored in these studies, however, is a deeper look at the gender politics and sociocultural factors underpinning the workers' experiences and shaping their professional identities. In addition, the LHWs' experiences are often not situated within the patriarchal¹⁹ and political systems they operate within. The main focus of this thesis, therefore, is to locate the workers' experiences within these systems.

Through a series of semi-structures interviews I explore the dynamics underpinning the relationship between LHWs, the Pakistani government, and the community at the systemic level. I chose to analyse the LHWs' experience from the workers' perspective instead of the official government view due to restrictions of space. In addition, I wanted to give the LHWs, who are in a less powerful position than the state, a voice in an academic space and a public forum. LHWs are a pivotal bridge between patients in low-income areas, and medical practitioners and policymakers. Gaining a deeper insight into the workers' experiences can lead to better healthcare policies and, in turn, improved healthcare services for Pakistan's underserved populations. Before delving into an in-depth analysis of the LHWs' experiences, however, a background on Pakistan and the LHW movement is necessary to contextualise the health workers' experiences. This will be discussed in the next few sections.

¹⁸ Assad Hafeez et al., "Lady health workers programme in Pakistan: challenges, achievements and the way forward," *JPMA* 61 no. 3 (2011): 210-215, http://jpma.org.pk/full_article_text.php?article_id=2633.html; Oxford Policy Management, *Lady Health Worker Programme: Third party Evaluation of Performance*, (Oxford: Oxford Policy Management, 2007).

¹⁹ I use the term patriarchal to mean any form of masculine and hierarchal system that is generally oppressive for women but also promotes systemic inequality which can be observed at the intersection of race, gender and socioeconomic class. For more details please see Yuval-Davis, *Gender and Nation*, 9. Also, see Section 3.4 for more details.

1.2 LADY HEALTH WORKERS VS. THE STATE: A BACKGROUND ON THE LHW MOVEMENT

Islamabad's Press Club, in Pakistan, is often the site of protests and April 18, 2012 was no different. A consortium of health workers, their supervisors, Lady Health Supervisors (LHS)²⁰, and LHW drivers²¹ protested outside the Club demanding better working conditions, regularisation of their profession and the payment of their salaries. They had given the government an ultimatum: give in to their demands by 3 p.m. or they would commit mass suicide. As the deadline loomed closer, and then passed, 25 of them sprinkled oil on themselves and attempted to burn themselves. Even though the police intervened, one man, an LHW driver, still suffered burn injuries²².

The April 18 protest was a dramatic climax to what has been an ongoing tussle between the government, and the LHWs and their supervisors over the past two years²³. During the summer of 2010, LHWs held a two-day hunger strike outside the country's parliament until the government agreed to meet their demands such as permanent employee status²⁴. A year later, however, the health workers had still not been given what they had been promised: regularisation of their jobs and timely payment of their salaries²⁵.

²⁰ The Lady Health Supervisors manage LHWs in assigned districts.

²¹ The LHW drivers are in charge of transporting the health workers for work-related duties.

²² Kundi, "Factors making LHWs say enough is enough,"; Ayesha Shahid, "Lady health workers take protest to another level," *Dawn*, April 19, 2012, accessed May 5, 2012, <http://dawn.com/2012/04/19/lady-health-workers-take-protest-to-another-level.html>; "LHW's stage sit in protest in Islamabad," Samaa TV, April 18, 2012, accessed May 5, 2012, <http://www.samaa.tv/newsdetail.aspx?ID=46357.html>.

²³ "Bushra Arain LHW Ghotki Protest," YouTube video 3:50, originally televised on Metro One, posted by "Idress Chouhadry," March 24, 2011, <http://www.youtube.com/watch?v=fDqtG3Z26Ro.html>; Kundi, "Factors making LHWs say enough is enough".

²⁴ "Government accepts demands of lady health workers," *Express Tribune*, June 4, 2010, accessed May 30, 2012, <http://tribune.com.pk/story/18851/govt-accepts-demands-of-lady-health-workers.html>.

²⁵ Kundi, "Factors making LHWs say enough is enough"; Shahid, "Lady health workers take protest to another level"; "LHW's stage sit in protest in Islamabad," Samaa TV; "Bushra Arain LHW Ghotki Protest," Metro One TV; Kundi, "Factors making LHWs say enough is enough"; "LHWs hold protest in

Since 2010, LHWs have staged *dharnas* (sit-in protests) in various cities, from the metropolis Karachi to the small city of Gotki to the capital Islamabad, to bring attention to their plight²⁶. Banding under the umbrella of the nation-wide organisation All Pakistan Lady Health Workers Association (APLHWA) - which was formed in 2010 - they have often held hunger strikes and protests at risk to their own lives. Many of the protests in 2011 and early 2012 turned violent. Shells and tear gas was thrown at the LHW demonstrators in Karachi resulting in minor injuries for three women while many fainted due to the tear gas²⁷. In Lahore, the strikers clashed with police as they tried to make their way towards Punjab's chief minister's (CM) home²⁸. The APLHWA's spokesperson Bushra Arain has publicly stated that "there are people threatening us, the girls [LHWs] are being intimidated"²⁹.

Despite these threats, the LHWs have shown great determination and tenacity. In Karachi, the LHWs re-banded after the shelling ended and continued their protest³⁰. In Lahore they made their way to the CM house where one of the minister's aides listened to their concerns

Karachi," Samaa TV, February 15, 2012, accessed May 5, 2012, <http://www.samaa.tv/newsdetail.aspx?ID=43194.html>.

²⁶ Ibid.

²⁷ "Lady health workers defy tear gas shelling, baton charge by police outside press club Karachi," PakMed InfoForum, February 16, 2012, accessed May 5, 2012, <http://pakmed.net/college/forum/?p=33693.html>.

²⁸ "LHWs rule the roost at the mall," *Pakistan Today*, October 22, 2011 accessed May 5, 2012, <http://www.pakistantoday.com.pk/2011/10/22/city/lahore/lhws-rule-the-roost-at-the-mall.html>.

²⁹ "Bushra Arain LHW Ghotki Protest," Metro One TV.

³⁰ "Dunya TV-15-02-12-LHW Protest Shelling," YouTube video 1:50, originally televised on Dunya News TV, posted by "dunyanews1," February 15 2012, <http://www.youtube.com/watch?v=xPUOPSseG5o.html>; Fakir Syed Iqtidaruddin, "Police baton-charge protesting lady health workers at KPC," *Business Recorder*, February 15, 2012, accessed May 5, 2012, <http://www.brecorder.com/top-news/1-front-top-news/45888-police-baton-charge-protesting-lady-health-workers-at-kpc.html>; "Lady health workers defy tear gas shelling, baton charge by police outside press club Karachi," PakMed InfoForum.

and agreed to their demands³¹. In addition, the LHWs have managed what most labourers striking in Pakistan have been unable to pull off: positive media coverage and public support. Their plight has garnered sympathy³² from the public as well as prominent politicians such as Marvi Memon, a minister of parliament³³. The Supreme Court even took suo motto³⁴ notice of their case and requested that the state inform the court of the progress of the negotiations between the government and the LHWs³⁵.

In January 2013, after three years of persistently fighting for their labour rights, the then prime minister of Pakistan, Raja Pervez Ashraf, regularised the LHW programme. The Pakistani leader agreed to meet with the health workers and discuss their demands after the LHWs held a rally on December 22, 2012 outside the Parliament in Islamabad. According to the most recent agreement, the federal government will cover the cost of the regularisation for 105,068³⁶LHWs from July 1, 2012 till 2015, with funding beyond that date to be considered and debated by the Council of Common Interests³⁷.

³¹ “Lady Health Workers protest in Punjab cities,” Awaz. TV, last modified on October 15, 2011, accessed May 5, 2012, http://www.awaztoday.com/News_Lady-health-workers-protest-in-Punjab-cities_1_13740_Political-News.aspx.html.

³² For more details, see Chapter Six.

³³“Bushra Arain LHW Ghotki Protest,” Metro One TV; “Govt. accepts demands of lady health workers,” *Express Tribune*, June 4, 2010, accessed May 15, 2012, <http://tribune.com.pk/story/18851/govt-accepts-demands-of-lady-health-workers.html>.

³⁴ When the court takes up a case or actions carried out by a judge without a formal petition filed by a party.

³⁵ “SC issues notices to health secretaries over lady health workers issues,” *Dawn*, April 23, 2012, accessed May 15, 2012, <http://dawn.com/2012/04/23/sc-issues-notices-to-health-secretaries-over-lady-health-workers-issue.html>.

³⁶ It is unclear how many workers there are exactly. The APLHWA spokesperson in her interview with the author stated that there 120,000 workers. The Ministry Health website states that there are over a 100,000 workers but there are no exact figures available. In my research I have come across figures as high as 130,000 and as low as 96,000. Nevertheless, based on public statements made by Bushra Arain and Pakistani media articles there are around a 100,000 workers currently in service.

³⁷ Ikram Junaidi, “100, 000 lady health workers get their service regularized,” *Dawn*, January 21 2013, accessed February 15, 2013, <http://dawn.com/2013/01/21/100000-lady-health-workers-get-their-service-regularised.html>.; “LHWs regularization of job to boost outreach programme,” *The Nation*, January 22,

One of the workers' representatives, Sajida Hameed, reflecting on the LHWs' circuitous relationship with the government remarked, "the program was initiated by former prime minister Benazir Bhutto and now her party's government has regularised us which is remarkable"³⁸. This piece of news, while worth celebrating, must be taken with a touch of skepticism. The government has touted similar promises to the health workers after they staged mass protests last year and in 2010³⁹. In both instances, the state agreed to give LHWs permanent status, in June 2010 and in July 2012, only to rescind on these offers. Indeed, the government stating that they have agreed to a concession and then backtracking has become somewhat of a pattern, and part of the tango between the LHWs and the state⁴⁰.

Before delving further into the analysis and the dynamics underpinning the tensions between the government and the LHWs, it is necessary to get a better understanding of the history of the LHW programme. In addition, in order to place this movement and the experiences of the healthcare workers within a Pakistani context, a background of the country particularly in regards to gender and health is required. Thus, both of these topics will be touched upon in the next few sections.

2013, accessed February 15 2013, <http://www.nation.com.pk/pakistan-news-newspaper-daily-english-online/islamabad/22-Jan-2013/lhws-regularisation-of-job-to-boost-outreach-programme.html>.

"Regularisation of Lady Health Workers Hailed," *Daily Times*, January 28, 2013, accessed, February 15, 2013, http://www.dailytimes.com.pk/default.asp?page=2013%5C01%5C28%5Cstory_28-1-2013_pg11_4.html.

³⁸ Junaidi, "100, 000 lady health wokers get their service regularized".

³⁹ "A long struggle," *Dawn*; "Government accepts demands of lady health workers," *Express Tribune*.

⁴⁰ Sehrish Wasif, "Strong ultimatum: Lady health workers threaten to set themselves alight," *Express Tribune*, April 17, 2012, accessed May 5, 2013 <http://tribune.com.pk/story/365714/strong-ultimatum-lady-health-workers-threaten-to-set-themselves-alight.html>.

1.3 HEALTH, GENDER AND POLITICS: THE GROWING PAINS OF THE LHW PROGRAMME

The Lady Health Workers Programme is often touted as the brainchild of the then Prime Minister, Benazir Bhutto in 1994. Indeed, it was during Bhutto's rule that the LHW programme was launched⁴¹. The history of its inception, however, can be traced back to the eighties, when the World Health Organisation (WHO) began placing emphasis on primary healthcare. A total of 134 countries and NGOs signed on to the Alma Ata declaration to show their commitment to improving primary health care. Given that Pakistan, till the early nineties, had not considerably improved its health statistics in the primary health sector such as maternal and infant mortality rates, the government worked with the WHO to come up with health programming that would. The result was the National Programme for Family Planning and Primary Health Care which came to be known more commonly as the LHW programme⁴². Thus, from the very beginning, international health agendas have shaped the country's primary health agendas and this has had both positive and negative consequences⁴³. The aim of the LHW programme was to create health awareness and collect raw data on the population, such as number of births, weight of newborns etc. However, it did not address the severe shortage of physicians or other medical expertise needed in many areas of the country, particularly, in more desolate rural and low-income areas⁴⁴.

While the LHW programme could be accommodating to more health needs of the population, its main focus remains contraception, birth control and vaccinations. As will be explored in Chapter Five this has much to do with how international organisations such as the

⁴¹ Rizwana Naqvi, "Profile: Saving mothers' lives," *Dawn*, April 15, 2012, accessed May 5, 2012, <http://dawn.com/2012/04/15/profile-saving-mothers-lives.html>.

⁴² Assad Hafeez et al., "Lady health workers programme in Pakistan": 210-215.

⁴³ These issues of programming and how they have affected the work experiences of LHWs are explored in more detail in Chapter Five.

⁴⁴ Participant 9, Dr Shershah Syed, in discussion with the author, September 2012.

United States Agency for International Development (USAID) and WHO fund the LHW programme⁴⁵. Even the roots of the programme can be traced to the turn of the twentieth century in the West: the LHW programme borrows heavily from the Community Health Workers Programmes popular in early 1900s in the US and Europe⁴⁶. The closest global term that is similar to LHWs is Community Health Worker (CHW). CHW, loosely defined, is a local resident, usually female, who acts as a “bridge” between the health institute and her “community”⁴⁷. The LHW could also be described in a similar way.

According to the Ministry of Health, the health worker is expected to provide health services such as advice on nutrition, family planning and carry out vaccinations for a 1,000 people. She is given 15 months of training and then expected to make daily rounds to the homes of various members of the community to collect data, carry out vaccination campaigns and give health advice on topics such nutrition and breast-feeding. She is also expected to set up a clinic (more commonly dubbed the “health house” by the LHWs) where she also carries out similar duties, dispenses non-prescription medicines such as Panadol⁴⁸, weighs babies etc. For this work, she is remunerated with a monthly salary of 7,000 rupees⁴⁹ (CAD 70)⁵⁰.

As numerous studies have pointed out, however, the LHWs job description has not only expanded since then, but they are increasingly expected to do more. This has happened without

⁴⁵ For a more detailed discussion, see Chapter Four.

⁴⁶ Jesus Ramirez-Valles, “Promoting health, promoting women: the construction of female and professional identities in the discourse of community health workers,” *Soc. Sci. Med.*, 47(1998)(11): 1749-1753.

⁴⁷ Ofosu-Amaah and Eng et al., cited in Jesus Ramirez-Valles, “Promoting health, promoting women,” 1749.

⁴⁸ Similar to Tylenol in Canada.

⁴⁹ “LHW,” National Programme for Family Planning and Health Care Ministry of Health Government of Pakistan, accessed January 25, 2011, <http://pakcyber.net/phc.gov.pk/site/lady-health-workers.html#5>.

⁵⁰ The wages are loosely based on the average of the 2013 currency exchange rate. Throughout this thesis when I have referred to any wages in rupees, I have converted its equivalent in CAD based on this exchange rate.

any parallel increase in resources, monetary compensation or regularisation of their jobs. In addition, there is no system of promotion nor does the programme allow for the more capable and skilled LHWs to be given further training⁵¹. These factors have also contributed to the LHWs' frustrations.

In order to work as an LHW, the candidates must have received at least eight years of schooling. This means they belong to 30.2 per cent of the country's female labour population who have had at least this level of education. The LHWs do need to be in possession of technical skills, and be able to collect data, and write reports. Thus their skills could be comparable to a clerk whose average monthly salary in 2011 was approximately Rs. 13, 649 (136.49 CAD). Yet, the LHWs are paid half of what a clerk is. The average monthly wages of a woman working in personal or community service sector in 2011 was Rs. 8, 912 (89.12 CAD)⁵². This means that even for the field they work in and their skills they provide, they are paid much less than their peers. While the monetary value of LHWs based on their training or their level of education is up for debate⁵³, the fact that they are often paid less than other less skilled workers has created resentment amongst health workers⁵⁴. While averages can be misleading, the typical health worker is very different from her fellow Pakistani women. She is more likely or eager to work unlike her peers, more assertive, educated and aware of her reproductive rights⁵⁵.

Now that the LHWs job description and programme has been discussed, it must be located in the wider Pakistani health context. This will be done in section 1.6, and the following

⁵¹ Based on Dr. Shershah Syed's discussion with the author, September 2012.

⁵² Pakistan Bureau of Statistics, *Labour Force Survey 2010-11*, accessed March 5, 2013, http://www.pbs.gov.pk/sites/default/files/Labour%20Force/publications/lfs2010_11/results.pdf

⁵³ See Chapter 2.2 for a more detailed discussion on the value of labour and work.

⁵⁴ Based on interviews of LHWs conducted by the author, September-December, 2012.

⁵⁵ Ibid.

two sections explore the background of the country's history and economics. While the government often blames a lack of funding for its reluctance to regularise the LHW programme, there are multifaceted reasons for this. These factors shall be discussed in the rest of this chapter.

1.4 PAKISTAN: A BRIEF POLITICAL BACKGROUND OF THE COUNTRY

Pakistan literally means the 'Land of the Pure'⁵⁶. While Urdu is the official language⁵⁷ of the country and 97 per cent of its citizens identify as Muslims, the country's ethnic mix, spoken language and geography dramatically changes from the south to the north. There are various ethnic groups that reside in the country and over 300 languages and dialects are spoken⁵⁸. Pakistan is divided into four provinces: Sindh, Balochistan, Khyber-Pakhtunkhwa⁵⁹ and Punjab. The most populous, politically dominant and wealthiest province is Punjab⁶⁰. At the other end of the spectrum is Balochistan which is the least economically developed province of the country⁶¹.

Since gaining independence, Pakistan has faced both internal insurgencies and external security threats⁶². Unfortunately, this has meant that the state has given priority to the

⁵⁶ Ian Talbot, *Pakistan: A New History*, (London: Hurst & Company, 2012), 26.

⁵⁷ At the time that it was made the official language of the country, only seven percent of the population spoke it. See Tariq Rahman, *Language, Ideology and Power: Language-learning among the Muslims of Pakistan and North India*, (Karachi: Oxford University Press, 2002), 217.

⁵⁸ Sean Sheehan and Shahrezad Samiuddin, *Cultures of the World: Pakistan*, (New York : Benchmark Books, 2004),85.

⁵⁹ Formerly known as North Western Frontier Province till 2010, the province's name was changed to Khyber Pakhtunkhwa under the political influence of Pakhtun nationalism much to the concern of other linguistic/ethnic minorities such as Hazaras, Saraikis and Chitralis who feel the name change marginalizes them further. See Bushra Maheen Rahman, "Is Khyber Pakhtunkhwa better off than NWFP?" *Express Tribune*, July 6, 2010, accessed May 1, 2013. <http://blogs.tribune.com.pk/story/424/is-khyber-pakhtunkhwa-better-off-than-nwfp.html>.

⁶⁰ Tarique Niazi, "Modernization, Modernity and Fundamentalism: The Pakistani Experience," *International Journal of Contemporary Sociology* 43, no.1 (2006): 125 – 150.

⁶¹ Sheehan and Samiuddin, *Cultures of the World: Pakistan*,34.

⁶² Talbot. *Pakistan: A New History*, 11-12.

development of defence over social welfare⁶³. Pakistan is nestled within a highly geopolitically tense region, and its neighbouring countries are China, India, Afghanistan and Iran. While its relations with China and Iran are relatively friendly, relations with India have been largely tense since Pakistan emerged in 1947 from the splitting of British Colonial India (more commonly known simply as the Partition) into two countries: a Muslim-dominated and Hindu-dominated one. The ongoing conflict between the two countries can be traced pre-Partition to the distrust between the parties, the Muslim League and the Congress⁶⁴, the disagreement over division of assets in 1947, and the dispute over the formerly Princely State of Jammu and Kashmir⁶⁵. There have been four Indo-Pak wars in the last six decades: in 1947, 1965, 1971 and 1999⁶⁶. Additional conflicts and proxy wars that both sides have engaged in have further deteriorated Indo-Pak relations⁶⁷. For instance, the 2010 terrorist attack in Mumbai, which was traced back to Pakistan, have further worsened the relations between the two⁶⁸.

In addition to India, Pakistan has fragile and tense relations with Afghanistan due to its northern neighbour's refusal to recognise the Durand Line, the boundary that separates it from the Pakistani province of Khyber-Pakhtunkhwa. The same ethnic group, Pakhtuns, resides on both sides of the border, and Afghanistan claims that the Pakhtuns have a right to self-determination. The official stance of Afghanistan is that an area of 190,000 square miles,

⁶³ For more details see Ayesha Jalal, *The State of Martial Rule: The Origins of Pakistan's Political Economy of Defence*, (Cambridge University Press, 1990).

⁶⁴ The Muslim League pushed for an independent state for Muslims while Congress was opposed to the idea.

⁶⁵ Talbot. *Pakistan: A New History*, 9-10.

⁶⁶ Peter Lyon, *Conflict between India and Pakistan: an Encyclopedia*, (Oxford: ABCCLIO, 2008), 82.

⁶⁷ Talbot. *Pakistan: A New History*, 9-10.

⁶⁸ Gareth Price, "India and Pakistan-Mumbai Aftermath: Keeping Control", *The World Today* 6, no. 1 (2009): 11-12.

stretching from Chitral into Balochistan named Pakhtunistan, belongs to Afghanistan. This has been the root of much conflict between the two states⁶⁹.

Military clashes took place between 1947 and 1963 until relative normalisation of relations for a decade before an internal coup removed the Afghani monarchy⁷⁰. The coup eventually led to the Soviet invasion of Afghanistan, and the proxy war fought between the USSR and the US in the country in which Pakistan was involved. The only other relatively stable period of relations between the two countries have been between 1996 and 2001 when Pakistan placed a proxy government, the Taliban, a militant Deobandi extremist group, in Afghanistan⁷¹. Tense relations have once again escalated between the two countries. For instance there have been rocket attacks launched across the Kunar-Bajaur border, and there has been a chill in relations between the two, with the Afghani government cancelling a joint-military operation in April 2013⁷².

Since 2001, Pakistan has also faced a number of internal security crises and militant attacks. For the past 12 years, it has been battling the Taliban, both, the Afghani Taliban that often cross its northern borders, as well as the Pakistani Taliban known more commonly as the

⁶⁹ S. M. M. Qureshi, "Pakhtunistan: The Frontier Dispute Between Afghanistan and Pakistan," *Pacific Affairs* 39, no 1&2 (1966):99-114.

⁷⁰ Julian Schofield, "The Anatomy and Future of Pakistan's Afghan Relations," *The Journal of Conflict Studies* 28(2008), accessed March 5, 2013, <http://journals.hil.unb.ca/index.php/jcs/article/view/11248/13421.html>.

⁷¹ Syed Farooq Hasnat, "Pakistan & Afghanistan: Domestic Pressures and Regional Threats: Pakistan's Strategic Interests, Afghanistan and the Fluctuating U.S. Strategy," *Journal of International Affairs*, 63, no. 1 (2009):141-155, accessed March 5, 2013, <http://jia.sipa.columbia.edu/pakistan%E2%80%99s-strategic-interests-afghanistan-and-fluctuating-us-strategy.html>.

⁷² Abdul Hadi Mayar, "Chill in Pak-Afghan Relations," *Pakistan Observer*, April 20, 2013, accessed April 30, 2013, <http://pakobserver.net/201304/20/detailnews.asp?id=204269.html>.

Tehrik-e-Taliban Pakistan (TTP)⁷³. The TTP has strongholds in the north-western areas of the country, and several military operations have been carried out since 2007⁷⁴ to uproot the TTP from these areas with little success. The Pakistani Taliban has been implicated in many recent terrorist attacks that have taken place during the elections⁷⁵. In addition, it has claimed responsibility or been behind many bombings and attacks on religious, government, military and civilian institutes⁷⁶.

Due to the security issues facing the state, the sectors that have historically been overlooked by the government and have been given lower priority are education and health. As will be discussed in the next discussion, this is evident in both, programming and the low budget allocated to the health sector.

1.5 RUNNING PROGRAMMES ON A SHOE-STRING BUDGET: SOCIAL WELFARE IN PAKISTAN

Given Pakistan's tense geopolitical history with its neighbouring countries, the internal political disputes, the militant conflicts, and the military operations carried out within its borders, it is not surprising that the defence budget is given priority over all other sectors of the country such as education and health. According to the WHO, Pakistan spent 2.2 percent of its GDP on health in 2009; this is a slight drop from three percent spent, almost a decade ago, in 2000. In

⁷³ Amna Syed, "VIEW: Swat Operation and the role of the army," *Daily Times*, August 9, 2012, accessed March 5, 2013, http://www.dailytimes.com.pk/default.asp?page=2012%5C08%5C09%5Cstory_9-8-2012_pg3_4.html.

⁷⁴ Mount Holyoke, "Swat Valley: Timeline on Swat Valley," accessed March 5, 2013, <http://www.mtholyoke.edu/~naqvi20r/classweb/swat/Timeline.html>.

⁷⁵ Omar Waraich, "As Pakistan prepares for crucial election, the Taliban turn to force to squeeze liberals out of power," *The Independent*, April 23, 2013, accessed April 25, 2013, <http://www.independent.co.uk/news/world/asia/as-pakistan-prepares-for-crucial-election-the-taliban-turn-to-force-to-squeeze-liberals-out-of-power-8585234.html>.

⁷⁶ Ben Brumfield, "Who are the Pakistani Taliban?" CNN Website, October 17, 2012, accessed March 5, 2013, <http://www.cnn.com/2012/10/17/world/asia/pakistan-taliban-profile.html>.

