WOMEN'S EMPOWERMENT THROUGH POLIO ERADICATION: AGENCY AND REPRESENTATION OF LADY HEALTH WORKERS IN PAKISTAN

by

SARAH AHMED

A DISSERTATION

Presented to the Department of Sociology
and the Division of Graduate Studies of the University of Oregon
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

December 2021

DISSERTATION APPROVAL PAGE

Student: Sarah Ahmed

Title: Women's Empowerment through Polio Eradication: Agency and Representation of Lady Health Workers in Pakistan

This dissertation has been accepted and approved in partial fulfillment of the requirements for the Doctor of Philosophy degree in the Department of Sociology by:

Michael Dreiling	Chairperson
John Foster	Core Member
Kemi Balogun	Core Member
Yvonne Braun	Institutional Representative

and

Krista Chronister	Vice Provost for Graduate Studies

Original approval signatures are on file with the University of Oregon Graduate School.

Degree awarded December 2021.

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DISSERTATION ABSTRACT

Sarah Ahmed

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Pakistan remains one of the two countries wherein Polio remains endemic. Central to the Polio Eradication project, led by the Global Polio Eradication Initiative (GPEI), are female community health workers. These women--who call themselves Lady Health Workers (LHWs)—deliver Polio vaccines door-to-door in their communities. This dissertation examines how the gendered labor of LHWs speaks to broader intersections of gender, development and global health. How does gendered work, necessary to polio eradication, affect local norms and representations within the healthcare industry? How does women's agency manifest when realized by a woman working in the polio eradication initiative as an LHW? In asking these questions, my dissertation traces the development and constructions of gender identity and norms for women on the ground. My analysis is informed by five years of follow up interviews, yielding theoretical contributions that depict tensions between gendered expectations and women's agency over time.

This dissertation includes excerpts from a previously published article (Ahmed 2020).

CURRICULUM VITAE

NAME OF AUTHOR: Sarah Ahmed

GRADUATE AND UNDERGRADUATE SCHOOLS ATTENDED:

University of Oregon, Eugene
University of Washington, Seattle
Hiram College, Ohio

DEGREES AWARDED:

Doctor of Sociology, 2021, University of Oregon
MS Sociology, 2016, University of Oregon
MA International Studies (South Asia), University of Washington
BA Political Science, Hiram College

AREAS OF SPECIAL INTEREST:

Gender
Development
South Asia

PROFESSIONAL EXPERIENCE:

Graduate Teaching Employee, University of Oregon, 2014-2021

Teaching Assistant, University of Washington, 2012-2013

GRANTS, AWARDS, AND HONORS:

Best Graduate Student Paper Award, Pacific Sociological Association, 2020.

Best Student Publication, University of Oregon, Department of Sociology, 2020.

Honorable Mention, Society for the Study of Sociological Problems (SSSP) Gender Student Paper, "Women Left Behind: Migration, Agency and the Pakistani Woman." 2020

CAS Dissertation Research Fellowship, Graduate school, University of Oregon, 2019.

Best Graduate Student Paper, SSSP Family Division, "'I am my own person,' Women's Agency and Resistance in Rural Pakistan, 2019.

Best Masters Paper Award, Department of Sociology, 2017.

PUBLICATIONS:

Gullickson, Aaron, and Sarah Ahmed. "The role of education, religiosity and development on support for violent practices among Muslims in thirty-five countries." *PloS one* 16, no. 11 (2021): e0260429.

Barker, Kathryn M., Erin C. Dunn, Tracy K. Richmond, Sarah Ahmed, Matthew Hawrilenko, and Clare R. Evans. "Cross-classified multilevel models (CCMM) in health research: A systematic review of published empirical studies and recommendations for best practices." *SSM-Population Health* 12 (2020).

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ACKNOWLEDGMENTS

I wish to express sincere appreciation to Professors Michael Dreiling, John Foster and Kemi Balogun for their assistance in the preparation of this manuscript. This research has been funded in part by the Department of Sociology, University of Oregon's Graduate School and Center for the Study of Women in Society (CSWS), and the American Institute of Pakistan Studies.

To the Lady Health Workers of Pakistan

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LIST OF ACRONYMS USED

BHU	Basic Health Unit
EDO	Executive District Officer
GPEI	Global Polio Eradication Initiative
IMF	International Monetary Fund
IRMNCHNP	Integrated Reproductive, Maternal, Newborn & Child Health and Nutrition Program
LFP	Labor Force Participation
LHW	Lady Health Worker
MO	Medical Officer
NGO	Non-Governmental Organization
NPHEA	National Program Health Employees Association
WHO	World Health Organization

"Sari lut mar da hisab hoye ga … Warna fer khooni inqalab hoye ga."
“There will be a bloody revolution if there is no justice done for the loot and plunder,” recited at a sit-in protest in Punjab in 2019 by the Lady Health Workers’ union called National Program Health Employees Association.

CHAPTER I

INTRODUCTION

In an interview with a female community health worker in rural Punjab, I asked how women can enter the homes of their patients, especially given that women there are not seen outside their homes. What happens, I asked, when a *na-mehram* (a male not related by blood to the woman), answers the door? The following is a quote from Sanya, a Lady Health Worker, which captures some of the larger themes I explore in my dissertation. Sanya told me, “I act [and talk] like a man when entering someone’s’ home for polio vaccinations.”

However, upon subsequent inquiries, a more complicated positionally of the female community health worker presented itself, particularly when I asked Sanya what she does with the money she earns from her job. Sanya replied that she gives the money to her husband, adding, “my husband will spend money more wisely than I can.” To be sure, this was not uncommon in my interviews. Most Lady Health Workers or LHWs explained to me that they give their salaries to their husband, head of the household, or mother-in-law. This act of giving away earned money to the husband or the male head of the household is significant, as it impacts the agency an LHW has in her household. Yet, as will be seen in this dissertation, many choices made by the LHWs demonstrate a negotiation or trade-off LHWs make as to not throw off the hierarchy in the household they are a part of.

So, despite talking like a man and being part of the collective that regularly challenges the state (as I will show in other chapters), most LHWs are acutely aware of gendered expectations put on them and the importance of preserving a particular image of themselves—as a pious woman, as an obedient wife or daughter-in-law—in the house and the community.

In this dissertation, I use qualitative methods to investigate the gendered impact of the global encounter between the Global North and postcolonial countries through global health development projects. At a macro level, I examine critiques of international development agencies replacing regional and/or national power, and the impact of such power struggles on women in the Global South. Specifically, I ask, how is a postcolonial nation impacted by neoliberal policies put forth by international development agencies that intervene to redress a local healthcare crisis?

I then examine the micro impact of the international political economy by centralizing the local social movement of Muslim female community health workers in the Global South. Specifically, I capture the experiences of female community health workers, locally known as Lady Health Workers or LHWs, in rural Pakistan. I argue that LHWs are affected by the nested layers of institutions at the local, national and global levels, as well as the contradictions that emerge. I tackle this in two parts, 1) How does a global healthcare crisis create space for a local social movement of Muslim female community health workers in Pakistan, and 2) How are female healthcare workers successfully demanding better working conditions?

I handle the above three questions by breaking them down into smaller themes. Specifically, I contend that Pakistan faces a double legitimacy crisis—on internal and external fronts—that has compelled responses, domestically and internationally. I show that Pakistan's contestation of power with tribal governance, clergyman and military, and its failure to provide its citizens' protection and basic amenities, including education, economic freedom, health services,

and safety from sectarian violence and terrorist attacks, have put pressure on the state to assert control and gain recognition of control over the country both internally and at the international stage. Compounding matters, the polio crisis exposes these failures domestically and internationally, forcing the Pakistani government to cede the management of health and welfare to international agencies, admitting the need to work with the polio eradication program, facilitated by a consortium of public and private international development agencies, collectively called the Global Polio Eradication Initiative or GPEI.

I argue that the continued ruptures in authority of the Pakistan state are amplified with the involvement of GPEI, adding to its double legitimacy crisis and creating new spaces for rural Muslim women to join a marginalized public work program defined as the Lady Health Worker's Program. As community health workers, these Lady Health Workers, or LHWs for short, are in a unique position given the global importance of the polio eradication program from a healthcare standpoint as well as Pakistan's image on the world stage. In my account, LHWs have made considerable headway in the last decade, in part due to the mobilization of the workers by two women, Rukshana Anwar and Bushra Bano Arain, who initially started a union together and now have two different unions in Pakistan, leading the National Health Programme Workers Association (NHPWA) and Lady Health Workers Welfare Association. Given that NHPWA is based in Multan, Punjab, this union is the focus of my dissertation

In April 2019, NHPWA shared on their social media page that they had successfully managed to negotiate with the Government of Pakistan to remove a freezing hire of LHWs, allowing for relaxation of the work LHWs have had to pick up over the last few years when someone moved, retired or resigned. In March 2021, the All-Pakistan Health Workers' Union

organized a sit-in protest outside of the Lahore High Court demanding they be given an increase in pay and promoted in line with how other government employees of Pakistan are promoted.

Lady Health Workers (LHWs) are female community health workers who are usually the first point in the public health sector for community members who cannot afford to pay for private hospitals. Additionally, LHWs are front line workers for the Polio Eradication Initiative. By January 2021, 39.6 million Pakistani children were given polio vaccines in the form of drops by the over 110,000 LHWs employed by the state nationwide. Yet, LHWs are chronically underpaid or paid only partially. They are largely invisible to the global partners funding GPEI, and neither the Pakistan state nor the World Health Organization (WHO), one of the major partners in GPEI, seek to redress their grievances. Given the structural setbacks and that many LHWs must contend with highly patriarchal gendered norms in the rural spaces they work in, the efforts of the union are quite remarkable. How did these women, predominantly from rural conservative communities with low education, engage both in personal and collective agency, helping to transform the public health discourse about polio eradication and the needs of public health workers?

Significance & Contribution to Literature

This dissertation contributes to social science knowledge in several ways. First, it highlights why existing representations of women in developing countries, as well as problematizes presumptions about the transformations that formal employment can bring forth. Instead, I argue that existing policy work and literature must prioritize women's lived experiences, who are affected directly by development and global health policies. Second, my research challenges assumptions made in policy papers and development programs that do not take into account variance in a woman's position across multiple settings including changes to

independent mobility, final decision-making and control over financial resources (Mumtaz and Salway 2005). LHWs are increasingly becoming more aware of the importance of their labor through negotiations with the state. At a macro level, my research also depicts the tensions at the administrative and state level that occur when global health projects can interject and sometimes curb the sovereignty of countries in the Global South.

The state plays a paradoxical role in this setup, such that it demands LHWs to 'act like a man' while on the job and also reprimand them for using similar tactics to challenge the state. I argue that institutions can reinforce inequalities while creating limited access to power for women to exercise autonomy, and (re)claim space. LHWs have to negotiate between these identities that require them to code-switch between subservient women at home and assertive workers outside the home. The shift to adopt more assertive behaviors in the home has not been apparent, with exception to a few LHWs that appear as outliers in the data presently, but I predict the trends will gradually change over the course of another 5-10 years.

Existing depictions of LHWs are scarce and in want of assessing empirical examples with broader (intersectional) theories of institutions, power and collective action. Closser (2015) emphasizes that LHWs are paid through a 'moral economy' such that LHWs are portrayed as heroes by the government as a means of compensating for lower wages. Mumtaz et al (2013) do something more novel and take into account social relationships that LHWs are a part of in their communities which contextualize invisible social boundaries that impede an LHW's mobility. Yet, both these portrayals do not address the means through which LHWs are challenging the state and local norms through their labor unions to overcome hurdles that threaten their personal wellbeing, mobility and compensation for labor.

In conversations with women who are the subject of these policies and discussions, I argue agency in its current form, particularly used by development scholars, must take into account broader socio-political, economic, racial, and gender hierarchies, more suitable for diverse settings. Further, I demonstrate through specific examples, from women's lived experiences, the ways gender expectations and agency change over the life course and are subject to the positionality of women that change temporally and spatially.

Methods

This is an updated excerpt that has previously appeared in a published article by me (Ahmed 2020).

The research was conducted in ten settlements around metropolitan cities in South Punjab in three rounds of interviews between 2015-2019. While the first settlement was chosen through knowing a local LHW in the area, subsequent settlements were selected through snowball sampling. I spoke with thirty-five women in one-on-one interviews and in focus group interviews. I spoke to LHWs while they worked in the clinic and accompanied them on their door-to-door checkups, and also followed them into their homes.

Of the thirty interviews conducted, twenty were in rural areas that did not have built roads, direct access to a school or a major hospital. These settlements were usually between three to five hours of a drive away from the closest city and had to be accessed via foot where roads were no longer available. In peri-urban areas, families considered themselves to live within the city, citing their close proximity to paved roads, hospitals and brick-and-mortar schools.

Interviews were done in Urdu and Punjabi. I also spoke with three doctors and two government employees in the Punjab Health Department to get a sense of the chain of command between the various actors. One of these individuals was a direct supervisor of the LHWs I had

interviewed, and another was in charge of the LHW program in Punjab overall. Informal interviews were also done with representatives of WHO and Rotary International to get a more complete picture. Follow-up interviews were done every year in the duration of the study in the summer with twenty-two who had not moved since my earlier rounds of interviews.

Of all the interviews and observations in both groups, only three interviews were recorded because participants were uncomfortable to speak with a recorder in front of them. Thus, I relied primarily on field notes, quickly jotting down phrases verbatim, and occasionally asked my interviewees to repeat themselves if I missed something, which they did not seem to mind.

Questions were semi-structured and began with asking what women do every day, the nature of their relationship with their relatives, especially with their mother-in-law, daughter(s), and husband. Responses comprised of what women thought of themselves both as individuals and in the larger group they identify themselves to be in, and their strategies to be successful mothers, wives, daughters, and sisters. For work-related questions, most semi-structured interviews began with asking participants why they had decided to become a LHW, challenges they have faced in the home and at the workplace, as well as what they do with the money when they are paid. In follow up interviews, I asked similar questions and tracked changes in answers and/or situations for the women to chart differences over time.

In my participant observation notes, I paid close attention to the nonverbal communication between my conversation partner and her observers. These observations were helpful to understand how women recognized and reinforced (local meanings of) power and space to those within themselves as individuals, the collective and outsiders (Emerson 1995). During the analysis, names were changed to protect the confidentiality of participants.

I translated and transcribed the data in MS Word. The analysis was done through line-by-line and axial coding using the highlight and comment features. Upon finding patterns in speech, behavior and cultural norms, I wrote memos to understand and draw out meanings to my findings in light of existing research and attempt better explain the rationale for the observed patterns and revisited the recordings and field notes.

Organization of the dissertation

The second chapter analyzes the dual legitimacy crisis that Pakistan faces internally and externally. I argue that this crisis creates a historical conjuncture for Lady Health Workers to negotiate their labor and working conditions in the polio eradication campaigns. The second chapter also looks at the status of women in Pakistan at the forefront of the double legitimacy crisis. How has the legitimacy crisis emerged and what space has it created for LHWs to demand better wages and safer working conditions? I also look at the history of women's status in Pakistan's checkered political history to offer insight into the importance of the healthcare crisis of polio in creating new spaces for women to do care work in the public sphere.

In the third chapter, I contextualize Pakistan's present-day problems by bringing forth a postcolonial lens to examine how public health outcomes are impacted by the uneven power negotiations between the state and the GPEI. I ask, how autonomous is a developing country when global actors come in to offer assistance in a healthcare crisis? Subsequently, I examine documents published by the independent monitoring board of the GPEI overseen by WHO to showcase the power tensions between a postcolonial country in the Global South and the largely Western-based GPEI organizations that oversee the progress of polio eradication programs in the Global South. I also draw from my own interview with a health department official to showcase

how this power struggle is felt within the health administration as well, among public healthcare employees.

Chapter four shifts the focus from the macro to the intermediary players. Here I examine the larger public healthcare system of Pakistan by using Acker's (1990) framework of inequality regimes to demonstrate the intersection of classism and sexism that are at play within the public healthcare system within which LHWs maneuver. Comparing female medical doctors with LHWs, I argue that while the system is inherently patriarchal, the intensity of patriarchy and treatment of women is different based of the socioeconomic status of the women in the healthcare sector. This helps to contextualize the question, what space(s) exist for women's mobility and agency within this institution within the health department(s) in Pakistan and more broadly in policy conversations between Pakistan and transnational companies?

Chapter five, originally published in *Gender, Place and Culture* (Ahmed 2020), subsequently focuses on LHWs and the community they are in to showcase how employment (and subsequently mobility) impacts a woman's sense of self. I analyze two groups of women: LHWs and women who are home-based workers. I argue that while both groups exhibit agency, their positionality due to their employment impacts the way they express this agency. Yet, I also demonstrate that in a largely patriarchal system, even a woman who is formally employed and earning is still subject to gendered norms, which challenges the expectations that are made on the empowerment employment can bring for women. The last chapter examines the National Program Health Employees Association (NPHEA), the LHW union, and showcases the recent demands as well as the tactics used for its success so far as it navigates issues of labor, gender and work as experienced by LHWs. This chapter also showcases a brief history of public sector unions in Pakistan, as well as the collective identity and union culture of NPHEA.

CHAPTER II

PAKISTANI STATE, A DOUBLE LEGITIMACY CRISIS, AND THE STATUS OF WOMEN IN PAKISTAN

The Pakistan state faces a double legitimacy crisis presently, whereby pressures internally and externally conspire to force state officials to (1) push back against Islamic insurgents and the Jirga courts and (2) allow international development agencies and NGOs to expand work in rural areas. At a local level, the state faces an internal legitimacy crisis and has sought to resolve this by seizing control over insurgent groups in Baluchistan, re-assert control against local informal courts that have been a sight for innumerable humans' rights violations, and confine radicalization of terrorists both from within and across the Afghan-Pak border. Globally, the Pakistan state faces an external legitimacy crisis on several fronts: the discovery by US forces of Osama bin Laden in Abbottabad, and violence on sectarian and tribal fronts have led to innumerable civilian deaths, bringing to question how legitimate the state's powers are.[1] The involvement of the US raid in Abbottabad, civilian deaths by drone attacks and occurrences of the Raymond Davis scandal and the Memogate scandal have thus weakened Pakistan's sovereignty.[2] Thirdly, and more recently, Pakistan has the unenviable distinction of being one of the two countries alongside Afghanistan, wherein Polio has not been eradicated.

This section analyzes the dual legitimacy crisis that Pakistan faces both at national and global fronts. I contend that Pakistan's response to this crisis has created a historical conjuncture such that transformations are occurring in the gender order at the village level, in the aftermath of

1. There are lots of debates regarding whether Pakistan is a failed state (see: A Heir 2006 and 2007; SP Cohen 2002; CC Fair 2010)
2. Raymond Davis was a CIA contractor who was found guilty in killing two

bills passed to protect marginalized populations, and the state's efforts to institutionalize formal state control at the local level. Collaborations of the state with international organizations further allow new opportunities for women in rural areas to become employed. In this double legitimacy crisis, state actors and institutions face continued contestation with tribal governance, clergyman and military, and exhibit failures to provide its citizens protection and basic amenities including education, economic freedom, health services and safety from sectarian violence and terrorist attacks. All of this has put pressure on the Pakistan state to assert control and gain recognition of control over the country both internally and at the international stage.

Women's Status in Pakistan: Political backdrop in Pakistan's history

The frequent absence of a stable form of governance in Pakistani has allowed multiple forms of authority to exist—notably the military, Islamic political groups, and landed elites based both in urban and rural centers. With the exception of one government, under President Zardari, all civilian governments have ended prematurely as a consequence of assassination or military takeovers. Consequently, a brief historical overview showcases the state's efforts in using power to bring forth more gender equality has historically been contested by landed, military and/or religious elites. It comes as no surprise then that the labor force participation (LFP) of women in Pakistan is less than the world average of 51.2% (Sarwar and Abbasi 2013). Khan and Khan (2009) attribute this in part to "rigid gender-role ideologies, social and cultural restrictions on women's mobility and integration in the workplace, segmented labor markets, lack of skills, and employers' gender biases that attach a lower value to female labor due to family expectations," (Khan and Khan 2009, 77-8).

The sociocultural norms that impact women's mobility and LFP in Pakistan can be traced back even to the influence of the Islamic groups that were present since the independence of Pakistan during the constitution making procedures, especially when the Board of *Ta'limaat-I Islamia* contested women's participation in politics (Afzal 1999). In the 1950 report presented by the Board of *Ta'limaat-I Islamia*, the board opposed women's participation in politics, claiming it would engender unnecessary social interactions among men and women in the political arena. The board prescribed that women could participate if they meet the two conditions: if they were over the age of fifty and if they observed *purdah* or veiling during legislative activities (Afzal 1999, 20-1).[3]

There was a shift in laws pertaining to women during the introduction of the 1961 Muslim Family Law Ordinance (MFLO) under General Ayub Khan's presidency (1958-1969). The MFLO ensured that men must seek written permission from their wife (or wives) before getting married to someone else.[4] This was a state-endorsed protection that women would receive without which their husband could be married to four women at a time without having to legally seek his wife (or wives') permission. To be sure, this was the first time in Pakistan's legislative history that the state codified and safeguarded women's rights (Weiss 2014).

The tone set by Ayub Khan's MFLO was soon reversed about a decade later. General Zia's (1977-1988) emergence as Pakistan's Martial Law leader was made possible by the disapproval ratings his predecessor, Zulfiqar Ali Bhutto (1973-1977), got from Islamic political groups. Upon replacing Prime Minister Zulfiqar, Zia adopted several strategies to ensure his dominance would remain unchallenged. Zia utilized religion to maintain his hold over the country. Among the

3. The ideas put forth in the Board of *Ta'limaat-i Islamia* bear resemblance to the image of women in Maudoodi's writings wherein both the Board and Maudoodi (according to Shehabuddin, 2008) concur that women should be at home and be responsible for reproductive duties such as raising children (Afzal, 21; Shehabuddin, 577).
4. Under Islamic law, polygamy is allowed and a man can be married up to four women at a time

Islamic policies drafted under his regimes, women were targeted specifically. Jafar (2004) states, “Zia turned to women as a tool and as a symbol of his transformation of Pakistan into the ideal Islamic state,” (Jafar, 36). In fact, Zia’s famous stance on women was described on the basis of *chaddar* [veil that covers most of the body] and *chaar diwari* [four walls—the idea that a woman’s place should be in the house] (Weiss 1999, 2001; Mumtaz and Shaheed 1987; Khattak 2010). The concept of *chaar diwari* was enforced when women were banned to enter the Pakistani Foreign Service, banks and other institutions owned by the state (Jafar 2004; Mumtaz and Shaheed 1987). Women’s mobility and visibility both on streets and in the media was also severely marginalized.

Zia introduced the *Zina* Ordinance of 1979 that outlined laws concerning fornication, adultery and rape. The *Zina* Ordinance was a part of the *Hudood* Ordinance, which outlined laws pertaining to theft, alcohol consumption and defamation, along with those under the *Zina* Ordinance:

> …There are several problems [with the *Zina* Ordinance] laws. First the law protects rapists who commit a crime in front of non-Muslims or women, or even in front of Muslim men who are not ‘pious’ or of ‘good repute.’ At the same time it leaves rape victims to be charged with extramarital sex—*Zina*—when they fail to prove that they were indeed raped (Jafar, 44).

In 1983, several rape victims were charged under the *Zina* Ordinance including Safia Bibi who had been raped by her landlord and whose pregnancy was seen as her “self-confession,” (Jafar, 44), as well as Lal Mai—the first woman to be publicly flogged under the Ordinance (Mumtaz and Shaheed 1987; Jafar 2004; Malik 2009).

Given Zia’s radical Islamic policies targeting women, many scholars hold Zia primarily responsible for the stagnation of women rights (Shahnaz 1986; Jafar 2004; Jamal 2006). Though Zia is complicit in slowing the progress of women rights, Zia’s regime allowed for religious elites

to become *more* powerful than they had been in the past, which has allowed Islamic clergymen to denounce recent attempts made by the state to secure women's rights. [5]

On broader level, whereas Islam has been used to limit women's presence in politics, as well as advocate for customary laws to remain in practice not all women believe Islam to be the main source of limitations put on them. This is seen in Malik's (2009) interviewees in his research on *Karo Kari* (honor killing) who argued that it is not the religion itself but rather, the tribal courts that are misinterpreting Islam. It is the extension of power that the state has allowed in areas like rural Punjab and KPK, which sanction informal courts to supplant state courts.

Hefner's (2005) research on the structure of Islamic mobilizations offers insight to how the influence of religious leaders is consolidated at the rural community and judicial levels, both of which are seen in *Karo Kari,* predominant in the province of Sindh. Hefner states:

> Islamic mobilizations owe their success not to formal ideology or top-down party organizations, but to local networks and relationships from which they draw their membership. Muslim mobilizations often take preexisting religious networks built around neighborhood mosques and religious schools and weave them together into a parallel Islamic sector, (Hefner, 10-1).

The inclusion of the community in neighborhood mosques and schools allows for specific Islamic interpretations to influence the masses. This spread of ideology can explain why the community is complicit in the *Karo Kari* rulings, as well as the mindset of the legal courts' lawyers. Both endorse the prescribed role of the Muslim woman, wherein the lawyers used Quranic

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5. It should be noted that it was during Zia's era that an increase in the reserved seats for women took place as well as the creation of the Women's Division in 1979, which later became the Ministry of Women's Development in 1989. Under the surveillance of the President and later the Prime Minister, this ministry was responsible to formulate and make laws to meet the needs of Pakistani women, undertake as well as promote research and development projects to address problems women faced (Kazi, Raza and Hafeez 1992). According to Anita Weiss in an interview, the development of the ministry was as a consequence of external global pressure (Weiss on New Books Network, 2016).

references to support their stance on the status of the Pakistani (Muslim) woman and her obligations to her family (Jamal 2006, 288-9).

The targeting of women in sociopolitical issues is not unusual and has been used beyond religious and landed elites discussed here. Jafar states:

> …Women and their position in Muslim culture have long served as a 'boundary mark' between the colonized Muslim societies and their Western rulers…No matter how "Westernized" the public sphere (men became, people could take comfort in the private sphere (women) as being untouched, unharmed, and unspoiled by 'Westernization,' (Jafar, 40)

Both the religious and landed elites continue to use their influence and sustain procedures, patriarchal in nature, that limit the status of women in Pakistan's society. Additionally, as is seen in the case of *Karo Kari,* sometimes, the influence of the landed and religious groups can create an intersection wherein *Jirga* courts legitimize rulings on the basis of Islam.

Musharraf's Era and Onwards: A Historical Conjuncture

It was under General Pervez Musharraf's (1999-2008) that Pakistan's strategic geopolitical position became prominent post 9/11 and the subsequent war against terrorism. A number of macro-structural developments took place because of which the gender order was affected, at least in the legislative and judicial levels wherein gender issues began to materialize. The 2000 Devolution Plan was passed that aimed to restructure local formal governance. Under this plan, women councilors would be appointed in local bodies. In 2006, under the Women's Protection Bill, rape fell under the Pakistan Penal Code, which is based on civil law. This has allowed rape cases to be trialed in state courts and not Islamic courts. Consequently, rape victims unable to provide four male witnesses will no longer be imprisoned (Masood 2006). To be sure, the policies adopted by Musharraf that impacted public policy in general and gender in particular could be

understood as a consequence of the pressures the Pakistan state encountered both internally and externally.

Under Zardari (2008-2013), more bills aimed to protect women were passed into law including the 2010 Protection Against Harassment of Women at Workplace Bill, the 2011 Acid Control and Acid Crime Prevention Bill and the National Commission on the Status of Women in 2012. In 2016, Nawaz Sharif's government passed the Women's Protection Bill.

Notably, military dictatorships in Pakistan created an environment for many political and social movements to emerge that have dramatically impacted the status of women in Pakistan. What is unique about the historical conjuncture created under Musharraf's years and beyond is the continued attention Pakistan has received since being catapulted into center stage post-9/11, and subsequently has brought into focus many socioeconomic problems faced by the state and its citizens, especially minorities.

Indeed, efforts by the state still need to be enforced more widely for transformation to materialize fully. Women's rights violations occur frequently, especially in rural areas that are still dominated by village councils and tribal (informal) courts. While bills and laws have been passed, skepticism remains on their efficacy due to lack of enforcement and/or incidences of honor killing, acid throwing, and *watta satta* (a tribal court sentence wherein a bridal exchange occurs between two households as a means of mediating conflict) are ongoing. Yet, the state's role has become more prominent in creating opportunities for women to access employment and basic healthcare facilities in the rural areas—which have previously remained unchecked.

As Pakistan became a US ally in the 'War Against Terror,' General Musharraf's regime was widely criticized in Pakistan for being pro-US. In his autobiography, Musharraf (2006) stated he had little choice but to accept the seven point with-us-or-against-us ultimatum that Colin Powell

presented. The seven points required Pakistan close its borders to Afghanistan, provide an access route to, and share intelligence files with, American forces (Keller 2001).

U.S. pressure on the Pakistan state to crackdown on terrorism internally remains, as depicted by U.S. President Obama's statements (Dawn News 2016). However, global pressure on the Pakistani state is not confined to its country's foreign policy but also social policies impacting Pakistani citizens. Until recently, the US had been funding Sesame Street to air in Pakistan for over four years (BBC 2012).

The Pakistan state's control within its borders has been the subject of discussion in mainstream news, political commentary, as well as in academia, wherein Pakistan's status as a 'failed state' has been brought to question (Kux 2001; Mohan 2004; Zaidi 2008; Lieven 2011). Osama Bin Laden's capture in 2011 by American forces on Pakistan soil, without collaboration with Pakistani forces, undermined the Pakistani state's legitimacy both internally, regarding its sovereignty vis-à-vis the United States, and externally, regarding its ability to efficiently capture bin Laden without US support.

Historically, Pakistan has had to concede to global pressure to publicly save face. This is seen in a few cases pertaining to women's rights issues. Weiss (2016), in an interview with New Books Islamic Studies, claims that General Zia, whose rule (1977-88) marginalized women's rights under controversial Islamic Hudood Laws, established the Women's Division under global pressure. This is also seen in the case of General Musharraf. In 2002, when Mukhtar Mai, a woman was gang-raped and her rapists were acquitted, Pakistan was critiqued for its penal code and failing to secure women's rights. Musharraf's initial comments that women make rape accusations for publicity and to seek asylum out of the country resulted in widespread outrage, after which Musharraf later denied his earlier comments (Al Jazeera 2005; BBC 2005; Kessler 2005). Hence,

it comes as no surprise that in the wake of Pakistan being critiqued for its low gender equality ratings (World Economic Forum 2015), the Pakistan state has been making more efforts to implement policies as bills, such as the Protection of Women Against Violence.

Consequently, the Protection of Women Against Violence Bill, passed in the Punjab provincial assembly unanimously on February 24, 2016, was met with opposition from clergymen in the Pakistan Council of Islamic Ideology (CII). The bill criminalizes abuse that can be in economic, psychological and verbal forms, as well as protects women from stalking and cybercrime. The CII, however, deems the bill unnecessary, claiming that Islamic law already provides women protection. Externally, the Pakistan state has had to face immense pressure to safeguard the basic rights of Pakistani citizens, especially women and religious minorities. While Pakistan has partaken in conventions like the Fourth World Conference on Women in Beijing (1995), is a signatory member of CEDAW (1996), and participated in numerous UN conferences, in recent years, the pressure on Pakistan to adopt a more liberal, progressive stance concerning many of its sociopolitical policies has become more visible.

Other legislation, such as the Protection Against Harassment at the Workplace Act 2014 are aimed to foster integration of women in the workplace. Yet, women's labor force participation (LFP) remains low (see figure below).

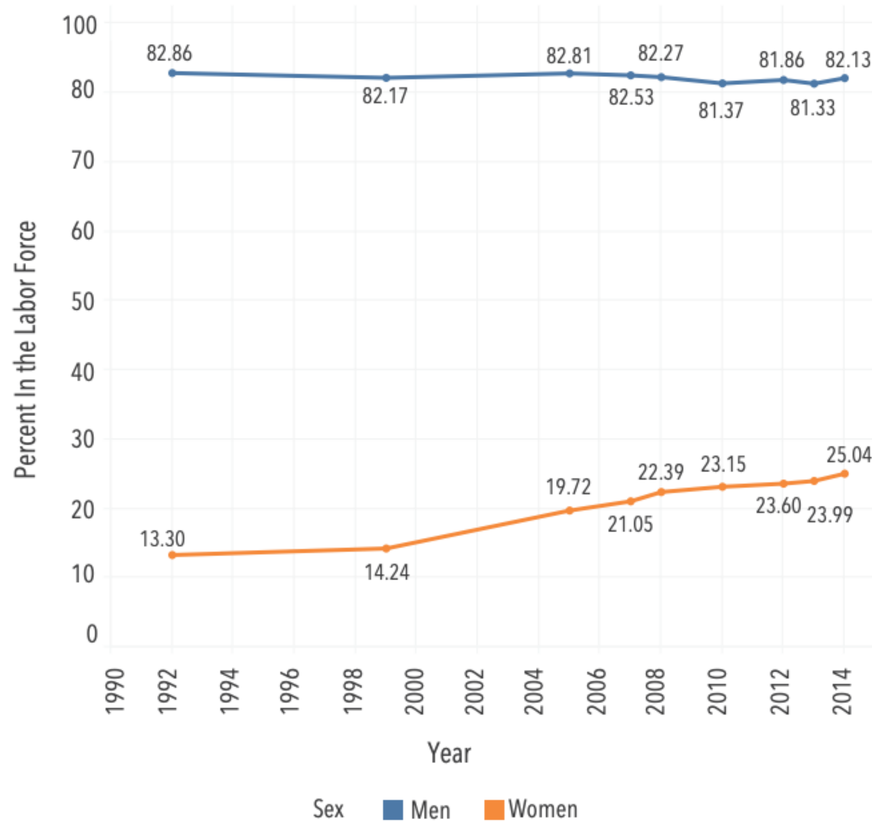

Figure 1: Men and women's labor force participation of Pakistan 1990-2014 (Salman et al 2018, 1)

Women's LFP in the healthcare sector is even lower, especially in the public healthcare sector, given that very little of the national budget is attributed to this sector. A 2010 study found that only about 0.6 to 1.19% of Pakistan's GDP was spent on the healthcare sector in the last ten years at the time of its publication (Shaikh et al 2010, 387). Yet, the rupture created by the state's legitimacy crisis has opened up new spaces for LHWs who leverage their role in regular polio campaign drives in Pakistan to negotiate better working conditions for themselves. Thus far, LHWs have secured permanent employment from seasonal hiring, an end to a hiring freeze, and are now demanding wage increases in the recent March 2021 strikes.

Yet, women's LFP in the public healthcare sector remains low given the low budget allocation of the state. This may be in part given that private healthcare remains a preferred choice

for most to receive treatment even though Mashhadi et al (2016) note that patients bear expenses when opting for private healthcare facilities. Government funded hospitals in Pakistan like Mayo Hospital often have long waiting lines. Some of the patients I met during field trips said they had come from villages to be checked and had to camp outside the hospital for days before a doctor would see them. As a result, many people strive to be seen at a private practice if they can afford to. LHWs, too, complained to me that they had a hard time getting women in the community to give birth at a BHU because "anyone who could scramble even a little bit of money opts to go to a private clinic because they are better equipped," one LHW, Ayesha, told me in a rural village in South Punjab. Another LHW remarked that many doctors stationed at publicly funded BHUs also have private clinics of their own that they sit at in the evenings and they are "doing a much better job there because they are being paid more." This is seen in other countries as well, such as Indonesia and Malaysia, where households of higher socioeconomic status opt for services from the private healthcare sector (Berman et al 1987; Heller 1982). The lack of funding and interest from the state to expand and improve public healthcare facilities could also in part impact the low LFP levels of women in this sector.

CHAPTER III

GLOBALIZATION AND POST-COLONIAL SOVEREIGNTY COLLIDE WITH A GLOBAL HEALTHCARE CRISIS

Imperialism still hurts, still destroys and is reforming itself constantly. Linda Smith[6]

In this chapter, I look at how do some of these problems arise in postcolonial Pakistan and the GPEI, as well as how public health outcomes are impacted by this postcolonial order. Additionally, how, specifically, is the work of remedying this fundamentally shaped by the same international power relations that gave rise to the colonial and postcolonial system. Finally, like the scourge of polio, how does the labor of resolving a public health crisis like polio confounded by these political, economic and historical forces, all of which are found in postcolonial government health bureaucracies that are highly gendered?

Important to understanding the role of LHWs in the GPEI-led polio immunization campaign is the larger network between postcolonial states, neoliberal global institutions and the bureaucracies that mediating between the two. LHWs' labor is an emblem of the international division of labor, often gendered, that is unequal due to the outgrowth of the larger political economic environment associated with neoliberal global capitalism. The federal civil service of Pakistan, particularly in the provincial health departments, oversees this work and is answerable to international development agencies like WHO, UN and Rotary International. Notably, this bureaucracy is often constrained in their administration of public health initiatives due to limited

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[6]. Smith, Linda Tuhiwai. *Decolonizing Methodologies: Research and Indigenous Peoples*. London; New York : Dunedin, N.Z. : New York: Zed Books ; University of Otago Press, 1999, 19.

autonomy by the state of Pakistan itself but also due to being representatives of a postcolonial state that has limited power in negotiations with international development agencies.

Pre-Partition India, under British colonialism, became a site of exploitation at the expense of the development the British economy enjoyed, seen especially in the case of the textile industry. Exploitation was possible through a high surplus value in colonies wherein development was low, poverty high and labor cheap (Amsden in Foster 2014, 166).

The process of state building in Great Britain was closely linked with its emergence as an imperial power, and India was its largest and most important colony. It is not just that the personnel who governed Indian were British, but the projects of state building in both countries—documentation, legitimation, classification and bounding, and the institutions therewith…The foreigners increasingly established markets which set the price of objects. By and large, until the early twentieth century, Indians were bystanders to discussions and polemics, which established meaning and value for the Europeans. (Cohn 1996, 3-4)

This exploitation is the underlying reason for Baran's (in Foster 2014) rebuttal to mainstream international development such that overpopulation and lack of entrepreneurship, among others, are the causes of a poor economy growth in third world states (Baran in Foster, 2014, 162). Baran showcases developed countries being economically prosperous at the expense of former colonies, now the Global South. The unequal economic distribution creates for developing countries to seek aid or loans often at the expense of their sovereignty to be given by developed countries and international agencies such as the IMF based in developed countries (Plank 1993; Mohan 1996).

Persistent economic inequalities mirror the political subordination of post-colonial nations in the Global South, like Pakistan. Dependent on international finance and foreign aid, their own

national development is mired in the legacies of colonialism, weak public administration, and reliance on multilateral institutions for aid and development planning. A similar tension is seen in this research as well, between the provincial healthcare departments and numerous global actors associated with the GPEI, resulting in a situation where Pakistan's government officials are accountable to GPEI monitoring and evaluation to ensure continual aid.

There is a lot of suspicious and mistrust by locals, especially in rural areas, regarding development projects that are funded by Western organizations. Subsequently, NGO personnel who must distance themselves from labels that connect them to the West, especially when they are associated with 'feminism' (Nagar 2010; Mitra 2011; Mohanty 2013; Khader 2014). This may also give insight as to why LHWs have not worked alongside with other women's movement in Pakistan, as the latter has frequently been accused by mainstream media of being 'too Western' and divorced from the realities of the common man (CITATION).