2009, 34 percent of the health expenditure consisted of government funds, 65.2 percent came from the private sector whereas 4.4 percent was due to external sources⁷⁷. Based on these figures, Pakistan ranks eighty-eighth in the world in terms of health expenditure spending⁷⁸.

Many of the family planning, nutrition awareness, reproductive health, vaccination and tuberculosis programmes are partially funded by foreign donors⁷⁹. From October 1, 2009 to September 30, 2012, for instance, USAID disbursed around 196.2 million dollars in aid for health programmes⁸⁰. Other major donors include Department for International Development (DFID), the Aga Khan Foundation, the United Nations (UN), USAID, Save the Children and WHO⁸¹. The low government expenditures are partially due to the priority given to defence spending. Between 2008 and 2012, Pakistan spent at least 3 percent of its GDP on military expenditures. However, this figure probably includes only capital expenditure on army personnel including social services for personnel⁸². In addition, when one looks at the actual budget breakdown, one gets a better idea of how spending on the armed forces is favoured over social welfare programming. For instance, in last year's budget, less than two percent was marked for higher education, whereas 20 percent was allocated to the defence budget⁸³.

⁷⁷ World Health Organisation, *World Health Statistics 2012*, accessed March 5, 2012, http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html.

⁷⁸ "People and Society," Central Intelligence Agency, accessed April 20, 2013, <https://www.cia.gov/library/publications/the-world-factbook/geos/pk.html>.

⁷⁹ Talbot. *Pakistan: A New History*, 29.

⁸⁰ "Budget and Spend Plan," USAID Pakistan, updated November 28, 2012, accessed February 15, 2013, <http://transition.usaid.gov/pk/about/budget.html>.

⁸¹ World Health Organisation, *Country Cooperation Strategy at a Glance*, accessed March 5, 2012, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_pak_en.pdf

⁸² "Military Expenditure (% of GDP)," World Bank, accessed April 20, 2013, <http://data.worldbank.org/indicator/MS.MIL.XPND.GD.ZS.html>.

⁸³ Shahbaz Raza, "Proposed budget share: 2% for higher education, 20% for military," *Express Tribune*, April 15, 2012, accessed April 20, 2013 <http://tribune.com.pk/story/364865/proposed-budget-share-2-for-higher-education-20-for-military.html>.

In addition, the government generates extremely low revenue as only one percent of the country's population, approximately 2.7 million people, pays direct taxes and the tax to GDP ratio is 9 percent⁸⁴. While industries pay taxes that are three times their GDP share, the agriculture sector, despite making up about 20 percent to a quarter of the GDP, pays none. This is because landowners, who are in political power, continue to block the introduction of an agriculture income tax⁸⁵.

The government's restrained finances are compounded by the high national debt. The country's external debt in 2011 was 32 percent of the Gross National Income⁸⁶. In that same year, Pakistan's public debt was 60.1 percent⁸⁷. Even though priority is not given to social welfare programmes, public spending in this sector is all the more important given that an estimated 28.3 per cent of the population was living below the poverty line in 2011⁸⁸.

1.6 DO BACHAY HEE ACHAY⁸⁹: POPULATION WELFARE AND REPRODUCTIVE RIGHTS IN PAKISTAN

With an estimated population of 185 million⁹⁰, Pakistan is the world's sixth most populous country. At 2.2 percent, it also has one of the highest growth rates in the region,

⁸⁴ Talbot, *Pakistan: A New History*, 8.

⁸⁵ Talbot, *Pakistan: A New History*, 29.

⁸⁶ World Bank, "Summary Table 1. Key indebtedness indicators, 2009–2011," *International Debt Statistics 2013*, accessed April 20, 2013, <http://data.worldbank.org/sites/default/files/ids-2013.pdf>

⁸⁷ "The World Factbook, South Asia, Pakistan," Central Intelligence Agency, accessed April 20, 2013, <https://www.cia.gov/library/publications/the-world-factbook/geos/pk.html#>.

⁸⁸ Talbot, *Pakistan: A New History*, 29.

⁸⁹ This phrase essentially means "It's good to have just two children". The slogan was part of a Pakistani government family planning marketing campaign that became popular in the country in the nineties.

⁹⁰ Michael Kugelman, "Pakistan's Demographics: Possibilities, Perils, and Prescriptions," in *Reaping the Divide: Overcoming Pakistan's Demographic Challenges*, ed. Michael Kugelman and Robert M. Hathaway, (Washington D.C: Woodrow Wilson International Centre for Scholars, 2011), 6.

outstripping India's (1.4 percent) and China's (0.6 percent) growth rates⁹¹. Some estimates state that a 100 million Pakistanis are under 25⁹², making this one of the largest youth bulges⁹³ in the world. The country's population according to the 1951 census (which included both East and West Pakistan) was 73 million. Considering that East Pakistan separated from the country and became Bangladesh in 1971⁹⁴, the current statistics indicate that the population has more than doubled in 60 years. According to some analysts, if the growth rate continues at the present rate, Pakistan will be the world's fourth largest country in terms of population (at 335 million) by 2050⁹⁵.

Policy makers in the international development and health sectors have critiqued inefficient government-run family programmes⁹⁶ for the high growth rate⁹⁷. They point out that there is an unmet need for birth control health services in Pakistan. Based on statistics of abortion rates in Pakistan, this certainly seems to be the case. For instance, one in seven pregnancies end in abortion⁹⁸ and 200,000 women are admitted every year into the country's

⁹¹ Ibid., 59.

⁹² Moeed Yusuf, "A Society on the Precipice? Examining the Prospects of Youth Radicalization in Pakistan," Kugelman, "Pakistan's Demographics," 78.

⁹³ Youth Bulge is a technical term that refers to the phenomenon of when youth aged 15 to 29 are disproportionately larger than the rest of the population in a country. See Justin Yufi Lin, "Youth Bulge: A Demographic Dividend or a Demographic Bomb in Developing Countries?" World Bank, May 5, 2012, accessed May 9, 2012, <http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividend-or-a-demographic-bomb-in-developing-countries.html>.

⁹⁴ Talbot. *Pakistan: A New History*, 25.

⁹⁵ Ibid., 227.

⁹⁶ The discourse on high growth rates often focuses exclusively on a lack of birth control health services. However, there are myriad reasons for the high birth rate. In addition, discourses on population control are often racialised and politicized. Both these issues are explored in more detail in Section 5.2 and 5.4.

⁹⁷ Kugelman, "Pakistan's Demographics," 7-8.

⁹⁸ Zeba Sathar, "Demographic Doom or Demographic Dreams: Pakistan at the Crossroads", in *Reaping the Divide: Overcoming Pakistan's Demographic Challenges*, ed. Michael Kugelman and Robert M. Hathaway, (Washington D.C: Woodrow Wilson International Centre for Scholars, 2011), 34.

hospitals due to unsafe abortions at a cost of 22 million US dollars⁹⁹. According to Zeba Sathar, there is a 25 percent gap between demand and supply of contraceptives in the country¹⁰⁰. Family planning services is provided by both the non-profit sector (39 percent) and the government (35 percent) with 13 percent of such facilities provided by NGOs¹⁰¹. Pakistan has lagged behind its neighbouring countries in checking its population growth which can be attributed to poor reproductive health services. Bangladesh and Iran, for instance, have had far greater success in reducing fertility rates. Analysts attribute this to stronger state support for family planning programmes in these two nations as opposed to the lack of focus and funding of such programmes by the Pakistani government¹⁰². In addition, policy makers point out that a lack of integration between the ministries of population welfare and health for delivery of services has resulted in an ineffective implementation of such programmes¹⁰³.

There is also a clear need for health workers trained in medical skills of birth deliveries and other neonatal services, such as mid-wives, *dais*¹⁰⁴ or health workers who have such technical expertise. The country's total population, based on the 1998 census, was 132 million

⁹⁹ Population Reference Bureau and National Committee for Maternal and Neonatal Health (Pakistan) "Pakistan on the Move: Family Planning, Reproductive Health and Development in Pakistan," in *Reaping the Divide: Overcoming Pakistan's Demographic Challenges*, ed. Michael Kugelman and Robert M. Hathaway, (Washington D.C: Woodrow Wilson International Centre for Scholars, 2011), 48.

¹⁰⁰ Sathar "Demographic Doom or Demographic Dreams: Pakistan at the Crossroads", 33.

¹⁰¹ Saba Gul Khattak, "The Challenges of Population Policy and Planning in Pakistan," in *Reaping the Divide: Overcoming Pakistan's Demographic Challenges*, ed. Michael Kugelman and Robert M. Hathaway, (Washington D.C: Woodrow Wilson International Centre for Scholars, 2011), 152.

¹⁰² Sathar "Demographic Doom or Demographic Dreams: Pakistan at the Crossroads", 33-36.

¹⁰³ Saba Gul Khattak, "The Challenges of Population Policy and Planning in Pakistan," in *Reaping the Divide: Overcoming Pakistan's Demographic Challenges*, ed. Michael Kugelman and Robert M. Hathaway, (Washington D.C.: Woodrow Wilson International Centre for Scholars, 2011), 145-160. Khattak, "The Challenges of Population Policy and Planning in Pakistan".

¹⁰⁴ Similar to mid-wives or Traditional Birth Attendants in the West who base their medical practices on indigenous knowledge.

while the number of women is 63.4 million¹⁰⁵. Given that 53 percent of Pakistanis are above the age of 15¹⁰⁶, it means there are probably at least 30 million women who are in need of reproductive health services in the country. While there is a high demand for such services, there is a clear shortage of medical and health practitioners. In Pakistan, for every 1,000 people there are 0.063 community or traditional healthcare workers, 0.557 midwives and nurses, and 0.813 physicians¹⁰⁷. The LHWs, therefore, provide much-needed services but are neither recognised nor monetarily compensated for these contributions.

1.7 OUTLINE OF REMAINING CHAPTERS

Now that a background to the LHW programme and movement has been given, and the research study has been located within a Pakistani context, the LHW work experiences can be analysed in further detail. Before doing so, however, my subjectivities must be situated. Thus, in Chapter Two, the methodologies and research setting is discussed. The LHWs' views on their jobs and professional identities, and their relationship with the community are looked at in Chapter Three. I also locate the health workers experiences within frameworks that draw on work in a postcolonial¹⁰⁸ tradition in this chapter. The spaces and institutes the LHWs work within are analysed from a gendered lens in Chapter Four. How transnational politics has influenced and shaped the LHW programme is looked at in Chapter Five. In Chapter Six, I

¹⁰⁵ "Population by Sex, Sex Ratio, Average Household Size and Growth Rate," Population Census Organisation, accessed April 20, 2013, <http://www.census.gov.pk/PopulationSex.html>.

¹⁰⁶ "Demographic Indicators – 1998 Census," Population Census Organisation, accessed May 9, 2013, <http://www.census.gov.pk/DemographicIndicator.html>.

¹⁰⁷ "Aggregated Data, Density per 1,000," World Health Organisation, accessed April 20, 2013, <http://apps.who.int/gho/data/node.main.A1444?lang=en.html>.

¹⁰⁸ As Ania Loomba argues "it is more helpful to think of postcolonialism not just as coming literally after colonialism and signifying its demise, but more flexibly as the contestation of colonial domination and the legacies colonialism." For more details on the debates surrounding colonialism and postcolonialism, please see Ania Loomba, *Colonialism/Postcolonialism: The New Critical Idiom* (London: Routledge, 1998).

analyse LHWs' public statements, and draw parallels between the LHW discourse and rhetoric in Pakistani politics.

CHAPTER TWO

NOTES FROM THE FIELD: METHODOLOGIES, RESEARCH SETTING AND POSITIONALITIES

2.1 INTRODUCTION

In the following chapter, I give a summary of my experiences in the field and how I approached the participants. I then discuss my research setting, the Pakistani city of Karachi. In addition, I reflect on my positionality and look at the power relations that existed between me, the researcher, and my interviewees. Finally, I discuss the limitations of my study.

2.2 ON THE GROUND: A BRIEF LOOK AT FIELDWORK AND METHODOLOGY

In order to gain a better understanding of the work experiences of LHWs, fieldwork was conducted over a two-week period in December 2011 and for a four-month period from September-December 2012 in Karachi, Pakistan. The country's largest city was chosen as a research site because it is a microcosm of Pakistani society. In many ways its large population of 21 million and its unique mix of ethnicities and religious communities¹⁰⁹ encapsulate and reflect the country's population as a whole. Since case studies¹¹⁰ can often deepen the understanding of the dynamics underpinning social phenomenon and larger sociopolitical forces¹¹¹, Karachi was ideal for studying these social forces. In addition Karachi is my home 'town': given the tense

¹⁰⁹ Talbot, *Pakistan: A New History*, 24-26.

¹¹⁰ Since case studies can have many different meanings, it is necessary to unpack what I mean by this term here. Case study can be taken to mean as defined by John Gerring "an intensive study of a single unit for the purpose of understanding a larger class of (similar) units. A unit connotes a spatially bounded phenomenon—e.g., a nation-state, revolution, political party, election, or person—observed at a single point in time or over some delimited period of time." See John Gerring, "What is a Case Study?" *American Political Science Review* 98, no.2 (2004): 342 for more details.

¹¹¹ Gerring, "What is a Case Study?"

situation between the government and the LHWs I realised that it would be an advantage to choose a place where I would have a better idea of how to access areas and who to approach.

Indeed, I found that my familiarity with the city and my existing network of contacts made it easier to navigate through the atmosphere of distrust that was prevalent amongst many of the health workers and LHSs. While it would have been ideal to supplement my data of an urban setting with the work experiences of LHWs in rural areas, this was not possible due to the security situation in the interior areas of the province of Sindh. While the initial plan was to conduct interviews in both, Karachi and the province's rural areas, the escalating tensions between the Sindh Nationalists and the government made it extremely difficult to safely reach most areas and get access to participants¹¹². The highways were blocked for days at a time and the increasing violent tactics such as bombings and targeted killings adopted by Sindhi Nationalists in cities such as Hyderabad and Multan made most areas inaccessible¹¹³. Instead, I confined my research to Karachi and conducted semi-structured interviews with LHWs working in five areas: Baldia Town, Orangi Town, Soldier Bazaar, Martan Quarters and Usmania Colony. In addition, I interviewed several other actors who worked in the LHW programme in some capacity or in a related field, and were familiar with its various issues.

An initial test of the interview questions was carried out during a week-long field trip in December 2011 in Karachi, Pakistan. Based on the participants' responses, the questions were tweaked to elicit more accurate responses for the fieldwork I conducted from September-

¹¹² Ikram Junaidi, "PPP offers to talk to Sindhi Nationalists," *Dawn*, October 12, 2012, accessed December 15, 2012 <http://dawn.com/2012/10/12/ppp-offers-talks-to-sindhi-nationalists.html>; "Khairpur mourns killings of five PPP men, journalist," *Dawn*, October 9 2012, accessed December 15 <http://dawn.com/2012/10/09/khairpur-mourns-killing-of-five-ppp-men-journalist.html>.

¹¹³ Shaik, Hafiz, "AT to block highways across Sindh on the 14th," October 8, 2012, *The Nation*, accessed December 15 <http://www.nation.com.pk/pakistan-news-newspaper-daily-english-online/national/08-Oct-2012/at-to-block-highways-across-sindh-on-14th.html>.

December of 2012. Interviewees were initially found through an informal system. I emailed and got in touch with former contacts who were working in either the medical or non-profit sector, and thus knew people who were working in the LHW programme. I then interviewed the health workers as well as the people in the medical field or the non-profit sector who had worked with the LHWs or for the programme.

I avoided finding LHWs or contacting them through official channels because the evident tension between the government and healthcare workers meant the LHWs were less likely to talk openly if I did, and I did not want potential interviewees associating me with the government. Given this environment, it took me much longer than expected to gain access to LHWs and earn their trust. For instance, during my research work carried out in Baldia Town, out of the six LHWs scheduled to be interviewed, four cancelled at the last minute because their supervisors found out about the interviews and forbade them to talk to me. While there were workers that were reluctant to talk to me, over time, I found many supervisors and LHWs whose trust I was able to gain, and who talked to me very openly about the issues, and the problems they faced.

The healthcare workers were recruited through the snowball effect¹¹⁴: once I would interview an LHW, I would ask her if there was anybody else that she could think of who would be willing to be interviewed by me. Following the December 2012 targeted killings of the LHWs who were conducting polio campaigns in Karachi, Peshawar and several other cities, I conducted follow up interviews with a few participants. This was because I felt that the contrasting

¹¹⁴ Snowballing sampling can be defined as “a technique for gathering research subjects through the identification of an initial subject who is used to provide the names of other actors. These actors may themselves open possibilities for an expanding web of contact and inquiry. The strategy has been utilized primarily as a response to overcome the problems associated with understanding and sampling concealed populations such as the deviant and the socially isolated”. For a more detailed discussion see Rowland Atkinson and John Flint. “Snowball Sampling,” In *The SAGE Encyclopedia of Social Science Research Methods*, ed. Michael S. Lewis-Beck, Alan Bryman and Tim Futing Liao, 1044-45. Sage Publications Inc., 2004.

narratives, in particular, the opposing statements of the government and the LHWs that were emerging in the media highlighted the dynamics underpinning the tensions between the two parties and I wanted to explore it more.

In light of the evident tensions between the government and the LHWs, and the reluctance of many workers to talk to me, I went through great care to make sure those I interviewed felt comfortable talking to me. I would either call or text message each LHW, and give them details about who I was, my background and what my research was about. I would then go visit them and conduct face-to-face interviews only once they gave their consent on the phone. I assured complete anonymity to all my participants, and took notes instead of recording the interviews. Most health workers were uncomfortable with being recorded and often objected to it.

After the initial few objections, I chose not to ask the participants about recording the interviews as I felt it was adding a barrier between the LHWs and me¹¹⁵. By removing the recorder from the interview setting, I hoped to reduce the “distance” or “the objective separateness”¹¹⁶ between the participants and myself. Also keeping in mind that “authentic, true voices emerge only when they are minimally constrained”¹¹⁷, I wanted to ensure that this was as welcome a space as possible and that the interviewees were not constrained by time, etc. I would

¹¹⁵ Charles L. Briggs, “Interviewing, power/knowledge, and social inequality,” in *Handbook of interview research: Context and method*, eds. J. F. Gubrium and J. A. Holstein, (Thousand Oaks: SAGE, 2002): 911-22.

¹¹⁶ John W. Creswell, “Philosophical Assumptions and Interpretive Methods,” *Inquiry and Research Design: Choosing Among Five Approaches*, (Thousand Oaks: SAGE, 2007): 20.

¹¹⁷ Briggs, “Anthropology, Interviewing, and Communicability in Contemporary Society,” *Current Anthropology* 48, no. 4 (2007):554.

usually start off the interview with ‘grand-tour’¹¹⁸ questions, and then ask specific questions based on issues raised by the LHWs themselves.

A total of 25 semi-structured interviews were conducted out of which 18 of them were with the LHWs. While I have drawn from the other interviews, it is these 18 interviews that form the heart of my thesis. The interviews were conducted in Urdu as I am a native speaker of the language. The interview transcripts were analysed in Urdu and were then translated into English to be included in the thesis. While I have tried my best to translate the gist of what the workers were saying into English, there are some Urdu words/phrases for which there is no equivalent in the English language. I have retained these words as they were spoken in the interview and have left them in italics in Roman Urdu¹¹⁹ along with brief explanatory notes.

I usually conducted a combination of individual face-to-face interviews with the LHWs followed by informal group discussions with a group of three or four health workers. In addition, I took notes during both the formal interviews as well when the workers would be having informal discussions. These informal group conversations were recorded as field notes in a journal. It was often during these informal group chit-chats that some of the most revealing and relevant information would come to light. I also found that LHWs were more relaxed during these discussions, and therefore more likely to express their opinions, and what they were really thinking.

¹¹⁸ By grand-tour questions, I mean the open-ended and general questions that were asked at the beginning of the interviews. For example questions such as “Tell me about the work you do” or “What do you think about the LHW programme?” were asked. The questions were then catered or tweaked based on the participants’ responses.

¹¹⁹ The Urdu script is similar to the Arabic script. Roman Urdu is Urdu written in the English script instead of the Urdu script.

These interviews and the field notes were analysed for their content and divided into themes. The documented conversations I had with the health workers were repeatedly read and examined, and divided according to the issues facing the health workers, till a coherent thematic pattern emerged. In addition, I used secondary sources such as reports, media publications and academic journals to gain a better understanding of my data.

The health workers interviewed cut across a spectrum of ages, ethnic, educational and work backgrounds. Their ages varied from 28 to 50, and most of them, 16 out of the 17, were married or widowed with children. The majority of them were Inter¹²⁰ or Matric¹²¹ pass but a few had higher educational training. One had a master's degree, and the other one was in the process of finishing her bachelors. Two had received additional certified training as midwives. Some of those interviewed had worked for a year or two while others had been in the field for 17 or more years. Regardless of their experiences, ages or backgrounds, they all had very similar views of their work experiences.

While many expressed their opinions very vocally, others were more diplomatic, and what they had to say has compelled me to reflect on the way society values labour and the way professional identities are formed. Before delving into a detailed analysis of the interviews, however, the research setting as well as the methodologies must be discussed. Section 2.3 explores the research setting, the metropolis Karachi, and summarises the city's socioeconomic demographics while section 2.4 discusses my positionalities and research approach.

¹²⁰ Equivalent to finishing two years of college after high school.

¹²¹ Equivalent to finishing high school in Canada.

2.3 APNA¹²² KARACHI: GENDER, LABOUR AND ETHNICITIES IN THE CITY

The provincial capital of Sindh, Karachi houses Pakistan's busiest and largest international port city. The city provides 15 percent of the country's national GDP and 42 percent of the value added in large-scale manufacturing¹²³. It is Pakistan's largest megapolis by population and size as 10 percent of the country's and 25 percent of the urban population resides in this city. It is also the world's sixth fastest growing megacity with 200,000 persons or 35,000 households added per year to Karachi¹²⁴.

What Karachi is like today is a far cry from the small seaport town it was prior to Partition: the overall population ballooned by over 400 percent between 1947 and 1981 due to migrants from the both India, and from various parts of the country. From half a million residents in 1947, Karachi now 'houses', according to the most updated figures, from 2007, 13 million people. In comparison, five million people call Lahore, the country's largest second city, their home¹²⁵. As of 2005, 34 percent of Pakistanis were living in urban centres¹²⁶. By 2025, this urban population is expected to increase even more to an estimated 100 million – with 19 million in Karachi and 10 million in Lahore¹²⁷. Considering that a large portion, at least more than one-

¹²² Apna means 'our' in Urdu. Thus Apna Karachi translated to "Our Karachi" which would be similar to when people say this is "my city, or our city". This phrase is commonly found in popular culture/lingo and can be likened to phrases such as "my city, my New York" or "I heart New York".

¹²³ Arif Hasan, "Karachi," *Participatory Development: The Story of the Orangi Pilot Project-Research and Training Institute and the Urban Resource Centre*, Karachi, Pakistan, (Karachi: Oxford University Press, 2010), 16.

¹²⁴ Master Plan and Environmental Control Department, Karachi Development Plan 2000, Karachi Development Authority.

¹²⁵ Population Division of the Department of Economic and Social Affairs at the United Nations Secretariat, World Population Prospects: The 2007 Revision and World Urbanisation Prospects <http://esa.un.org/unup.html>.

¹²⁶ "Situation and trends in key indicators: Urban population by country," World Health Organisation, accessed April 20, 2013, <http://apps.who.int/gho/data/node.main.235?lang=en.html>.

¹²⁷ Talbot, *Pakistan: A New History*, 26.

third of the country's population, will be concentrated in cities within the next 12 years, studying the effects of the government's health policies in an urban setting is essential.

Affectionately called “mini-Pakistan”, Karachi, is the most heterogeneous area in Pakistan and is a melting pot of all ethnicities ranging from Punjabis and Muhajir to Hazaras. ‘Aliens’ such as Afghanis, Burmese and Bangladeshis are not counted in the official census but are estimated to number around 1.2 million or more¹²⁸. Some provinces are considered the domain of certain ethnicities: for example, the Pakthun are indigenous to Khyber-Pakhtunkhwa and the Baloch to Balochistan. However, Karachi has the third largest Pakhtun population and has more Baloch than Quetta, the largest city in Balochistan. This unique ethnic mix has contributed to the vibrant cultural cityscape but it also led to increasing ethnic conflict and struggles over land and resources. Militia-like mafias, many of which are affiliated with political parties, play a central role in these conflicts and have contributed to the violence in Karachi¹²⁹.

Given that the city is the industrial hub of the nation, it is not surprising that a large number of labour migrants, 22.11 percent, reside in Karachi. However, despite the wide industrialization, 75 per cent of the labourers work in the informal sector¹³⁰. The gender ratio of the working population is highly skewed: while only 3.5 percent of female Karachiites work, 47.82 percent of their male counterparts do so¹³¹. Thus, it is highly rare for women in the city, like the LHWs to be working, and is probably a factor in their employers' negative attitudes towards them. This aspect is explored in Section 4.3.

¹²⁸ Hasan, *Participatory Development*, 18, 19.

¹²⁹ Talbot, *Pakistan: A New History*, 26.

¹³⁰ Hasan, *Participatory Development*, 16.

¹³¹ These figures are based on the last census which was conducted in 1998 in Pakistan. For more details see “Karachi (Urban) Summary of Socio-Demographic Data”, Hasan, *Participatory Development*, 235-238.

There is an ongoing census taking place in Pakistan which started in 2011 but will not be completed till 2014. See “Census 2011” at <http://www.census.gov.pk/census2011.php> for more details.

However, women in Karachi do not lag that far behind the men when it comes to education: the male to female literacy ratio is 71.17 to 60.35 percent¹³². These figures can be misleading, and it must be kept in mind that Pakistan's Population Census Organisation defines a literate citizen as "a person who can read a newspaper and write a simple letter in any language"¹³³. In addition, in 2006, four percent of Pakistani women in the 20-64 age groups had attained upper secondary education¹³⁴ (matric and intermediate pass). This means that most of the health workers interviewed in this study are more educated than the national average.

While the programme stipulates that there is to be one LHW assigned for every 1,000 people or approximately 150 households¹³⁵, there clearly are not enough LHWs currently in employment to serve the entire targeted population in low-income semi-urban/urban areas. In 2006, approximately 60 percent of Karachi's population lived in *Katchi Abadis*¹³⁶. Thus, an estimated 8.5 million people or 1.2 million households lived in these slum areas¹³⁷. Given that there are currently 105,086 LHWs working nation-wide¹³⁸, there is clearly a shortfall of workers in the city. This means for programmes where every individual has to be targeted, i.e. in polio

¹³² Ibid.

¹³³ "Literacy Raio by Sex," Population Census Organisation, accessed April 20, 2013, <http://www.census.gov.pk/Literacy.html>.

¹³⁴ Asif Wazir, Anne Goujon and Wolfgang Lutz, Table 3.3 in "Education and Population: Closely Linked Trajectories for Pakistan," in *Capturing the Demographic Dividend in Pakistan*, ed. Zeba A. Sathar, Rabbi Royan, and John Bongaarts, (New York: Population Council, 2013), 28.

¹³⁵ Ministry of Health Government Pakistan *National Programme for Family Planning & Primary Health Care Annual Report 2007-2008* accessed January 15, 2012, <http://pakcyber.net/phc.gov.pk/Downloads/annualreports08.pdf>

¹³⁶ This literally means incomplete areas and the closest equivalent, in the West, would be slums or ghettos.

¹³⁷ Hasan, *Participatory Development*, "Populations of Katchi Abadais", Table 2.3, 19.

¹³⁸ Ikram Junaidi, *Dawn* "100, 000 lady health workers get their service regularized".

campaigns, the LHWs are expected to cover a larger area than the one they have been assigned. This adds tremendous stress to their daily work and takes away from their regular duties¹³⁹.

Now that the LHWs experience has been contextualised within the sociopolitical and health frameworks of Karachi, my own research lens must be located. My own perspective is rooted within certain socioeconomic and geographical roots, and in the following section I explore this.

2.4 THROUGH THE LOOKING GLASS: REFLECTIONS ON FIELDWORK, POSITIONALITIES AND ‘THIRD-WORLD’¹⁴⁰ FEMINISM

Donna Haraway, a noted scholar of feminism and scientific discourse, points out feminist objectivity translates to “limited locations and situated knowledge” and that “it allows us to become answerable for what we learn how to see”¹⁴¹. I agree with Haraway: my perspective is

¹³⁹ For a more detailed discussion on this, see Chapter Five.

¹⁴⁰ I have used the term ‘Third-World’ instead of the now more politically correct Global South because this word is still used in the literature discussions around feminism and I am borrowing this term, in many ways, from these scholars. I also wanted to use a word that the reader would be able recognise. I have put it in single quotes because I do not agree with the civilization hierarchy that this term denotes. But aside from that, it must be kept in mind that whether we use the term Global South or Third World or developed/developing we are still reinforcing power relations inherent in these dichotomies. It is not merely about changing the word but actively dismantling a hierarchal system.

I do not identify myself as a ‘Third World’ feminist nor do I necessarily ascribe to the fact that my viewpoints can only be defined or labeled as ‘Third World’ feminism; the closest term available in academia that ascribes to my political stance is ‘Third World’ feminist. While I am not a fan of ‘isms’, if I had to label myself or coin a phrase that would aptly describe what kind of feminist I consider myself to be, I would say that I am a Pakistani-Canadian, postcolonial, anti-state feminist. Alas, such a term does not exist.

Also, for me, feminism means working against hierarchy or oppression in any form. And I believe that equality between the genders can be attained in many ways, and working within local cultural, social and religious contexts. While Western feminists may argue that the only way to achieve equal rights is by completely stripping the systems that define women/gender in that way, I align more with postcolonial feminists who argue that there is no universal definition of woman or gender, and thus, the status of women must be located and redefined within cultural, socioeconomic and geographical locations.

¹⁴¹ “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective,” *Feminist Studies* 14, no. 3(1988): 583.

embodied within my upbringing, culture, socioeconomic class, family values, the places I have lived, and the historical and geopolitical systems that have shaped me in tangible and intangible ways.

I grew up in Karachi, and compared to a majority of my fellow city residents living in *Katchi Abadis*, I have had a privileged upbringing. I am highly educated: I am a graduate student and belong to a class of working professionals. I attended a Catholic school that was one of many institutes in the country teaching a curriculum designed by the UK-based University of Cambridge¹⁴². In our eleventh and thirteenth years of schooling, my peers and I took the board exams, the General Certificate of Education (GCE)¹⁴³ exams that were regulated by Cambridge University representatives through the British Council in Pakistan. I continued to work within or be shaped by Western pedagogy when I lived in Canada and did my undergraduate degree here. I am influenced by it even now and am writing this thesis based on frameworks and models that have emerged from a Western institute. I have approached this research based on a format designed by Western institutes such as Letter of Information and Consent Forms; concepts that are, in many ways, unfamiliar to many Pakistanis¹⁴⁴.

I cannot escape or decouple these Western influences from who I am or how I operate, I can simply acknowledge its existence. As the noted sociologist, Ashis Nandy, states “the West is now everywhere, within the West and outside; in structures and in minds¹⁴⁵”. At the same time, it

¹⁴² “University of Cambridge International Exams,” British Council, accessed April 30, 2013, <http://www.britishcouncil.org/pakistan-exams-gce-cambridge.html>.

¹⁴³ The GCE exams are available in Commonwealth countries such as Pakistan, Sri Lanka and Singapore.

¹⁴⁴ Many of the LHWs were familiar with this process but only because they have had employees from multilateral institutes such as WHO etc. interviewing or conducting surveys with them previously.

¹⁴⁵ “Rethinking Development,” International Society for Ecology and Culture, accessed April 30, 2013, <http://www.localfutures.org/issues/rethinking-development/rethinking-development.html>.

is because of the many advantages and opportunities that this system provides and has afforded me that I am able to undertake the intellectual endeavours I am pursuing today.

My roots and upbringing is Pakistani and in many ways so is my perspective. But at the same time the lens through which I see the world is also not just Pakistani but also Western¹⁴⁶. It must be kept in mind, however, that the concepts of modernity and science that have become a part of Pakistani society are not simply Western in its roots. Western science and medicine that were incorporated into society during British India were, as Gyan Prakash and David Arnold argue, indigenised, transmuted and translated by Western-educated Indians¹⁴⁷. Thus in many ways, I am the result of a knowledge system that is as much local as Western, and my perspective is as much of an insider as that of an outsider.

I consider myself neither a 'Third World' feminist nor a Western feminist but somewhere in the middle. I fall in neither the imagined categories of the East or the West. As the feminist and anthropologist, Lila Abu-Lughod, points out the 'East vs. West' dichotomy is, in itself, a social construction of colonialism, and then postcolonialism¹⁴⁸. Nevertheless, there is something to be said for the geographical and social realities within which one is bounded. Thus, what I grapple with is whether I can critique neocolonialism¹⁴⁹ when, in many ways, I am a product of

¹⁴⁶ What do I mean when I say I am a product of Western knowledge and outlook? By this term I mean the way of thinking, approaches and culture historically rooted in European countries which stems from the Enlightenment, and has been shaped by Christianity as well as the classical culture of Greece and Rome. For more details see James Kurth, "Western Civilization, Our Tradition," *The Intercollegiate Review*, 2004:5-13.

¹⁴⁷ Gyan Prakash, "Translation and Power," *Another Reason: Science and the Imagination of Modern India*, (Princeton: Princeton University Press, 1999), 49-86; David Arnold, "Introduction," *Colonizing the Body State Medicine and Epidemic Disease in Nineteenth-Century India*, (Berkeley: University of California Press, 1993): 1-11.

¹⁴⁸ Lila Abu-Lughod, "Contentious Theoretical Issues: Third World Feminisms and Identity" *Women's Studies Quarterly* 26, no. 3&4 (1998):25-29.

¹⁴⁹ There is no one definition of neocolonialism. I use this term drawing on Kwame Nkrumah's definition of neocolonialism. Nkrumah calls neocolonialism "the State which is...in theory, independent and has all

the West¹⁵⁰. This, however, is not the only inherent contradiction: as a self-proclaimed feminist, I am critiquing a masculinised, hierarchal system using the frameworks set by a masculine institute.

However, if one follows this logic that would mean if one is a product of capitalism, one cannot critique it. Or coming from a position of privilege one cannot challenge the social hierarchy one is born into. The inherent contradictions within one's self should not stop us from questioning the status quo. As Valerie Renegar and Stacey Sowards argue there is a sense of agency to be gained "from the use of contradiction as a means of self-determination and identity".¹⁵¹ I hope that by being a researcher "who refuses to speak from a position of unsituated knowledge¹⁵²" I can account for these inherent contradictions, gain a sense of ownership of my views and my work, and challenge the status quo.

Power Relations, Positionalities and Hierarchy

The lens through which one studies a social phenomenon is shaped not just by "situated knowledges"¹⁵³ but also by hierarchal structures. As the postcolonial feminist Chandra Mohanty

the outward trappings of international sovereignty. In reality its economic system and thus its political policy is directed from outside. In other words, even though the state is deemed to be independent, it is still politically and economically dependent on sovereign countries and international organisations. For more details, please see Kwame Nkrumah, *Neo-Colonialism, The Last Stage of Imperialism*, (London: Thomas Nelson & Sons, 1965).

¹⁵⁰ Rey Chow, "Where have all the Natives Gone?" in *Feminist Postcolonial Theory*, ed. Reina Lewis, (London: Taylor and Francis: 1994), 324-352.

¹⁵¹ Valerie R. Renegar and Stacey K. Sowards, "Contradiction as Agency: Self-Determination, Transcendence, and Counter-Imagination in Third Wave Feminism," *Hypatia*, 24, (2009) (2): 1.

¹⁵² Abu-Lughod, "Writing against Culture," in *Recapturing Anthropology*, ed. Richard Gabriel Fox, (Santa Fe: School of American Research Press, 1991): 137-163.

¹⁵³ Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14 no. 3 (1988): 581.

emphasizes “feminist scholarly practices exist within relations of power”¹⁵⁴. This is not only inherent in the interpretation of their findings but also in the field such as face-to-face interviews and interactions with research participants. As several scholars state, power relations are inherent in any social interactions, including interviews, and in these instances it is the researcher who is likely to be in a more powerful position than the interviewee¹⁵⁵. Keeping this in mind and to mitigate the unequal power dynamics, I made myself as open as possible to questions by the interviewees. I would also give the participants my local contact information, in addition to the Queen’s University contact. I felt that this would make me more accessible and, thus, more ‘accountable’ to them. I also felt that this put me on a more equal footing with my participants. I also allowed great say in how the interviews were conducted. As previously mentioned the recording of the interviews was stopped at their request, and I took extra measures to ensure they were comfortable and willing to talk to me. I also took great care to ensure that they were interviewed at a location and time with which they were at ease. The interviewees choose the place of the interview whether it was their homes, clinics or any other public space.

Nevertheless, I was aware during the interview process, that there were many factors at play, and there might be things that they could have said to me but did not because I was from a different socioeconomic class, educational or professional background than them. As Manderson et. al point out “no two interviews are alike: Each is the unique outcome of the characteristics of the individuals and the uniqueness of the time and place in which they interact. Yet, structural factors, including class, gender, and age, also shape the relationships of the research participants

¹⁵⁴ Chandra Talpade Mohanty, “Under Western Eyes: Feminist Scholarship and Colonial Discourses,” *Feminist Review* 30 (1988): 62.

¹⁵⁵ Briggs, “Interviewing, power/knowledge, and social inequality”: 911-22.

and the process of interviews”¹⁵⁶. While I have tried my best to temper all the various factors that are at play, it must be kept in mind that this research and analysis is the product of someone of my positionality.

2. 5 CONCLUSION: LIMITATIONS OF THE STUDY

As discussed in the last section, what the interviewees said to me was determined by my positionality as a researcher. Thus, it is possible there is relevant information that did not come to light due to the dynamics of the researcher-participant relationship. While I have tried my best to mitigate these limitations, there are always some barriers that cannot be completely overcome. In addition, I interviewed a small sample of health workers. As mentioned in Chapter One, there are at least a 100,000 LHWs working country-wide in Pakistan. Out of these workers, I have only drawn on the experiences of 18 workers. My study was also restricted to one region of Pakistan, the city of Karachi. The metropolis can be considered a microcosm of the nation in terms of its ethnic, cultural and linguistic diversity¹⁵⁷. Nevertheless it is only a small part of a culturally, linguistically and geographically diverse country¹⁵⁸. Thus, due to the study’s small sample and the limited areas it was carried out in, all of my research cannot be generalised¹⁵⁹ and applied to every area of Pakistan.

Many of the issues that were brought up during the interviews and that are discussed in Chapter Three such as low wages, untimely delivery of salaries and a high work load have been

¹⁵⁶ Lenore Manderson, Elizabeth Bennett and Sari Andajani-Sutjahjo, “The Social Dynamics of the Interview: Age, Class, and Gender,” *Qualitative Health Research* 16, no. 10 (2006): 1317-1334.

¹⁵⁷ Hasan, *Participatory Development*, 18, 19.

¹⁵⁸ Sean Sheehan and Shahrezad Samiuddin, *Cultures of the World: Pakistan*, (New York : Benchmark Books, 2004),85.

¹⁵⁹ David F. Hultsch et al., “Sampling and generalisability in developmental research: Comparison of random and convenience samples of older adults,”*International Journal of Behavioral Development* 26, no. 4 (2002): 345–359.

documented in studies conducted in other parts of the country¹⁶⁰, as well as in the mass media¹⁶¹, and can be generalised. In addition, this aspect of the research adds to the existing literature on LHWs. Other issues regarding professional identities and the effect of the polio campaign on the LHWs' work experiences and work-related stress warrant further study. These issues are discussed in Chapter Four and Five respectively, and are aspects of the health workers' experience that are rarely discussed in the literature on LHWs.

While this study did not cover large areas of Pakistan, or had a statistically significant number of participants, I do believe there is value in this type of research. The small sample size of this study allowed me to conduct in-depth interviews, and the work experiences of LHWs in more detail than would be possible in a study with a larger number of participants¹⁶². As, pointed out by the scholars Mira Crouch and Heather McKenzie, "it is in the nature of exploratory studies to indicate rather than conclude"¹⁶³. In many ways this research is similar in its aim. The lived experiences of the LHWs that I have documented in this thesis merely indicate the various complex issues facing health workers that can and should be studied in more detail.

¹⁶⁰ Hafeez et al., "Lady health workers programme in Pakistan, Oxford Policy Management "*Lady Health Worker Programme: Third party Evaluation of Performance*.

¹⁶¹ Kundi, "Factors making LHWs say enough is enough"; "A long struggle," *Dawn*.

¹⁶² As pointed out by many researchers, qualitative descriptions and an indepth interaction with participants can reveal important or relevant results/findings that may have been missed in larger studies or quantitative research. Margaret H. Kearney for instances states "Observations, informal conversations, interviews, and document analyses used together can capture each participant's unique and context-specific viewpoint and story embedded in its cultural and historical milieu. It is not expected that these embedded stories, relatively few in number, represent all individuals...instead, each personal constellation is a set of findings unto itself, from which conclusions about similar combinations may be drawn." For more details see Margaret H. Kearney, "Going Deeper Versus Wider in Qualitative Sampling", *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 36, no. 4(2007): 299. Also see, Margarete Sandelowski, "Focus on Research Methods: Whatever Happened to Qualitative Description?" *Research in Nursing & Health* 23 (2000): 334-340, and Mira Crouch and Heather McKenzie, "The logic of small samples in interview-based qualitative research," *Social Science Information* 45, no. 4 (2006): 483 – 499.

¹⁶³ Crouch and McKenzie, "The logic of small samples," 492.

CHAPTER THREE

LABOUR OF LOVE: PROFESSIONAL IDENTITIES AND GENDERED HEALTH CARE

3.1 INTRODUCTION

As mentioned in Chapter One, LHWs are paid half of what workers with similar skills are paid in other fields in Pakistan. For instance a clerk in Pakistan earned Rs. 13, 649 (136.49 CAD)¹⁶⁴ per month in 2011. LHWs monthly salaries, in comparison, were Rs. 7,000 (70 CAD)¹⁶⁵ in the same year. They are paid even less than their peers working in the same labour sector as them. For instance, the average monthly wages of a woman working in personal or community service sector in 2011 was Rs. 8, 912 (89.12 CAD)¹⁶⁶. Why are LHWs remunerated less relative to their peers? In this chapter and the next, I look at why the health workers labour is valued so little and why they have struggled for professional recognition.

In the first half of this chapter, I explore the labour feminists' and economists' debates on labour and wages in relation to the LHWs' work experiences. The value of the labour LHWs provide is discussed from two perspectives: the labour economists' and the health workers'. In the second half of this chapter, I discuss how LHWs' themselves view their profession and how they value the work they do. In addition, I show that the professional value, wages and

¹⁶⁴ The wages are loosely based on the average of the 2013 currency exchange rate. Throughout this thesis when I have referred to any wages in rupees, I have converted its equivalent in CAD based on this exchange rate.

¹⁶⁵ "LHW" National Programme for Family Planning and Health Care Ministry of Health Government of Pakistan, accessed January 25, 2011, <http://pakcyber.net/phc.gov.pk/site/lady-health-workers.html#5>

¹⁶⁶ Pakistan Bureau of Statistics, *Labour Force Survey 2010-11*, accessed March 5, 2013, http://www.pbs.gov.pk/sites/default/files/Labour%20Force/publications/lfs2010_11/results.pdf

prestige¹⁶⁷ associated with work is shaped not just by economic factors but also by social and historical ones.

3.2 PAID TO CARE: HOW LABOUR IS VALUED

Neoclassical economists argue wages are determined by the supply and demand of human capital in the job market¹⁶⁸. That is, if the employer is looking for a labourer with a certain set of skills, and individuals possessing those qualifications are in low supply, the employer will pay higher wages to the worker. For example, if there is a need for educated managers in the market and there is a low supply of qualified, educated managers, employers will increase the wages to attract the needed labour. If there is an excess supply of such managers, on the other hand, employers will lower the wages¹⁶⁹.

As many economists and feminists labourers have argued since then, this is a highly simplified model to explain the discrepancy between wages earned by workers in the job market. Many economists, for example, point out that the inequalities in wages arise due to the difference in negotiating power of workers¹⁷⁰. In addition, segmentation theorists, argue that the employers market is not uniform but is divided or segmented into primary and secondary sectors. The working conditions are different in both sectors. Workers in the primary sector are provided with stable jobs, require a high level of skills and are paid high wages. Those working in the secondary sector are paid low wages, provided little or no training, and need to possess little or

¹⁶⁷ Over here, prestige is defined as “the social expression of the labor value given up by subjects to institutions and their agents in return for the perceived security of (occupational) privilege”. See Stephen Shapiro, “Intellectual Labor Power, Cultural Capital, and the Value of Prestige,” *South Atlantic Quarterly* 108, no. 2 (2009): 250.

¹⁶⁸ Oren M. Levin-Waldman “From a Narrowly Defined Minimum Wage to Broader Wage Policy,” *Review Of Social Economy* 69, no. 1 (2011):77-96.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

no skills to do the job. The secondary sector is dominated by minorities and women, and there is little incentive for people to stay at these jobs¹⁷¹.

Labour feminists¹⁷² agree with segmentation theorists, and argue that the market discriminates against women, and is segmented by gender with men working in more prestigious job positions than women¹⁷³. Feminist economists have debated on why this is. According to devaluation theorists, women are paid less than men due to the gender bias of employers. That is managers see work positions or occupations dominated by women as less valuable. These occupations are eventually seen as feminine and those working feminine jobs are therefore remunerated less than their counterparts working masculine jobs. That is, in the eyes of the employer, the jobs that require feminine skills such as face-to-face interaction, care of the elderly or children, or emotions are valued less than masculine skills¹⁷⁴. Devaluation theorists would, therefore, argue that the reason LHWs are compensated so little is because their jobs are viewed as feminine. Other theorists argue that low pay and undesirable jobs become feminised. According to these scholars, while both men and women desire to work in prestigious, well-paying jobs; managers, due to their gender bias, prefer hiring men. Thus, a crowding-out effect

¹⁷¹ Michael Reich, David M. Gordon and Richard C. Edwards, "A Theory of Labor Market Segmentation," *The American Economic Review* 63 no. 2 (1973): 359-365.

¹⁷² See, for example, Paula England, *Comparable Worth: Theories and Evidence*, (New York: Aldine de Gruyter, 1992) ; Barbara F. Reskin and Patricia A. Ross, *Job Queues, Gender Queues: Explaining Women's Inroads into Male Occupations* ed. Barbara F. Reskin and Patricia A. Ross, (Philadelphia: Temple University Press, 1990); Elaine Joy Sorensen, *Comparable Worth: Is It a Worthy Policy?* (Princeton: Princeton University Press, 1994).

¹⁷³ Paula England, "Gender Inequality in Labour Markets: The Role of Motherhood and Segregation," *OUP Journals*, (2005):264-288.

¹⁷⁴ Elaine Joy Sorensen, "Is the Underpayment of 'Women's Work' Discrimination?" *Comparable Worth: Is It a Worthy Policy?* (Princeton: Princeton University Press, 1994): 42-57; Ronnie J. Steinberg, "Comparable worth in gender studies" in *International Encyclopedia of the Social and Behavioral Sciences*, Vol. 4 ed. Neil J Smelser, Paul B Baltes, (Oxford: Cambridge University Press, 2001), 2393–2397.

takes place where men are hired over women for the high-salaried jobs, and women are compelled to choose the more undesirable jobs¹⁷⁵.

Care work is considered feminine labour¹⁷⁶ and other theories have emerged to explain the low wages prevalent in the field. The ‘public good’ framework argues that caring for the elderly, the sick or children is a form of public good that is not rewarded by the market. The ‘prisoner of love’ theorists argue that health workers have less negotiating power because they become emotionally attached to the people they care for. That is, they are reluctant to go on ‘strike’ or refuse to work because they care too much about the people they serve. The commodification of emotion theory shows how exploitative and extractive it is to sell emotional labour. The ‘love and money’ framework posits that people will not genuinely care for someone if they are compensated well¹⁷⁷.

Many academics argue that care workers are not given high wages because of the way the market is structured¹⁷⁸. For instance, Nelson argues that there is an “under-demand” for care work because the “major direct recipients of intensive care-giving are often too young, too old, too sick or too poor to be able to turn their desires into effective demand on the private market”¹⁷⁹. Himmelweit, on the other hand, argues that since the marginal returns of labour of care workers is limited due to the nature of their work, employers “resist wage rises” as this

¹⁷⁵ Barbara F. Reskin and Patricia A. Ross “Part I: Explaining the Changing Sex Composition of Occupations,” in *Job Queues, Gender Queues: Explaining Women’s Inroads into Male Occupations* ed. Barbara F. Reskin and Patricia A. Ross, (Philadelphia: Temple University Press, 1990), 1-69. ; Myra H. Strober and Carolyn L. Arnold, “The dynamics of occupational segregation among bank tellers,” in *Gender in the Workplace* ed. Clair Brown and Joseph A. Pechman, (Washington DC: Brookings Institution: 1987), 107–148.

¹⁷⁶ Paula England, “Emerging Theories of Care Work,” *Annual Review of Sociology*, 31(2005): 381-399

¹⁷⁷ Ibid.

¹⁷⁸ Julie A. Nelson, “Of markets and martyrs: Is it OK to pay well for care?” *Feminist Economics* 5, no. 3 1999: 43–59; Susan Himmelweit, “Can we afford (not) to care: prospects and policy?” in *New Working Paper Series*: 15, (London: Gender Institute, 2005): 1-45.

¹⁷⁹ Nelson, “Of markets and martyrs”: 56.

drastically cut into their profits¹⁸⁰. What is often ignored in these debates is that low wages can lead to lower motivation and poorer quality of healthcare¹⁸¹ which are measurable indicators, and which can be accounted for in wages. Indeed, on-the-field accounts show that even though LHWs enjoy their work, the stress, and the low and irregular pay has made them dislike their jobs. If alternatives were available, many LHWs, given their poor working conditions would quit their existing jobs.

How LHWs are Affected by their Pay

LHWs are not only paid less than their peers, often their salaries do not come on time. Some of the workers I interviewed were not the breadwinners of their families, and therefore did not absolutely need money at the end of the month. Some pooled in their earnings with their husbands, and it was these combined wages that allowed the couple to financially support their families. Others, however, were the sole earners in their households, needed their salaries to pay the bills, and often had to resort to loans to make ends meet.

One of the LHWs, Tanya¹⁸², points out their salary is not a livable wage to support a family:

“Everything is so expensive now; in 7,000 [rupees] [70 CAD] for a woman who has 5 children – and no husband) – in 7,000 [70 CAD] how do you make ends meet? For so many months, the salary hasn’t come – three months salary is still due. It’s the third month now [without pay]. I’d be happy when the salary is increased, when the salary becomes regular. I am happy with the job but just not with the salary.¹⁸³”

¹⁸⁰ Himmelweit, “Can we afford”: 8.