Subsequently, in addition to deviating gendered norms of leaving the home, LHWs are also vulnerable because they take part in a vaccine campaign that is compensated by Western organizations (GPEI). Consequently, targeted shootings of female community health workers in Pakistan distributing polio drops are testament of the increased suspicion that has intensified in Pakistan at the societal level following debates on sovereignty following Osama bin Laden's capture which was made possible by the CIA through an immunization drive cover up (Svea 2015; Khan and Sahibzada 2016). To be sure, the coverup caused a big setback as vaccine hesitancy increased after this incident. LHWs and other health professionals told me repeatedly that one of the biggest reasons for parents to deny their children of the polio drops was because they were suspicious of the contents of the vaccine. LHWs often told me they had to explain to their community members that the polio vaccine was not designed to make Muslims sterile, which was

a common rumor that fueled vaccine hesitancy in many rural villages. In a conversation with a local Rotary International representative, I was told that that the fight to end polio in Pakistan was set back 10 years due to the vaccine hesitancy that emerged specifically after Osama bin Laden's arrest. As a result, CIA announced they would no longer use vaccinations as a cover up in the future (Chappell, 2014).

Neoliberal globalization's emphasis on development and socioeconomic progress on the individual—rather than the collective—has made aid and development programs problematic. My research shows that particular attention and rigorous research of local politics and culture must be done to ensure that project goals that emphasize certain words—like empowerment and agency—must be used cautiously and in line local understandings and reactions to them. Furthermore, an on-the-ground analysis of the sociocultural and political histories can also reveal the mistrust that comes from the erosion of community and publics that can lead of failure of projects, which in this case would emerge due to widespread vaccine hesitancy in rural and remote places where polio numbers remain high.

The Developing State, Gender and Neoliberalism

How does Pakistan's postcolonial status and relation to international and global "development institutions" show up in the administrative discourse of the GPEI? And how is this discourse gendered in particular? Developing states are under pressure to adopt neoliberalism as a development strategy (Connell and Daddos 2014). In the case of Bangladesh and the Grameen Bank, Karim (2008) contends that the latter is able to function (seemingly) freely on ground by virtue of providing services that the state is unable to. In the absence of the state's resources and protection, NGOs like Grameen Bank are portrayed in Karim's work as gatekeepers to the market

where they set the rules for women to enter, play, and remain in the game. NGOs "are re-territorializing rural subjects as new subjects of a market driven democratization…national political parties, NGOs, clergy, all of whom are making claims on rural female subjects for their adherence" (Karim 2008, 12).

In the case of the polio eradication project as well, the GPEI bring forth resources, personnel and insight that it provides to the state of Pakistan in ways that make the state (and its health sector employees) compliant to the GPEI organizations and their employees.

Therefore, a postcolonial lens helps contextualize the growing pressures on countries in the Global South that often subordinate to global institutions. Subsequently, while Karim's (2008) work shows that NGOs do have an important position in delivering basic resources to communities, as well as functioning as training grounds for women to learn how to operate in the market; without the intervention of the state, women must pay hidden costs that may reinforce the structural oppressions the free market is allegedly created to help them break out of.

To be sure, the subordination of countries in the Global South to global institutions is worsened by neoliberalism and women often bear the burden. When neoliberalism has the capacity to challenge and even dismantle some hierarchies, it does so by supplanting older hierarchies with new ones. This is seen in the case of Rudrappa's (2016) research of Indian surrogate mothers who enter a different power relationship, defined by race and class lines vis-à-vis the intended mother. In terms of race specifically, Rudrappa (2016) finds that surrogacy allows for women to reinforce existing racialized stereotypes as 'good' Indian mothers: "In addition to their availability, Indian working-class women are ideal mother workers. Given the traditional mores of Indian societies, very few working-class women consume alcohol, smoke, or illicit drugs," (Rudrappa 285). And again:

> Third world women…provide emotional, physical and intellectual labor to further the comforts of first world individuals…I ask what sort of demands first world consumers make, that is, the expectations they have that shape the labor experiences of third world women," (Rudrappa 282).

Is a woman's ability to partake in a globalized market giving her an opportunity to gain empowerment or is she reifying the exploitative market by participating? This is a question that Constable (2009) asks when she draws the victim-agent binary that is constructed in gender and migration. Research focused on women partaking in this global market, as domestic help or brides-for-purchase offer a different labor altogether: one that reaps and confines them to their femininity by putting a price on their emotional labor and love. Constable (2009) asks, "yet the question remains of how the commodification of intimate relations is understood and experienced by those involved in such relationships and processes," (Constable 2009, 54).

Several questions and contradictions arise from this discussion: firstly, *how* is gender reified and reinstated to marginalize women that are able to partake in the global market—namely, who are the actors and/or institutions that catalyze this? If Harvey (2006) is right in his assertion that neoliberalism compels us to be employed, what choice do individuals have wherein they are marginalized on the basis of gender, race and class? Furthermore, how does globalization and space that it offers to women re-create the ways we understand motherhood, femininity and family?

A report by Bari and Pal for the Asian Development Bank (2000) states that:

> women have borne the brunt of the social costs of recession and structural adjustment measures in Pakistan. Inflation, high unemployment, and increasing poverty have put enormous pressure on women to contribute to family income. Women's labor force

participation tripled during the intensified period of structural adjustment from 5.1 percent in 1987-1988 to 14.6 percent in 1993-1994, (Bari and Pal 2000, 9).

Most women in Pakistan subsequently work in the informal sector, which only intensify exploitation as standard labor legislation or legal measures rarely cover their vulnerability (9). Consequently, most women I spoke with, especially LHWs, suggest that there is a level of protection by being employed in the public sector as they are affiliated with the government, which implies a sense of stability and security especially when hired permanently, with a pension upon retirement, in contrast to the informal and/or private sector. To note also is that many desirable jobs in Pakistan that Khan and Khan (2010) capture as high status in their research are connected to the government or army, such as superior civil services officers and army officers, (Khan and Khan 2010, 81).

Modernity, Development Discourse, Gender & Globalization

One of the pioneers of modernization theory, Rostow (1960), puts a central focus on Western societies, which is reminiscent in many ways of colonialism wherein a Eurocentrist approach (see Amin 1989) leads to the social construction of the Occident and the Orient. Within the Occident and the Orient, the former is culturally and economically superior to the latter (see Said 1978). Such an approach to culture has historically put emphasis on Western ideas of individualization and subsequent Western notions of freedom and agency seen in women's empowerment, as well as preference of 'rational' scientific methods over local knowledge(s) that may be passed down generations and may not necessarily be brandished with college degrees and scientific theories. Wells and Wirth's (1997) quote seems poignant here when they say that, "the

globalization and dominance of western intellectual epistemology (and scientific and technical knowledge) erases history and cultural distinctiveness," (Wells and Wirth 1997, 301).

Dependency theorists (see Amin 1989) and postcolonial scholars (Bagachi 2008) have criticized this earlier form of development that in many ways seems to maintain the hierarchy of power seen during colonialism between the metropole and its colony. Gender scholars have also critiqued earlier forms of development that have either disregarded the role of women and gender norms in development, or more recently, critiqued the Western ways of looking at women and gender norms is societies that are not Western (see Moghadem 1993 and Saunders 2002).

Gender is approached in development in three different ways, Women in Development (WID), Women and Development (WAD) and Gender and Development (GAD). A more recent approach, put forth by Bhavnani et al (2016), stresses the importance of Women, Culture and Development (WCD), which takes away the prejudice of one culture over another and instead looks at societies and existing challenges *within* the context of local cultural values and norms (Collins in Bhavnani et al 2016).

WID's evolution is largely attributed to Boserup (1970, mentioned in Bhavnani et al 2016), who pointed out how development, until the time of Boserup's work, largely excluded women in development projects (Bhavnani et al 2016, 5). WID attempted to bring more equity in the way development projects included women and access to the development projects, however seemed to miss out of larger considerations on *why* women were excluded. Subsequently, GAD emerged as a more encompassing approach that argued gender and gender relations, at the site of development, need to be considered for a more inclusive and effective project. This approach seemed more inclusive than WID for it did not narrowly focus on women but the larger systems at work that continue to keep women from accessing resources with their communities. While this

is used by policymakers today, Bhavnani et al (2016) are quite critical of this approach, calling the ways the concept of gender is used by development practitioners to be quite reductionist and "failing to grapple with issues of power, conflict and the larger social, cultural and political contexts that frame women's ability to resist conditions of oppression (Bhavnani et al 2016, 6).

WCD emerges to fill the gap left by WID and GAD, to address the "larger analysis of the ways in which capitalism, patriarchy and race/ethnicity shape and are shaped by women's subordination and oppression," (Bhavnani et al 6). As such, the WCD takes into account lived experiences of the women affected by development projects that is cognizant of women having agency, and not see them as "victims in need of rescuing from their cultures," (Bhavnani et al 2016, 6). Concomitantly, the WCD approach is more holistic in its attempts to understand the culture and gender relations to create a more collaborative instead of top-down way of helping communities get the resources and amenities they need. Priya Kurian (in Bhavnani et al 2016) further adds "a WCD approach needs to acknowledge…an understanding of culture as not merely an embodiment of the lived experiences of people, but as ideas, norms and values that also suffuse the concepts of environment, development and, more specifically, science and technology," (Kurian in Bhavnani et al 2016, 16).

In development projects, gender ideology and gender relations become ways to theorize who has the monetary control and decision-making powers in a household and in the society. To be sure the GAD approach puts central focus on these concepts and how they impact economic development. This can also help funding organizations to assess the efficacy of dispersing loans, creating job opportunities and resources in a given site. Gender ideology, especially in a patriarchal society, helps theorize the traditional roles women and men play and could add insight into

developing deterring a project to formally employ women outside the house in a site where women do not leave their homes and are expected to stay at home.

Gender relations add insight through which development institutions realize how power imbalances (through loan dispersals and employment) can make women even more vulnerable to violence and/or isolation in certain sites depending on societal ideas of gender and what women 'ought' to do in contrast to men.

The World Health Organization and Pakistan's Health Department: Perspectives from the Field

As the discussion above highlights, the tension between a country's aspirations for autonomy, especially as a developing country, and global institutions that emerged in the postcolonial context, bring distinct challenges to the administration of health care and the implementation of a major vaccine initiative. In a conversation with a healthcare administrator overseeing Punjab's polio eradication project, I got the sense that the administrator was quite reluctant to have to answer to representatives of GPEI. Specifically, the healthcare administrator said, "Pakistan was able to successfully eradicate the smallpox without such monitoring, we could do it again." In contrast, local representatives of WHO and Rotary International, told me how they had more power than government employees during the polio vaccination drives.

Still, this approach has been lauded by the Integrated Reproductive, Maternal, Newborn & Child Health and Nutrition Program (IRMNCHNP) officers I spoke with, who informed me that more funds and autonomy have been generated at the provincial level because of this move. Since then, I was told that even more offices and positions have been created, such as executive district

officers (EDOs) and chief EDOs to further extend and expend resources at the ground/community level and up. One IRMNCHNP recalls that,

> Since 2007 [and before the 18th amendment] we didn't have[enough] budgets [sic]…even if we had to buy *choti see choti cheez* [the most insignificant thing], we had to write to the head office and then the head office would ask at the provincial level…now that we have health councils, each BHU has a separate budget, 3-4 lakh [300,000-400,000 PKR monthly or 1932-2576 USD] for daily expenses, for the patient's betterment, local doctors sit I their BHU and work with other members of the committee to create [and demand an increased budget per annum, (IRMNCHNP officer 2019)

Though an IRMNCHNP officer and a deputy DHO oversee different aspects, they work together to ensure health objectives are achieved monthly and yearly that the federal government outlines. Meetings run long and into the evenings, especially during the polio campaigns. The government owned health department buildings are also home to offices for local representatives of WHO, UNICEF and Rotary International. During polio campaigns, WHO and Rotary International have their own observation staff to monitor LHWs on the ground. In the evenings of the five-day plan, higher ups from both organizations meet to exchange notes with government officials on any problems they notice that IRMNCHNP officer must address.

There is some contention in having to be answerable to the representatives of WHO and Rotary, which I was able to capture in my interview with the IRMNCHNP. In an excerpt from the interview attached below, this tension is seen wherein the IRMNCHNP describes the tricky position they are in. They recall a time when the Department of Health was not answerable to outsiders, particularly during the time Smallpox was eradicated. The involvement of WHO and Rotary is, in fact not circumscribed to providing funds but also includes Pakistanis hired as

representatives that monitor and oversee LHWs on the rounds. Additionally, these organizations have their own offices *within* the government owned buildings that are otherwise meant only for the government officers in the Department of health (see picture below):

Board outside a Department of Health building in Punjab, which also houses WHO and Rotary offices

Sarah: You're in a tricky position/liaison—diplomatic affair

IRMNCHNP: yes, we are accountable. If there's a complaint, we must address it.

Sarah: so you're under immense pressure

IRMNCHNP: yes…each complaint has to be addressed

Sarah: how much autonomy does the government/health department have in making policies or at the times when WHO/UNICEF make complaints about the program, if any?

IRMNCHNP: [pauses and begins with some hesitation]: this is something only the higher ups can answer…

Sarah: in your position what are your most difficult responsibility as part of polio complaint

IRMNCHNP: polio worker in fields are not being paid enough [by WHO]

Sarah: yes, LHWs complain that they are made to work 5 days and paid for 3

IRMNCHNP: right

Sarah: …and who sets this pay?

IRMNCHNP: WHO

Sarah: right, that's what I was told by the LHWs as well.

IRMNCHNP: right

Sarah: but you personally don't have to face any additional scrutiny during the campaigns?

IRMNCHNP: there's a lot more work for me too and responsibilities increase during this time

Sarah: does the health department's normal functions then seize during these campaigns?

IRMNCHNP: we must do it because of national emergencies…*kerna perta hai* [we have to do it]

[Sarah talks about ethics/confidentiality and that she's not affiliated with WHO/Rotary]

Sarah: has there been a campaign ever before like polio in Pakistan's history?

IRMNCHNP: no—in the 70s and 80s there was smallpox [that we eradicated] …there was only the Pakistan health department and no international agencies though funding was there with WHO

Sarah: wow, so the health department was able to do this on their own without any help

IRMNCHNP (*clarifying*): no, there was funding from WHO…

Sarah (*interjecting*): right, I mean on supervision or monitoring on the ground

IRMNCHNP: right, yes…not that and there were the same [kind of] vaccinators like today and we [the health department] were able to eradicate smallpox in 10 years.

Sarah: even If you look into documents by GPEI you see that even if polio finishes, they are planning to stay for monitoring for 4-5. Its along term plan.

IRMNCHNP: right, right.

Sarah: What do you foresee in the future between WHO (or GPEI, larger) and Pakistan (the health department)?

IRMNCHNP: Well, first we have to get zero polio cases nationally, and for 3 years, after which we can be certified as polio-free.

Sarah: right, and in the Nigerian case, it restarted once a new polio case was found

IRMNCHNP: exactly

Sarah: wow…that seems like a long procedure

IRMNCHNP: (laughs): *aisa hee hai…aisa hee hai…aisa hee hai… [that's how it is…that's how it is…that's how it is…]*

The tension arising from government officials feeling like they have to be answerable to representatives of WHO and Rotary (often also Pakistani themselves, interestingly), transposes a new lens in understanding postcolonial relations between former colonies and colonizers, a theme that has been previously explored in the development literature. Furthermore, there are colonial undertones in the power dynamic between WHO (and other GPEI) representatives and government employees in the administration. The reluctance of Pakistani healthcare administrators to report to foreign organizations of their progress seems to be due to a perceived encroachment upon their autonomy to perform their duties. A simple reading of publications by WHO using a postcolonial lens also reveals WHO finds developing countries have an overreliance of funding and resources

by WHO, even after eradicating polio. I show this in the following section, where I examine the long-term plans of WHO in Pakistan and Afghanistan pertaining to the eradication of polio.

III (b) A POSTCOLONIAL LENS ON THE POLIO ERADICATION INITIATIVE: A Content Analysis

I implemented content analysis to examine thirteen publications of GPEI published under WHO as well as the Pakistan and Afghanistan national government progress reports on Polio ranging from publication dates from 2003 to 2017. Through the content analysis, I cross-examine my findings with development discourse and critique the way gender is present and talked about in the Polio work.

I trace the development and constructions of gender identity and norms, power and privilege, and intended (expansion or realization of) agency and empowerment for women on the ground. The question thusly becomes a three-pronged investigation mirroring a Hegelian method of examination at the family, civil society and state levels (Hegel in James 2017). The middle tier, when transposed to my own research, is the role non-governmental organizations (NGOs) play in facilitating discourse at the state level and implementing programs at the family/local level. It is this tier that I will focus in, in this paper, wherein I examine the ways gender is being looked at in the publications pertaining to the Polio initiative. Questions of sovereignty and power also occur, which I mention, but do not highlight at length due to time and space constraints. However, these will be added and expanded in another section of my dissertation.

Within examining the role of gender in development projects, I found LHWs to be pivotal in carrying out the work for these development projects. Through these discussions, it seemed that

LHWs have an increased sense of agency and decision-making powers, more than their female counterparts who stay at home in the largely patriarchal circles both women are a part of.

To be sure, the occupation of LHWs has become a vehicle of change for many women who are first generation workers, and there is much that can be discussed on how (and why) LHWs may not overtly defy gender norms but are slowly changing the way women are becoming more visible in the workforce. It is these LHWs and the work they do, as well as the gender norms they navigate and defy that I wanted to find in the publications. While LHWs are highlighted by WHO in a webpage dedicated to them (WHO Lady Health Workers 2017), I did not find information about them at length in the reports I reviewed.

Findings

The principle finding of this chapter is that gender or culture are not highlighted enough in progress reports. This has been an interesting find, as the WHO does have publications dedicated specifically to why looking at development through a gendered lens matters, yet these ideas do not emerge in the GPEI project notes at all. This is particularly problematic, given the majority of the vaccinations are done by female community health workers, and the access these female health workers have is in part due to gendered expectations of women being caregivers in the highly patriarchal fields they work in, Afghanistan and Pakistan. The literature for the most part seems to use titles that strip gender from the community health workers, opting to call them frontline workers (FLW) or community health volunteers (CHV). Additionally, the rhetoric in the publications is the tone adopted by the donor agencies when talking about the states receiving aid, which seemed to me very reminiscent of literature we discussed on imperialism and colonialism.

This is not a huge leap in analysis, given the uneven power dynamic setup between donor giving agencies and aid receiving entities.

Gender in GPEI Publications and National Government Progress Reports on Polio

I examined thirteen full reports pertaining to the Polio campaign spearheaded by GPEI, of which three were published by the national governments of Pakistan and Afghanistan. In these reports, I was primarily looking for the ways gender is talked about at the community level, wherein the project is being carried out, and within the health workforce, specifically female health workers. To be sure, gender is one of the critical areas that WHO works in through the various global health projects, and it is one of the main components highlighted in the Sustainability Development Goals (see WHO 2015, "Health in 2015"). Additionally, it should be noted that WHO has written about female community health workers and gender at length in publications that focus on these topics (see WHO 2006, "Gender and health in Eastern Mediterranean Region"; WHO 2006, "Gender analysis of health care access and utilization in Pakistan"; WHO 2007, "Cross-cutting gender issues in women's health in the Eastern Mediterranean Region" and WHO 2013, "Increasing access to health care services in Afghanistan with gender-sensitive health service delivery") as well as webpages devoted to the issues (see WHO Pakistan's Lady Health Workers 2008; WHO Gender 2017). However, these conversations are largely missing in publications pertaining to the Polio eradication project.

At the national government level, female health workers are mentioned briefly but only pertaining to increasing the female vaccinators: The Pakistan National Emergency Action Plan for Polio Eradication 2016-17, written jointly by the Pakistan Ministry of National Health Services, Regulations and Coordination, the National, Provincial and FATA Emergency Operations

acknowledges that most vaccinators are female, but very briefly. The stats on how many of the 10,055 community health workers are women, is also glaringly missing in its infographic (PNEAP 2016). Furthermore, in this report, the community health workers are called *Sehat Muhafiz* or 'guardians of health,' which strips the mostly female community health workers of their gendered work title and sweeps away the importance of the gendered work and role women play as female health workers (or Lady Health Workers, as they define themselves in my interviews with them). In this report, the work LHWs are doing is hinted at but not explicitly credited to them.