¹⁸¹ Adzei and Atinga, “Motivation and retention of health workers”: 467-485; Leiter, Harvie and Frizzell, “The Correspondence of Patient Satisfaction and Nurse Burnout.”: 1611-1617.

¹⁸² To protect the privacy and safety of the interviewees, throughout this thesis, the interviewees have been given pseudonyms.

¹⁸³ Participant 3, LHW, in discussion with the author, September-December 2012.

Shiza agrees with Tanya, stating that “if you go according to the expenses, it’s nothing”¹⁸⁴. Maheen, a LHS, also has similar concerns, emphasizing that “dual jobs are not allowed but how will we manage the household budget otherwise? We can’t starve for three months, now can we? Usually after three years, those on a contract, they are made permanent but they didn’t do that with us.”¹⁸⁵

It is, however, not just the low wages but the untimely delivery of their salaries that has contributed to the LHWs’ stress¹⁸⁶. During one interview session at a clinic in Soldier Bazaar, news broke that the workers’ salaries had finally been deposited into their bank accounts. The LHWs were impatient to finish off their interviews and head over to the bank as soon as possible. They grew so restless that I cut the interviews short and offered to drive them to the bank. Not knowing when their salaries will come has added to the workers’ worries and leaves them very anxious. The low wages and the untimely salary payments was the one job-related factor that seemed to cause the most stress to the workers.

Many workers who were the only wages earners in their households had to resort to taking out loans to make ends meet. “They don’t give it on time. They give it after 2 to 3 months. I have to take out loans and then return them because my pay doesn’t come on time,” says Parveen¹⁸⁷. Similarly, Nadia says, “I have a lot of problems because the salary isn’t regular. I take loans from my brothers and sisters”¹⁸⁸.

The low pay not only adds stress but has also contributed to the LHWs’ low morale. The fact that less educated and skilled workers are paid more than health workers has created

¹⁸⁴ Participant 11, LHW, in discussion with the author, September-December 2012.

¹⁸⁵ Participant 4, LHW, in discussion with the author, September-December 2012.

¹⁸⁶ Based on interviews conducted with the LHWs by the author, September-December 2012.

¹⁸⁷ Participant 6, LHW, in discussion with the author, September-December 2012.

¹⁸⁸ Participant 16, LHW, in discussion with the author, September-December 2012.

resentment amongst some of the LHWs. Maheen, for instance, states “maids earn more than me. Team’s [Polio team] pay has increased but they have decreased ours. It’s not easy to get [another] job. Who will give us one?”

The stress and demoralisation that accompanies low wages has made workers dislike their jobs. Studies indicate that health workers who enjoy their jobs deliver better care¹⁸⁹. Thus, the LHWs’ low wages and stress has probably affected their job performance. Whether and how much of an effect the workers’ wage-related stress has on patient care is outside the scope of this study but it is a factor that should be looked into further.

LHWs and their Relations with the Community

Public good theorists argue health workers provide “benefits that go far beyond the direct recipient” that cannot be captured by their wages without state intervention¹⁹⁰. Based on interviews, it does seem that LHWs do provide such public goods for which they are not remunerated. For instance, LHWs cultivate personal bonds with their patients, and give back to their communities in numerous ways. The workers’ interest in their patients goes beyond the job description. “We go to a woman’s house 10 times and that is when she goes to the clinic,” says Sabeen, one of the health workers¹⁹¹. Others have taken this a step further and arranged for medical aid for entire neighbourhoods that they work in. Tehmina, for instance, noting how poor

¹⁸⁹ Adzei and Atinga, “Motivation and retention of health workers in Ghana’s district hospitals,” 467-485; Leiter, Harvie and Frizzell, “The Correspondence of Patient Satisfaction and Nurse Burnout.”: 1611-1617.

¹⁹⁰ England, “Emerging Theories of Care Work”: 395; Paula England and Nancy Folbre, “Care, inequality and policy,” in *Child Care and Inequality: ReThinking Carework for Children and Youth* ed. Francesca M. Cancian, Demie Kurz, Andrew S. London, Rebecca Reviere, Mary C. Tuominen, (New York:Routelage, 2002): 133-144.

¹⁹¹ Participant 8, LHW, in discussion with the author, September-December 2012.

people cannot afford to take time out from their busy schedule to go to a clinic, organised free medical camps in the area she works in:

“There should be medical camps and free checkups [for patients]. Poor people they rarely leave [their homes/work to go to a clinic] because they say it takes time. There are such camps in other areas and I arrange similar ones in my area. There is a family planning hospital here and I get medicines from them because I talk to them [have cultivated a relationship with them]. We are not allowed to do this [arrange for medical camps] but I do as much as I possibly can.”¹⁹²

Another health worker, Tanya, distributed medicines for free in her neighbourhood even before she joined the LHW programme. Pointing out that the free medicines that came with being an LHW was an added ‘benefit’ for her, and was part of the reason she became an LHW, she states:

“When I moved here, for five years, when I worked as a midwife, I bought medicine from the store and I delivered it [to the patients] for free. When my husband was alive – he worked for Brooke Bond – I didn’t lack for anything. Then, I would treat for free sometimes. When my husband fell sick so then I thought why not [train for the LHW programme]? They give training, you get to learn something or the other and the medicines, I’d get for free.”¹⁹³

Gul, states how the job has allowed her to be more involved in the community and in keeping the neighbourhood clean. “Our area is very unclean. The men are in charge. The men of the community have formed a committee. My husband is part of the committee and I get him to push them to clean the area; there is sewage or trash [everywhere]”, she says¹⁹⁴.

Thus, LHWs provide far more services and public good than they are paid for but their productivity and the benefits they provide are not captured by the wages they are paid. In addition, their wages are not calculated based on the quality of care that they provide which is a measurable indicator. So far, the LHWs’ discrimination of wages has been discussed from the economic perspective. In the next section, I look at LHWs’ construction of professional identities

¹⁹² Participant 7, LHW, in discussion with the author, September-December 2012.

¹⁹³ Participant 3, LHW, in discussion with the author, September-December 2012.

¹⁹⁴ Ibid.

and how their struggle to be recognised professionally can be explained by social and historical factors.

3.3 SETTling FOR LESS: REFLECTIONS ON WORK, PAY AND SELF-WORTH

Several scholars argue that inherent within the constructions of identities are power relations, and that identities are political in nature¹⁹⁵. Thus, what others label individuals as, or how they view themselves reveal volumes about the power structures that people operate within. By reconstructing one's identity, individuals resist not just the labels that have been imposed on them but also the hierarchal systems of which they are a part of. As Stuart Halls states, "Identities are about...becoming rather than being; not 'who we are' or 'where we come from', so much as what we might become, how we have been represented and how that bears on how we might represent ourselves."¹⁹⁶ In the next few sections, I look at LHWs' construction of their professional identities¹⁹⁷. I then locate these discussions within the context of Pakistan's social and medical hierarchy.

A Perceived Lack of Identity

LHWs long to be viewed as medical professionals and grapple with their perceived lack of identity. "We don't have an identity. We are just LHWs. We don't even have ID cards. We are

¹⁹⁵ Mary P. Sutphen and Bridie Andrews, "Introduction" in *Medicine and Colonial Identity*, ed. Mary P. Sutphen and Bridie Andrews, (London: Routledge, 2003), 1-13.

¹⁹⁶ Stuart Hall, "Who Needs 'Identity'?" in *Questions of Cultural Identity* ed. Stuart Hall and Paul du Gay, (London: SAGE, 2003): 4.

¹⁹⁷ Over here, professional identity can be taken to mean "one's professional self-concept based on attributes beliefs, values, motives, and experiences". Holly S. Slay and Delmonize A. Smith "Professional identity construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities," *Human Relations* 64 no. 1(2011):86.

in need of a card. How would you know that we are LHWs if you had just met us?” Sabeen¹⁹⁸, points out in a matter-of-fact tone. She is not the only one to tell me so. During my fieldwork, the health workers would lament that they do not have an identity card suggesting that having a card would somehow give them the much sought after validation of being a professional.

Many workers would often give the example of having no ID card as proof of the lack of importance given to them by their employers. An ID card is important for practical reasons especially since people approached in the neighbourhood are able to verify who the LHWs are. However, there was a keen interest with this object for practical reasons and due to the level of professionalism the ID card represented. For the health workers, it seemed that an ID card equated to an acknowledgement of their work’s importance. The LHWs who worked for the polio campaigns also had no ID cards but recently some workers had been issued one. At one of the clinics where I was conducting interviews, during the tea break Gul¹⁹⁹ pulled out a card, and Tanya²⁰⁰ who was also there keenly looked it over. Tanya wanted to get a card for herself as well and quizzed Gul on how she managed to get an ID card. Similarly, when I was interviewing a group of workers, Nida²⁰¹, Sania²⁰², Zehra²⁰³ and Nadia²⁰⁴ at one of the LHWs’ homes, the discussion, at one point, turned to how they needed to have an ID card. One of the younger members, who had recently joined and been issued a card, whipped it out of her bag. They all passed it around, inspecting it and commenting on it. While it may seem insignificant to an outsider, an ID card was important to them because it is associated with a level of

¹⁹⁸ Participant 8, LHW, in discussion with the author, September-December 2012.

¹⁹⁹ Participant 2, LHW, in discussion with the author, September-December 2012.

²⁰⁰ Participant 3, LHW, in discussion with the author, September-December 2012.

²⁰¹ Participant 13, LHW, in discussion with the author, September-December 2012.

²⁰² Participant 14, LHW, in discussion with the author, September-December 2012.

²⁰³ Participant 15, LHW, in discussion with the author, September-December 2012.

²⁰⁴ Participant 16, LHW, in discussion with the author, September-December 2012.

professionalism. It is not domestic workers or labourers who carry around a piece of ID but those who are employed in offices or institutes which are *masculine* spaces²⁰⁵ and are seen as far more prestigious. Thus, there is a clear association between ID cards and professional status among the LHWs.

Expressing regret over not having an ID card, however, is not what really upset the workers. It is what a lack of ID represented; that not having a card meant the LHWs do not matter. “We are nothing,” says one worker poignantly²⁰⁶. It is as if they have been erased from the public imagination, that they are invisible members. In fact, they are often treated just as such. One LHW mentioned how when they would go to the hospital dispensary for medicines, “they [the hospital staff] act as if they don’t know us. We don’t even have an identity”²⁰⁷.

LHWs Comparing their Work to Other Professionals

Just like the LHWs express their lack of importance through them not being acknowledged as professionals, they would often point out how valuable their work is by comparing themselves to medical professionals, in particular, doctors. Tanya, who works part-time as a mid-wife as well, and has been in the field for over 13 years, proudly pointed out to me “there are a lot of clinics but the women come to my clinic [health house]. There is a clinic run by [a local doctor] near my house but when there is a delivery case at his clinic, he calls me to come in and deal with the patient. I am the one who delivers the baby”²⁰⁸. Thus, Tanya is not just proud that she is seen as a good mid-wife and that the women in her community trust her and

²⁰⁵ Daphne Spain, “Gendered Spaces and Women's Status,” *Sociological Theory* 11, no.2 (1993): 137.

²⁰⁶ Participant 12, LHW, in discussion with the author, September-December 2012.

²⁰⁷ Participant 10, LHW, in discussion with the author, September-December 2012.

²⁰⁸ Participant 3, LHW, in discussion with the author, September-December 2012.

seek her care, it is because she is sought out by a doctor. Working alongside a doctor in a clinic, it seems, validates the work she does, and positions her as a valued working member of society.

Tanya is not the only one who expressed how good a healthcare provider she is by comparing herself to doctors. Other LHWs often drew the same analogy when emphasizing the importance and worth of their work. As one worker put it succinctly “We do give more [in terms of work] than doctors but we are paid less”²⁰⁹. Similarly, Zehra states: “I really liked this field; in this field you are constantly in touch with and get to know mothers and children. I had always wanted to become a doctor and this way I was able to achieve my lifelong wish.”²¹⁰ Thus, for many LHWs, their contributions and what they provide is considered just as good as what other healthcare practitioners, particularly doctors, provide.

For others, becoming an LHW was the default career they took because they could not become doctors as it was proving too difficult to do so due to financial or personal reasons. As Gul told me one morning at the clinic, “I didn’t become a doctor because I had to take care of the children. Because the work is in the same area, it is easy to take care of the kids”²¹¹. Similarly, Yusra reminisced that, from a young age, she had “wanted to become a doctor or a nurse [but] the *halaat* [circumstances] were such that what could I do?”²¹² Thus, while being a doctor is far more prestigious and the profession they aspired to, being an LHW was considered as good enough, in the sense that they are still able to interact with patients.

While LHWs see their job as part of a spectrum that stretches from doctors to nurses to the work that they do, it seems, the job market, their employers and the medical community do

²⁰⁹ Participant 8, LHW, in discussion with the author, September-December 2012.

²¹⁰ Participant 8, LHW, in discussion with the author, September-December 2012.

²¹¹ Participant 2, LHW, in discussion with the author, September-December 2012.

²¹² Participant 5, LHW, in discussion with the author, September-December 2012.

not. The question that then arises: Why is this so? Labour feminists²¹³ would argue that this is because LHWs, which is a female-dominated profession, is seen as feminine, and that feminine jobs are devalued in the market²¹⁴. Although this may be true of many Western countries, in the subcontinent, the healthcare for women has always been the domain of women. That is, in the West, the professionalisation of childbirth and the rise of the obstetrics profession meant that the work became the domain of male professionals. Gradually healthcare services such as childbirth shifted from female traditional birth attendants or midwives who historically managed such services to hospitalized services²¹⁵. In South Asia, including Pakistan, however, it was women who led the professionalisation of childbirth. Thus, can it really be seen as *masculine*? Or is there something more nuanced at work? In the following section, I explore these issues in further detail and look at the professionalisation of childbirth through a lens that draw on work in a postcolonial tradition.

3.4 LADY DOCTORS VS *DAIS*²¹⁶: A HISTORY OF MEDICAL HIERARCHIES

In 1988, when it became public knowledge that Benazir Bhutto, who was leading the agitation against General Zia, was pregnant, the military dictator gave the green light for elections thinking that Bhutto would not campaign²¹⁷. He was proven wrong. As the celebrated politician, who went on to become the first and (until now) only woman to serve as Pakistan's

²¹³ See England, *Comparable Worth: Theories and Evidence*, 40; Reskin and Ross, *Job Queues, Gender Queues: Explaining Women's Inroads into Male Occupations*.

²¹⁴ Ibid.

²¹⁵ Cecilia Van Hollen, *Birth on the Threshold. Childbirth and Modernity in South India* (Berkeley: University of California Press, 2003), 13, 15, 32.

²¹⁶ Similar to mid-wives in the West who base their medical practices on indigenous knowledge.

²¹⁷ "Women in Power reveal what it takes: Benazir Bhutto, Former Prime Minister of Pakistan; Pregnancy and Politics," BBC, accessed April 1, 2013, http://www.bbc.co.uk/worldservice/people/features/wiwp/statcon/bhutto_pro3.shtml.

prime minister²¹⁸, stated “General Zia called the first democratic elections since 1977 when he learned that I was pregnant, thinking that a pregnant woman couldn’t campaign, I could, I did and I won so that disproved that notion”²¹⁹.

That Bhutto campaigned while pregnant, however, is not the only aspect where she defied the norm. It was also the kind of healthcare she sought out during her pregnancy. Back then, the politician’s personal life was a source of speculation in the media and the public, so it caused quite a stir when it was revealed that her gynecologists was Lady Dufferin Hospital’s Dr Faridoon Sethna, a male doctor²²⁰.

Even now, female doctors, especially female gynecologists have an advantage over their male counterparts as women prefer seeing female doctors. As Papanek points out the “lady doctor is an urban phenomenon” and there is a certain prestige associated with women in the field of medicine and pedagogy²²¹. This is reflected in the popularity of doctors and teachers as career choices for women. Currently 80-85 percent of students in Pakistan medical schools are female. However, it should be noted that the number of those that end up practicing as doctors is still low. For instance, according to the Pakistan Medical and Dental Council, of the 132,988 doctors registered with them, 58,789 are women²²².

²¹⁸ “Women in Power reveal what it takes: Benazir Bhutto, Former Prime Minister of Pakistan; Brief Biography” BBC, accessed April 1, 2013, http://www.bbc.co.uk/worldservice/people/features/wiwp/statcon/bhutto_pro2.shtml.

²¹⁹ “Women in Power, Pregnancy and Politics,” BBC, accessed April 1, 2013, http://www.bbc.co.uk/worldservice/people/features/wiwp/statcon/bhutto_pro3.shtml.

²²⁰ “Child No. 2,” *Orlando Sentinel*, October 25, 1989, accessed April 20, 2013, <http://articles.orlandosentinel.com/keyword/pakistani-prime.html>.

²²¹ Hannah Papanek, “Purdah in Pakistan: Seclusion and Modern Occupations for Women,” *Journal of Marriage and Family* 33 (1971), 525.

²²² Rebecca Santana, “Pakistan’s Medical Schools – Where the Women Rule,” *AP*, April 19, 2013, accessed April 20, 2013 <http://bigstory.ap.org/article/pakistans-medical-schools-where-women-rule>.

The demand for healthcare practitioners catering to women being female is not a new phenomenon. Rather, it has been so historically since the biomedicalisation²²³ of childbirth in pre-Partition India. Unlike in the West, where childbirth shifted from taking place at home under the supervision of a midwife to “hospitalized births...with male obstetricians in charge”, in the subcontinent obstetrics has never been the domain of men²²⁴. Why this is so will be discussed in the next section.

A History of Western Medicine in South Asia

The biomedicalisation of childbirth and the rise of allopathic²²⁵ medicine as the dominant form of medical treatment under pre-Independence India took place under a public welfare movement that arose in the West during the industrial revolution²²⁶. At the turn of the twentieth century in Europe and the United States of America (USA), discourse on public health was focused on depopulation and high infant mortality rates. Governments designed and funded programmes that addressed issues of population and birth control. Historians have traced this increasing ‘concern’ of the state to the dominance of capitalism. In particular, a healthier and

²²³ Over here I take biomedicalisation to be the process that is derived from Western medical expertise which becomes the “relevant basis of decision making” under most circumstances and settings. See Arthur Frank in Van Hollen, *Birth on the Threshold*, 11.

²²⁴ Van Hollen, *Birth on the Threshold*, 13, 15.

²²⁵ Allopathic medicine refers to contemporary “clinical medicine based on the principles of physiology and biochemistry” that initially emerged in the West. In Pakistan, the allopathic medicine would refer to the biomedical practices that were introduced into pre-Partition India during colonisation of the subcontinent. Allopathic doctors, in turn, would be used for those health practitioners who have trained in medical colleges based on the medical model introduced by the British during colonial India or have been educated in medical colleges that were established during colonial India. For more details please see: Kenton Kroker, “Historical keyword Biomedicine,” *The Lancet* 371, no. 9630 (2008): 2077; Roger Jeffery, “Allopathic Medicine in India: A Case of Deprofessionalisation,” *Economic and Political Weekly* 13, no. 3 (1978): 101-113.

²²⁶ Maneesha Lal, “The ignorance of women is the house of illness: Gender, nationalism and health reform in colonial north India,” in *Medicine and Colonial Identity*, ed. Mary P. Sutphen and Bridie Andrews, (London: Routledge, 2003), 14-40.

larger population is believed to be equated with a better and greater labour pool and, therefore, higher productivity²²⁷.

It was around this time, in the early 1900s, that there was a notable shift in the medical discourse in British Colonial India²²⁸: Whereas previously indigenous medical knowledge systems had borrowed or co-existed with Western and masculinised forms of medical knowledge, Ayurveda and other indigenous medical knowledge systems were now dismissed as inferior²²⁹. The use of biomedicine to reinforce racial hierarchies and ‘white’ superiority during the Eugenics movement is well documented²³⁰ and the case of India is no different. Western medicine was, thus, a “potent discursive and instrumental means”²³¹ by which the colonized population was depicted negatively. While scholars do debate the extent or degree to which these medical discourses have shaped the identity of Pakistanis and Indians, it has, nevertheless, influenced it²³².

Most allopathic doctors in British Colonial India were white male and female doctors²³³ and most of the women who practiced medicine were part of Christian missions. The first woman doctor to work in the subcontinent was Clairra Swain. She landed in India in 1869 from Pennsylvania, USA and belonged to the Methodist Women’s Foreign Missionary Society. Swain trained medical assistants, headed a hospital that was built by funds donated by the Nawab of

²²⁷ Ramirez-Valles, “Promoting Health, Promoting Women,” 1749-1762; Van Hollen, *Birth on the Threshold*, 37.

²²⁸ Throughout this section, when I refer to India or the subcontinent I mean British Colonial India which split in ,both, 1947, and then again in 1971, to become the countries of Pakistan, India and Bangladesh.

²²⁹ Maneesha Lal, “The ignorance of women,” 14-40.

²³⁰ Kalpana Wilson, “Population Control, the Cold War and racialising reproduction,” *Race, Racism and Development* (London:Zed Books), 2012: 68-96

²³¹ Maneesha Lal, “The ignorance of women,” 15.

²³² Ibid

²³³ Van Hollen, *Birth on the Threshold*, 37-39.

Rampur and even served as the Rani of Khetri's court-appointed physician²³⁴. Ida Scudder, a gynecologist, was the All India Obstetrics and Gynecological Congress's first president and was one of the founders of the world-renowned Christian Mission School. In fact, most of the women who came to India to work as doctors enjoyed a level of professional respect and privilege not afforded to them by their male colleagues in the West²³⁵.

In 1885, the Countess of Lady Dufferin Fund was established with the goal of training midwives and doctors in the USA and Europe, and eventually India. Women began attending medical colleges in India in 1875²³⁶, and it was around this time that the oldest medical college in India began accepting female students. There were, however, few Indian female students who enrolled at these colleges. One of the first four women doctors in the world, Mary Scharlieb, a Manchester merchant's daughter and an Indian, Muthulakshmi Reddi, were among the graduates²³⁷. Reddi was an exception, the majority of the students were British, American or Anglo-Indian women until 1930 when the Madras government changed the requirement that training be provided in English, and allowed for training in vernacular languages²³⁸.

Contemporary Western Medicine in Pakistan: the Language Hierarchy in Pakistani Medicine

Van Hollen points out that one of the ways that "women of European descent" held on to their privileged position was by insisting that "better quality of care could be guaranteed only by

²³⁴ Kumari Jayawardena, "The Medicine Women," *The White Woman's Other Burden: Western Women and South during British Rule*, (New York: Routledge, 1995), 75-90.

²³⁵ Van Hollen, *Birth on the Threshold*, 37-39.

²³⁶ Van Hollen, *Birth on the Threshold*, 38-56.

²³⁷ Jayawardena, *The White Woman's Other Burden*, 75-90; "History of MMC", Madras Medical College, accessed April 20, 2013 from <http://www.mmc.tn.gov.in/history.html>.

²³⁸ Van Hollen, *Birth on the Threshold*, 38-56.

providing training...in the English Language”²³⁹. Thus, it was only local or white women in socially privileged positions who were able to get access to these medical colleges and training. Similar dynamics play out in Pakistani medical colleges today as even now most of the training is in English²⁴⁰. Thus, it is only a minority of English-speaking elite fluent in the language²⁴¹ who can gain admittance into and be successful in medical colleges.

While English is not the national language of Pakistan, in addition to Urdu, it is one of the country’s official languages. Even though Urdu is the national language and English is legally the official language under the 1973 Constitution, for a majority of Pakistani neither languages are their mother tongue. Approximately 44.15 percent of Pakistanis speak Punjabi, 15.42 per cent speak Sindhi, 10.53 speak Siraiki, 14.10 speak Sindhi, 7.57 speak Urdu and 3.57 speak Balochi and 15.42 speak Pashto²⁴². Most Pakistanis speak Urdu and/or English in addition to their mother tongue.

Just like the country’s legislative and administrative levels are operated in English or Urdu, so too is the education system. Rahman writes that this has created an “English-vernacular divide [which] is also the class divide”²⁴³. Post-independent Pakistan inherited three forms of education systems divided along socioeconomic class divisions: madrassas that cater to the rural and poor; the vernacular²⁴⁴-medium and Urdu-medium schools which working and middle-class children attend; and English-medium schools where students from upper-middle and elite class

²³⁹ Ibid.

²⁴⁰ Tariq Rahman, “Language and Education Policy in Pakistan,” *Encyclopedia of Language and Education*, eds. Stephen May and Nancy H. Hornberger (Heidelberg: Springer, 2008): 383-392.

²⁴¹ Ibid.

²⁴² “Population by Mother Tongue,” Population Census Organisation, accessed April 20, 2013, <http://www.census.gov.pk/MotherTongue.html>.

²⁴³ Rahman, “Language and Education Policy in Pakistan,”: 391.

²⁴⁴ By vernacular language I mean the native language or dialect spoken by the populations residing in the respective regions. Thus, in Sindh, for example, the most dominant vernacular language would be Sindhi.

backgrounds study. The current education system, Rahman argues, is still based on the one that was introduced by the British in pre-Partition Pakistan. While madrassas existed before British rule, a chain of English and Urdu medium schools were introduced when the country was colonised²⁴⁵.

Higher education was taught in English in post-1947 Pakistan. Since then, however, all other subjects except for sciences, medicine and engineering have increasingly been taught in Urdu and the vernacular languages²⁴⁶. Thus, medical colleges are still predominantly taught in English and one would have to be well-versed and fluent in the language to not only gain admission but to do well in school.

Contemporary Western Medicine in Pakistan: the Masculinisation of Pakistani Medicine

Given that medical colleges in Pakistan are still modeled on the British system²⁴⁷ and classes are conducted in English, they are viewed as ‘Western’. There exists not only a language hierarchy within Pakistani medical systems but also patriarchy and socioeconomic divisions. When Western medicine became the dominant form of medicine in India, it did not merely bring with it a gender neutral form of knowledge or system. Knowledge, like many other social aspects can be gendered, points out Sylvia Walby²⁴⁸. The more focused the knowledge economy is on science and technical expertise, Walby argues, the more masculine the economy is²⁴⁹. In addition, R.W. Connell point out that, institutes and systems can be masculine, and that it is a

²⁴⁵ Rahman, “Language and Education Policy in Pakistan,” 383-392.

²⁴⁶ Ibid.

²⁴⁷ Jeffery, “Allopathic Medicine in India: A Case of Deprofessionalisation”: 101-113.

²⁴⁸ Sylvia Walby, “Is the Knowledge Society Gendered?” *Gender, Work and Organization* 18, no. 1 (2011): 1-29.

²⁴⁹ Ibid.

certain form of highly hierarchal masculinity that has been ‘exported’ to the metropolises due to colonisation²⁵⁰. During British colonisation of India, medical knowledge and the medical system became more masculine and patriarchal in nature.

Feminists such as Valentine Moghadam have traced patriarchy down to a particular region which stretches from Northern Africa to the Middle East including the Indian subcontinent and parts of rural China. Moghadam defines patriarchy as “a kinship-ordered social structure with strictly defined sex roles in which women are subordinated to men”²⁵¹. However understanding patriarchy in this way does not take into account the level of agency some women have within such a social system and that it is often women who oppress other women. It also ignores how women are discriminated due to other systems of oppression such as racism and capitalism²⁵². Thus, I take patriarchy to mean a system that promotes gender inequality and is oppressive for women at the intersection of race, gender and socioeconomic class. When looked at from this perspective it makes sense why even though women dominate the field of obstetrics and women’s health, the system is highly hierarchal. Women can be just as ingrained with patriarchal values as their male counterparts²⁵³. The masculine systems in which women operate are patriarchal and this is reflected in the highly hierarchal medical community which exists today.

²⁵⁰ Raewyn ‘R.W.’ Connell, “The Big Picture: Masculinities in Recent World History”, *Theory and Society* 22 no. 5(1993): 597-623.

²⁵¹ Valentine Moghadam, “Patriarchy and the Politics of Gender in Modernizing Societies: Iran, Pakistan and Afghanistan” *South Asia Bulletin* 13 (1993) no. 1&2: 121.

²⁵² Yuval-Davis, *Gender and Nation*, 9.

²⁵³ Van Hollen, *Birth on the Threshold*, 38-56.

3.5 CONCLUSION

The level of ‘superiority’ and exclusivity associated with Western medicine and doctors in pre-Partition India still exists in the medical system in Pakistan today, albeit, in a more nuanced form. The low wages and prestige afforded to LHWs, therefore, has to do with the historical and social hierarchy they operate within as well as the way the job market functions. The LHWs face discrimination based on their gender and socioeconomic status, and also because of the economic and patriarchal systems they work in. In the next chapter, I look at how the gendered spaces the LHWs work in have contributed to their struggle to be recognised as professionals by their employers.

CHAPTER FOUR

WORKING WITHIN THE *CHAR DEVAREE*²⁵⁴: SEXUAL POLITICS, GENDERED SPACES AND PROFESSIONAL IDENTITIES

4.1 INTRODUCTION

It took Lady Healthcare Workers (LHWs) three years of protests against the Pakistani state for the government to finally agree to give the LHWs better working conditions and timely payment of their salaries, and regularisation of their jobs. While they have been given better labour rights on paper, the LHW continue to be treated with little value by their employers. In addition, as discussed in Chapter One, the government is still reluctant to provide better compensation to the LHWs in spite of the documented effectiveness of the workers' health services²⁵⁵. As discussed in Chapter 1.6, LHWs fill a much needed gap between the demand and supply of maternal and child health services. Why is it, then, that the Pakistani government seems to have placed such little value on LHWs and their work?

Labour feminists would argue that the reason behind LHWs being so 'undervalued' is that their work is considered *feminine*²⁵⁶. As feminist scholars in the late eighties and nineties argued, jobs themselves can be gendered²⁵⁷, and those that are viewed as *feminine* are considered inferior and pay less than those that are perceived as *masculine*. Seen through the lens of

²⁵⁴ *Char Devaree* literally means the "four walls" in Urdu; however it is used more in the metaphorical sense – in English the closest description would be "confined to the house". In popular discourse the phrase associates powerlessness with domesticity.

²⁵⁵ See Zulfikar A. Bhutta et. al "Improvement of perinatal and newborn care in rural Pakistan through community-based strategies: a cluster-randomised effectiveness trial," *Lancet* 377, no.9763 (2011): 403-12; Alison Tonks, "Community health workers successfully treat perinatal depression in rural Pakistan," *British Medical Journal* 337 (2008):656; John Zarocostas, "WHO issues guidelines on retaining health workers in rural areas," *British Medical Journal* 341(2010):c3774.

²⁵⁶ See Chapter 3.2 for more details.

²⁵⁷ For instance, see England, *Comparable Worth: Theories and Evidence*; Reskin and Ross *Job Queues, Gender Queues: Explaining Women's Inroads into Male Occupations*.

devaluation theory²⁵⁸ one can argue that LHWs are not compensated for their work in terms of wages or benefits because their jobs belong to a female-dominated field, and are viewed as an extension of their domestic duties. Indeed, as established previously, community health workers have historically been volunteer positions or tasks that were carried out by women in the community²⁵⁹. Therefore, it is possible that the labour provided by LHWs is seen as *feminine*, an appendage of domesticity and, therefore, not professional. On closer look, however, it seems that there could be other reasons why LHWs are viewed as neither professional nor deserving of better labour rights.

Jobs are not the only aspect of work that can be gendered. The space one operates in can also be viewed as *masculine* or *feminine*²⁶⁰. I argue here that the reason for the LHWs limited successes in getting the government to meet their demands is that in addition to the *feminine* nature of their work, their work is confined to *feminine* domains. That is their employers do not really see the work LHWs do as professional because it is carried out in a domestic setting. This effect is all the more compounded given the hierarchal and *masculine* nature of the health profession²⁶¹. In addition, as discussed in Chapter Three certain medical professions may be seen as more prestigious than traditional or community-oriented approaches due to their historical and contemporary association with being Western/modern²⁶². Thus, it is these social dichotomies that play a central role in the LHWs' struggle regarding the professionalisation of their work and labour rights.

²⁵⁸ See Section 3.2 for more details.

²⁵⁹ See Section 1.3 for more details.

²⁶⁰ Spain, "Gendered Spaces and Women's Status," 137-141.

²⁶¹ Ellen Kuhlmann, "Gender differences, gender hierarchies and professions:

An embedded approach to the German dental profession," *International Journal of Sociology and Social Policy* 23, no. 4/5(2003); Jeroen Pool, "Hospital Management: Integrating the Dual Hierarchy?" *International Journal of Health Planning and Management* 6 (1991): 193-207.

²⁶² Van Hollen, *Birth on the Threshold*, 55, 56.

In the following chapter I explore how the feminine/masculine and ‘modern’/‘traditional’ dichotomies have shaped the job role and work identities of LHWs. I first discuss dichotomies in relation to gender and gendered spaces. I then locate this dynamic within the Pakistani context and the LHWs’ reflections on their work. Finally I discuss how these dichotomies have molded the LHWs’ and society’s view of the workers’ labour value.

4.2 GENDERED SPACES, NORMS AND HIERARCHIES

As many scholars argue, gender identities are social constructs²⁶³ and like other forms of identity, gender is transient and shifts over time and space²⁶⁴. Gendered norms and spaces must, therefore, be understood within the geographical, cultural, historical and sociopolitical locations within which they are shaped, imagined and re-imagined. To gain a deeper insight into the role gender plays in perceptions of work, identities or oppression one must, as Yuval-Davis puts it, understand gendered relations in “historically specific ways” and how they are “constructed in different societies and the way they are reproduced”²⁶⁵. Thus, what one means by gendered norms and gendered spaces will first be defined. These terms will then be situated within a Pakistani context.

Debates on Gender, Discourse and Hierarchy

It was during the “gender-sex” debate that emerged during the second wave of feminism in the eighties that academics began to view gender difference as constructs of cultural and social

²⁶³ See for instance Judith Butler. *Gender Trouble: Feminism and the Subversion of Identity*, (New York: Routledge, 1990); Alison Assister, *Enlightened Women: Modernist Feminism in a Postmodern Age*. (London. Routledge, 1996); Christine Delphy, “Rethinking Sex and Gender,” *Women Studies International Forum* 16, no. 1 (1993); Ann Oakley, *Sex, Gender and Society* (London: Temple Smith, 1985).

²⁶⁴ Stuart Hall, “Introduction: Who Needs Identity?” in *Questions of Cultural Identity*, ed. Stuart Hall and Paul Du Gay, (Sage: London, 1996), 1-17.

²⁶⁵ Nira Yuval-Davis. *Gender and Nation* (London: Sage Publications, 1997), 46.

factors as opposed to biological ones. Many second-wave feminists, therefore, argued that while biological differences cannot be erased, those arising due to culture can be, and that if these social constructions were dismantled, equality between the sexes would be achieved²⁶⁶. Yuval-Davis, on the other hand, argues that instead of focusing on the “biology-culture”/”gender-sex” debate, both gender and sex should be treated as discourses²⁶⁷.

If one looks at sex and gender as not merely constructs but discourses, *why* social constructs of gender can be oppressive begins to make more sense. As the works of Jacques Derrida and Edward Said show, discourses can be used to reinforce social and racial hierarchies. Both these scholars argue that dichotomies are constructed in such a way that there is a dominant or superior group contrasted with the inferior or the “Other”²⁶⁸. Thus, the notions of femininity and masculinity cannot be defined independent of each other. Like many other social concepts such as good/bad, noble/savage, modern/traditional, our understanding of these terms is shaped by their contrasts; we perceive them subjectively in relation to each other. Feminists argue that viewed within this framework, what is feminine is deemed inferior to what is deemed masculine²⁶⁹.

Gendered Spaces and Hierarchy

The feminine/masculine dichotomy, as countless scholars have pointed out, does not simply shape social relations, gender depictions or discourses, but also systems and spaces. And embedded within such spatial structures are power relations which reinforce and attribute a

²⁶⁶ See for example, Butler, *Gender Trouble*; Assister, *Enlightened Women*; Delphy, “Rethinking Sex and Gender”; Oakley, *Sex, Gender and Society*.

²⁶⁷ Yuval-Davis, *Gender and Nation*, 9.

²⁶⁸ Jacques Derrida in Harriet Bradley. *Gender*, (Cambridge: Polity Press, 2007), 14-25; Edward Said, *Orientalism*. (New York: Vintage, 1979):1-28.

²⁶⁹ Bradley, *Gender*, 19.

perceived lower value to women²⁷⁰. While status and privilege are situated within culture²⁷¹ and geography, in most societies men's experiences or that which is masculine is often given more value or prestige over that which is feminine²⁷². Thus, "masculine knowledge" associated with masculine spheres is given importance over "feminine knowledge" associated with the domestic domain²⁷³. For instance, home remedies are perceived as 'backward' in comparison to pharmaceutical drugs.

This logic, as Marxist feminists point out, extends to work under a capitalist system as well. Thus, labour produced in factories or offices is financially rewarded as opposed to labour produced at home²⁷⁴. This means that 'gamblers' in the stock market (read financial traders) are paid extremely well for their work whereas those raising society's next generation (read parents) are not paid at all. It is, however, not merely the existence of masculine/feminine spaces that shapes the status of women in society, the intensity of this segregation matters too, as is shown by the scholar Daphne Spain through a historical and geographical analysis of spaces. She concludes that the "more pronounced the degree of spatial gender segregation, the lower is

²⁷⁰ Valentine Moghadam, "Patriarchy and the Politics of Gender in Modernizing Societies: Iran, Pakistan and Afghanistan" *South Asia Bulletin* 13, no. 1&2 (1993); Spain, "Gendered Spaces and Women's Status," 137-14.

²⁷¹ Over here, culture can be taken to mean as Raymond Williams defines it as "a whole way of life--the common meanings; to mean the arts and learning--the special processes of discovery and creative effort". See John Eldridge and Lizzie Eldridge, "Culture and Society," *Raymond Williams: Making Connections*, (London: Routledge, 1994), 45.

²⁷² Carol C. Mukhopadhyay and Patricia J. Higgins, "Anthropological Studies of Women's Status Revisited: 1977-1987," *Annual Review of Anthropology*, 17 (1988): 461-495; Sherry Ortner and Harriet Whitehead, "Introduction: Accounting for Sexual Meanings," *Sexual Meanings: The Cultural Construction of Gender and Sexuality*, ed. Sherry Ortner and Harriet Whitehead. (Cambridge: Cambridge University Press, 1981), 1-29.

²⁷³ Sylvia Walby, "Is the Knowledge Society Gendered?" *Gender, Work and Organization* 18, no. 1 (2011): 1-29.

²⁷⁴ Mariarosa Dalla Costa and Selma James, "The Exploitation of the Wageless," in *The Power of Women and the Subversion of the Community* (Bristol: Falling Wall, 1972), 10-15.

women's status relative to men's²⁷⁵. That is, the more clearly demarcated the divisions between the sexes in the public or private sphere, the more devalued is the labour associated with feminine spaces. For example, teaching at feminine spaces such as schools is less prestigious than teaching at masculine institutions such as universities. According to Spain, in a place like Pakistan, where the cultural norm of sexual segregation called purdah (veil) is followed, work associated with the feminine domain would be devalued more than in societies or countries where such cultural norms do not exist. But does purdah really shape how LHWs labour is perceived and their professional identities established? In the next section, I explore this very question. First, however, what I mean by purdah in the Pakistani context must be explored.

Locating Gendered Spaces in the Pakistani Context

The purdah can be better understood if one looks at this cultural act or practice as temporally and spatially dynamic. Thus, in Pakistan, the purdah's perception and use is shaped by socioeconomic class, ethnicity, level of religiosity and sexual politics. For instance, sociologists have pointed out that Pakistani women wear the burqa for myriad reasons. Many women from lower socioeconomic groups wear the purdah for practical reason and to avoid being harassed in public spaces such as buses. Some wear it for religious reasons while for others it is linked to their status and social identities²⁷⁶

In popular culture the purdah is often understood as physical seclusion or separation in form of a *zenana*, harem, hijab, burqa or abaya but the purdah can be abstract or what Hanna

²⁷⁵ Spain, "Gendered Spaces and Women's Status," 137.

²⁷⁶ Riffat Haque, "Gender and Nexus of Purdah Culture in Public Policy", *South Asian Studies* 25, no. 2(2010):303-31.

Papanek calls, “the social forms and psychological features” of the purdah²⁷⁷. That is, it should be understood as a cultural norm that dictates the behaviour of women and men regarding sexual modesty, even in the absence of its physical forms. At its simplest, it can be understood as an “instrument of sexual segregation”²⁷⁸. In many ways it is similar to other such concepts that can be found in South Asian societies such as the Hindu concept of *kapu*, a cultural norm that dictates a form of modesty in communication, and interactions between men and women including abstinence from sexual relations²⁷⁹.

The cultural norm of *izzat* (honour) is interlaced with the concept of the purdah. While this concept applies to both men and women²⁸⁰, it is usually the woman, whose sexual modesty is associated with the family’s or the community’s *izzat*. Just as many feminist scholars have argued that a woman’s body can be representative of a nation²⁸¹ so too, the ‘honour’ or integrity of a Pakistani family is embodied within a Pakistani woman²⁸².

Now that the social norms of the purdah and gendered spaces in the Pakistani context have been explored, how these norms and sexual segregation influence and shape the professional identities and the work experiences of the LHWs can be explored. I do this in the following section.

²⁷⁷ Hannah Papanek, “Purdah in Pakistan: Seclusion and Modern Occupations for Women,” *Journal of Marriage and Family* 33, no. 3 (1971):517.

²⁷⁸ Sumaira Rehman and Muhammad Azam Roomi, “Gender and Work-life Balance: a Phenomenological Study of Women Entrepreneurs in Pakistan,” *Journal of Small Business and Enterprise Development*, 19, no. 2(2012):211.

²⁷⁹ Alisa O’Connor, “Lions, Tigers, and Freedom Birds: How and Why the Liberation Tigers of Tamil Eelam Employs Women,” *Terrorism and Political Violence*, 19(2007):43–63; Tahira Gonsalves, “Media Manipulation and Agency: Women in the LTTE of Sri Lanka.” *The Ahfad Journal* 22, no. 2(2005): 36-52

²⁸⁰ Shaheed cited in Rehman and Roomi, “Gender and Work-life Balance,” 211.

²⁸¹ Nayanika Mookherjee, “Gendered embodiments: mapping the body-politic of the raped woman and the nation in Bangladesh,” *Feminist Review* 88(2008).

²⁸² Shaheed cited in Rehman and Roomi, “Gender and Work-life Balance,” 211.

4.3 *PURDAY KAY PEECHAY*²⁸³: LHWs AND GENDERED SPACES

Just as in any other social space in Pakistan, the cultural norms of *purdah* and *zenana*²⁸⁴ dictate interactions between men and women in the medical sphere as well. Women are more likely to open up to other women about personal matters related to their health and their bodies. And even when women do seek out healthcare in the public setting, such as hospitals, they tend to seek out female healthcare practitioners. Also, under most circumstances, it is women who can enter private domains²⁸⁵.

Thus, LHWs are in a unique and important position to deliver healthcare services. As a former director of the LHW programme in Sindh points out, it is only with female LHWs, in particular married workers, that other women are more likely to open up to and discuss their issues. “For a married girl to instruct another on nutrition, feeding, hygiene, we prefer that they be married,” he points out,²⁸⁶ citing certain taboos and cultural norms around what married women will discuss with single women regarding sex and childbirth. Gul, an LHW, who has worked for 12 years in the field, emphasizes the same point, stating that while there are single women, married women are preferred as “they go into a lot of detail [on birth control and reproduction]”²⁸⁷. While the preference for married women may seem odd, it definitely influences how open women are in their discussions. The anthropologist Cecilia Van Hollen discovered the same during her study on child birth in Tamil, India. As she recalls:

“When I talked with women about childbirth during my trip in 1993 I did not have a child of my own. Just as women were reluctant to discuss the details of their birth experiences with

²⁸³ This phrase means “behind the veil/curtain”

²⁸⁴ The *zenana* is a women’s quarters/space allocated only for women in the home.

²⁸⁵ Papanek, “*Purdah in Pakistan*,” 522-525.

²⁸⁶ Participant 19, LHW, in discussion with the author, September-December 2012.

²⁸⁷ Participant 2, LHW, in discussion with the author, September-December 2012.

their daughters or daughter-in-laws who had not yet had their first child, they were hesitant to speak to me freely about this subject. In 1995...I had a child myself and told them about my own birth experiences, they were much more at ease talking with me”²⁸⁸

Thus, there is something about the *lived* experience that creates a stronger bond between two people sharing a life event such as childbirth, discussing intimate issues such as birth control or sex, or simply talking about their health and their bodies. As shall be explored in the next section, this also applies to the bond created between the healthcare provider and those seeking healthcare.

LHWs and the Community

It is evident from the way many of the LHWs reflect on their work that they take pride in how it has allowed them to form more intimate relationships with the other women in their neighbourhoods. Their work has also compelled the health workers to explore their own gender and reproductive rights. As Kiran, an LHW based in Orangi Town, states “I enjoy it [the work], you realise and learn so many things. You understand so much [about women’s issues and the community] so many women are just so helpless”²⁸⁹.

Another health worker, Sabeen, after reflecting on what she likes about the job states, “I really like it, helping people feels good. To give advice to another women feels good...as such it is good work. We spread knowledge to people”²⁹⁰. Gul feels the same way: “My area’s people like me very much, they are all very happy. When I solve their problems, then it makes me happy,” she says²⁹¹. A few mentioned how it has changed the way they look at their own

²⁸⁸ Van Hollen, *Birth on the Threshold*, 32.

²⁸⁹ Participant 1, LHW, in discussion with the author, September-December 2012

²⁹⁰ Participant 8, LHW, in discussion with the author, September-December 2012

²⁹¹ Participant 2, LHW, in discussion with the author, September-December 2012.

reproductive rights. For instance, Nida, Sania and Zehra pointed out that they would have spaced the birth of their own children if they had known about the various birth control options²⁹². “I didn’t know about these things before [birth control] otherwise I would not have had four children so quickly,” says Zehra.

Some LHWs have formed close personal bonds with their clients even though they have had to initially struggle to gain a foothold in their community and go through the growing pains of being accepted. Risham, who works in the Martin Quarters areas, recalls “in the beginning when we were carrying out the registrations, there were problems. But now, they call us over [to their homes] for tea, they even invite us over for weddings” adding that they are now affectionately called “polio *wali* ²⁹³ aunty, vaccination aunty”²⁹⁴.

It is these personal bonds that are instrumental, directly or indirectly, in shifting people’s attitudes towards certain medical practices or vaccination programmes. For example, one worker pointed out that her “neighbours didn’t give [their children] the polio drops before” but that since she has been “carrying out fieldwork they do so”. Thus, there is a level of implied trust and bonding that would not have been possible if these health practices and advice were carried out within an institutional setting.

It is the LHWs who happen to belong to the same gender and socioeconomic background as the target population who are effective at getting their messages on health care and nutrition heard. This is because LHWs are in a unique position to gain access to these feminine spaces and

²⁹² Participants 13, 14 and 15, LHWs, in discussion with the author, September-December 2012.

²⁹³ *Wali* or *wala* in Urdu simply means “belonging to” or the “trade of”. *Wali* is the feminine form of the word and refers to women whereas *wala* is the masculine form of the word and refers to men. Thus, polio *wali* simply translates to the woman who carries out polio-related work.

²⁹⁴ Participant 12, LHW, in discussion with the author, September-December 2012.

form personal bonds with the community members. Essentially, they are the pivotal bridge between mothers, especially those who live in ‘traditional’ households, and medical practitioners and policymakers.

LHWs, Hierarchy and Gendered Spaces

It is the LHWs access to *feminine* spaces that has made them effective in delivering health services in impoverished areas in ways that ‘modern’ forms of medicine such as hospitals, clinics and doctors cannot deliver. However, the lack of status afforded to them by their employers is also due to the *feminine* spaces in which they operate²⁹⁵. As Rani bluntly put it: “If we go to our THOs²⁹⁶, sirs, doctors and say that we should get more pay they tell us ‘you just go to houses’”²⁹⁷.

In addition, the LHWs are still seen as belonging to the private sphere, and working within a public sphere has made them more vulnerable to sexual harassment. As Zehra points out, “If we go to a house and ask ‘is there a toddler or young child here?’ they reply ‘now we will try for one [a child]’, and these are not young boys saying this, its older men. It is easy for men to go out in the field but it is not easy for us²⁹⁸”. Nida, another LHW, says she has had similar experiences.

“When I was registering the homes, at this one house when I would ask ‘are there any women living here? [that I can talk to?], the man of the house would ask me ‘do you have any medicine for male virility?’ I stopped going there for a few months – like 2 to 3 months.”²⁹⁹

²⁹⁵ Spain, “Gendered Spaces and Women's Status,” 137.

²⁹⁶ Tehsil Housing Officers. THO is an officer or manager who supervises various LHWs at the *tehsil* or district level.

²⁹⁷ Participant 18, LHW, in discussion with the author, September-December 2012.

²⁹⁸ Participant 15, LHW, in discussion with the author, September-December 2012.

²⁹⁹ Participant 13, LHW, in discussion with the author, September-December 2012.

Nadia, however, points out that they have little choice in the matter. “When a male is rude, then you are more intimidated and hurt but you have to tolerate them,” she states³⁰⁰. One of the ways that they are attempting to navigate the public-private sphere is by wearing the abaya, a head-to-toe cloak. Abayas and burqas can be as Papanek points out “a liberating invention, since it provides a kind of portable seclusion which enables women to move out of segregated living spaces while still observing purdah”³⁰¹. “We don’t normally wear abayas but we wear it for work,” adds Nadia³⁰². A likely reason behind Nadia and her peers choosing to wear the garment is the sense of security it provides. As Nida, points out she feels “more safe with the abaya”³⁰³.

4.4 CONCLUSION

As discussed in this chapter, the gendered spaces within which LHWs operate are a double-edged sword. It means they are more effective than *masculinised* medical professionals in delivering health services and raising public health awareness among Karachi’s disadvantaged communities. However, it has also contributed to their marginalisation and perceived lack of professional identity. As established in Chapter Three, a social and linguistic hierarchy and patriarchy are present in the Pakistani medical system. The LHWs struggle for professional recognition is compounded by discrimination they face due to the social, historical and patriarchal factors in addition to the fact that they operate within gendered spaces. In essence, the workers are challenging a historically hierarchal system while operating within it.

So far, LHWs’ experiences have been located within the medical and social hierarchies. In the next chapter I situate these experiences in a neocolonial system, and show how the workers’ experiences are shaped and influenced by the politics of policy makers in Pakistan.

³⁰⁰ Participant 16, LHW, in discussion with the author, September-December 2012.

³⁰¹ Papanek, “Purdah in Pakistan: Seclusion and Modern Occupations for Women,” 520.

³⁰² Ibid.

³⁰³ Participant 13, LHW, in discussion with the author, September-December 2012.