The '*Sehat Muhafiz'* approach in 2015-2016 had two key mass-media stages. The first, "we are all intertwined," was designed to present vaccination as a social norm amid the backdrop of the interconnectedness of family children and the traditions that define a place and culture. The second phase, "strangers no more," was timed with broader efforts to improve training and resolve delayed payment and morale issues. Building on the social-norms approach of intertwined, Strangers No More sought to directly build trust for the '*Sehat Muhafiz*.' Vaccinators are presented as fathers, mothers, and members of the community with full lives, talents and skills not limited to their role in the polio programme, (PNEAP 2017, 32).

In the 2017-18 update to the report, entitled (Pakistan's) National Emergency Action Plan for Polio Eradication, another title, Frontline Workers (FLW) and community-based vaccination (CBV) is added to the list of how the health workforce and their labor is being labeled (PNEAP 2017). This is in addition to the *Sehat Muhafiz* branding that continues from the 2016-17 report. According to this report, CBV workforce, inclusive of supervisory tiers accounted for 18429 workers in 2017, with a female representation of 81% (PNEAP 2017, 21).

Interestingly, the report succinctly glosses over issues of the strikes that occurred nationwide of LHWs who demanded back pay for months of not being paid. The female workforce

is mentioned in this report again briefly, "the local, female profile of the vaccinator remains the cornerstone in building trust with caregivers and the community. There is a need to continue motivating vaccination teams, building their capacity to sustain pressure and negotiate with the community and households," (PNEAP 2017, 28).

At another point the report states that 82% of the caregivers taking care of children who are being vaccinated prefer female vaccinators and that, "where caregivers do not fully trust the vaccinator who knocks on their door, they are simply less likely to support vaccination," (PNEAP 2017, 30). Here again, I found the summaries of the gendered work and negotiations LHWs make to be erased or reduced. Furthermore, it is also interesting that caregivers in this context, mostly—if not all—women in the highly patriarchal circles, are not identified to be women.

In a 2017 interview with then Pakistan Senator Ayesha Raza Farooq, the Prime Minister's Focal Person for Polio Eradication, Senator Farooq is keen to credit the ruling political party's government in the progress for polio eradication. Only when asked by the interviewer about the role of women in the polio eradication project does Senator Farooq talk about the female health workers as "the most important component," calling them *sehat muhafiz* and frontline female workers, that "brave all kinds of odds," (interview, Farooq in Coffee with Polio Experts 2017).

In a similar report published by Afghanistan called, "(Afghanistan's) National Emergency Action Plan for Polio," no search results were found for 'gender,' 'women,' or 'culture.' Search results for women in the health workforce was mentioned only twice, and in a similar pattern to Pakistan's reports, in objectives of including more female vaccinators. The labor of the community health workers, primarily women, is also termed gender neutral as community health volunteers (ANEAP 2016).

Shifting focus on to GPEI, the organization has released reports on the dismantling process upon the completion of the Polio Eradication project, in its series of Endgame Strategic Plans (PEESPs). In the 2017 semi-annual status report, entitled “Progress against the Polio Eradication and Endgame Strategic Plan,” a word search for ‘gender’ or ‘female’ was not found (PEESP 2017). In the Polio Eradication and Endgame Strategic Plan 2013-18 (PEESP 2013), a 134-page document, female health workers are mentioned four times: in discourse of hiring more females, the need for them to be accompanied by male family members in areas that oppose vaccination, and the health incentives that need to be included to incentivize the female health workers. The search results for “culture,” and “gender” rendered one result each in the entirety of the134 pages of the document (PEESP 2013).

The trend continues. In the 2016 GPEI Annual report, (GPEI 2016), ‘gender’ and ‘culture’ rendered no results and ‘female,’ rendered a single result. Community health workers here are being labeled as community-based vaccinators (GPEI 2016).

The hiring process of lady health workers is talked about very briefly in a 2017 report entitled, Country Cooperation Strategy for WHO and Pakistan (CCSWP 2017):

> A cadre of lady health workers (LHWs) was established at the grass-roots level in 1994 in order to ensure that health education, reproductive health, vaccination, control of and other communicable diseases, promotion of safe water and sanitation and other aspects of primary health care could be made easily accessible to the local community. The LHWs have completed secondary education, are preferably married, and reside in the catchment areas, which they serve. They are subsequently trained to provide preventive, promotive and simple curative care. Currently, 22000 LHWs and 705 lady health workers supervisors are working in the field in Sindh, while around 4000 more LHWs are required to cover the entire rural population of the province, (CCSWP 2017, 14).

Again, more insight on the work they are doing, and how gender and culture both play a role here in the success of the implementation of the program is not talked about.

Colonial Overtones in Publications Regarding Aid-Receiving States

The GPEI created an entity to monitor the polio transition process named the Transition Independent Monitoring Board (TIMB) that was created 2016-2018, after which a new program is planned to be set up by WHO. This section analyzes one of the reports by TIMB published in 2017. The language used in the report describing the power dynamic between aid-receiving countries and aid-giving entities was particularly startling, especially seen in the context of a postcolonial and neoliberal lens, and not very different from language used in structural adjustment programs to put conditions of countries in the Global South before they can receive aid. For example, the report states, "If polio eradication succeeds but poorer countries' public health services collapse in the initiative's wake, it would be a major failure of global governance and stewardship," (TIMB 2017, 4).

Holding a postcolonial country in the Global South like Pakistan responsible for the failure of a polio eradication program seems quite problematic given the challenges the state has to face that may be imposed by other countries—one particular example is the CIA operation's immunization drive cover up that was used to find Osama bin Laden resulted in immunization workers being targeted by militants and severely halting the progress of polio eradication drives in the country (BBC 2014).

There also seems to be language that is reminiscent of decolonizing processes in the subcontinent wherein British leaders remained in India to oversee transfer of power even after India had officially become independent from British Rule, such that the highest seat of power,

the governor general, was given to a British person: "The GPEI could provide consultants to aid with the planning process and support countries at the global level with transition guidelines and consultations," (TIMB 2017, 22).

The language here also seems self-servicing by way of demonstrating a lack of trust in the country's ability or autonomy to manage without GPEI. In reading this, the language seems sympathetic while also looking down at the countries:

> Contributing to the lag are a lack of resources and technical expertise to carry out the planning process and the fact that country health staff necessarily must prioritize more pressing matters…also, working against a quick planning process is the GPEI's long life: in Africa, there are countries that have not seen the poliovirus in 10 or 15 years, but are still receiving GPEI funding. It is hard for them to believe that a structure that has always been there will really disappear, (TIMB 22).

Subsequently, the publication stresses the importance of GPEI to remain an influential player in the Polio campaign locally even after its term ends: "A post-GPEI world that does not pay attention to the global and regional components of leadership (e.g., in vaccine-preventable disease surveillance coordination) will be weaker by far," (TIMB 25). Again, this seems to be striking: will these developing countries ever become autonomous from GPEI (the organization itself and its representatives)?

GPEI is funded by various organizations but also becomes an avenue for developed nations to invest in its visions (i.e. Polio free world). One possible interest could be what the relationship is between the aid receiving country and the donating country in a transaction overseen by GPEI:

> The Danish government agreed to fund the establishment of India's National Polio Surveillance Project because of its belief that such surveillance would benefit the control of other communicable diseases…The Danes justified their support based on the plague scare in

> Surat, India, in the early 1990s. Regardless, it is clear that donors will expect countries to take much more responsibility, (TIMB 24-5).

Further Work

In this chapter, I bring a postcolonial critical lens to the GPEI and demonstrate through interviews and analyses of reports published by GPEI and national governments the power struggle that emerges between the state and international agencies over the eradication of polio in Pakistan. I also examined how gender and culture are being framed, with a particular emphasis on how the female workforce, as community health workers and vaccinators, are highlighted. Through content analysis, I determined that while WHO and GPEI value gender and gender mainstreaming in global health, the publications specific to polio and how gender, culture and female health workers affect this work is largely absent. At national levels, I found that while women working in the field identify themselves as LHWs, they are stripped off their gendered titles and referred mainly as 'frontline workers,' 'community health workers' and 'community-based vaccinators.'

A larger recognition of the work that female health workers do in the field is required within the full reports published by GPEI and WHO, as well as the national governments highlighting polio efforts. A richer discussion intersecting gender, globalization and development is imperative in opening dialogue to ensure the dignity of caregivers, the children who receive Polio vaccinations, and the lady health workers that occupy a very large space within the health workforce of the Polio initiatives. This is particularly important in the ways the labor of female health workers is credited (see Maes and Kalofonos 2013), which specifically in Pakistan was not paid by the government to the LHWs on time, causing nationwide protests of Lady Health Workers in 2016 and 2017 (Pakistan Today 2017).

Lastly, another glaring problem in these reports has been the missing discourse about gender, gender relations and how these are perceived in Pakistan in contrast to ideologies in non-Western societies. For my own research that incorporates critiques of colonialism, postcolonial theory and to an extent dependency theory. As such, making women more visible, focusing on the gendered relationship between production and reproduction, through a cultural lens that does not denigrate or fetishize women's lived experiences is important to recognize the labor value of women. It is only through such a means of analysis and discourse that development can be a democratic approach to empower the marginalized, non-elite, communities, instead of attempting to modernize them.

CHAPTER IV

LADY HEALTH WORKERS VS. PAKISTAN'S PUBLIC HEALTHCARE SYSTEM

How does the organization of the Pakistan healthcare system reify inequalities embedded in class and gender hierarchies among female workers in the healthcare field? In this chapter, I analyze interviews with workers in the healthcare system in a city of Punjab to demonstrate the ways gender and class both remain key factors that hinder a lower- and middle-class woman's ability to get paid on time, rise up in the hierarchy of the organization and get respect from both her male and female superiors. I draw from Acker's (1990) analysis on inequality regimes to showcase how class and gender impact female community health workers differentially and intersectionally in their everyday experiences at the workplace. Subsequently, I demonstrate gender and class both must be taken into context to understand the everyday sexism and classism women experience, shown in the differential ways more educated and seeming well-off female medical officers are treated with more respect compared to Lady Health Workers, who are the frontline workers for Pakistan's publicly funded primary healthcare.

Literature Review

Acker (2006) notes that hierarchies at the workplace are inherently gendered, and racialized, and gives the example of the top positions in the US being occupied by white men. How can we measure inequality in a workplace? Large wage differences, power differences, and the invisibility of inequalities maintain the steepness of the hierarchy and concentrate power at the top (Acker 2006; Acker 2009). Although women have entered in the workplace, they still experience many hurdles given gendered expectations on their labor as well as occupations themselves being

assumed to be gendered. Additionally, women may also have to work the second shift (see Hochschild and Machung 1989), while more visible in developing countries but also prominent in Western and developed countries. In South Asia specifically, gender disparities are generally rooted in patriarchal and patrilocal conditions (Jejeebhoy and Sathar 2001). However, scholars have noted that women will experience different gender relations on a wide range of factors beyond socioeconomic differences, including social systems, as well as cultural norms and practices, which can vary across classes and families as well as whether women are in urban or rural areas (Jejeebhoy and Sathar 2001; Roomi and Parott 2008; Jali and Islam 2017).

Most young married women generally are expected to stay at home and do household chores and care work, especially in rural areas that are largely patriarchal (Alavi 1988; Jejeebhoy and Sathar 2001). Jalal (1991) adds that women have little choice but to acquiesce, especially when gendered inequalities are reinforced by Islamic morality. In instances where women do work, this should not be seen as an indicator of their autonomy and subsequently may not have control over what they earn (Jejeebhoy and Sathar 690). Alavi (1991) notes that "no woman, even one with an independent career in a city, can set up a home on her own without the saya (lit: shade or protection) of a male. A divorced woman or a widow must turn to her father or brother, unless she has a grown-up son under whose protection she can live," (Alavi 1991, 125). Women's dependence on their social reputation and physical security tied to their families, specifically a male member, are important to note to understand why employment may not render autonomy or empowerment to most women in Pakistan, especially those who are poor and/or live in rural spaces. In the latter, especially, it is not only the head of the household, but the entire kinship system that is male dominated that has a stake in subordinating women (Alavi 1991).

Little has been done that has changed the gendered expectations or relations for women, especially those who are poor and/or living in rural areas. Shaheed (2010, 856) explains that while commissions on women have been appointed, they are mostly ignored due to lack of financial resources, inefficient personal as well as frequent changes in government, especially prolonged military rule. Most activists and movements are generated from within the middle and upper classes, as seen during demonstrations defying the draconian laws during General Zia-ul-Haqq's regime (Shaheed 2010, 856).

Gender at the workplace

Work itself is inherently gendered, given the way that work is divided as paid/unpaid, formal/unformal. Women globally do most of the world's care work, which is often informal and unpaid. The site of this unpaid and informal work is also primarily in the house, and this notion is reinforced by sociocultural and religious norms that persist in many patriarchal and religiously conservative spaces, including Pakistan. Even when women do work paid and formal work, it is largely impacted by expectations that are largely gendered. Acker (1990) reminds us:

> The concept 'a job' is thus simply a gendered concept, even though organizational logic presents it as gender neutral. 'A job' already contains the gender-based division of labor and the separation between the public and the private sphere. The concept of 'a job' assumes a particular gendered organization of domestic life and social production, (Acker 1990, 149).

Workplace structures have labor expectations for workers that are inherently gendered (Britton 2003; Williams 1995). In some cases, not meeting these gendered expectations render consequences including harassment or not being promoted up in the organizational hierarchy (Miller 1997; Vallian 1999). Mackinnon (1979) adds that for women especially, expecting and

tolerating sexual harassment is considered a part of accepting a job. Subsequently, workers may inherently perform gender at the workplace every day (West and Zimmerman 1987 and Butler 1990) that may be affected by the culture and context at the organization they are working in (Connell 1995; Salzinger 2003). As such, these gendered performances can be evaluated positively or negatively through rewards or punishment, which in turn reinforce the gendered hierarchies in that organization (Acker 1990).

Class also plays a critical role in the ability for workers to get the job and perform it. The inextricable link between economic and social status is especially consequential to a woman's ability to work, especially in developing and religiously conservative areas where a high-status occupation that is paid well and has a good reputation, and therefore more likely to be safe, is limited to applicants with degrees, as well as social and cultural capital. As such, women with little or no education, usually because of not being able to afford education especially in developing countries, may not have access to apply for such jobs. Even when hired, the ability to move up the organizational ladder, too, can be hinged upon specific class- and gender-based expectations. An intersectional analysis of jobs as being both gendered and class-based is important to understand how organizations perpetuate patriarchal and classist policies that keep marginalized people out.

When women in Pakistan do work, they are marginalized, especially in the private sector. Ali (2000) explains that this is because of the "informalization of jobs and the deregulation of the labor market. Moreover, because of occupational segregation and women's immobility, an overcrowding of women in female-dominated occupations…[which] lowers their wages and enables employers to profit from this cheap labor," (Ali 2000, 1). In addition to being exploited for their labor, women are subject to varying levels of harassment from their male colleagues. Mirza's (1999) research showcases the everyday sexism and harassment women in middle-level

positions in the urban city of Lahore, as well as tactics they must use in order to negotiate space and power in the office including creating fictive kinship systems with male colleagues, social distancing and creating their own (women's) spaces. Mirza (1999) also concludes that women opted into occupations where contact with the opposite sex was minimal and they did not have to leave their offices to do outside work.

In 2010, the Harassment of Women at the Workplace was passed to redress harassment issues working women faced every day. However, while turning the bill into a law was a crucial step, it was not put into practice, similar to the lack of implementation of rights despite Pakistan being a signatory to many international documents that advocate for women's rights (Sadruddin 2013).

Pakistan's healthcare: an example of an inequality regime

Rooted in colonial legacy, Pakistan's healthcare system maintains the inherent unequal power distribution between the British and natives in colonial India. Kumar (1998) writes that the basis of public health policy in colonial India was primarily out of concern for British troops in India. Hospitals and medical institutions were subsequently primarily for the military and civil population for the British living in India, followed by the troops, a reflection of the priorities of the colonial government (Tandon 2015). At the peak of the British Raj, those at the top and in charge of most institutions, including foreign policy and defense were British, and the healthcare administration was no different. Today, access to the highest positions in the healthcare administration remains inaccessible to most, and the patriarchal and classist norms of Pakistan's society remain inherent. Most positions in the system thus are occupied by men, with a few positions occupied by women, who are usually from the middle- or upper-middle class. Preference

for women to work in the healthcare industry in Pakistan also rests upon the gendered expectation of women being nurturing, as well as the status of a medical practitioner, especially a doctor, seen as highly (socially) reputable.

Stipulated tasks of LHWs	Additional tasks undertaken by LHWs
1. To register and educate all eligible couples, in the catchment population, about family planning methods 2. To distribute oral contraceptives pills, condoms and Injectable contraceptives to eligible couples 3. To facilitate IUD and surgery from nearest centers for eligible couples 4. To maintain a register of all pregnant mothers and children under 5 years in the catchment population 5. To look after pregnant mothers and issue them with pregnancy cards 6. To provide iron and folic acid tablets for pregnant mothers and women of reproductive age. 7. To encourage and facilitate antenatal, birth and post natal care by a skilled birth attendant (SBA). 8. To facilitate Expanded program of immunization 9. To provide basic treatment and appropriate referrals for children with diarrhoea and acute respiratory infections 10. To raise awareness about balanced nutrition 11. To educate women of all ages on common ailments 12. Encourage breastfeeding and complimentary feeding 13. Health education through growth monitoring of children 14. To promote use of iodized salt in the community 15. To provide treatment for common ailments 16. To provide awareness on prevention from Malaria and TB and participate in DOTS management 17. To provide awareness on prevention and control of HIV/AIDS and STDs 18. To promote principals of basic hygiene 19. To prepare and submit a monthly report about her work, on a structured proformas, to the attached health facility (FLCF) 20. To maintain a close liaison with the Lady Health Supervisor (LHS) 21. To provide medicine/supplies provided by the government, to the catchment population 22. To maintain close liaison with the attached health facility for Skill training, Supplies and Supervision (3 Ss) as well as for referral.	◆ Immunization - NIDs: About 20 million polio doses were administered by LHWs - MNT: LHWs role was recognized in the success of neonatal tetanus elimination campaign and they vaccinated hard to reach groups of women in difficult areas - Measles campaign: In the recent nationwide measles' elimination campaign almost 100% coverage was achieved by involving LHWs. ◆ Emergency relief activities - Earth quake relief 2006 - Flood relief 2007-8 ◆ TB DOTS: LHWs play a vital role in case detection and case retention to enhance treatment completion and cure rates. ◆ Malaria control: RBM programme utilizes LHWs in various malaria control activites. ◆ Innovations: Various innovations have been introduced in the programme after pilot testing through LHWs to extend these PHC services to the community.

◆ DOTS; Directly Observed Therapy Strategy, STD: Sexually Transmitted Diseases, FLCF: First Level Care Facilty, NID: Natioanl Immunization Days, MNT: Maternal Neonatal Tetaus, RBM: Roll Back Malaria, PHC: Primary Health Care

Table 1: Tasks for LHWs. Source Hafeez et al (2011)

Healthcare in Pakistan is accessible through the public and private sector, with the latter being poorly funded but relatively more affordable and therefore accessible to most of the population (Shaikh 2010; Bahalkani et al 2011). The armed forces have their own hospitals, that are funded by the Fauji (meaning: army) Foundation, which generates finances commercially (such as having their own branded food at grocery stores) to maintain a social protection system (Mashhadi et al 2016). There is little expenditure from the national budget into the public healthcare system.

According to Shaikh et al (2010) most developing countries have public health care systems whereas the private sector, in contrast, is usually more superior, given that it is has more resources. As a result, contracting, in terms of public funded initiatives, is usually seen such that many health initiatives are supported by a collaboration between the public and private sectors together. One of the BHUs I visited, for example, was partially funded by an NGO. Such contracting allows for more effective and quicker response rates than would be otherwise possible for a publicly funded healthcare facility to achieve alone (Shaikh et al 2010). 104 BHUs in Rahim Yar Khan, for example, were handed over to NGOs and the partnership involved managers and medical officers being hired on contract and being paid competitive salaries—about 150 percent—and a reorganization of management responsibilities within the BHU and improving the physical infrastructure of the facilities (Shaikh et al 2010, 388). Increased salaries are particularly important for public healthcare officials, as most employees have reported high levels of job dissatisfaction because of a combination of low salaries, poor working conditions, nepotism, lack of training opportunities or career advancement (Bahalkani et al 2011).

Other examples of such public-private partnerships in the healthcare sector include the national programs for malaria, tuberculosis and HIV/AIDS control, as well as family planning services through GreenStar Network (Ahmed et al 2010). Yet, Ather and Akhtar (2014) note that most private tertiary healthcare services are established in urban areas only, rendering them difficult and expensive to access for poor people in rural areas.

In contrast to jobs in the private sector, the public sector is favored, especially in female-dominated occupations such as nurses or teachers. Alavi explains that "lower middle-class families find it degrading to let their women take up jobs as domestic servants or to work on the factory floor," (Alavi 1988, 1329; Grunenfelder 2013). However, most 'respectable' jobs, especially those

like public school teachers or nurses in public hospitals require high education qualifications, which are usually unattainable for most women in rural spaces where there may be a dearth of schools as well as strict mobility norms that hinder girls to go to school.

At the heart of the public healthcare facilities is the Lady Health Worker Program, which hires female workers at the community level to provide primary care in rural areas too far from major hospitals. LHWs are trained for 15 months and learn how to provide antenatal care and identifying symptoms to common illnesses. LHWs are also the frontline workers during the Polio Eradication Campaigns, wherein they go door to door to administer polio drops to children who are eligible, usually under the age of 5 (see Ahmed 2019; 2020). Many LHWs who had been employed since the start of the program report that educational requirements were a lot more flexible in the first few years of the program. Additionally, recruitment in the Lady Health Worker program has a strong emphasis on a woman's social reputation in her community over her educational status. More recently, the educational requirements have become a lot more rigid and many women who have a high school diploma or a college degree opt to become LHWs. This, I was told was due to the reputation and respect of being hired as a public servant (government employee), as well as the lack of other suitable jobs available to women in rural and peri-urban areas that did not require them to travel too far from their home.

Mumtaz et al (2003) demonstrates that LHWs experience similar hinderances at the workplace, including abuse of power, disrespect and harassment from male colleagues and as well as lack of opportunities to advance in their career. Similar to Grunenfelder's (2013) findings about female NGO activists, Mumtaz et al's (2003) participants report contradictory expectations of them split between their identities as workers/employees and wives/daughters-in-laws. As a result,

most women recognize the expectations put on them in the different spaces they move in and must change their language and behavior accordingly to not breach these gendered roles.

LHWs in my research comply to these gendered expectations yet, unlike in Mumtaz's et al (2003) research, they have unionized and use their union as a physical and social space to demand better pay and working conditions. There have been successful inroads including a union bargained recognition of LHW as permanent government employees instead of seasonal workers, and more recently, the removal of a hiring freeze on new LHWs by the government. Yet, LHWs have to continually demand to be paid on time, as demonstrated by the frequent strikes they organize or threaten in order to be taken seriously (Gilani 2019). Additionally, my research also shows chasms across class lines in women in the healthcare industry that color the demands of the union to be of specifically employed women from working class backgrounds. In contrast, female doctors or medical officers (MOs) do not experience inequalities in the same way, nor have their own unions like those of the LHWs. The following section highlights the differences by providing a comprehensive overview of the healthcare infrastructure in Pakistan and the work women in the healthcare industry do at different levels.

Background

After the devolution plan in 1999, the healthcare system was devolved such that the provincial governments were now responsible for policymaking, planning and the implementation of health programs whereas the federal government does the monitoring, negotiating with donors, participating in international meetings, regulatory function and managing federally controlled hospitals and (health) offices (Ather and Akhtar 2014). Shaikh et al (2012) state that the aim for this was to "improve service delivery and increase healthcare utilization at grassroots level,"

(Shaikh et al 2012, 28). Policymaking, monitoring and training are at the federal level. For polio particularly, the prime minister appoints a focal spokesperson, who has the official title 'Prime Minister's Focal Person for Polio Eradication.' Some scholars, like Nishtar et al (2013) have noted that at the federal level, focus should be on "coordination, technical support and discharging of responsibility for federal roles rather than exercising bureaucratic and financial controls over provinces, which was the case [before the devolution]," (Nishtar et al 2013, 2294). Subsequently, they advise that a central national policy at the federal level would ensure a unified vision for health that is exercised "in view of the federal government's interprovincial equity promoting role (Nishtar et al 2013, 2294).

	Pakistan	**India**	**Nepal**	**Sri Lanka**	**Bangladesh**
Workforce	Lady Health Workers (LHW)	Accredited Social Health Activist (ASHA)	Female Community Health Volunteer (FCHV)	Community Health Volunteers (CHVs)	Shasthya Shebikas (SS)
Year of commencement of programme	1994	2005	1988	1976	1977
Total workforce	125,000	939,000	53,000	15,000 (approx.)	80,000
Population per CHW	175 households (1,000-1,200 people)	200 households (approx. 1,000 people)	125 households (approx. 600 people)	20 households (approx. 100 people)	250-300 households per month
Main tasks	Maternal, neonatal and child health, family planning, health promotion, immunization	Family planning, institutional delivery, child health, health education	Safe motherhood, child health, family planning, immunization	Support in prevention programmes, data collection, and health campaigns.	Health education, treatment of basic health problems, collect health information, and make referrals to health centres
Training	3 months + 12 months in the field	23 days	18 days	14 days (2 weeks)	28 days (4 weeks)
Remuneration (annual)	USD 1650	USD 500	USD 75	No remuneration at all	US 52 (monthly average of BTK 360)

Table 2: Community health programs in various South Asian countries. Source ILO (2018)

Planning, financing and resource allocation is done on the basis of administrative units of Pakistan: provinces oversee districts, that oversee tehsil. A union council is the smallest

administrative unit in Pakistan. In each district, a Department of Health government building is housed in the most populous city. For example, in the Lahore district, the Department of Health (called District Health Office or DHO) building is in the city of Lahore, for the Multan district, it is in Multan city. Punjab has thirty-four districts. Within a district, the officials at the district level, housed in the populous city of the district oversee all government employees within that district, who are serving within each administrative unit within the district, with the MO or medical officer, at the lowest rung, serving at a single BHU. As was explained to me by an MO, a newly graduated doctor who is hired as a government employee in the public healthcare system is hired as a MO and usually stationed at a BHU before making their way up eventually to the District Headquarter Hospital.

The health system offered by the Pakistan government is hence separated in two ways, a primary-secondary healthcare system, and a teaching/specialized healthcare system. At the center of the primary and secondary healthcare system (called by officers as primary-secondary) are BHUs that are built within communities wherein the LHWs go door-to-door. Each BHU has 30-40 LHWs that work there, thereby serving around 30-40,000 people in the community. More complicated cases are referred upward to Rural Health Centers (RHCs), or Tehsil headquarters or the District headquarter, with the latter having more experienced staff as well as better facilities.

The second category comprises of facilities that fall under the specialized and teaching healthcare sector. This includes bigger health unit facilities with more specialized staff and teaching professors to train future doctors. One such example is the public medical school called Nishter Medical College in Multan.

At the District Health Office

As stated before, each district has a government building, called the District Health Office, wherein public officials oversee funds and operations pertaining to objectives laid out by the federal government. At the district health office, there is a district health officer (also called DHOs by LHWs, which can sometimes get confusing without context to distinguish the office and officer). Under this officer is a deputy officer, referred locally as the deputy DHO. The deputy DHO is the main contact person for most personnel various healthcare facilities in that district to go to for problems with salaries, to take leave, et cetera. This includes the medical officer or MO, usually a female doctor who is designated as the highest-grade officer at the BHU. Lines are usually long to meet with this officer, and my interviews with a deputy DHO at his workplace was frequently paused so he could attend to pending requests of personnel from various healthcare facilities to ask for paid leave or a question regarding salary.

LHWs do not fall under the responsibility of the deputy DHO. Instead, for their requests pertaining to salaries and salary leave, they must go to the Integrated Reproductive Maternal, Newborn & Child Health and Nutrition Program (IRMNCHNP) officer, referred to locally called the IRMNCHNP: officer. Aided by UNICEF, this program started in 2012 as a consequence to the Health for All and Millennium developmental goals. The IRMNCHNP was a union of two programs, the mother and child program and the national program for family planning, with an added element of nutrition for children. The IRMNCHNP: officer now has jurisdiction over the LHW program, including supervisors of LHWs, and is answerable to questions pertaining the performance of the LHWs, especially during vaccination campaigns including Polio. The 18th amendment, under which the healthcare system was brought from the national to the provincial level has thus created a highly complex network of facilities, offices and positions.

At the BHU level

Within the BHU, the medical officer or (MO) is the highest ranked officer, directly answerable to the deputy district health officer. In most of my visits, the MO was always a woman, perhaps to help make local female populations comfortable for checkups. The MO is usually a

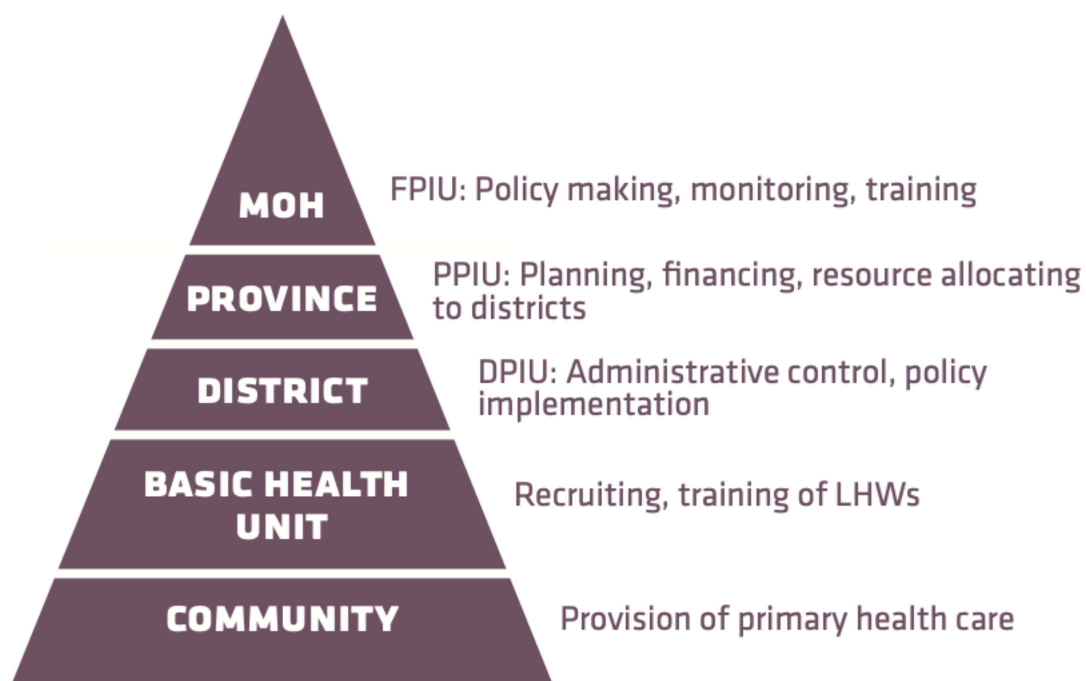

Figure 2 Integrated Management of the LHW Program Source Zhu et al (2014)

recent graduated medical student who has to serve at least one year at a BHU before moving to a different hospital. MOs will only see patients that have been escalated to them by Lady Health Visitors. Lady Health Visitors (LHVs), like MOs, have their own office where they see patients. Contrary to their title, they do not visit patients' homes. They are usually the first contact person for LHWs if there is a complicated situation the LHW cannot handle, and may escalate it to the MO. Thereafter, the MO may decide to send the patient to a secondary healthcare facility if she feels that the BHU does not have the necessary medical diagnostic equipment to treat the patient.

The MOs I spoke to seemed quite uninterested in being stationed at a BHU, which are usually not equipped with much staff or medical tools, are usually in rural and peri-urban settings. "My entire family thinks I am in some dump, and I am!" one MO, Ayesha, told me during a tea break. When talking about the LHWs, most MOs seemed critical, often calling the LHWs uneducated and unruly. The LHWs, too, usually would comment on MOs not having their best interest, especially because they would be posted elsewhere within a couple of years. Strong disdain for the large gap on the basis of class and cultural capital seemed to separate the two groups.

In contrast to the MOs, LHWs are more aligned with their immediate supervisor, a Lady Health Supervisor (LHS). One LHS supervises between 25-30 LHWs. From my interviews, while LHS are trained with the necessary medical trainings and orientations, their primary responsibility is working with the LHWs, keeping attendance and holding monthly meetings to ensure LHWs are on track to complete the targets and goals the district health office gives. LHSs are also pivotal in the collective organization and action of the union, and most union leaders are LHSs themselves. In my interviews with LHSs, who hold important positions in the union, including the president herself, I asked frequently why LHSs are not mentioned specifically for the work they do during press coverage of the strikes LHWs have done in the past. In fact, the president herself is called the president of the Lady Health Worker union, even though she is an LHS. All responded that there are just not enough LHSs compared to LHWs, and because of the high number, it is less confusing to just have LHW be the name for the union and movement. That said, in my interview with the president of the union, I was told that the union bargains for LHWs, LHSs and even drivers and other supporting staff in BHUs.

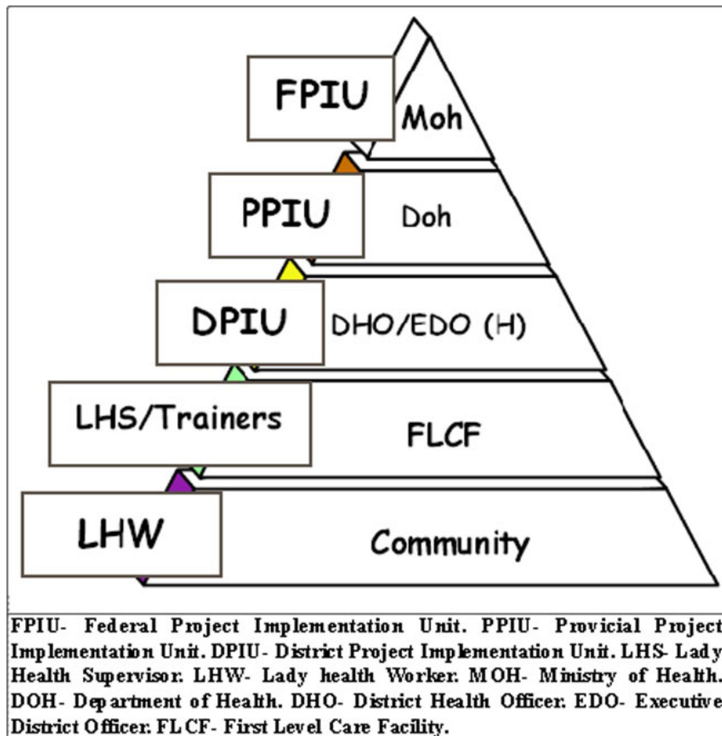

Figure 3: Organizational structure of the LHW program (Hafeez et al 2011, 210).

Findings and Analysis

Class Distinctions Among Women in the Healthcare Field

Class-based tensions seemed to be distinct between lady MOs and LHS/LHWs. Whenever I visited a clinic to interview LHWs, my preference to meet them instead of the MO was heralded as a gain for the LHWs, who complained that they were not respected by the MO. One LHW, Zunaira, chuckled to her colleagues that today they were the VIPs and not the MO, as someone from the US had come to hear their experiences. Despite being visibly younger than my participants, at LHW meetings I was given the utmost respect because of the attention and care I took in taking notes and listening to LHWs. My particular socioeconomic class was also compared by LHWs to that of the MO. But, as one participant told me, “you are not like her [MO]. You are nicer and speak and dress simpler despite sounding more educated and brought up in a better

family. The basis of such comparison was often a higher education degree than most LHWs, though I met a handful who were pursuing graduate degrees as well. In the case of equal education to a MO, private schooling was another status marker that was used against LHWs by the MO as well as healthcare administrators in the main offices. To be sure, the respect I was given by LHWs was not matched by MOs, who saw me as an equal at best. In contrast, by male healthcare administrators, I was treated as a young female student who knew nothing. For the latter, I had to frequently namedrop people I knew in the government to be taken seriously.

A stark contrast in the socioeconomic positions between the LHWs and MO further consolidates the differences. Ayub & Siddiqui's (2013) book in investigating attrition rates of LHWs in Pakistan's KPK province also highlights the lack of trust and respect doctors have of LHWs. As one MO told me, "LHWs are so ill-trained. They take too long [to treat] and don't know anything. They will only bring women [to the MO] when it's too complicated and too late." On the other hand, Lady Health Supervisors (LHSs) and LHWs share stories of MOs forcing patients to go to their own private clinics in the evenings, where they can charge higher fees that go directly into their pockets.

Even in the rare circumstances wherein an LHS could afford a car, there still seemed to be important differences created on the basis of social capital, accent, clothing choices and other tools pointing towards an MO being more 'modern' and 'educated' than an LHW/LHS. This was seen in the case of the LHW union president, who said she was not taken seriously by her MO by her car was not conditioned like the MO's. I was also analyzed with the same lens by LHWs. One LHW, Bubbly, asked me why I did not wear designer clothes or bags even though "I could" like the MO. This was said with affection, again marking me as a "good" upper class person compared to the MO, but also said with some confusion as well. When I would tell my Another marker was

my Urdu accent, which does not have a Punjabi flair to it despite being brought up in Punjab, indicating to the LHWs that I probably went to private school and was spoken to in English or Urdu instead of Punjabi at home, which are both seen as more 'proper' despite Punjabi being the regional language of the province and most well understood in the region I was in.

Patriarchy at the District Health Office

There is a clear feeling of isolation and otherness that LHWs feel when going to the DHO to ask for days off, updates on being paid on time, et cetera. In a conversation with the president of the LHW union, Rukhsana told me, "people in charge of us [in the DHO building] do not even know much about the work we do. Why don't they hire experienced LHS as advisors at that level? Usually, retired government officers with no prior experience to the kind of work we do are hired as program directors. Are we an NGO?"

Going to the DHO building to make complaints or appeals is also an ordeal, as most LHS and LHWs informed me. One LHS said, "sometimes they make our girls (LHWs) stand there for hours just to insult them. There is no place to sit in those areas because they are packed. These girls are there for hours for simple requests [to take some time off, for example]." The government has often neglected LHWs, and most LHWs are not paid on time.

Furthermore, despite being regularized as government employees, LHWs do not share the same benefits as other government employees, such as free or subsidized healthcare access, even if they are injured during work. They are also not reimbursed for expenses during work, including having to buy new shoes every month. Manzoora told me, "I have to walk so much every day, especially during the polio campaigns. I need to buy shoes every month because they wear out. That's another expense I need to put aside for work. The government tells us not to make an issue

out of it." The work as an LHW is in addition to the second shift of carework and household chores LHWs do (see Hochschild and Machung 1989). Though three LHWs reported they had help from their mothers to help take care of the kids, most LHWs told me they would wake up at four in the morning to perform the morning prayer, after which they would make breakfast, clean the house and get their children ready for school before going to work themselves.