CHAPTER FIVE

CAUGHT IN THE MIDDLE: LHWS AND TRANSNATIONAL POLITICS

5.1 INTRODUCTION

From July 2012 up to the present, May 2013, LHWs and other health workers who have been working on polio campaigns in Pakistan have been murdered in a string of targeted attacks³⁰⁴. While no party has explicitly claimed responsibility for these attacks, the media and security personnel suspect the Pakistani Taliban³⁰⁵. While the militant group might have been the one to pull the trigger, as will be explored in this chapter, the workers were working in an extremely hostile and suspicious environment due to the geopolitics of the country. This tense atmosphere as well as the increasing resistance, not just by militants, but by community members can be traced to United States (US) military intervention in Pakistan³⁰⁶. However, the LHWs have been affected by foreign agendas and policies in other ways too. As shall be explored later, many multilateral and bilateral organisations such as USAID, WHO, DFID and the UN have shaped the agendas of local primary health care programming.

In this chapter, I locate the LHWs' work experience in a wider geopolitical system that exists due to the relations between the Pakistani government, multilateral and bilateral organisations and the US. In effect, I situate LHWs experiences within a neocolonial context. I first look at how US military intervention is linked to the target killings of the healthcare

³⁰⁴ "Six polio workers shot dead in Pakistan," *Dawn*, December 19, 2012, accessed January 30, 2013, <http://dawn.com/2012/12/19/six-polio-workers-shot-dead-in-pakistan.html>.

³⁰⁵ *Ibid.*

³⁰⁶ Mcneil Jr., "C.I.A. Vaccine Ruse May Have Harmed the War on Polio," *The New York Times*, July 9, 2012, accessed April 30, 2013, http://www.nytimes.com/2012/07/10/health/cia-vaccine-ruse-in-pakistan-may-have-harmed-polio-fight.html?pagewanted=all&_r=1&.html.

workers. I then discuss LHW's on-the-ground work experiences and their reflections on how the programme and training has changed over the years. I then analyse foreign funding for the health programmes in Pakistan. Finally, I discuss the effect of these donor policies on the LHW programme.

5.2 OF OSAMA BIN LADEN, US IMPERIALISM AND POLIO CAMPAIGNS: HOW TRANSNATIONAL POLITICS CAN AFFECT HEALTH POLICIES

On a moonless night on August 8, 2011, two MH-60 Black Hawk helicopters carrying 23 Navy US Seals hovered over the Pakistani town of Abbottabad and landed in the compound of a house³⁰⁷ known locally as Waziristan Haveli³⁰⁸. They descended on the residence looking for one man: Osama Bin Laden. After 40 minutes the team left with their mission accomplished – in tow was Osama's dead body and computer equipment likely to contain relevant data and information. They left behind a helicopter downed during the operation, and the bodies of the Bin Laden residents killed during the US Navy operation³⁰⁹. Amongst those who died at Waziristan Haveli were Osama's son Khalid, Abu Ahmed al-Kuwaiti, Bin Laden's courier, Abrar, al-Kuwaiti's brother and Bushra, Abrar's wife³¹⁰. A group of three women and 13 children had been bound with plastic ties and had been left behind by the Navy Seals³¹¹. Nearly a year later, on 17 July 2012, a UN Ghanian doctor, Constant Dedo, working on the polio campaign, and his driver were

³⁰⁷ Nicholas Schmidle, "Getting Bin Laden: What happened that night in Abbottabad," *The New Yorker*, August 8, 2011, accessed April 30, 2013, http://www.newyorker.com/reporting/2011/08/08/110808fa_fact_schmidle?currentPage=all.html.

³⁰⁸ Orla Guerin, "What was life like in the Bin Laden compound?", BBC News, May 9, 2011, accessed April 30, 2013, <http://www.bbc.co.uk/news/world-south-asia-13266944.html>.

³⁰⁹ "Osama Bin Laden's death: How it happened," BBC News, September 10, 2012, accessed April 30, 2013, <http://www.bbc.co.uk/news/world-south-asia-13257330.html>.

³¹⁰ Schmidle, "Getting Bin Laden".

³¹¹ "Osama Bin Laden's death," BBC News.

ambushed in a gun attack in Karachi³¹². Although no one made an immediate connection between the two incidents, it was the CIA manhunt for Osama Bin Laden that triggered the chain of events leading to Dedo's death. Dedo, was the first of many such health workers to be targeted in this way.

A few months later, six polio workers were killed in Pakistan over a span of two days in what appeared to be coordinated attacks³¹³. On December 18, 2012, four polio workers, Fahmida, Madiha, Kaneez Fatima and Naseem³¹⁴, were shot dead in different parts of Karachi³¹⁵. A day earlier Umer Farooq Mehsud, a polio campaign volunteer in Karachi's Gadap area was the victim of a similar attack³¹⁶. In the Shagai suburb of Peshawar, a 17 year-old volunteer was killed³¹⁷. These were the early examples of a series of attacks against health workers: a supervisor and her driver were killed on December 19, 2012, the same day the UN and WHO halted its polio vaccination campaigns nation-wide in Pakistan³¹⁸. Seven more health workers were murdered on January 2013 in Swabi in the province of Khyber-Pakthunkhwa. In the same area and month, a policeman charged with protecting health workers involved in the resumed

³¹² Saeed Shah, "Shooting of UN doctor imperils Pakistan's campaign against Polio," *The Guardian*, July 17, 2012, accessed January 30, 2013, <http://www.guardian.co.uk/world/2012/jul/17/shooting-un-doctor-pakistan-polio?INTCMP=SRCH>html.

³¹³ "Six polio workers shot dead in Pakistan," *Dawn*

³¹⁴ "Probe into polio workers' killing under way," *Dawn*, December 20, 2012, 15.

³¹⁵ "Gunmen kill five polio workers in Pakistan," *Dawn*, December 18, 2012, accessed January 30, 2013, <http://dawn.com/2012/12/18/gunmen-kill-four-female-polio-workers-in-karachi.html>.

³¹⁶ "Another polio worker killed in Sohrab Goth," *Dawn*, December 18, 2012, accessed January 30, 2013, <http://dawn.com/2012/12/18/another-polio-worker-killed-in-sohrab-goth.html>.

³¹⁷ Jason Burke, "Polio vaccination workers shot dead in Pakistan," *The Guardian*, December 18, 2012, accessed January 30, 2013, <http://www.guardian.co.uk/world/2012/dec/18/polio-vaccination-workers-shot-pakistan.html>.

³¹⁸ "Pakistan killings near Peshawar disrupt Polio campaign," BBC News, 19 December 2013, accessed April 30, 2013, <http://www.bbc.co.uk/news/world-asia-20779388.html>.

polio campaign was shot dead. Two more policemen suffered the same fate in February and April of the same year³¹⁹.

While no one has claimed responsibility for this or any of the other attacks, the media have frequently drawn links between the polio worker murders and the Pakistani Taliban, radical militant groups operating in the country. A senior police officer Shahid Hayat, investigating the killings, also suspects the various Taliban factions³²⁰. While the culpability of the Taliban is probable but not certain, the militant group had certainly been very vocal about its anti-vaccination campaign stance.

In June 2012, the Taliban publicly announced the ban of polio and other vaccination campaigns in Waziristan claiming that it was a cover for espionage, and that the ban would not be lifted until US drone strikes ended in Pakistan's tribal areas. Maulvi Nazir, who controls large parts of South Waziristan distributed pamphlets in Urdu stating that the Afridi case proved that "infidel forces are using media, education and development as a tool to gag Muslims"³²¹ and that "in the garb of these vaccination campaigns, the US and its allies are running their spying networks in Fata"³²². A similar ban linking the end of the moratorium on vaccination campaigns to the cessation of drone strikes was implemented earlier in the month in North Waziristan by Hafiz Gul Bahadur, the area's Taliban leader³²³.

³¹⁹ "Pakistan 'policeman killed' guarding anti-polio worker," BBC, 26 February 2013, accessed April 30, 2013, <http://www.bbc.co.uk/news/world-asia-21585291.html>.; "Pakistan police officer guarding polio workers killed," BBC, 10 April 2013, accessed April 30, 2013, <http://www.bbc.co.uk/news/world-asia-22096638.html>.

³²⁰ "Six polio workers shot dead in Pakistan," *Dawn*; Shah, "Shooting of UN doctor"

³²¹ Zahir Shah Sherazi, "Another militant group bans vaccination seeks end to drone strikes," June 25, 2012, accessed April 30, 2012, <http://dawn.com/2012/06/25/another-militant-group-bans-polio-vaccination-seeks-end-to-drone-strikes.html>.

³²² Shah, "Shooting of UN doctor"

³²³ Pazir Gul, "Taliban link anti-polio drive to cessation of drone attacks," June 17, 2012, accessed April 30, 2013 <http://dawn.com/2012/06/17/taliban-link-anti-polio-drive-to-cessation-of-drone-attacks.html>.

The backlash to such campaigns came in the wake of revelations that a Khyber-Pakthunkhwa (KP) based doctor, 33-year-old Shakil Afridi, carried out a fake vaccination campaign for the US intelligence agency, the Central Intelligence Agency (CIA). This was part of an elaborate plan to obtain DNA from the bin Laden family to verify that he was the wanted fugitive residing at Waziristan Haveli³²⁴.

The militants were not the only ones openly opposing the polio campaign. There was also increasingly visible resistance from communities in the North-western parts of Pakistan, which have been frequently terrorised by US Predator drone strikes³²⁵. Since 2004, there have been 355 drone strikes in the region and 2,000 to 3,300 people have been extra-judicially killed due to such attacks³²⁶. Reportedly, it is the Pakhtun and Afghan refugee population, both in KP, and in cities' slum areas, who most likely view polio workers as working for a Western-backed

³²⁴ Saeed Shah, "CIA organised fake vaccination drive to get Osama bin Laden's family's DNA," *The Guardian*, July 11, 2011, accessed April 30, 2013, <http://www.guardian.co.uk/world/2011/jul/11/cia-fake-vaccinations-osama-bin-ladens-dna.html>.

³²⁵ "The Year of the Drone," New America Foundation, accessed May 1, 2013, <http://counterterrorism.newamerica.net/drones.html>.

³²⁶ Drone strikes are missile strikes carried out by unmanned planes by the US government. According to the US administration, the strikes are highly precise and target only militants. So far, these attacks have been carried out in both Yemen and Pakistan since 2004. As of May 2013, there have been approximately 428 strikes in total resulting in the death of between 2,500 to 4,000 people. The number of innocent people who have been killed in these strikes is up for speculation as the process is entirely extrajudicial. Three US citizens have also been killed in these strikes: Anwar al-Alwaki, his sixteen-year-old son, Abdul Rahman Alwaki and Samir Khan. While the names of the US citizens are public knowledge, and the militants killed are also named, most of the innocent people killed in these strikes are not mentioned by name or identified in the mass media.

For more details see:

"The Year of the Drone"; "The Covert War on Terror," The Bureau of Investigative Journalism, accessed May 1, 2013, <http://www.thebureauinvestigates.com/category/projects/drone-data>; "How a US Citizen came to be in America's Cross Hairs," *New York Times*, March 9, 2013, accessed May 1, 2013, <http://www.nytimes.com/2013/03/10/world/middleeast/anwar-al-awlaki-a-us-citizen-in-americas-cross-hairs.html?pagewanted=all&r=0>.html. ; "Jeremy Scahill: The Secret Story behind Obama's Assassination of Two Americans in Yemen," Democracy Now, accessed May 1, 2013, http://www.democracynow.org/2013/4/23/jeremy_scahill_the_secret_story_behind.html. ; Jeremy Scahill, *Dirty Wars: The World is a Battlefield* by Jeremy Scahill, (New York: Nation Books), 2013.

campaign, and are the most reluctant to let polio workers operate in their areas³²⁷. After the Afridi ploy was revealed to the public, angry villagers in the tribal areas near the Afghan border chased polio workers away³²⁸.

The circulating rumours about the polio drops not being halal³²⁹, that it contains the AIDS virus, or is being used to sterilise the Pakistani population do not help matters either³³⁰. While such speculations may sound like conspiracy theories, there is a recorded history of policies set by states and multilateral organisations that have resulted in the illegitimate and forced sterilisation of populations. For instance, in Bangladesh, in many cases, food relief was provided to individuals conditional upon sterilisation. Similarly, in India, the government set an impossibly high target for sterilisations which resulted in forced sterilisations and kidnappings. An investigation revealed that after public employees from Purnapur, Uttar Pradesh had their salaries stopped in December 1993 for not meeting the government targets, they kidnapped women from neighbouring Nepal, and forcefully sterilised them in warehouses³³¹. NGOs and reporters have also documented how pharmaceutical companies often ‘dump’ birth control drugs and medicine in the Global South after they have been determined to be too unsafe to use in the West. Often, these medicines are distributed through family planning programmes in developing countries that are supported and funded by international multilateral organisations such as the USAID, WHO and the World Bank³³². Thus, Pakistanis’ suspicions of western/state-sponsored

³²⁷ Donald G. McNeil Jr., “Getting Polio Campaigns Back on Track,” *The New York Times*, December 24, 2012, accessed April 30, 2013, http://www.nytimes.com/2012/12/25/health/getting-polio-campaigns-back-on-track.html?_r=1&.html.

³²⁸ McNeil Jr., “C.I.A. Vaccine Ruse”.

³²⁹ The Islamic equivalent of kosher; food and drink permissible to consume under Islamic law.

³³⁰ Ibid.

³³¹ Wilson, “Population Control, the Cold War and racialising reproduction,” 68-96.

³³² Lynda Newland, “The Deployment of the Prosperous Family: Family Planning in West Java,” *NWSA Journal* 13, no. 3 (2001): 22-48.

medical campaigns and family planning programmes are not as far-fetched as they initially appear.

So far, how US military and political interventions are affecting polio campaigns in Pakistan have been discussed. But policies of other foreign agencies, and bilateral and multilateral organisations have also influenced LHWs' on-the-ground experiences and the LHW programme agenda. These two issues will be discussed in the following sections.

5.3 CATCH 22: LHWs AND POLIO CAMPAIGNS

Working on the polio campaign was a great source of stress for the LHWs even before many of their colleagues became victims of the targeted killings discussed earlier. The polio vaccination rounds are usually carried out by the workers with the help of volunteers who are hired specifically for this purpose. For their efforts, every campaign worker is paid 250 rupees (2.5 CAD) a day while their supervisors are paid 270 rupees (2.7 CAD) a day³³³.

The campaign is conducted by the US Centers for Disease Control and Prevention, the Rotary Foundation, WHO and the United Nations Children's Fund (UNICEF) in coordination with the Pakistani government. The main goal of the polio campaigns is to eradicate polio globally, and is known as the Global Polio Eradication Initiative (GPEI)³³⁴. Six billion dollars have been spent on GPEI programmes since 1988 when the initiative was formed³³⁵. While the

³³³ Based on interviews conducted with LHWs September 2012-December 2012; "News in Brief," *Dawn*, May 9, 2013, accessed May 10, 2013 <http://dawn.com/2013/05/09/news-in-brief-318.html>.

³³⁴ World Health Organisation, "Media Center," accessed May 5, 2013, <http://www.who.int/mediacentre/factsheets/fs114/en.html>.

³³⁵ Svea Closser, "Resisting Eradication: The Cultures of Global Health and Local Health Systems in the Polio Eradication Initiative in Pakistan," (PhD diss., Emory University, 2012), 68-72.

WHO has managed to reduce the incidence of polio by 99 per cent, the disease is still endemic in three countries in the world: Afghanistan, Nigeria and Pakistan³³⁶.

WHO has its own representatives on the ground overseeing the execution of the campaign and the programme. There are over 40 foreign consultants permanently positioned in the country and many others who work in Pakistan on a temporary basis. In sharp contrast to the field workers, who are paid 7.5-12.5 dollars for their work, these consultants' salaries and per diem amounts to 10,000 dollars a month.

The campaign to vaccinate 30 million children all over the country is usually carried out for three days followed by two 'catch-up'³³⁷ days³³⁸. In areas where there have been no cases of polio, the campaigns are carried out three to five times a year, in areas where there have been cases of polio, a campaign is carried out every month³³⁹. To carry out such a vast campaign over 200,000 vaccinators are needed and it is the Pakistani government's responsibility to provide the labour force³⁴⁰. Since the health ministry does not have so many employees, it often recruits LHWs for the job. Most LHWs, who are hired on a contract-basis and are regularly threatened with losing their job by their employers³⁴¹, have little choice but to say yes.

As the following summary of the work experience of the LHWs shows the polio campaign increases their work burden at the cost of their regular duties. In addition, by

³³⁶ World Health Organisation, "Media Center".

³³⁷ There are often two additional days allocated in addition to the three-day polio vaccination campaign. These two days are to be spent catching up to cover the designated areas if due to unforeseen or unexpected circumstances the polio vaccinators are unable to finish their assigned quota of vaccinations

³³⁸ Svea Closser, "Resisting Eradication," 68-72.

³³⁹ Ibid, 33.

³⁴⁰ Ibid, 76.

³⁴¹ Based on interviews conducted with the author September 2012-December 2012. While the LHWs did not ever mention that they have been coerced into working on the polio campaign by being threatened with losing their jobs, the LHWs have mentioned how their employers and polio campaign managers often threaten to fire the LHWs if the workers do not do as they are told.

participating in these campaigns they are more vulnerable to sexual harassment, and physical and life-threatening violence. They are treated poorly by both their employers as well as by the communities they serve when it comes to the polio campaigns. The WHO's and UN's policies of systemic checks and area sweeps³⁴² may look efficient on paper but it translates into a system which puts immense pressure on LHWs and polio workers, demoralises them, and means they work additional hours for little or no pay³⁴³.

An Additional Work Burden: Polio Campaigns vs. Regular Duties

For most LHWs the tightly scheduled five-day³⁴⁴ campaign not only adds additional stress but increasing workload for very little pay. "They [the administration] bother us a lot over the polio [campaigns]. There is a problem with that. We have to go door-to-door and they give us very little salary for that," points out Maheen³⁴⁵. In addition, many feel more apprehensive and insecure about carrying out door-to-door vaccination in unfamiliar areas than they do about conducting community work in their neighbourhoods. Comparing the various tasks Javaria simply states:

³⁴² The WHO representatives will pick random homes in areas where a polio campaign is being carried out, and see if any child under five has been vaccinated or not. This is to ensure that each and every possible child has been vaccinated. Many workers I interviewed complained that they are asked to vaccinate entire areas again even if one household has been missed out.

³⁴³ According to many health workers interviewed they often do not even receive this meager per diem or are paid months after the polio campaign has finished. One health worker recounted to me how she was made to vaccinate all children residing in a particular area a second time and was then still not given her pay. "They said that we missed out on one child so they refused [to pay us]. So then we swept the area and went back to them but they still did not give me money. The money had come from UNICEF but they didn't give it to us". Participant 9, LHW, in discussion with the author, September-December 2012.

³⁴⁴ Sometimes these campaigns go beyond the allotted five days. Workers are not compensated for the extra time they put in. As the LHW Irfana states in an interview with the newspaper *Dawn*: "Often the three-day campaign is extended to six days but the government doesn't raise the amount". For more details see Faiza Ilyas, "Undeterred, lady health workers demand security," *Dawn*, December 20, 2012, P15.

³⁴⁵ Participant 4, LHW, in discussion with the author, September-December 2012.

“The community work is easy but the biggest issues are with the polio campaigns. When we go to the houses, they [the residents] say that come inside [and] inject the vaccinations. So, we are scared that they will rape us or try to ‘touch’ us; we have put our lives on the line. When it comes to the polio [campaign] we are scared. We feel unsafe; we think what will happen to us. We go to unfamiliar places”³⁴⁶.

Zehra, emphasizing the safety aspect, says “when we are doing our fieldwork and we are visiting homes, we feel safe but when we are carrying out the polio campaign, then, there are homes [people residing at these homes] who don’t understand”³⁴⁷.

The demands placed on the workers by their employers to fine comb areas and ensure that each and every targeted individual has been vaccinated add tremendous stress and pressure on them. “The Gallup and UNICEF *walay* [people], they come to the area and if they find out that even if three children were missed out on, then, they make us do the whole campaign again and they don’t give us money for that; whoever has been given the medicine, you have to give it to them again,” points out Maheen³⁴⁸. Javaria, on the other hand, complained that her employers did not give her any time off even she was five-months pregnant and tired easily from all the physical work: “They make us work like dogs...They say to us that [what we do] is health work but they don’t care about our health at all”³⁴⁹.

With increasing larger areas to cover, little or few breaks, and no available facilities for lunch or toilet breaks, running around door-to-door in the hot weather adds up: “When we go for the polio campaign, it is more difficult... We won’t even get any volunteers... we don’t even get a break; even if we want to eat or drink, we have to go back home. There are no facilities

³⁴⁶ Participant 9, LHW, in discussion with the author, September-December 2012.

³⁴⁷ Participant 15, LHW, in discussion with the author, September-December 2012.

³⁴⁸ Participant 4, LHW, in discussion with the author, September-December 2012.

³⁴⁹ Participant 9, LHW, in discussion with the author, September-December 2012.

available,” states Risham³⁵⁰. “Every day we go to 200 houses. First there were 10 teams now there are five; in 1998 there were 10 teams. They have made the areas so big,” adds Javaria, pointing out how the LHWs’ workload has increased over the years in regards to the polio campaign³⁵¹.

Working on vaccinating entire areas for polio also comes at the cost of the LHWs neglecting their regular duties: this means they often have a lot of catching up to do in the following weeks after the campaign has ended. Tehmina, who is responsible for 1,200 people, says she usually sees around 40 people or six homes a week but that “when we are busy with polio then the week after we increase it to eight to nine homes”³⁵². Another worker interviewed, Gul, who has worked for 12 years in the field, and enjoys many facets of her job, says the one downside is the weeks devoted to polio: “Because of polio [campaign] there is a lot of *khwaree*³⁵³; you have to take care of 2,900 children and we have to do our work for the week on top of that³⁵⁴. “In each building there are 80 houses...that’s a lot of work,” points out Yusra, breaking down how much work the campaign actually is for them³⁵⁵.

Thus, the polio campaign has negatively affected the primary health care services the LHW programme is meant to provide. In addition, the way the campaign is designed, for instance the door-to-door vaccinations, makes the workers more vulnerable to violence and harassment. This will be discussed in the next section.

³⁵⁰ Participant 12, LHW, in discussion with the author, September-December 2012

³⁵¹ Participant 9, LHW, in discussion with the author, September-December 2012.

³⁵² Participant 7, LHW, in discussion with the author, September-December 2012.

³⁵³ To find something to be a hassle; something that involves a lot of running around or a lot of effort.

³⁵⁴ Participant 2, LHW, in discussion with the author, September-December 2012.

³⁵⁵ Participant 5, LHW, in discussion with the author, September-December 2012.

Insecurity and Polio Campaigns

The added element of harassment that often accompanies the work of polio vaccination has made the campaign particularly distasteful for LHWs. As Yusra, who is based out of Soldier Bazaar states, “when we do the polio campaign, there are men who tease us and say make us drink it [the polio vaccine drops] too”³⁵⁶.

It is the aspect of life-threatening insecurity, however, that has pushed many LHWs over the edge: “I feel unsafe with the polio campaign. The Afghanis say no [to us carrying out the programme]. I have stitches...they shot at me two to three times but now that area has become better [to go to] because there were meetings. The councilors talked to them; the WHO was involved,” points out Gul³⁵⁷. This shooting incident occurred before the workers were targeted and even now³⁵⁸, while the administration scrambles to rectify the situation, suspicions and fears about the polio drops persist. “Now, even the *ulema*³⁵⁹ are saying that the polio drops are just to kill the virus [but] people say that it [the polio campaign] is a conspiracy of the Jews,” says Nida³⁶⁰. Zehra states that religious people and religious cleric have told her “that the medicines are for *nasal khoshi*^{361,362}. She also adds that many people are now fearful of being associated with the polio campaign. “There are so many...who have called and said ‘you’re not giving polio drops, are you?’ Before, people [community members, parents of children who were being vaccinated] were satisfied but after this [the murder of the polio workers] they are scared”³⁶³.

³⁵⁶ Participant 5, LHW, in discussion with the author, September-December 2012.

³⁵⁷ Participant 2, LHW, in discussion with the author, September-December 2012.

³⁵⁸ During the time the interviews were conducted from September-December 2012.

³⁵⁹ An educated class of Islamic legal scholars.

³⁶⁰ Participant 13, LHW, in discussion with the author, September-December 2012.

³⁶¹ The closest that this phrase could translate to would be “the murder of your race/ethnicity”.

³⁶² Participant 15, LHW, in discussion with the author, September-December 2012.

³⁶³ Ibid.

Some residents find the process of chalking that LHWs use to indicate whether children under five residing at a home have been vaccinated bothersome. As Zehra recounts: “They ruin the chalking. When we return to [these homes], they have erased the marks; the residents don’t let us make a mark with chalk on their walls, they say we are spoiling them”³⁶⁴. In light of recent events, however, this technique has taken on a more suspicious tone. As one analyst, critiquing chalking aptly puts it: “Even in friendly areas, the vaccine teams have protocols that look plenty suspicious. If a stranger knocked on a door in Brooklyn, asked how many children under age 5 were at home, offered to medicate them, and then scribbled in chalk on the door how many had accepted and how many refused — well, a parent might worry”³⁶⁵. A more feasible approach, especially in the wake of recent events would be to have a central area where people who want to get their children vaccinated do. “The way the current [security] situation is, they [the administration] should set up a camp where people can go and get their vaccinations done,” points out Nida.

That the administration has not considered how these campaign-related activities might arouse suspicion reflects how policy makers are disconnected from on-the-ground realities. The polio campaign, however, is not the only multilateral funded programme that has had unintended consequences on the LHW programme. In the next section, I look at how bilateral funders, in particular, USAID, have shaped the programme.