Often, it is men who are at higher ranks appointed in the DHO, in part because of the cultural beliefs that are largely still in place for most districts and also in part because of the colonial legacy that maintained power over subjects by employing only White British employees at important ranks overlooking their Indian subordinates (Tandon 2017). The patriarchal tensions between men and women are bifurcated over class, especially when comparing the experience of a MO and an LHW/LHS: while both are women, MOs are generally seen to have a higher cultural capital and are often related to powerful families/relatives in high positions. Yet, everyday patriarchal interactions persist, that can be understood from a cultural and religious lens. A district health officer may still not give attention to a MO and keep her waiting in his office for some time before attending to her however, she will have a place to sit and will also be offered tea and snacks as she waits.

These important gender-class based transcripts also extended towards me such that District Health Officers did not seem to take me seriously because they saw me as a young student from the US who did not know any better. In one occasion, an officer took my pen and paper from me in frustration to draw a table for me since I was "not doing it right," later asking a lady MO waiting in the corner of his office to explain it to me while he attended to other matters. In another occasion, I told a district health officer the rank of my mother, a government officer herself and a much higher ranked official than him, which changed the tone of the conversation completely. Yet, there

still seemed to be misogynist undertones in our conversation, wherein he lectured me to get married and not waste my time in "such research projects" that are not important. My identity as a woman, more importantly an unmarried woman, was still at the forefront, this time not as a means for the officer to speak to me rudely since I was affiliated to a highly ranked public official, but out of a paternalistic concern for my well-being and safety. Patriarchy persisted but cloaked in the form of concern.

Again, it is an intersection of my class and social capital that set me apart from LHWs and LHSs in the eyes of a female MO, and why I was frequently asked to join them for tea or lunch when I visited a BHU to speak to LHWs. Suffice to say, I may not have had the same treatment if I was not a studying in the US and belonged to an upper-middle class family. As such, gender and class *both* need to be considered to analyze the micro interactions happening between men and women, lower and higher ranked officials at the DHO. Subsequently, an LHW in my interviews and observations, seemed to be treated the worst given her socioeconomic status and being less likely to have connections with higher ranked public officers.

Everyday sexism and the paradoxical messages to LHWs

It is worth noting that the messages LHWs are given as part of their training for their job is paradoxical to how they are treated by their mostly male superiors at the DHO. This offers an interesting analysis, as male officers and the larger public healthcare system seems to be acutely aware of the sociocultural and religious norms that make LHWs more vulnerable in the field. For example, the rule for LHWs to be married before they can be hired from a functional perspective is for the LHWs' safety, as married women are assumed to be more protected than their single counterparts, similar to why an officer advised me to quit my research that entailed doing

"dangerous fieldwork alone" and instead be protected and safe at home. To be sure, a female MO need not be married to be hired, mirroring my earlier discussion of class and gender both being a factor. In my interviews, LHWs also told me that they were repeatedly told in trainings to "act like a man," as part of their job in order to enter homes for vaccinations and check-ups wherein they might face any obstruction.

The inherent gendered expectations imposed upon an LHW are hence situational: she is hired to go door to door because of her identity as a woman who is more likely to be nurturing and maternal. Keeping the cultural and religious norms aside, as a woman, she is also assumed less dangerous and less likely to inflict sexual or physical abuse on her door-to-door visits. Yet, in order to gain access into homes where she may not be welcome, she is trained to be more dominant and commanding, like that of a man. She must be married for her own safety and to gain more social capital from her in-laws' reputation yet she is not given special considerations or accommodations to ensure she can still be a good mother or daughter-in-law by repeatedly being denied sick leave or family leave. Finally, while she is encouraged in her trainings to act and speak like a man, she is made to stand in long queues at the DHO and appease to her (usually) male superior in conversations laced with patriarchal undertones. Grunenfelder (2013) shows similar findings for NGO activists in Pakistan, who have to maintain roles as workers and wives that can often be contradictory. Some of the strategies Grunenfelder (2013, 607) explains the female NGO workers might keep in touch with other female workers throughout their field visits, minimizing work outside the office to avoid being in vulnerable positions, and asking their husband to pick and drop them to work, whenever possible.

In these moments, the union becomes an important platform to make demands by relying on large numbers and threatening to strike during polio campaigns. In the past, LHWs across the

country have staged sit-ins in front of government buildings to ask for their salaries that have been held up for months at a time. More recently, in March 2019, the union successfully stopped the hiring ban that was put on LHWs since 2017.

Conclusion

This chapter outlined the organizational architecture of the healthcare sector in Pakistan, with a focus on the working conditions of Lady Health Workers (LHWs), specifically in Punjab, Pakistan. Women in rural spaces of Punjab, Pakistan, have very little options of employment. When they do work, they must work the second shift by cooking, cleaning and taking care of their children in addition to their work as an LHW. In contrast, most MOs, have hired help. At the workplace, LHWs are subjected to many problems, including being harassed by both their female and male superiors at their workplace, the BHU, as well as at the district health office where they have to ask for paid sick leave and/or to be paid on time.

LHWs are also given contradictory messages wherein they are trained to "act like a man" when doing door-to-door visits to ensure they can enter homes to vaccinate children. Yet, they are expected to not behave in the same way when speaking with their male superiors. This is in addition to the gendered expectation of being a good mother and daughter-in-law that LHWs comply to at home. Female medical officers are also subject to everyday sexism, such as made to wait their turn in the office when asking for paid leave, being called 'bachi' or young daughter by their superiors, a clear disregard for their earned title as doctors. Yet, even in these examples, the sexism is more subdued due to MOs being perceived as coming from better off families than LHWs, as well as possibly having relatives in the government and/or army. For example, while both LHWs and MOs are made to wait at district offices, the MO can sit in the privacy of her

superior, in an air-conditioned room whereas LHWs are made to wait in halls with no fans, often sitting on the floor even when there may be space inside their superior's office room.

Though the government of Pakistan is a signatory for many international conferences and more recently even passed a bill in 2010 to penalize harassment at the workplace, little has been done to implement these laws into practice. The poor working conditions, lack of career advancement and overall marginalization of LHWs within the public healthcare sector has many similarities to Acker's (1990) description of inequality regimes. These conditions have created for some LHWs to resort to collective action, specifically in the form of strikes as a union, to demand better treatment and timely pay, which will be a topic I take up in a subsequent paper.

CHAPTER V

"I AM MY OWN PERSON, " WOMEN'S AGENCY INSIDE AND OUTSIDE THE HOME IN RURAL PAKISTAN

(this chapter originally published in an article (Ahmed 2020 and has been edited to be a part of this dissertation)

In an effort to find new ways of operationalizing gender, power and space, existing notions of women's agency in developing countries have been re-examined across social science disciplines (Mohanty 1984; Kabeer 1997; Alidou 2005; Korteweg 2008; Bilge 2010; Sen 2013). Within this literature, there remains a gap in assessing how agency differs in the way it is exercised across urban-rural boundaries, through opportunities that arise from global health issues. In what ways do women, often portrayed as marginalized in rural areas of Punjab, Pakistan, claim agency and space?

Kabeer (2011), Abu-Lughod (2002) and Mahmood (2001) push for a more diverse and inclusive understanding of what gender justice and women's empowerment mean that take into account the rich cultural and historical processes of developing countries. Using Reader's (2007) concept of patiency and agency, I explore the larger social institutions, particularly the family system or *biradari,* which at face value confines women's mobility but upon a closer examination, also serves as a resource for women to have a support system and network of trust with other women. Finally, adopting Mumtaz and Salway's (2009) concept of social geography, *biradari* also allow women to move in different physical and social circles while still being seen as moving "within the home."

Such contextualized portrayals of women are a departure from mainstream depictions of women in developing countries that are sometimes reinforced by locals in the upper echelons of

the (urban) society.[7] Mumtaz and Salway (2009) claim that such a conception of women has policy implications, which can be problematic when used as a basis of standardized indicators in reproductive health literature. This is because such standardized indicators do not take into account women's lived experiences that vary temporally and spatially.

In this chapter, I use employment (and subsequently mobility) as a means of contrasting between two groups of women.[8] Women in the first group are home-based workers, performing care work and stay at home, within their *biradari*, and may sometimes contribute by making handicrafts or helping take care of livestock. Women in the second group are formally employed by the state as community health workers and must work door-to-door, outside the home and their *biradari*. Using this framework, I make the following arguments in this paper: 1) women in rural areas exercise agency in ways reflective of their socioeconomic position within their local communities. 2) Women who are formally employed and work outside their home are, over time, exhibiting differences in how they see themselves and their labor. That said, 3) both groups contend with patriarchal norms and gendered expectations rooted in the social and cultural geography they are a part of. How women negotiate and work around these norms and expectations are, so far, quite similar.

This chapter is based on data gathered between 2015-2018 as a part of my doctoral dissertation, which explores women's agency, power structures and institutions in rural areas of Punjab, Pakistan. During my fieldwork I conducted interviews, participant observations and focus groups with thirty women living in various permanent and temporary settlements in rural Southern

[7] In conversations with government employees in the Punjab health department, as well as informal discussions with housewives of upper-class military and bureaucratic officers, I found there to be a common misconception that rural women do not leave their homes.

[8] It should be noted that what constitutes as 'inside' and 'outside' the home refers to more than just physical geography. Here I am referring to Mumtaz and Salway's (2005) description of the social geographies that women in rural areas use to distinguish "inside" and "outside" their home, as well as "family" and "strangers." I explain this in more dept in later sections.

Punjab to demonstrate the mechanisms and discourse of agency that occur, as well as speaking with five doctors and health department employees. As mentioned above, two groups emerged from the women interviewed: one group comprised of the Lady Health Workers (LHWs), community health care workers employed by the state who provide basic primary healthcare services, particularly antenatal care, in their community.

The LHW program began in 1994 by the Government of Pakistan, otherwise known as the National Programme of Family Planning (Khan 2011). LHWs train for 15 months to give antenatal care and diagnose common illnesses. Afterward, they complete 12 months of on-the-job training. An LHW is then assigned to a local health facility and a map of households she visits for regular check-ins. LHWs are also the frontline workers for national immunization programs like the polio vaccination campaign.

The second group comprises of home-based workers: women in the same sites who do not go outside of their homes to work and work among members of their *biradari*. These women primarily perform care work, make small handicrafts to sell and take care of livestock. Some women in this group are relatives of LHWs and take care of the latter's children when LHWs are out on duty. Both groups of women, however, are still expected by their families to perform care work as part of their duty as mothers, daughters and wives.[9]

The findings of this chapter are in line with third world and postcolonial feminist scholarship (see Mohanty 1984). I argue that even within the most rigid patriarchal structures in rural areas of South Punjab dominated by traditions and customs, women exercise agency when captured within the larger social, cultural and historical processes specific to the site of analysis.

[9] Two more papers are forthcoming to discuss each of the groups of women in this chapter in more detail to bring forth themes, institutions and actors that could not be discussed at length for both groups due to time and space constraints.

Women's Status in Pakistan: A historical overview

As mentioned in chapter two, in Pakistan, efforts to dismantle the oppressive gender order have been disrupted frequently by gyrations of the Islamization of political authority, persistent military, and class dominance. The development trajectory for the country has fallen short on the 'modernity' track. Repeatedly, the state fails to bring forth gender equity and basic health services to its people. Despite becoming a nuclear power, the state has failed in human development—particularly indicators of social equity, development, and quality of life. To be sure, Pakistan ranked as the second-to-worst in the Global Gender Gap Study between 2016 and 2018 (Schwab et al 2016; 2017; Schwab 2018).

Indeed, efforts by the state still need to be enforced more widely for a transformation to materialize fully. Women's rights violations occur frequently, especially in rural areas that are dominated by village councils and tribal (informal) courts that intersect religious interpretations with local customs to maintain an oppressive hold on women.

The feudal system, reified by the British, allocated power to families loyal to the British administration, and remains in post-colonial Pakistan. This system continues to challenge state control, specifically in areas like FATA and Khyber Pakhtunkhwa (Malik 2009; Javid 2011). In Punjab, Pakistani officials and lawyers assured me the informal tribal courts have since been dismantled, and only the very remote areas in Southern Punjab are still governed by informal courts. For the remaining villages in Punjab, and in areas wherein I conducted my fieldwork, state courts in large cities serve as the primary judicial body. Sakeena, one of the Lady Health Workers (LHWs) I interviewed, told me that when she had marriage problems, she lodged a complaint at the local state court.

Yet, the prevailing notions of constraining women's visibility in the community permeates even in spaces like my field, not dominated by tribal courts, in part due to the Islamic mobilizations that weave together oppressive and misogynist customs, rooted in subjective interpretations of Islamic teachings with little discourse, into local communities through religious schools and mosques. This sheds light into the community's complicity in honor killing rulings, as well as the mindset of the legal courts' lawyers who may uphold customs that constrain women's rights in rural areas. For the latter, this is seen in cases wherein the lawyers have used Quranic references to support their stance on the status of the Pakistani (Muslim) woman and her obligations to her family (Jamal 2006, 288-9). Honor killings occur to police women's mobility and decision making. One of the more shocking incidences occurred in 2014 when a twenty-five-year-old woman was stoned to death by her family at the steps of the Lahore High Court in Punjab for marrying by choice (Dawn News 2014).

In my interviews, women in rural areas expressed the need to send their girls to school but complained the schools were often miles away and inaccessible. The notion of what constitutes 'inside' the home and 'outside,' based on proximity to members of the *biradari*, also makes it harder to send daughters to schools even when schools are close by (Mumtaz and Salway 2009).

Though bills and laws have been passed, skepticism remains on their efficacy due to a lack of enforcement, and whether these can change the gendered expectations in local communities. Subsequently, participants interviewed in this chapter describe efforts that can be seen as pushing against prescribed gendered expectations and norms in overt and covert ways. Women's reluctance to partake in overt forms of resistance are understandably rare, given how gender-based violence in rural areas remains as a tool to police women's mobility. This holds true in rural areas where a woman's honor is tied to her *biradari's*, and deviating norms can result in alienation and/or

punishment not only from the *biradari* but from the community as well to set an example. Many LHWs in my interviews complained about being chased around by dogs and sneered at by community members for leaving their homes to go door to door for work.

***Biradari*, social geography and rethinking agency**

Both groups of women primarily lived in joint patrilineal family systems, with the exception of two LHWs who were separated from their husbands and lived with their parents. Participants lived in close proximity to other female family members and often gathered in an open courtyard, central to each other's homes where women and their young children worked on chores together, namely knitting, cooking and cleaning. A hierarchy in these groups was visible, such that the oldest woman, usually the mother-in-law, spoke to me first when welcoming me, as well as answering questions in the focus groups. Younger women would find an excuse to take me to a different room to speak with me more frankly.[10]

Mavra, a nineteen-year-old newly-wed home-based worker, took me aside to speak to me privately and expressed her discontent living with her mother-in-law and husband's first wife. Her demeanor was much more estranged when in front of her in-laws. When her mother-in-law asked her to show me inside the house by herself, she quickly apologized for appearing aloof once she was alone with me. "Baji (sister), I hope you understand I was not being rude to you on purpose. I did not want my mother-in-law or my husband's first wife to be suspicious of me talking ill of them behind their back." Since polygamy is allowed in Islam wherein a man can be married up to four times, Mavra told me her husband worked in a city five hours away and probably lived there

[10] This included LHWs, too, who abided to this hierarchy when inside their home.

with a third wife. At home, Mavra, along with her husband's first wife and mother-in-law, made woven beds, and handicrafts, which Mavra's husband would collect and sell when he returned. The family system and hierarchies observed during interviews are better understood in the context of the larger social unit men and women see themselves as a part of. In many instances, including Mavra's, marriages were arranged within the family, such that a woman's aunt would also be her mother-in-law, thereby keeping the women within the *biradari*. This social unit of the rural settlements, called *biradari* is where:

> a person participates in a network of relationships that have bearing on his/her economic and social wellbeing. The central elements of *biradari* membership are blood relationships, affective ties, trust and reciprocity. These, in turn, generate a system of claims and obligations as well as rights and responsibilities, (Mumtaz and Salway 2009, 1351).

Each settlement I visited had between 3-5 *biradaris*. *Biradari* is particularly important for women as it ordains gendered hierarchies between men and women, and within women and helps them draw boundaries between family and strangers, particularly with men. The *biradari* is simultaneously a source of reifying patriarchal norms imposed on women's mobility and decision-making by the men who sit at the top of this network, as well as a means of consolidating a network among women for advice and support to navigate around the patriarchal norms and gendered expectations in the *biradari* and outside. Mumtaz and Salway (2005) further elaborate:

> The identity of the people who share a space at a particular moment in time determines whether the space is classified as 'baar' (outside) or 'ander' (inside) space. Presence of biradari members, both women and men, creates a socially acceptable 'inside' space, while

the presence of a non-biradari man, or even a woman, creates an 'outside' space (Mumtaz and Salway 2005, 1761).

During the day, when interviews were conducted, most men were working in the fields close by and would come home in the evenings. Among home-based workers, three women, including Mavra, had husbands living in nearby cities who came home between once a week to once a month. No stark differences were observed for the purposes of this paper: in the absence of their husbands, the gendered expectations were upheld by other members of the *biradari* such as the father-in-law and mother-in-law.[11]

Yet, most families' attitudes towards women becoming formally employed as LHWs were not as negative as I had initially expected, in part because of the higher costs of living and increasing poverty levels in rural areas (Khan 2011). Most LHWs insisted their in-laws and husband were very supportive of their decision to apply to the program because of the money that it would generate. Nearly all LHWs indicated that a portion of their salary went towards their children's education. Khan (2011) states that the LHW program is a major employer for women in the formal sector and is especially important in households to support the family wherein the husband brought in no income at all.

Some LHWs noted that their employment has helped other women in their *biradari* to also seek employment themselves. As noted above, my observations captured *biradari* as simultaneously hindering women's ambitions while also providing women the space and resources to cope with these restrictions. For example, while immediate members of the *biradari* approved

[11] An argument could be made that these women are Left Behind Wives (LBWs), hence invoking literature on LBW and how this particular identity has implications on their positionality and agency. Upon more visits to the field, I hope to explore this concept for a future paper by speaking with more women with migrant husbands.

LHWs to work, LHWs noted that distant relatives were sometimes still hesitant to approve of this change. This helps contextualize why women seemed an agent in one domain of their life in certain spaces while appearing more passive in other situations, around certain family members. In such moments where agency is not apparent, Reader (2007) reminds us to analyze moments that appear as passive and as submission with caution.

Reader (2007) claims that the opposite of agency is patiency, and a person who has agency in one domain in their life can have patiency in another relationship or domain. She argues, "it is not fine to give agency all the attention and to pretend that the non-agential aspects of our life are somehow less human, less valuable, less our own," (Reader 2007, 604). The stress on agency must take into account, and dignify moments, which at face value seem void of agency. Saba Mahmood (2001) captures this in her participants when they practice *sabr* (patience or endurance) in the face of hardship. She states, "but *sabr*…marks not a reluctance to act; rather it is integral to a constructive project, a site of considerable investment, struggle and achievement (Mahmood 222).

Participants in this study, particularly LHWs, exercise agency in some interactions during work hours, while exhibiting patiency at home so they can go back to work the next day with little opposition from family members. Home-based workers spoke to me in private about their ambitions and asked for advice on how they can send their daughters to school while keeping their distance from me in front of their mother-in-law. The seeming lack of agency in their interactions at home and among household members should not be deemed as passivity or a failure. Likewise, having a binary understanding of *biradari* as disempowering or empowering institution is also

problematic.[12] Such binaries can fail to capture why women codeswitch to 'passive' behavior that appears disempowering at face value.

"Talk like a man": LHWs outside the home

Outside of their homes, LHWs were visibly mobile and willing to negotiate their own spaces as working women in many ways their counterparts could not (Closser 2015). When asked how they were taught in training to confront men during their rounds, LHWs told me they were trained to "talk like a man." Sanya, an LHW added, "initially, it was awkward but after a while, I think people now know what I do as an LHW and it's much easier to go into homes for my work." LHWs have their own unions, run by their immediate supervisors, LHSs (Lady Health Supervisors) at BHUs. There are two nationwide unions presently, one headquartered in Sindh and another in Punjab, led by two LHSs who initially worked together but separated after differences. Both unions demand worker safety conditions and timely stipends by threatening to go on strike during important nationwide vaccination programs where LHWs are frontline workers, notably the polio immunization campaign.

These unions, particularly the one based in Multan, Punjab, has been pivotal to LHWs in Punjab to become permanent government employees, get raises and more recently, have the government reverse a hiring freeze to the program. In further interviews conducted in cities for a forthcoming paper, the union plays a central role to LHWs who participate in protests in front of government buildings to demand timely payments and worker safety. In the last four years of my research, I found the *biradari* to still be more influential in rural areas.

[12] Some LHWs in cities have, over time, also started to refer to their fellow LHWs as a *biradari,* citing it as a sisterhood. To be sure, there are still important gendered hierarchies based on socioeconomic status and age, similar to *biradari*, which can still impost new power structures on LHWs in this newly constructed *biradari.*

Yet, despite talking like a man and being part of a collective that regularly challenges the state, most LHWs are acutely aware of gendered expectations and the importance for preserving a pious image of themselves in the community. Mariam, an LHW would only travel with her husband when performing door-to-door checkups. When I asked her why, she told me she wanted to ensure she had a witness in case any community gossip ensued targeting her for having an affair. Such gossip not only jeopardizes an LHW's physical safety but also can cause her to lose her job if her community does not respect her, as the job is hinged upon her social standing in her community.

Another LHW, Tamana, whose character was destroyed when rumors started about her cheating on her husband with someone from her assigned houses. *Bechari* (poor woman), it became so difficult for her to work that she had to leave town. I do not want to have that happen to me. Having my husband with me assures me of my physical safety and preserving my *izzat* (honor) in the community.

Mariam wanted to ensure no one challenged her reputation which is quite important for her personally but also professionally as a community health worker. Her decision to have her husband walk with her during checkups protects her from the reactions she is subject to for trespassing gendered expectations and norms of the area. Mariam's decision is a sobering reminder of the challenges women in these spaces must face despite being formally employed and paid by the government. In my recent trip to the field, Mariam's husband had become a driver at the BHU and drove Mariam around on his motorbike during vaccination campaigns. In my sample, four LHWs had husbands who became drivers. This is in line with Mumtaz and Salway (2005), who claim that women adapt their gender identities and behaviors to demonstrate compliance with dominant gendered expectations. To be sure, not all LHWs' husbands could secure this position, due to the

hiring freeze on LHWs that was imposed by the government a few years ago until it recently got lifted, in March 2019. Since drivers usually accompany LHWs, the hiring ban also impacted their hires.

Sakeena, an LHW, is grateful for her employment as it has given her financial autonomy to separate from her husband when he demanded she quit her job or leave him. When I asked her why she did not quit, she responded, "Why should I quit? What guarantee do I have that after I quit, he will support me and my kids? If he cannot support us, then why should I quit? I am my own person, and I have my own identity. No one can take that away from me." Yet, instead of living alone, Sakeena lives with her parents. She told me that she will also not agree to a divorce in fear of it affecting her reputation in her community and its impact on her children, despite having separated from her husband for three years. Sakeena also relies on her father and brothers to represent her in court over false allegations she says her in-laws put on her out of spite.

Both Sakeena and Mariam have acquired more mobility and financial resources because of their employment as LHWs, yet both demonstrate negotiating with the larger patriarchal norms to avoid overtly challenging local gendered expectations. In Sakeena's case, she agreed that her husband did not contribute to her in any way but was reluctant to badmouth him or his family or consider filing for divorce. Though she sees herself as autonomous and accomplished, she relies on her father and brothers for physical protection against her in-laws, and to represent her in court against legal battles with her husband and his family. Mariam, on the other hand, protects herself and her *izzat* (honor) by having her husband accompany her on her door-to-door visits every day.

Women are cautious in the way they make decisions because they have as much to lose as they have to gain from overtly disrupting gender patterns that maintain social relationships (Basu 1996; Kabeer 1997). Such observations are in line with the argument Mohanty (1984) made about

disrupting literature that presents women in developing countries as a monolithic oppressed category.

The examples of Mariam and Sakeena, as well as LHWs' reliance on their unions for support to navigate imposing patriarchal norms, are different ways LHWs exercise agency within the confines of the larger patriarchal norms that pervade the community they live in. Rashid (2013) reminds us that a woman's power is in challenging and, more importantly, changing the existing social understandings of gender roles, not necessarily in leading households.

Despite the perks that their employment gives them, all LHWs except for one did not want their daughters to become an LHW, citing difficulties they face in getting paid on time and the snide remarks they still receive for going door-to-door, seen under negative light in their community. Maha, an LHW, explained to me that women [should be] seen either in the home or at best, as teachers at a school. Those, she claimed, are the "reputable" jobs. Yet, I did not encounter a teacher who lived in the communities I visited. I assume that like the medical doctor and nutritionist in BHUs, teachers may live outside of the rural areas I researched in, and commute to the nearest schools that were usually not close by in the settlements I visited.

Still, Maha noted that over the years there has been a gradual acceptance of the work LHWs are doing, though there is still criticism LHWs face from some community members even today. This opinion was not shared by all. Muneeba, another LHW who lived closer to a major city, said that she still is mistreated by some members of the community for going door to door, calling her the "polio lady," and setting their dogs after her. Muneeba added, "In times like this, when I am mistreated, I feel like I embarrass my family and children. They seem visibly hurt and disappointed by the taunts and mistreatment I receive." This sentiment is consistent with the findings of Mumtaz et al (2013) who found LHWs' work in Attock, Punjab was considered shameful by local people.

However, Muneeba did agree with Maha that things are much better now than they were when she first started work as an LHW six years ago.

Agency within the home

Understanding the inner mechanisms of structure and power in the home is particularly important to discern how structure and power are being challenged in ways specific to the South Asian context (Nagar 2000). Women in both groups exemplified an acute awareness of their gendered positions in their home, their relationships and available resources, and how these impacted their negotiation powers with their in-laws and husband.

Women also rely on each other inside the home. As noted previously, most home-based workers within a *biradari* gathered in a central common space or courtyard daily to perform chores together. It was within these spaces that young women, still aware of the hierarchies within these spaces, would ask for advice. This included asking women how to most effectively use the money for food and household expenditure, planning meals and children's futures. More importantly, this was also a space to talk about marriages of daughters. During a group interview in such a setting, an older woman and seeming matriarch in the group advised a newly married woman, her niece, how to appeal to her husband. Hina, a mother of three, reflects:

> I always find my husband is in a better mood after he has eaten. It also depends on what kind of day he is having. I am a mother—of course, I want what is best for her [her daughter]. But what can I do besides bring it up in a manner that doesn't upset him? I pray to Allah that she finds a good home.

When the conversation of marriage came up in another group of home-based workers gathered in a similar setting, an older woman suggested talking to one's father-in-law and/or

mother-in-law depending on one's relationship with them. Maheen, a woman in her forties, had a different opinion regarding the subject; "Marriage is always a compromise no matter where you go. I have taught my daughters to be good wives. Whenever they have a problem, they come to me for advice and I will always tell them how to keep their husband and family happy." Matrimonial harmony is prioritized by mothers, as in this case, to constrain the influence a woman's mother-in-law will have when tensions in marriage arise. Bazla, a doctor stationed at a BHU, told me that many women she meets want to go on birth control but are hindered by their mother-in-law from doing so. Mothers-in-law have a clear hierarchy over their daughters-in-law, but gender still supersedes age. When older sons come with their mother and wife, it is the son that makes final decisions. When asked why this happens, Bazla explained, "he may be her son, but he is still a man, and that trumps his status as her son."

LHWs, too, depend on home-based working women to share their care work with. Often, LHWs have their mothers or sisters take care of their children when they are working outside. At home, LHWs were not very different: they seemed to abide by the same hierarchy as home-based workers. In fact, many LHWs would work the double shift, going directly into the kitchen to cook or clean once home. LHWs also reported waking up early, usually around five, to have enough time to pray, cook breakfast and clean before heading to work.

Shabana, an LHW, was a middle-aged woman who lived in a joint family with her husband and had a different attitude outside the home and inside. As an LHW, she appeared to be confident in her interactions with her supervisors and patients. Yet, as our conversation moved from her clinic into her home, her tone and body language changed immediately in the presence of her mother-in-law, who was waiting for Shabana to come home and give her tea and start making food. "Outside, I am an LHW but here I am a wife, a mother, and a daughter-in-law. What to do?

I am happy my family does not object to me working," Shabana laughed and told me when I inquired about her sudden codeswitch. Shabana's mother-in-law seemed to praise her a lot in front of me, telling me how Shabana was able to juggle her housework and job at the same time, and she had no qualms with the work her daughter-in-law did because she trusted her. Maintaining a good reputation with her in-laws, it seemed, helped Shabana keep her job with little opposition from her family members.

As noted before, participants desired their children to be educated, particularly daughters. LHWs, subsequently, had more disposable income for their children and prioritized education, even if it meant having their children move closer to schools in another city, where the LHW's parents lived. Shabana's decision to work a double shift also meant she could secure a better future for her daughters, whom she hoped would one day go to college.

For home-based workers, education for daughters was important too. Rida, a twenty-year-old girl who was born and raised in the city but married into a family that resided in a small village, and now a home-based worker, was adamant to not let her daughter have a similar fate:

> I want my daughter to be educated. I cry every night because I cannot adjust here. I cannot go out on my own to shops. It has been three years and I do not understand the ways of living. I don't know what I will do but I cannot let my daughter get married to someone here. I have already started picking up a craft to save so I have more say in matters pertaining to her.

Rida presently might not have the resources to exercise agency yet if we use Reader's (2007) framework, her present patiency does not take away from her willingness to exercise agency in the longer term, through her desire to educate her daughter in hopes of it giving her daughter a better life and more options than she had.

Women who were home-based workers did not have much disposable income, and like Rida, relied on making handicrafts and stitching clothes. A few reported asking their husbands for pocket money without their in-laws knowing. Naveen, whose husband lives in another city, said that in private conversations with her husband, she always asks him to bring her money on his visits:

> I have to do it very sweetly and implore him otherwise he will not listen. He has another wife and two other children. But since I am the youngest, I try to do my best to make him happy and have some money on my own…Who knows what is in the future? I need to have some money of my own to feel secure.

Sometimes, home-based working women would try to sell me handicrafts and the woven beds they made. Where available, women would also try to sell me livestock and fish. When I would ask about the price, they would consult a male member in the house or their mother-in-law. In peri-urban areas, women even gave me their cell phone numbers, so I could contact them if I wanted to get handicrafts made on demand. On one occasion, Ayesha, a forty-year-old mother and home-based worker, mistook me as a state employee. Upon meeting me, she began telling me of all the repairs that their house needs and how I needed to urge my superiors to give her more funds, explaining that her house was built in a flood-stricken area and would not survive should another flood occur. Once I clarified who I was, the conversation topic, and her imploring tone, both changed.

Though constrained by overarching restrictions governed by *biradari*, women still find resources and opportunities within this structure for bettering their own lives and their children's. Mainstream depictions of women in developing countries, including perceptions maintained by

local middle- and upper-class Pakistanis living in urban cities, must take into account a multitude of factors to recognize women exercising agency in overt and covert ways. In Afghanistan, for example, Lila Abu-Lughod (2002) suggests women's priorities might be more towards maintaining ties with family and observing piety, which is in contrast to the so-called universal discourse of gender justice believed to hinge upon "emancipation, equality and rights" (Abu-Lughod, 787). Kandiyoti (1988; 1998) and Kabeer (2011), too, caution that there is not a universal way to understand constructions of gender identities and networks.

Temporal and spatial differences in how women perceive being connected to one another, with men, and their communities gives insight into the ways the struggle for equality and gender justice is different in rural areas of developing countries. Subsequently, as my observations and ethnographic work indicate, the women I spoke with have different ways of negotiating space and power contingent on their gendered identities, relationships with their family and community in the *biradari*.

Discussion & Concluding Remarks

Using ethnographic evidence from rural Punjab, Pakistan, this chapter argued that an over-emphasis on active agency, must be challenged to legitimize lived experiences of women in developing countries. A woman exercising agency in one domain of her life does not necessarily mean she can exercise agency in all other aspects of her life. Concomitantly, not being able to exercise agency across all aspects of her life does not rob a woman of her agency (Reader 2007; Mahmood 2001).

At the individual and group levels, women in rural areas exercise agency in various ways within the larger structures of patriarchal norms enacted through the family (*biradari)* and

gendered expectations and norms in the community outside the *biradari*. Women in these spaces rely on one another in the family to distribute care work (especially in the case of LHWs), chores, and to exchange advice.[13] Women also demonstrated an acute awareness of the gendered hierarchies and social relationships within their *biradari* and were cautious in negotiating their identities as to not overtly challenge these hierarchies and norms, thereby avoiding conflict.

New avenues for women's formal employment outside the home have emerged through government-funded programs such as the LHW program. As a result, women who are able to work outside their homes have new spaces, resources, and opportunities to exercise agency. Two LHWs, for example, were able to separate from their husbands because of having increased financial autonomy. Other LHWs were able to contribute more towards their children's education.

Women who do not have formal employment and who largely comply to the *chaddar aur chaar* diwari (veil and four walls) are eager to send their daughters to school, and families struggling financially are more supportive of women becoming LHWs. Yet, access to schools in more remote areas of rural Punjab restricts women to have the necessary education to gain formal employment. Despite these circumstances, women I met are relentless in finding opportunities to make more money and attain more financial security for themselves and their children. This is seen in the examples of a home-based working woman, Ayesha, mistaking me for a state employee and requesting government assistance, while others tried to sell me their handicrafts and livestock. Another newlywed, Mavra, was adamant to learn crafts from her in-law, while other LHWs, sent their children to their parents' houses in a different village closer to a school.

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[13] Mumtaz et al (2013) found that LHWs in Attock, Punjab, were primarily visiting homes inside their *biradari* (and hence 'inside' their social geography) in order to minimize being shamed by the community for working 'outside.' I did not find this consistent with my findings, perhaps because of changing norms and more acceptance since the Mumtaz et al (2013) paper was published. The Government of Pakistan has quotas on the number of deliveries each LHW must report, making it quite difficult for LHWs to not work outside of their *biradari,* at least in my sample.

Agency, as we currently understand, must be challenged and updated to reflect the lived experiences of women across diverse settings. An overemphasis on autonomous action, (unaccompanied) mobility, control over finances can lose sight of complex social relationships, bonds and networks women rely on to navigate power structures in tight-knit rural communities of developing countries and create better living conditions for themselves and their children.

CHAPTER VI

NATIONAL PROGRAM HEALTH EMPLOYEES ASSOCIATION: LHW UNION DEMANDS, TACTICS & SUCCESSES

Sitam kero gay sitam kereingay

Karam kerogay karam kereingay

Hum admi hain tumharay jesay

Jo tum kerogay woh hum kereingay!

if you oppress us, we will oppress you

if you show us generosity, we will show you generosity

we are humans like you

whatever you do, we will do too!

LHWs have developed a moral vision for justice in their public health work; a vision that is in solidarity with each other and one that pushes back on the gendered features of public service work. The chant above was made by Rukhsana Anwar, president of the National Program Health Employees Association (NPHEA), the union that represents LHWs, on a Facebook video on February 9th, 2020. This was a day before NPHEA declared a protest to be held in Islamabad. NPHEA, one of the two national unions representing LHWs in Pakistan. This one, headed by Anwar, is based in South Punjab, and is the focus of this dissertation. The sit-in in Islamabad lasted a couple of days, after which Anwar drove to Lahore for a sit-in outside the Secretariat office for another six days, covering the protest day and night on her public Facebook profile. As of March

29, 2021, the union's demand for a twenty-five percent increase in allowance for health workers in Punjab has not been met. Anwar continues to appear on news segments on national television, demanding the government honor this pay increase. Numerous editorials in local newspapers have also covered the sit-ins in Islamabad and Lahore. How have LHWs been so successful to thrust their voices in the public arena so powerfully?

The union is particularly media-savvy to connect with its members. Members use Whatsapp, a popular messaging app, to talk to one another about issues they are facing, announce meetings and strike venue details. On Facebook and Instagram, Anwar uses her personal accounts to document the successes of the union as well as media coverage of the union. She also shares pictures of herself meeting other LHWs in various districts. These rounds are especially more frequent after a strike is announced. All pictures are public and accessible even without a Facebook account.

Consequently, the union uses many different tactics to bring all members on board for strikes and to publicize their efforts to larger audiences nationally. Given the objectives of this union, it closely resembles to what Moody (1997) describes as social movement unionism. Dreiling and Robinson (1998) note:

> The ideal–typical "social movement union" has economic interests to represent and collective bargaining functions to perform, but it also part of a larger social movement that aims to reform (or revolutionize) the economic and political order to bring them more into line with ideals of economic justice and democracy. A vitally important weapon in this struggle for social movement unions, is the capacity to generate strong membership commitments to their union. Such commitments can motivate participation in a variety of forms of collective action, even when unions have very limited material resources with which to supply selective material incentives. To achieve and maintain the high levels of membership commitment that they need, social movement unions must encourage members' sense that they "own" their unions, that

they decide their priorities and strategies and are responsible for realizing those goals collectively (Dreiling and Robinson, 167-8).

The NPHEA employs social movement tactics, as defined above to boost visibility and member activism. For this reason, it is pertinent to also consider what Ray (1999) refers to as 'protest fields,' which "consist of groups and networks that oppose those who have the power in the formal political arena and may or may not share the logic of politics in the larger political field, although they are constrained by it," (Ray 1999, 8). Ray (1999) justifies this by suggesting that protest fields incorporate "cultures, histories and institutions of politics in general," (Ray 1999, 8). This, for Ray (1999), reduces excessive structuralism and individualism, which is particularly useful for her fieldwork based in India. In this chapter, I employ the concept of social movement unionism to capture the significant organizational features of the LHW union (National Program Health Employees Association or NPHEA) as well as the concept of protest fields to illuminate the important role that intersecting organizations, media, activists, and state agencies play in shaping discourses about LHWs, their public health mission, and justice for their work.

Public sector unions

Johnston (1994) argues that public sector unions have a very different behavior than private sector unions, since government employees in the public sector must adopt strategies keeping in mind the bureaucratic institutional logic and political power relations. Subsequently, public employment and unions must be understood within a larger framework analysis of the state given that a public sector union's demands, "successes and failures depend on the political-bureaucratic context in which mobilization occurs," (Johnston 1994, 209).

NPHEA mirrors political organizations in many ways, especially the notion of a charismatic leader being the face and identity of the entire organization. This is seen not only in the example of the Muslim League headed by Quaid-e-Azam, the founder of Pakistan but also in most other political parties as well that are known primarily by the leadership: Bhutto family and PPP, Nawaz Sharif and PML-N, Imran Khan and PTI. Similarly, both LHW unions are known primarily by their leaders, Bushra Arain (Sindh) and Rukhsana Anwar (Punjab), more so than the registered names of the union. In my field work, most LHWs referred to the union as "Rukhsana's union." This is in line with Johnston's (1994) observation of unionists becoming leaders of social movements, given that leaders of public sector unions are successful when framing the demands of their unions in the public interest and organize groups beyond the membership to support it. The recent coalition between LHWs under NPHEA and government employees demonstrates the latter. Johnston (1994) also sees public sector unions more as social movement unions, given that these have to make their case to a wider public and to political bureaucracies. These include motives that cast a wider net to include demands for the larger community including good schools and are generally led by charismatic leaders.