³⁶⁴ Participant 13, LHW, in discussion with the author, September-December 2012.

³⁶⁵ Mcneil Jr., “Getting Polio Campaigns Back on Track”.

5.4 USAID AND FAMILY PLANNING: DONORS, RECIPIENTS AND TECHNICAL FIXES IN THE LHW PROGRAMME

Given that only 2.2 percent of Pakistan's GDP is marked for health and education³⁶⁶, many social welfare programmes end up being run, in part, with international donor funds. For example, according to the WHO, USAID and DFID are major contributors to the nutrition and health programmes. Other such as the Asian Development Bank, UNICEF and the Aga Khan Foundation mainly fund reproductive health programmes³⁶⁷. Just like the WHO-led polio campaign has affected the LHW programme, international donor's agendas have influenced the focus of the programme in other ways too. This shall be discussed in the next section.

Medical Supplies in the LHW Programme

Under the LHW programme, the workers are supposed to be regularly provided with medical supplies. Half of the workers I talked to, however, mentioned how medicines for colds, fevers and coughs as well as multivitamins and folic acid are no longer provided as they previously were. One thing the LHWs have in excess supply, however, are condoms and birth control pills³⁶⁸. While there is demand from the community members they serve for medicines, the workers do not have any to give. "These days we only get things and medicines for family planning. People ask us for medicine but we don't have anything with us," says Nadia³⁶⁹. Another LHW, Gul, points out how they would be given monthly supplies but now "a lot of medicines such as fever tablets, they [the administration] aren't giving them anymore"³⁷⁰. Similarly, Parveen states that "it would be nice to have medicines just to show them or tell them

³⁶⁶ World Health Organisation, *World Health Statistics 2012*, accessed March 5, 2012, http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html.

³⁶⁷ World Health Organisation, *Country Cooperation Strategy at a Glance*, accessed March 5, 2012, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_pak_en.pdf

³⁶⁸ Based on interviews of LHWs, in discussion with the author, September-December 2012.

³⁶⁹ Participant 16, LHW, in discussion with the author, September-December 2012.

³⁷⁰ Participant 2, LHW, in discussion with the author, September-December 2012.

which ones they need”³⁷¹. Tanya, who is passionate about her job and patients, went into a very long discussion on the LHWs no longer being provided with a supply of necessary medicines:

“If the LHW doesn’t even have medicines then what do we tell [our patients]? Before, you got bandages, cough syrup, [and] stomach medicine. Now, you don’t get anything. Now we’re just given birth control pills and condoms. Eight to nine months ago they stopped giving it. We have to listen to so many complaints. We don’t have medicines for women and children. I sometimes buy it but they should give it. Before folic acid used to come, now we give subscriptions. Before there were multivitamins, now they don’t even give cotton balls”³⁷².

Thus, while improving nutrition and primary health care for low-income populations was the main aim of the programme, it seems, the emphasis has shifted purely to family planning and polio. The probable reasons behind this change, as will be explored in the next section, has to do with how these projects are funded. The focus in particular is on USAID, as it is one of the largest bilateral funders of Pakistan’s health sector.

US Aid and Pakistan

Since 2001, when the US began its War on Terror³⁷³ Pakistan has become one of US’s top aid recipients. In 2010, for instance, amongst America’s recipients of assistance, Pakistan

³⁷¹ Participant 6, LHW, in discussion with the author, September-December 2012.

³⁷² Participant 3, LHW, in discussion with the author, September-December 2012.

³⁷³ Instead of being called the US War *on* Terror (WoT) it should be called the US War *of* Terror. WoT began, following the September 11, 2001 terrorist attack by al-Qaeda on the World Trade Center in New York which killed 3,000 civilians. Since then, in its hunt for al-Qaeda militants and operatives, the US has militarily invaded or carried out operations in Afghanistan, Iraq, Pakistan and Yemen in partnership with NATO forces. WoT, in its 12-year-existence, has claimed the lives of hundreds of thousands of Afghani, Iraqi, Yemeni and Pakistani civilians. The majority of those dead are Afghans and Iraqis. While the exact figures are hard to calculate and are up for speculation, various organisations and institutes have carried out studies.

The Costs of War project estimates that between 151, 000 to 202,000 civilians have died in Afghanistan, Iraq and Pakistan due to the ongoing conflicts. According to a study carried out by the *New England Journal of Medicine*, 151,000 Iraqis have died from March 2003 to June 2006 as a result of the US-led invasion of Iraq. According to a UN report, at least 14,728 Afghans have lost their lives between 2006-2012 as a result of the violence and conflicts that stems from the US invasion of the country. The figures from 2001-2006 are speculated to be higher. *The Guardian* journalist Jonathan Steele estimates that 19,480 people had died by May 2002, due to the 2001 US intervention and bombing of Afghanistan.

ranked second, after Afghanistan and before Israel. As a partner in US's 'War on Terror', Pakistan has received aid worth 15.8 billion dollars from 2002 to 2012, two-thirds of which is security assistance³⁷⁴. The amount of non-security or civilian aid marked for Pakistan was increased to 1.5 billion dollars annually or 7.5 billion for the next five years when the US Congress passed the Enhanced Partnership with Pakistan Act of 2009³⁷⁵. The funds were to be disbursed through the US-federally mandated international aid agency, USAID. From 2009 to May 2013, working in partnership with Pakistani federal and provincial government, local contractors and institutes, USAID had spent 2.8 billion dollars on the five main sectors of education, health, energy, economic growth and stabilization³⁷⁶.

The main goal of the health programmes funded and directed by the USAID is to "save 190,000 lives over five years through a network of innovative public-private partnerships that will reduce maternal and infant mortality and increase health pregnancies and birth spacing"³⁷⁷. Approximately 142.24 million dollars have been allocated for various health projects from 2008 to the current period³⁷⁸. Under the "Health Supplies Distribution Project" 13 million dollars have been spent from September 2011-2012 ensuring "the availability of contraceptive commodities"

For more details see: Jonathan Steele, "Forgotten Victims," *The Guardian*, May 20, 2002, accessed April 30, 2013, <http://www.guardian.co.uk/world/2002/may/20/afghanistan.comment.html>; "Civilians Killed and Wounded," *Costs of War*, accessed May 1, 2013, <http://costsofwar.org/article/civilians-killed-and-wounded>.

³⁷⁴ Congressional Research Service, *Pakistan: US Foreign Assistance*, 6, October 4, 2012, accessed May 1, 2013, <http://www.fas.org/sgp/crs/row/R41856.pdf>

³⁷⁵ Congressional Research Service, *Pakistan: US Foreign Assistance*, 8, October 4, 2012, accessed May 1, 2013, <http://www.fas.org/sgp/crs/row/R41856.pdf>

³⁷⁶ "Mission Overview," USAID Pakistan, accessed May 1, 2013, <http://transition.usaid.gov/pk/about.html>.

³⁷⁷ "Health," USAID Pakistan, accessed May 1, 2013, <http://transition.usaid.gov/pk/db/sectors/health.html>.

³⁷⁸ Ibid.

and to “build local capacity for sustainable contraceptive commodities supply”³⁷⁹. Funding from such projects is most likely the reason why LHWs have supplies of condom, instead of cold medicines. In addition, USAID spent approximately 48 million dollars on family planning programmes such as projects promoting spacing births, and the commercial marketing of contraceptives³⁸⁰.

Of Technical Fixes and Family Programming: Recommendations for the LHW programme

USAID’s focus on birth control projects is not surprising given that it is a significant part of its agenda. The agency has given money to 95 countries, including 45 sub-Saharan African states, for family planning purposes. As Yuval-Davis points out much of the programming is driven not out of concern for controlling the population but due to ‘national interests’. For instance, the Regan administration spent three billion dollars on population control as part of development aid in the wake of CIA reports that described high birth rates leading to ‘political instability’ in the Global South³⁸¹.

Even if population control by the state is justified and considered reasonable, promoting the use of condoms and birth control pills does not address the various social and systemic reasons behind the high birth rate in Pakistan. Instead this type of programming highlights what many development anthropologists have called ‘technical fixes’. That is policy makers have come up with a problem that can then be solved technically without considering its effectiveness

³⁷⁹ “Health: Health Supplies Distribution Project” USAID Pakistan, accessed May 1, 2013, http://transition.usaid.gov/pk/db/sectors/health/project_178.html.

³⁸⁰ “Health: Family Health Project,” USAID Pakistan, accessed May 1, 2013, http://transition.usaid.gov/pk/db/sectors/health/project_89.html.

³⁸¹ Yuval-Davis, *Gender & Nation*, 34.

or weighing its implementations in practice³⁸². There are various cultural reasons behind wanting a high birth rate. For instance, children provide a safety net for people residing in countries where there are no or poorly developed social welfare programmes to take care of the elderly or ill³⁸³ as is the case in Pakistan. In addition, the high infant mortality also probably plays a part³⁸⁴. For instance, Pakistan ranks twenty-fifth in the world in infant mortality rates, with 59.3 deaths for every live 1,000 births³⁸⁵. Thus, family planning programmes do not address the social and systemic reasons behind Pakistan's high birth rate. It would therefore be more sensible to spend money on training LHWs to acquire the needed skills or focusing on mid-wife programmes than on simply distributing contraceptives.

Many professionals working in the field have similar critiques on the focus of the LHW programme. As Dr. Shershah Syed, founder of the NGO, Pakistan National Forum on Women's Health, points out that even now "70 per cent of the deliveries are done without a skilled health worker. You need two years training to get a skilled health worker...if you need to get an everyday C-section carried out or there is a medical emergency, how will the maternity and child mortality rate go down?"³⁸⁶ Even the health workers themselves are cognizant of the further skills they should acquire: "If there was practical training then that would be much better...like they have for nursing. We wish that we do get basic training. If there is a problem during the

³⁸² Tania Murray Li, "Development in the Age of Neoliberalism," *The Will to Improve: Governmentality, Development and the Practice of Politics*, (Durham & London: Duke University Press: 2007), 230-269; Emma Crewe, "The Silent Tradition of Development Cooks," in *Discourses of Development: Anthropological Perspectives* ed. R.D. Grillo & R.L. Stirrat (Oxford & New York: Berg, 1997), 59-80.

³⁸³ Yuval-Davis, *Gender & Nation*, 34.

³⁸⁴ Ibid.

³⁸⁵ "The World Factbook," CIA, accessed May 5, 2013, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html>.

³⁸⁶ In discussion with the author, September-December 2012.

delivery then we can't do anything. We can give suggestions but we can't do anything," points out one of the LHWs³⁸⁷.

Many LHWs, seeing the demand for birth-delivery 'professionals' such as *dais*³⁸⁸ and mid-wives, have trained for it and work in both their old and new jobs. As Mrs. Imtiaz Kamal, secretary general of the National Committee for Maternal Health explained, a trend has emerged of late: "We discovered that many of the LHWs are working as *dais* when at a workshop, out of 14 attendees, 12 were LHWs," she says. She points out that while in their initial job description, the health workers were simply supposed to assist the *dais* or mid-wives in the deliveries, they have eventually acquired the skills and started working as *dais* or mid-wives themselves³⁸⁹.

While USAID aims "to reduce maternal and infant mortality and increase health pregnancies and birth spacing³⁹⁰," through the projects it funds, options other than a focus on birth control should be looked into. A better approach, for the Pakistani government and its international partners, as Dr. Syed³⁹¹ has suggested, would be a focus on training mid-wives. "What is the alternative to LHWs? Have skilled, competent mid-wives. There are 150,000 mid-wives".

5.5 CONCLUSION

While the initial focus of LHW programmes was on raising awareness that would contribute to decreasing infant and maternal mortality, and providing basic public and primary health care services, the focus of the programme has shifted. This is due to oversight by the Pakistani government and because of the way these programmes are often funded. In addition, as

³⁸⁷ Participant 9, LHW, in discussion with the author, September-December 2012.

³⁸⁸ The closest Canadian equivalent to *dais* would be Traditional Birth Attendants.

³⁸⁹ In discussion with the author, September-December 2012.

³⁹⁰ "Health," USAID Pakistan.

³⁹¹ In discussion with the author, September-December 2012.

highlighted with the case study of the polio campaign, multilateral organisations' agendas can have unintended consequences on the ground, and have also affected the LHW programme negatively. Thus, health workers are often caught in the crosshairs of the effects of poor development programming. The geopolitical environment that the workers operate in has compounded these effects further.

While this chapter may portray health workers as unwilling actors with 'choiceless' choices, as shall be explored in the next chapter, LHWs have shown agency, and are resisting the system they work within in their own way. In Chapter Six, I look at how LHWs have reconstructed their identities using nationalist rhetoric.

CHAPTER SIX

ARE LHWS HEROES, MARTYRS OR VICTIMS? POLITICAL RHETORIC AND IDENTITY POLITICS

6.1 INTRODUCTION

During post-independence Pakistan, Begum Rana Liaquat Ali Khan³⁹², one of the country's female leaders, emphasized that it was Pakistani women's duty, "to work towards the defence, development and betterment of the country...this [was] not the time for [them] to sit quietly in their homes. They [had] to come out of their homes to learn to work and then teach others to do so"³⁹³. Indeed, female citizens of the newly created state of Pakistan were repeatedly called on to perform their duty and to sacrifice their time for the nation. One of the ways to do so was to provide health services to Pakistani citizens³⁹⁴.

As I shall explore further in this chapter, LHWs have interlaced their demands for better working conditions, with a similar rhetoric of sacrifice, duty and martyrdom. This can be seen as a re-appropriation of the tropes of health, sacrifice and patriotic duty that entered into the national imaginary in 1947. First, a history of Pakistan's nationalist discourse will be addressed. This will be followed by a discussion on the rhetoric used by the health care workers in the LHW movements. Finally, whether the discourse on sacrifice and martyrdom leads to political power will be analysed.

³⁹² Rana Liaquat Ali Khan was the first lady of Pakistan. She was the founder of the non-profit group All Pakistan Women's Association which promoted women's rights and empowerment through various social and economic programmes. She also helped form Pakistan's Women National Guards and the Pakistan Women Naval Reserve. She was Pakistan's ambassador to the Netherlands and Italy, and is the only woman to serve as a governor of a province in the country. She was also closely involved in the Pakistan movement in pre-Partition India. For more details see *An Introduction to Women's Parliamentary Caucus*, Parliament of the Islamic Republic of Pakistan.

³⁹³ Rana Khan quoted in Sarah Ansari, "Polygamy, Purdah and Political Representation: Engendering citizenship in 1950s Pakistan," *Modern Asian Studies* 43, no. 6 (2009): 1438.

³⁹⁴ Ibid.

6.2 GENDERED DISCOURSES: WOMEN, SACRIFICE AND NATIONALISM

Islam, women and sacrifice have been part of the public discourse around Pakistan's citizenship and national imaginary since the creation of the state in August 1947³⁹⁵. In fact, during the movement for the creation of Pakistan in pre-Partition India, Jinnah, the leader of the Muslim League movement, called upon Muslim women to do their part. As he stated in 1938, "no nation [could] make progress without the co-operation of its women. If Muslim women support their men as they did in the days of the Prophet of Islam, we should soon realise our goal."³⁹⁶

After independence, the government continued to call upon the services of women. The need to provide logistical, medical and moral support to the often destitute refugees coming in across the border, provided opportunities for women to extend their "former philanthropic concerns"³⁹⁷ into slightly new territory. In addition, these were seen as social services and therefore, an extension of women's domestic duties. Soon after Partition, in 1947, Begum Rana Liaquat Ali Khan formed the Pakistan Women's Volunteer Service (PWVS). Under the PWVS umbrella women helped out refugees and provided services such as medical aid, and distributed food and clothes. The Pakistan Women's National Guard (PWNG) and the Pakistan Women's National Reserve (PWNR) were formed soon after, in 1948 and 1949, respectively. They aimed to train women in the basics of physical fitness, defence and nursing³⁹⁸.

³⁹⁵ Tahir Naqvi, "Migration, Sacrifice and the Crisis of Muslim Nationalism," *Journal of Refugee Studies*, (2012): 1-17; Ansari, "Polygamy, Purdah and Political Representation," 1421-1461; Amina Jamal, "Gender, Citizenship, and the Nation State in Pakistan: Willful Daughters or Free Citizens?" *Signs* 31 no. 2 (2006): 283-304.

³⁹⁶ Ansari, "Polygamy, Purdah and Political Representation," 1434

³⁹⁷ *Ibid.*, 1438.

³⁹⁸ *Ibid.*, 1437.

As the history of post-conflicts show, however, once a conflict or nationalist movement ends, women lose the political and economic emancipation they had gained during the time. They are instead expected by men to forgo the public sphere, revert to the private and assume traditional roles³⁹⁹. Pakistani women were no exception to the rule. However, post-Partition organisations such as PWNG, PWRN and PWVS allowed women to redraw the lines between the private and public spheres in Pakistani society. That is, they were still able to participate in public but within limitations of the national imaginary. A Pakistani woman was a good citizen if she participated in the public sphere and provided social services (which were seen as an extension of domestic duties)⁴⁰⁰. The LHWs, as shall be discussed next, emphasize this association between being a dutiful citizen and providing welfare services.

LHWs and Nationalist Rhetoric

The LHWs are not the only government employees to demand better pay and benefits from the state. In 2013 alone both teachers and junior-level doctors working at government institutes in Pakistan have protested for better working conditions⁴⁰¹. And like the LHWs, these workers have staged demonstrations in previous years. For instance, there have been teacher protests in the province of Sindh in 2009⁴⁰², and in Punjab in 2011⁴⁰³ and 2012⁴⁰⁴. Doctors in

³⁹⁹ Susan Willett, "Introduction: Security Council Resolution 1325: Assessing the Impact on Women, and Security", *International Peacekeeping* 17, no. 2(2010): 142-158; Heidi Hudson, "Peacebuilding through a Gender Lens and the Challenges of Implementation in Rwanda and Cote d'Ivoire", *Security Studies* 18, no. 2(2009): 287-318; Nadine Puechguirbal, "Discourses on Gender, Patriarchy and Resolution 1325: Textual Analysis of UN Documents", *International Peacekeeping* 17, no. 2 (2010): 172-187.

⁴⁰⁰ Ansari, "Polygamy, Purdah and Political Representation," 1437.

⁴⁰¹ "Doctors protest," *Dawn*, February 13, 2013, accessed March 1, 2013, <http://dawn.com/2013/02/13/doctors-protest-3.html>; "Teachers protest continues," One Pakistan, posted February 21, 2013, accessed March 1, 2013, <http://pakistan.onepakistan.com.pk/news/city/islamabad/179072-teachers-protest-continue.html>.

⁴⁰² "Teachers protest across Sindh," *Dawn*, May 28, 2009, accessed March 1, 2013, <http://archives.dawn.com/archives/76359.html>.

⁴⁰³ "Protest for salaries: Unpaid Punjab teachers win court battle," *Express Tribune*, October 19, 2011, <http://tribune.com.pk/story/277144/protest-for-salaries-unpaid-punjab-teachers-win-court-battle.html>.

Lahore demonstrated for higher salaries in March 2013, and a similar doctors' strike took place in the city two years ago⁴⁰⁵.

The health workers, however, have managed to generate public interest and media attention, something many labourers protesting in Pakistan are unable to do⁴⁰⁶. One of the reasons for this could be the Pakistani nationalist tropes of sacrifice and martyrdom prevalent in the LHW rhetoric. For instance, a teacher from the Railway Schools Lady Teachers Association protesting in Lahore on December 10, 2012 points to the “the fundamental rights of downtrodden Pakistani lady teachers” and the fact that “lower educated staff” receive higher pay and benefits as reasons to justify higher pay and benefits for their profession⁴⁰⁷. In contrast, the LHWs' discourse emphasizes the ‘sacrifices’ they have made for the nation. For example, when asked about the tensions between the government and the health workers, APLHWA's Karachi head, Naseem Munir, states:

“For so many years we helped – because of us, because of LHWs, the infant and maternal mortality rate has decreased. We saved the lives of the nation's mothers and children. We kept on listening to people's threats and had a sword on our heads. But despite this, what did we get? ...two LHWs died. One was from Multan and she committed suicide; she had two children and her husband didn't have a job, and her pay wasn't regular.”⁴⁰⁸

Munir, in the above statement, does not argue that the health workers deserve better working conditions because they provide health services. Instead, she points out that they are

⁴⁰⁴ “Punjab Teachers Union: Protests called off after govt pledge,” *Express Tribune*, November 8 2012, accessed March 1, 2013 <http://tribune.com.pk/story/462275/protests-called-off-after-govt-pledge.html>.

⁴⁰⁵ “Doctors protest denial of revised pay package,” *Dawn*, March 2, 2011, accessed March 1, 2013 <http://dawn.com/2011/03/02/doctors-protest-denial-of-revised-pay-package.html>.

⁴⁰⁶ “Bushra Arain LHW Ghotki Protest,” Metro One TV.; “Govt. accepts demands of lady health workers,” *Express Tribune*, June 4, 2010, accessed May 15, 2012, <http://tribune.com.pk/story/18851/govt-accepts-demands-of-lady-health-workers.html>.

⁴⁰⁷ “PR women teachers protest for service regularisation,” *Daily Times*, December 10, 2012, accessed March 1, 2013, http://www.dailytimes.com.pk/default.asp?page=2012%5C12%5C10%5Cstory_10-12-2012_pg13_3.html.

⁴⁰⁸ Participant 18, LHW, in discussion with the author, September-December 2012.

serving the nation by serving its women and children. Themes of sacrifice, patriotic duty and helping the nation through medical aid become intertwined in her speech. Just as Rana Liaquat Khan reminded the nation that it was every Pakistani woman's duty to assist in developing the country and helping out in clinics, Munir reminds the Pakistani public that they did as asked and carried out their patriotic duties. She implies that they now should be rewarded accordingly for their sacrifices. Similarly, following the killing of the polio workers in a string of targeted attacks on December 18, Munir points out that it is the people "who are trying to secure the nation's future [who] are being targeted with bullets"⁴⁰⁹. Once again a link is drawn between Pakistani national interests and the services the workers were providing.

6.3 LHWs, SACRIFICE AND MARTYDOM

Two of Pakistan's most influential and powerful parties, the Pakistan Peoples Party (PPP) and the Muttahida Qaumi Movement (MQM) have made sacrificial tropes part of their political discourse. MQM's political rhetoric builds on the discourse on citizenship used by the Muhajir community while PPP emphasizes its leaders' martyrdom. The LHWs have drawn similar parallels between their sacrifices and citizenship. The political parties' rhetoric will be looked at first and the LHWs' discourse will be discussed next.

MQM's Political Rhetoric

During the 1947 Partition, British India was split into Pakistan, containing the Muslim-majority provinces, while the Hindu-majority states formed the nation of India. Muslim populations in India who were deemed to be under threat of communal violence were allowed to migrate to the newly formed state of Pakistan. Muslims residing in the Hindu-majority provinces, on the other hand, were discouraged by the Muslim League leaders to migrate to

⁴⁰⁹ Ibid.

Pakistan. That is, even though the discourse on Pakistan was that it was a state created for Muslims residing in pre-Partition India, the Muslims who migrated from the Muslim-minority states, the Muhajirs, were viewed as transgressing official policy by the Pakistani state, and were not recognised as true citizens⁴¹⁰. In order to legitimise themselves as Pakistanis, the Muhajirs reconstructed the narrative on their migration “in the sacrificial decision to abandon India *for* Islam”⁴¹¹. The Muhajirs, thus, argued that theirs was the “true sacrifice” as they were forcefully uprooted and had to abandon “their physical and cultural habitats”⁴¹².

This sacrifice trope was continued in the political discourse of the Karachi-based party, the Muttahida Qaumi Movement (MQM), formed in 1985 to politically represent the concerns of the Muhajir community in Pakistan. Since 2002, the party has established itself as the biggest and most powerful political party in Karachi⁴¹³. While many factors can be attributed to its success, one of them is the way it has reconstructed itself to appeal to the Muhajir identity of sacrifice. For instance, MQM’s leader, Altaf Hussein, often emphasizes sacrificial themes in his rhetoric and speeches. In a 1994 teleconference, he states “We are left with half-achieved independence. Muslims got the country, but we are still slaves. Before it was the foreigners, the colonialists and today we are slaves to our own people. We went through many sacrifices. Muhajirs never were, or have been, enemies of Pakistan. Don’t push us away. In an interview, he points out that “Pakistan is the gift of the sacrifice of our elders”⁴¹⁴.

⁴¹⁰ Naqvi, “Migration, Sacrifice and the Crisis of Muslim Nationalism”: 1-17.

⁴¹¹ Ibid: 5.

⁴¹² Bilal Baloch, “The Role of Leadership and Rhetoric in Identity Politics: Muttahida Qaumi Movement (MQM), a Case Study,” *Al Nakhlah* (Winter 2012): 7.

⁴¹³ Ibid.

⁴¹⁴ Ibid.

PPP's Political Discourse

Shaheed has been used to great political effect by the PPP, one of Pakistan's biggest and most successful political parties. It has ruled the country from 1971 to 1977, briefly from 1988 to 1990, and from 1992 to 1996. It finally completed a full five-year term in office, from 2007 to 2012⁴¹⁵. Both of PPP's former leaders, Benazir Bhutto⁴¹⁶, who was assassinated and Zulfikar Ali Bhutto, who was hanged in prison⁴¹⁷, are referred to as *shaheed* by the PPP in public statements and in its marketing campaigns⁴¹⁸.

The term *shaheed* encapsulates not just religious but also political ideologies. A narrow theological interpretation would be restricted to a person/people committing suicide or willingly dying for a greater political or religious cause⁴¹⁹. In the Pakistani political context, however, this term, is even applied to people who could be considered as victims. It has become part of the country's political discourse and is an extension of the nationalist rhetoric of Pakistan being a

⁴¹⁵ "About Party," PPP, accessed May 13, 2013, <http://www.ppp.org.pk/pppchange/about.html>.

⁴¹⁶ Benazir Bhutto was assassinated on December 27, 2007 at an election rally in the Pakistani city of Rawalpindi in the lead up to the country's 2008 election. The Pakistani government blame the Taliban for the attack but Behtullah Mehsud, the Taliban leader in South Waziristan denies the accusations. The prosecutor in Benazir Bhutto's murder trial was shot dead in Islamabad in March 2013. See "Q&A: Benazir Bhutto assassination," BBC, last updated May 3, 2013, accessed May 5, 2013, <http://www.bbc.co.uk/news/world-asia-22394552.html>.

A UN report investigating Bhutto's assassination was released on April 15, 2010. For more details see http://www.un.org/News/dh/infocus/Pakistan/UN_Bhutto_Report_15April2010.pdf

⁴¹⁷ Zulfikar Ali Bhutto was hanged on April 3, 1979 during the military regime of Zia ul Haq. Bhutto was given the death sentence for murdering a political opponent. The Bhutto murder trial took place in a tense political environment, and many observers point out that the murder trial was conducted unfairly and that several judges involved in the case showed bias. For more details see "On this Day; 1979: Deposed Pakistani PM is executed," BBC, accessed May 13, 2013, http://news.bbc.co.uk/onthisday/hi/dates/stories/april/4/newsid_2459000/2459507.stm.html.

⁴¹⁸ See "Shaheed Zulfikar Ali Bhutto", PPP, accessed May 13, 2013, <http://www.ppp.org.pk/pppchange/about.html> and "Mohtarma Benazir Bhutto," PPP, accessed May 13, 2013, <http://www.ppp.org.pk/bb.html>

⁴¹⁹ Shannon Dunn "The Female Martyr and the Politics of Death: An Examination of the Martyr Discourses of Vibia Perpetua and Wafa Idris," *Journal of the American Academy of Religion* 78, no. 1(2010): 202–225.

state created for Muslims⁴²⁰. Thus, being a martyr within Pakistan's national imaginary is not just a religious sacrifice but a patriotic one. PPP often draws these links between the party's former leaders and martyrdom.

For example, in the weeks leading up to December 27, 2012, the death anniversary of Benazir, Pakistani cities are dotted with billboards displaying either pictures of the former leader or a montage of the Bhutto family. The pictures are often accompanied by slogans such as *shaheed mohtarma* Benazir Bhutto, *shaheed* Zulfiqar Bhutto, and *jeeyay Bhutto* (or the English slogan, long live the Bhuttos). For example, one poster, which depicts Benazir, in her now characteristic white dupatta, states: "Alive, she was Benazir, as a martyr, she is Benazir; she is now part of the destiny of the martyr Bhutto family"⁴²¹. Another, commemorating Zulfiqar Ali Bhutto's thirty-third death anniversary states "we present *khiraj-e-aqeedat*"⁴²² to shaheed Zulfiqar Ali Bhutto"⁴²³. Thus, in the public imagination, the Bhuttos are always associated as martyrs for the nation: the public is told that they are the ones who have given the ultimate sacrifice demanded by the state. Their deaths are the extreme expression of patriotic duty.

Sacrifice Tropes in LHW discourse

Similar rhetoric, with the emphasis on *qurbani* or sacrifice can be found in an interview of a LHW on an episode of the talk show, *News night with Talat*. The show aired following the suicide of Rukhsana, an LHS from Multan, and featured a government representative who

⁴²⁰ Naqvi, "Migration, Sacrifice and the Crisis of Muslim Nationalism," 1-17.

⁴²¹ "PPP's Bhutto Fan Page," Facebook, accessed May 1, 2013

http://sphotos-f.ak.fbcdn.net/hphotos-ak-ash3/p480x480/557336_390646764357114_1401617271_n.jpg

⁴²² Like the term *shaheed*, *khiraj-e-aqeedat* is theological in its origin. It was often used to describe the immense faith of Prophet Muhammad. The closest translation would be "an overwhelming show of intense faith and loyalty".

⁴²³ Demotix, accessed May 1, 2013 http://static2.demotix.com/sites/default/files/imagecache/a_scale_large/1100-8/photos/1333483032-33rd-death-anniversary-ceremony-of-zulfiqar-alibhutto_1140518.jpg

claimed that the administration simply did not have the funds to pay the LHWs' salaries. In response to these statements, the LHW angrily points out:

“The state has a right to take services from us but they don't have the funds to give us our pay so then on what basis have they hired us?...our minister from Multan...he should have carried out the *qurbani* [sacrifice] of goats [on Bakra Eid]⁴²⁴, not the *qurbani* [sacrifice] of our lady health supervisor.”⁴²⁵

Similar to the rhetoric of MQM and PPP, the theological themes of *qurbani* and suffering are prevalent in this discourse. The LHWs emphasize that they have literally sacrificed themselves and can be considered martyrs. For example, when Bushra Arain, APLHWA's chairperson, is questioned about one of the workers who set himself on fire⁴²⁶ during the April 18, 2012 LHW protest, she points out “We are dying in any case then why not sacrifice our lives for the betterment of others?”⁴²⁷

Arain, thus, portrays the struggle of the LHWs in terms of martyrdom. Politicians like the Bhuttos have used the rhetoric of *shaheed* for political gain and to garner public support. In Pakistan, martyrdom and sacrifice have been used by politicians to legitimise their rise to power. In other words, they suffered to obtain their political position and are ‘deserving’ of it. It seems women can gain even more political clout through their portrayal of suffering than men can. As Dagmar Hellman-Rajanayagam, in his discussion on how religious discourse shapes South Asian

⁴²⁴ Bakra Eid is an Islamic festival that takes place in the country annually. During this religious festival, people will often kill, in their homes, goats or cows they have bought a few days or weeks earlier; the animals are considered a ‘sacrifice’. The ritual is a symbolic re-enactment of the story, told in both the Bible and the Quran, of Prophet Ibrahim who agreed to sacrifice his son to show his dedication to God or Allah.

⁴²⁵ DawnNewsPakistan, “News Night with Talat-Lady Health worker commit suicide-Part-4,” YouTube video 5:36. Posted November 24, 2010, <http://www.youtube.com/watch?v=fCLE9uZoLKo.html>

⁴²⁶ Kundi, “Factors making LHWs say enough is enough.”

⁴²⁷ Sehrish Wasif and Umer Nangiana, “LHWs Protest: Pushed to limits man sets himself on fire,” *Express Tribune*, accessed May 5, 2013, <http://tribune.com.pk/story/366731/lhws-protest-pushed-to-limits-man-sets-himself-on-fire.html>.

politics points out “from their suffering women can derive power, strength and authority”⁴²⁸. For the LHWs this means that reconstructing their identities as ‘suffering women’ garners them public support and sympathy. Something which is essential in getting their demands heard.

As shown in this chapter, the LHWs have made effective use of political and nationalist rhetoric to generate public sympathy for their cause, and to get their demands heard in the public space including the media. In the next section, I look at what the future holds for the LHWs and what tactics and options they have in making their labour movement more effective. I finally give a summary of my research’s findings and explore potential practical applications of the LHWs’ case study.

6.4 CONCLUSION

So far, LHWs reflections on their professional identities and their work experiences have been situated within patriarchal and neocolonial systems. In addition, the rhetoric of their demands has been located within Pakistani political and nationalist discourse. What have not been discussed are the tactics employed by the LHWs. In the last section of my thesis, I look at what direction the health workers can take their movement and what the future holds for them. In addition, I give a brief overview of my analysis, findings and possible practical applications.

What the Future Holds for the LHWs

As mentioned in the introduction of this thesis, the LHWs are in a perpetual tango with the Pakistani state. They hold nation-wide strikes, sit-ins and protest, and the government agrees to make the necessary changes. However, the Pakistani state then backtracks and does not deliver

⁴²⁸ Dagmar Hellman-Rajanayagam, “The Living Sacrifice...? Heroes, Victims, Martyrs,” in *Goddesses, Heroes and Sacrifices: Female Political Powers in Asia*, ed. Dagmar Hellman-Rajanayagam and Andrea Fleschener (Berlin: LIT-Verlag, 2008): 22.

on these promises⁴²⁹. The LHWs, thus, are caught in the crosshairs of what Richard Day calls the “Politics of Demand”⁴³⁰. He points that it is wrongly assumed that the state is a “neutral arbiter, a monological consciousness that, upon request, dispenses rights and privileges in the form of a gift”⁴³¹. While Day is referring to the failure of the state-based policy of multicultural liberalism, it can be generalized and applied here. The reason for the circuitous nature of the LHW movement is its failure to recognise that the state is “a neutral arbiter” that can be pressured into delivering the LHWs’ demands. Day advocates exploring alternatives to the state. However, the health workers are not simply protesting against the state, they are striking against their employers. And it must be noted that most LHWs have limited economic and social resources and face a bleak job market. They do not have the option of leaving their existing exploitative job to find one that is less exploitative, and they face ‘choiceless choices’. Many LHWs simply cannot afford to explore an alternative to the state.

There are few options available to LHWs such as suspension of their services on a mass scale till the state brings the changes the workers demand into effect. They can also continue to protest as they have done so far. While it has not been effective in bringing about the systemic change the LHWs are fighting for, it has resulted in piece-meal compensations. For instance, after protesting for months in early 2012, in August of the same year, the workers were finally paid three-months of salaries they were owed by the government⁴³².

⁴²⁹ “A long struggle,” *Dawn*; “Government accepts demands of lady health workers,” *Express Tribune*; Wasif, “Strong ultimatum: Lady health workers threaten to set themselves alight”.

⁴³⁰ Richard J.F. Day, “Tracking the Hegemony of Hegemony: Postmarxism and the New Social Movements,” *Gramsci is Dead: Anarchist Currents in the Newest Social Movements* (Toronto/London: Between the Lines/Pluto Press, 2005): 80.

⁴³¹ *Ibid.*

⁴³² “LHWs get three months’ salaries,” *The News*, August 19, 2012, accessed May 6, 2013.

A change in Pakistan's political leadership also provides a sliver of 'hope'. On May 11, 2013, the nation elected a new leader in the first peaceful democratic transition of power in its 67-year history. Nawaz Sharif, who has been elected prime minister twice before, emerged the clear winner in what was predicted to be a close election race by analysts⁴³³. Like all his political predecessors, Sharif promised to economically develop the nation stating "we are the change" in his acceptance speech⁴³⁴. Unfortunately, 'change' is a word that, in the post-Barack Obama era, has become clichéd, contrived and associated with false promises. Whether, the new government will provide Pakistanis, including LHWs, with what can be demanded of any state - their basic labour rights - remains to be seen. For now, the health workers have continued to voice their demands.

On May 6, 2013, when the country was in the grip of pre-election fervor and rallies⁴³⁵, the LHWs in Mardan held their own rally. They wanted the government to give them their salaries for the months of March and April. Mardan's LHW president Baji Roshan pointed out that the government also owed them "stipends of the last six polio drives"⁴³⁶. One can hope that unlike the previous administration, the new one will deliver on the LHWs demands. If that does not happen, however, based on their past, one can expect the health workers to continue voicing their demands.

<http://labourwatchpakistan.com/?p=10058>. html.

⁴³³ Mohammed Hanif, "Pakistan elections: how Nawaz Sharif beat Imran Khan and what happens next," *The Guardian*, May 13, 2013, accessed May 14, 2013, <http://www.guardian.co.uk/world/2013/may/13/pakistan-elections-nawaz-sharif-imran-khan>.html.

⁴³⁴ Amanda Hodge, "Nawaz Sharif vows change for Pakistan as Imran Khan's hopes dashed," *The Australian*, May 13, 2013, accessed May 14, 2013, <http://www.theaustralian.com.au/news/world/nawaz-sharif-vows-change-for-pakistan-as-imran-khans-hopes-dashed/story-e6frg6so-1226640657726>. html.

⁴³⁵ Cyril Almeida, "Punjab: Pakistan's political heartland," *Al-Jazeera News*, May 6, 2013, accessed May, 2013, [http://www.aljazeera.com/indepth/spotlight/pakistanelections/2013/05/201356183748182877](http://www.aljazeera.com/indepth/spotlight/pakistanelections/2013/05/201356183748182877.html).html.

⁴³⁶ News in Brief," *Dawn*, May 9, 2013, accessed May 10, 2013 <http://dawn.com/2013/05/09/news-in-brief-318>. html.

Generalisability of the Research and Contribution to the Literature

This research has highlighted several issues facing LHWs such as low morale, a high work load, disrespect by managers, a lack of professional identity, irregular pay, low wages and stress stemming from working on the polio campaign. In addition, the health workers face systemic discrimination due to their gender⁴³⁷ and low socioeconomic status⁴³⁸. Multilateral and bilateral agendas also negatively affect the outcomes of the LHW programmes and the LHWs' work experiences. The health workers face life-threatening risks on their jobs, particularly in regard to the work they carry out for the WHO-led polio campaigns. While the study cannot be generalised to all of Pakistan, it does shed light on some of the relevant issues facing health workers in the country.

As mentioned in the introduction, globally, there is a high turnover of low-wage health workers⁴³⁹. Retention of workers such as UCWs, mid-wives and community health workers is important given the unmet need for primary healthcare services in both developing and developed countries⁴⁴⁰. An estimated one billion people globally have no access to healthcare services⁴⁴¹. In addition, there is a shortfall of conventional medical practitioners such as doctors. For instance, according to the WHO, approximately half of the world's population resides in rural areas but these areas are served by only 24 percent of the world's doctors⁴⁴². Thus, health

⁴³⁷ See Chapter Three for more details.

⁴³⁸ See Chapter Four for more details.

⁴³⁹ Stone and Weiner, "The Long-Term Care Frontline Workforce," 11; George, "A midwife crisis: Not enough doctors, not enough midwives"; Hardy, "How Canada's midwife shortage forces healthy mothers into hospitals".

⁴⁴⁰ Ibid.; Zarocostas, "WHO issues guidelines" ..

⁴⁴¹ Zarocostas, "WHO issues guidelines".

⁴⁴² Ibid.

workers could be essential in narrowing the supply-demand gap for medical experts and practitioners.

Health studies often focus on how socioeconomic status⁴⁴³, race⁴⁴⁴, gender⁴⁴⁵ social networks⁴⁴⁶ and spaces⁴⁴⁷ affect patients. For instance, studies focus on how health-seeking behaviour is determined by the intersecting factors of geography, gender and socioeconomic status⁴⁴⁸. Other research looks at how the health of populations is influenced and shaped by their social network, gender or the spaces they operate in⁴⁴⁹. What is rarely discussed in health research, however, is that similar determinants affect health workers and practitioners just as much as they affect patients. Determinants such as gender, spaces and socioeconomic status can influence health workers' morale, motivation, delivery of services and practitioner-patient

⁴⁴³ James S. House, Ronald C. Kessler and A. Regula Herzog "Age, Socioeconomic Status, and Health," *The Milbank Quarterly* 68, no. 3(1990): 383-411; Lisa Berkman and Arnold M. Epstein, "Beyond health care -- socioeconomic status and health," *The New England Journal of Medicine* 358, no.23 (2008): 2509-10. doi:http://dx.doi.org/10.1056/NEJMe-0802773; Nancy E. Adler, Thomas Boyce, Margaret A. Chesney, Sheldon Cohen, Susan Folkman, Robert L. Kahn, and S. Leonard Syme "Socioeconomic Status and Health: The Challenge of the Gradient," *American Psychologist* 49, no. 1 (1994): 15-24.

⁴⁴⁴ M. D. Eisner et al. ,*Journal of Epidemiology and Community Health* 65, no. 1 (2011):26 – 34; Vickie M. Mays,Susan D. Cochran,and Namdi W. Barnes "Race, Race-Based Discrimination, and Health Outcomes Among African Americans," *Annual Review of Psychology* 58 (2007): 201-225; Tyson H. Brown, Angela M. O'Rand and Daniel E. Adkins "Race-Ethnicity and Health Trajectories Tests of Three Hypotheses across Multiple Groups and Health Outcomes," *Journal of Health and Social Behavior*, 53(2012): 359.

⁴⁴⁵ Margaret Denton, Steven Prus and Vivienne Walters, *Gender Differences in Health: A Canadian Study of the Psycho-Social, Structural and Behavioural Determinants of Health*. (Ottawa: Center for Applied Social Research, 2006), 1-46; Paul A Bourne, and Desrmond Brooks, "Gender, Women and Health: Gendered Health Differences," *International Journal of Collaborative Research on Internal Medicine & Public Health*3, no. 7 (2011): 550-574.

⁴⁴⁶ Kirsten P. Smith and Nicholas A. Christakis "Social Networks and Health," *Annual Review of Sociology* 34 (2008):405–29; Thomas W. Valente, *Social networks and Health: Models, Methods, and Applications* (Oxford; New York: Oxford University Press, 2010): 1-277.

⁴⁴⁷ Dick Saarloos, Jae-Eun Kim, and Harry Timmermans "The Built Environment and Health: Introducing Individual Space-Time Behavior," *International Journal of Environmental Research and Public Health* 6, no. 6(2009): 1724–1743; Ruth Young "Prioritising Family Health Needs: A Time–Space Analysis of Women's Health-Related Behaviours," *Social Science & Medicine* 48, no. 6 (1999): 797-813.

⁴⁴⁸ Young "Prioritising Family Health Needs".

⁴⁴⁹ Berkman and Epstein, "Beyond health care -- socioeconomic status and health", Bourne, Brooks, "Gender, Women and Health: Gendered Health Differences; Smith and Christakis "Social Networks and Health".

interaction. Through this study, I have highlighted the importance of considering the effect of such factors on health workers when designing health policies and development programming.

Most literature on LHWs often focuses on how effective the health workers are in delivering health services and treating the members of the communities they serve. For instance, studies have shown that in areas where health workers operate, there are lower infant and maternal mortality rates than those areas where no health workers are present⁴⁵⁰. Research has also shown that LHWs have been instrumental in lowering the incidence of pneumonia in urban and rural populations⁴⁵¹. Pilot studies have demonstrated that LHWs can be trained to diagnose and treat eye health issues⁴⁵² and depression in populations⁴⁵³. Thus, most research on LHWs does not focus on their work experiences. Even studies that look at the health workers' experiences are quantitative studies⁴⁵⁴. They are not ethnographies that examine the experiences of the LHWs in depth. In addition, such research does not locate the daily work experiences and the professional struggles of the LHWs within neocolonial and postcolonial systems. By conducting an in-depth study on the LHWs and locating their experiences within various political, neocolonial and postcolonial systems, I have addressed this gap in LHW literature. In addition, in my research, I also look at the health workers' self-agency, their struggle for professional identities as well as the rhetoric used in the LHW movement. These are all issues that have yet to be substantially addressed in the health and labour research work on LHWs. Thus, this study contributes to research in the fields of health and labour.

⁴⁵⁰ Zahid A Memon et al., "Implementing community-based perinatal care: results from a pilot study".

⁴⁵¹ "Pakistan: Lady Health Workers take on child pneumonia – and win," IRIN ; Abdul Bari et al., "Community case management of severe pneumonia".

⁴⁵² Khan et al., "Women Health Workers: Improving Eye Care in Pakistan".

⁴⁵³ Farooq Naeem et al., "Screening for Depression in the Community by Lady Health Worker".

⁴⁵⁴ Hafeez et al., "Lady health workers programme in Pakistan"; *Lady Health Worker Programme: Third party Evaluation of Performance*, Oxford Policy Management.

Practical Applications for the Research Findings

Even though this study on Pakistan's LHWs cannot be generalised, it nevertheless highlights issues that could result in such low retention of health workers. The discussions in this thesis indicate various factors that could be playing a role in lower worker retention and morale. The factors affecting LHWs' work experiences warrant more extensive study, and should be explored as determinants affecting health workers' experience in other settings.

Certain changes to the LHW programme such as opportunities for LHWs to advance in their jobs, better career opportunities, ID cards, projects that are aimed at the professionalization of LHWs, and timely delivery of salaries could go a long way in boosting LHW morale and increasing worker retention. An increase in wages and monetary compensation that takes into account the skills and professional experiences provided by the health workers should also be considered. The WHO polio campaign should increase the number of its vaccinators and provide training in working in risky environments to the polio workers. In addition, it should arrange for better security for its polio workers when the workers are working in the field. Policymakers could drastically improve the working conditions of the LHWs by making such changes to the LHW programme. However, it must be noted that these recommendations are not absolute, and further studies across larger populations should be carried out before implementing these changes.

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APPENDIX 1: GENERAL RESEARCH AND ETHICS BOARD APPROVAL LETTER



December 21, 2011

Ms. Maliha Diwan
Master's Student
Department of Global Development Studies
Queen's University
Kingston, ON K7L 3N6

GREB Ref #: GDEVS-021-11; Romeo # 6006488

Title: "GDEVS-021-11 Problems faced by Lady Health Workers (LHW) in the field and its impact on the efficacy of the LHW Programme in Sindh"

Dear Ms. Diwan:

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled "**GDEVS-021-11 Problems faced by Lady Health Workers (LHW) in the field and its impact on the efficacy of the LHW Programme in Sindh**" for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen's ethics policies. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, of any adverse event(s) that occur during this one year period (access this form at https://eservices.queensu.ca/romeo_researcher/ and click Events - GREB Adverse Event Report). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes to the level of risk, applicant characteristics, and implementation of new procedures. To make an amendment, access the application at https://eservices.queensu.ca/romeo_researcher/ and click Events - GREB Amendment to Approved Study Form. These changes will automatically be sent to the Ethics Coordinator, Gail Irving, at the Office of Research Services or irvingg@queensu.ca for further review and clearance by the GREB or GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

A handwritten signature in black ink that reads "Joan Stevenson".

Joan Stevenson, Ph.D.
Professor and Chair
General Research Ethics Board

cc: Dr. Spencer Moore and Dr. Rebecca Tiessen, Faculty Supervisors
Dr. Susan Soederberg / Dr. Magda Lewis, Co-Chairs, Unit REB
Michelle Knapp-Hermer, Dept. Admin.

APPENDIX 2: GENERAL RESEARCH AND ETHICS BOARD APPROVAL LETTER



December 21, 2012

Ms. Maliha Diwan
Master's Student
Department of Global Development Studies
Queen's University
Kingston, ON K7L 3N6

GREB Romeo #: 6006488

Title: "GDEVS-021-11 Problems faced by Lady Health Workers (LHW) in the field and its impact on the efficacy of the LHW Programme in Sindh"

Dear Ms. Diwan:

The General Research Ethics Board (GREB) has reviewed and approved your request for renewal of ethics clearance for the above-named study. This renewal is valid for one year from December 21, 2012. Prior to the next renewal date you will be sent a reminder memo and the link to ROMEO to renew for another year.

You are reminded of your obligation to advise the GREB of any adverse event(s) that occur during this one year period. An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours. Report to GREB through either ROMEO Event Report or Adverse Event Report Form at <http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html>.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementation of new aspects into the study procedures. Your request for protocol changes will be forwarded to the appropriate GREB reviewers and/or the GREB Chair. Please report changes to GREB through either ROMEO Event Reports or the Ethics Change Form at <http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html>.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

A handwritten signature in black ink that reads "Joan Stevenson".

Joan Stevenson, Ph.D.
Professor and Chair
General Research Ethics Board

c.c.: Dr. Spencer Moore and Dr. Rebecca Tiessen, Faculty Supervisors
Dr. Susan Soederberg, Chair, Unit REB
Michelle Knapp-Hermer, Dept. Admin.

APPENDIX 3: INTERVIEW QUESTIONS

The following is a sample of interview questions that were addressed to the LHWs. The order of the questions does not necessarily reflect the order that they were asked in in the field. In addition, the questions were changed according to the responses of the LHWs. The follow-up questions asked at a later date or during the same interview varied. The questions listed below are the standard questions I asked each LHW but the actual interviews and questions differed from one participant to the next. It must also be noted that the questions were asked in Urdu; the questions below have been translated into English.

1. What is your name, age and marital status?
2. Can you tell me a bit about your educational background?
3. How many months did you train for as an LHW?
4. How many years have you worked as an LHW?
5. How many households do you cover?
6. What areas/districts do you work in?
7. How many households/patients do you visit in a week?
8. How many hours per week would you say you work as an LHW for?
9. What is your monthly salary?
10. How many number of hours would you say you spent in the following activities:
 - a) Household visits
 - b) Seeing patients at health house
 - c) Administrative work
 - d) Working with village or women committee
 - e) Other activities:
11. How do you find the work environment?
12. What is your preferred mode of travel? And do you problems getting access to said transport?
13. What is the attitude of the tehsil supervisors (THOs)/officers/ LHSes towards you?
14. Does your family support what you do?
15. Do you have access to amenities and facilities (daycare, toilets etc) at your workplace/in the field?
16. What is the attitude of the community towards you?

17. Do you find that the training is adequate for the duties that your job requires?
18. Does your pay arrive on time?
19. Do you have any issues with the programme?
20. What do you think of the overall health care facilities in the area?
21. Is there any part of your job that you particularly like/dislike? If so, please give more details.
22. Is this your only job? Or do you have another job?
23. Why did you choose to become an LHW?
24. Why are you no longer working as an LHW [if participant is no longer working as an LHW]? Why did you choose an alternative job?
25. If there was one thing that you would want to change about the programme what would it be?