Labor union laws in Pakistan have had a checkered history, given the ban on unions frequently, especially under military rule. Pakistan also has various acts that limit or ban workers it calls essential workers, such as agricultural workers. The Essential Services Maintenance Act of 1952 is one example that can be invoked by the government of Pakistan to curtail or ban strikes (Malik et al 190). There are many examples of the government using brute force on public and private sector unions: in 1967, workers of the Railway Port Trust and the Railway Workers' Union in Lahore (Raza and Mansoor 2016). In 1972, under the democratically elected Bhutto government, police opened fire on laborers in Karachi during demonstrations and again the next

day on the funeral procession of one of the workers killed (Raza and Mansoor 2016). Yet, unions have persisted, especially in the public sector. Malik et al (2011, 190) report that most public sector organizations are unionized, including workers in Postal Services, Railways, PTCL (telephone), WAPDA (electricity). In comparison, union activities in the private sector are fairly limited (Malik et al 2011, 190). In 2016, the Supreme Court of Pakistan ruled that government workers can unionize and protest without punitive action by the government.

Unions, Gender, and Class in Pakistan

The successes of the LHW union are particularly significant given the larger sociopolitical context the union operates in. In a labor force survey conducted by the International Labor Organization, the labor force participation of women was 21.9 percent (ILO 2018). Moreover, the rate of unionization in Pakistan is generally low and is mostly male dominated in both the membership and leadership ranks (Parveen and Ali in Chhachhi and Pittan, 1996, 141-2).

Parveen and Ali (in Chhachhi and Pittan1996) also contend that most female workers did not know what a trade union was or their right to collective bargaining, which the authors had to explain before conducting their survey (Parveen and Ali in Chhachhi and Pittan 1996, 143). In a 2016 interview, Farhat Parveen, executive director of NOW Communities, noted that the Pakistan labor laws pertaining to trade unions, specifically the Industrial Relations Act of 2012 does not enable workers to form unions, adding that only one percent of laborers are organized and most of them are in the public sector (Raza and Mansoor 2016). NOW communities is an organization that campaigns for working women's rights in Pakistan. In contrast, women's organizations are usually created for and mostly led by upper-class women who usually have different agendas than working class women (Parveen and Ali in Chhachhi and Pittan 1996, 143 and Fleschenberg in Roces and

Edwards 2010, 166). LHWs and their union leaders have engaged in forms of collective action that defy expectations and trends in Pakistan.

To grasp the intersection of gender and work protests by LHWs, it is imperative to consider how class plays a significant role in South Asia. Ray (1999) states that, "identities are never purely based on gender, but always on class, religion and other complementary and competing categories as well," (Ray 165). Speaking on workers' organizations in Pakistan, Candland (2007) agrees that class solidarity is an important factor, and often overlaps with non-class identities such as ethnicity and language. Fleschenberg (in Roces and Edwards 2010) adds feminism in Pakistan has suffered especially because it is deployed by mostly (upper) middle-class and elite activists, who are often charged with being too Western and hence promoting a foreign agenda (Fleschenberg in Roces and Edwards 2010, 166). Thus, Fleschenberg (in Roces and Edwards 2010) concludes that the high fragmentation and stratification in Pakistan's society has little cross over experiences and interactions across class lines. Yet, scholars like Mumtaz (2005) and Ali (2000) argue that advances made in women's rights in Pakistan are due to the spaces created by upper class women, who have used their privilege, resources and social capital to challenge patriarchal discourses by the state and civil society in Pakistan.

In the case of NPHEA, the collective identity is divided on the basis of socioeconomic lines against their employers, which often include female medical officers who are immediate supervisors to LHWs. Moreover, in the February 2020 protest, the union organized along with other government employees in the same rank as them. In the aforementioned video shared on Facebook, Anwar notes that "even though we have worked independently [in the past], we are working together with all the government servants…we know there is strength in uniting with other government servants [of similar rank as us]." In fact, Anwar and her colleagues in the video

consistently used the word "*mulazmeen*," or civil service workers, often colloquially called civil servants, a more inclusive term than "LHWs," which Anwar has primarily used for all her press interviews and speeches. At the time of writing this on February 9, 2020, this video was shared over fifty times with over a thousand views.

Movement Tactics by LHWs: Strikes, sit-ins and *dharna* culture

Since the beginning of the LHW program, most successes that LHWs have had have been possible due to the mobilization under the LHW union (NPHEA). This includes becoming regularized as government employees, stipend increases to keep up with inflation, increased security and timely payments. Whereas earlier protests were focused on being paid on time which the government had failed to do multiple times, rendering protests nearly every year, more recent demands include removing the hiring freeze, increase of pay as well as promotions of LHWs, and pensions. Beyond formal demands, protests by the union to demand their work be treated with dignity. The demands by NPHEA have also become more expansive to include members of groups previously not in prior strikes, including (male) drivers.

The ongoing legitimacy crisis of the Pakistan state, underscored by frequent changes in the government including military takeovers, recent changes to public healthcare structure from federal to provincial, and actions to appease regional and global powers, create space for public employees including LHWs to publicly complain about the incompetency of the government and subsequently go on strike. Sit-in protests, long marches and strikes are uncommon in Pakistan, but created important turning points in Pakistan's political history, including the Lawyer's Movement and subsequent Pakistan Long March of 2009 that catalyzed General Musharraf to ultimately step down. However, marches and sit-in protests became especially commonplace after the national

2013 election result, which was dubbed as being rigged by PTI chairman Imran Khan, who demanded a recount. Though Khan was largely unsuccessful in this demand, his *dharna*s became widely covered by television news and newspapers, which began calling the frequency of the protests to characteristic of what they called "*dharna* culture."

Government employees and lawyers have also found sit-in protests and long marches to be quite effective in receiving nationwide attention for their demands from the government. LHWs, particularly, gained coverage in the past by declaring a strike and/or sit-in protests outside government buildings. Additionally, NPHEA has also been able to use to its advantage the growing publicity and importance LHWs have gained by being a part of the polio eradication program as well as the joining hands with other public civil servants to amplify their demands.

To note is the impact of nationwide coverage of the union on Anwar herself. The large number of LHWs willing to go on strike has empowered Anwar as a prominent leader. In some of the interviews I had with her, she was frequently interrupted with calls and messages from local politicians who wanted to recruit her or create an alliance with her union. When I asked why the union is locally called the union for LHWs, she told me because LHWs are more in number in comparison to LHS. Given the successes of NPHEA, Anwar has been frequently courted by local politicians, as well as other public sector unions.

In February 2020, NPHEA created an alliance with other government service officers of the same ranking (Basic Scale 17 and under) to protest the inflation and tax surges of Prime Minister Imran Khan's administration. In exchange for the LHWs' attendance, their demands of increasing pay and introducing promotion packages for LHWs was also added to the common slogans shouted at the protest. This alliance was deemed the All-Pakistan Government Employees Grand Alliance. To note is that in most of the coverage taken of the protest, NPHEA is seen sidelined and chanting

on slogans by the mostly male-driven strike. Whereas strikes organized by NPHEA in the past have been primarily sit-in protests, LHWs could quite possibly be seen using new negotiation tactics that they have learned from this new alliance for the members and leaders of the LHW union.

Collective identity: sisterhood, boundary-making and union culture

Social movements are simultaneously the dramatic demonstration of human agency— that is, they determine their own course, and we must take their internal dynamics seriously— and they are inextricable from their contexts, shaped by encounters with and structures of the state, employers, dominant culture, and other social movements (Meyers et al 2010, 302)

In the interviews and conversations, I had with various LHWs, there was always a profound sense of solidarity and sisterhood among the LHWs, especially when talking about their union. Older union leaders, including Anwar herself, referred to younger LHWs as her children. In an interview she noted that she doesn't feel an ego-complex that she's an advisor (the idea that she should have more power as a LHS and oversees LHWs). She added:

mein yeh samajti hon k who humaray bachay hain...woh is qaabil nahi k woh awaaz otha sakein...unki taleem kam hai on mein confidence nahi, onhein dabbaya jaa sakta hai / I think of them as my children. They are not equipped to raise their voices...they are not very educated [and thus] they do not have confidence [therefore] they can be pressured [controlled].

Depending on their ages, LHWs will refer to each other as their children, older/younger sisters. On a public facebook video to announce a strike on March 12, 2021, Anwar ended her speech saying that "*hum sab aik hain; national program humari shanakht hai aur humari pehchaan hai*," [the lhw union is one family; it is our identity].

Silke Roth (in Flam and King 2005) notes in her analysis of the Coalition of Labor Union Women that sisterhood is parallel to the term of brotherhood, common in the labor movement (Roth in Flam and King 2005, 193). This, Roth suggests, "implies a relationship that goes beyond a voluntary association; it suggests family bonds, personal and expressive relations among members and officers," (Roth in Flam and King 2005, 193). In fact, emotion work is necessary to understand collective action (Jasper 1998; Hercus 1999; Goodwin et al 2001). For women's social movement organizations, specifically, emotion work creates a sense of collective identity (Rupp and Taylor 1999 and Reger 2004).

Getting a sense of an organization's collective identity is particularly important because it can drastically affect a movement's organizational structure (Meyer et al 2002, 297). For Belinda Robnett (in Meyer et al 2002):

Collective identity is made up of shared "cultural capital" that members acquire through the deployment of knowledge within the movement and use to constitute themselves in their own terms. Through collective identity processes, movement actors develop a shared cultural toolkit, (Robnett, Belinda 267).

The collective identity forged through solidarity and shared objectives also helps to create boundaries around the community (union), that helps distinguish it from the rest of the society (Reger in Meyer et al 2002). According to Buechler (1990), this creates for a free space within the group to define its own culture, goals and identity. Reger (in Meyer et al 2002) notes, "Boundaries can be symbolic marked through use of language, signs, symbols, artifacts or, as I argue, can be delineated through organizational structure," (Reger in Meyer et al 2002, 173).

The familial kinship cast over the LHW union is thus helpful in two ways: it allows LHWs to feel a sense of solidarity, therein facilitating more conversation, exchange of ideas and

difficulties in an otherwise hierarchical society where power is vested by virtue of age, social and economic class, or a combination of these. Consequently, there is also a dialectic sense of duty that the union leaders and members have to maintain their roles. Lofland (1996) notes that affective bonds and personal loyalty play a significant role in the recruitment (and retention) process. Secondly, this familiar solidarity may also create comradery and a sense of belonging that most LHWs might not have, given the alienation caused by the work they do in highly patriarchal areas.

As mentioned before, most women are first generation formal employees in their families and the juxtaposition of a union as family might also be a natural evolution of the union given how women in rural Punjab are traditionally confined to the inner sphere. In my interviews, I was also frequently referred to by older LHWs as their daughter/child (*beti/beta*), or an older sister (*baaji/behan*) by younger LHWs out of fondness. This is also extended to their patients as well, where community members will refer to LHWs as their sisters. Subsequently, there is a sense of duty that arises from this care and emotional work in the work LHWs do. In one of my interviews an LHW told me, “we do this work to save the children. Whenever I fear for my safety, I remind myself that I am saving someone’s child.”

Notably, the lexicon used is quite common in Pakistani society, wherein strangers are called a sibling (*bhai/behan*), a parent (*maa/baap*) or the wife of a brother (*bhaabi*) out of respect, to create a sense of closeness and/or most importantly to create a distance between members of the opposite sex. The logic for the latter is that a woman calling an unrelated male acquaintance ‘brother,’ can discourage any sexual advances. This technique is seen especially among younger and/or married women. It is also used by married men to distance themselves from unrelated women to give women a sense of safety and/or avoid any gossip that can impact their reputation.

Yet, the blurring of personal and professional boundaries can also create problems, as can be analyzed in the ways Anwar talk about the members in the union. Here, an intersection between her identity as the union president and her role as one of the older women happens, wherein the so-called child/daughter may be considered too naïve and worthy of protecting. In fact, younger LHWs are also sometimes called "*larkiyan/bachi* or young girls/kid" by the older female union leaders, especially when the younger LHWs are being criticized by their union leaders. During a group interview with union leaders, a senior LHW noted to one of her colleagues, "the girls [newly recruited LHWs] do not know what they are doing—I had to teach one how to take a biometric reading!" On another occasion she exclaimed to another colleague, "*dekho yeh larkiyan kya draamay baazi kerti hain!* Look what kind of dramatics/antics these young girls [LHWs] perform!"

Despite the solidarity and claim of family, clear demarcations exist between union leaders, who are all Lady Health Supervisors (LHS), and the general membership of the LHW union. The power difference between Lady Health Supervisors, who supervise between twenty-five to thirty LHWs in the structure of the LHW program, is thus transplanted onto the structure of the union as well. Unequal participation and power differences within unions are common, as seen in the case of Roth's (in Flam and King 2005) work on Coalition of Labor Union Women (CLUW).

Union leaders usually also have a government issued car unlike LHWs, as well as better living conditions. Therefore, the term of endearment '*baji'* that LHWs refer to their union leaders can also be interpreted as an acknowledgement of the clear status difference. In a few of my interviews with the general members of the LHW union in remote villages, there remained a general unawareness of the larger politics and agenda of the union leadership. Many a times LHWs were unaware about the two unions that exist at the national level. It was usually the LHS locally that were briefed (see diagram for the organizational structure) by union leaders and asked to

disperse the necessary information to LHWs assigned to them. When asked how LHWs in remote areas are recruited to show up at protests, one LHS remarked, “we just tell them [LHWs] where to go and they go. We do not give them a lot of information so as to confuse them.”

Use of Islam

Islam continues to play an important role in the identity and security of LHWs inside the office and outside and was one of the most prominent features during my interviews. Most, if not all, LHWs I have met, keep their heads covered with a *dupatta,* especially when making house calls and in meetings with men around. This may be arguably an attribute of their class, as female medical doctors who sit in the BHUs are often seen not wearing a *duptta*. Yet, it should be mentioned that this tactic was also used by former Prime Minister Benazir Bhutto herself, who wore a *dupatta* in all her political gatherings despite belonging to the upper class as well as having been western educated before becoming political active.

In nearly all interviews where LHWs were asked about their daily routines, waking up early in the morning for the *Fajr* prayer was almost always mentioned. Additionally, many LHWs also mentioned that along with passing on health information about ongoing viruses to community members, LHWs would also share Quranic verses and hadith (sayings of the Prophet). This could be for several reasons. for one, it creates a connection beyond just disseminating health information. However, it may also be due to adding to their image of being a good Muslim woman—one which not only could give them more credibility by distancing themselves from being “foreign agents” given their affiliation with Western funding (see earlier sections), but also as a security measure against rumors of being immoral women that can pose a serious social and physical threat to their well-being. This image of being a good Muslim also pairs well with them

being good citizens who sacrifice time with their own families for a greater cause, thereby adding to their social capital in their community as well. Piety also seems to be used as a coping mechanism for LHWs to bear hardships in their work. In one of my interviews an LHW told me, “we do this work to save the children. Whenever I fear for my safety, I remind myself that I am saving someone’s child. I am doing God’s work and helping His creatures, so I try to not think too much about the time I do not get to spend with my own child because I am trying to help another child.” Hence, being a public health care worker, service to the community is also an expression of religious devotion and often intersects with an LHW’s sense of duty rooted in her identity as a mother as well.

The mentioning of god is prominent in the political rallies and speeches Anwar uses on social media and in interviews aired on national television. For example, in press interviews Anwar always begins her responses and speeches by first saying “*bismillah*,” (in the name of God), often thanks God for any of her union’s achievements and cites Islamic teachings and examples to reinforce her arguments when speaking to the government in her interviews.

Though it can be argued that it may be a culturally ingrained norm to use words such as *inshaAllah, mashaAllah* (translation: God willing, thanks to God), it should still be noted that by doing so, Anwar and other LHWs maintain their identity as Muslim women, which allows them to not be alienated by the masses they seek support from. This is in contrast to feminists belonging to or primarily catering to upper classes who are dubbed as western agents and/or not good Muslims, thereby not being representative of the masses. The difference in press coverage and public sentiment of the more critical reporting of the nationwide Women’s March (*Aurat* March) in Pakistan to that of the less critical sit-ins of LHWs proves an effective litmus test to showcase the efficacy of LHWs prioritizing their image as Pakistani citizens and as Muslim women. In

contrast, most women who attended the Aurat March were reported as elite, educated and not representative of the average Pakistani woman (see Khan 2021).

Legitimacy as being the sole representative of LHWs across Pakistan

On March 9, 2021, Bushra Arain, president of the other LHW labor union based in Karachi, Sindh, changed her personal Facebook page name to "All Lady Health Worker Program Union." This change comes after Rukhsana Anwar has been on the news since February 2021 as well as her Amnesty International interview. Though both women began the initiative to represent LHWs together, in an interview Anwar told me that due to disagreements, each decided to go their separate ways. Thus far, they both claim to represent LHWs nationally, despite Anwar having more prominence in Punjab and Arain in Karachi. As mentioned before, Arain was significantly more difficult to access and did not seem to be as close to LHWs on the ground in Karachi. In contrast, I was able to contact Anwar within two days after asking a LHS for her contact information.

As mentioned before, most LHWs in Punjab are unaware of Bushra Arain's labor union altogether. In more rural areas, LHWs are members of the union because of Anwar's popularity. In fact, in most interviews, LHWs did not know all the demands of the union they were a part of. Instead, I was told that they believed in whatever Anwar was demanding from the government. Charismatic leadership is especially important in Pakistan's political history, given the examples of most political parties in Pakistan known primarily by their leaders: Imran Khan's PTI, Bhutto's' PPP, Nawaz Sharif's PML-N, et cetera. In fact, the struggle for Pakistan, too, was made possible by the charismatic leadership of Mohammad Ali Jinnah. Hence, LHWs continue following Anwar due to the successes they attribute to her since her leadership (find a way to rephrase better).

It remains to be seen how the growing popularity of Anwar will create any friction or identity crisis given that both Arain and Anwar claim to be the spokesperson of LHWs, though Anwar has become more inclusive in her demands in the past few years to include groups other than LHWs. Consequently, the union uses social movement union tactics, but struggles to expand democratic principles of inclusion. The union is expanding involvement of LHWs, educating them on issues they would otherwise not learn about, and at the same time, doing so with a maternalistic sentiment.

CONCLUSION

Sitam kero gay sitam kereingay
Karam kerogay karam kereingay
Hum admi hain tumharay jesay
Jo tum kerogay woh hum kereingay!

if you oppress us, we will oppress you
if you show us generosity, we will show you generosity
we are humans like you
whatever you do, we will do too!

(Chant by Rukhsana Anwar, President of NHPEA, in a public Facebook video in 2021)

At the beginning of the dissertation, I posed three questions: 1) how is a postcolonial nation impacted by neoliberal policies put forth by international development agencies that intervene to redress a healthcare crisis? 2) How does a global healthcare crisis create space for a local social movement of Muslim female community health workers in Pakistan? 3) How are female healthcare workers successfully demanding better conditions?

To answer these questions, I have shown that the Pakistan state faces a double legitimacy crisis at the local and international levels. Specifically, I contended that for more than half a century, Pakistan's national government has wavered between political authoritarianism, military rule, and representative democracy. Exacerbated by gyrations of the Islamization of political authority, persistent military, and class dominance, and the rigid maintenance of a repressive gender order, the development trajectory for Pakistan has fallen short of expectations for human development and the 'modernity' track. Repeatedly, the state fails to bring forth gender equity and basic services to its people including healthcare, education, and safety. Thus, while Pakistan

did become a military and nuclear power, it has failed in human development—particularly evident with indicators of social equity, development, and quality of life (see the 2020 Gender Gap Index by the Geneva-based World Economic Forum that ranked Pakistan 151 out 153 in global gender equality).

Pakistan's status as one of the last two remaining countries with active cases of polio further consolidates its lack of control, especially in rural spaces where numbers remain high. Amidst this healthcare crisis, female community health workers known as Lady Health Workers, have emerged as an important class of workers that are important for the state of Pakistan to save face at the international level, and also important to GPEI as they are the frontline workers to eradicate polio in one of the last two countries, alongside Afghanistan. Lady Health Workers or LHWs, have leveraged their work frequently to negotiate better working conditions by their employer, the Government of Pakistan. Notably, LHWs' have two unions—one based in Karachi and another in Multan, the latter of which is the focus of this dissertation called NHPEA (National Health Program Employees' Association).

NHPEA uses many tactics in line with public sector unions to publicize its demands in mainstream newspapers, television interviews, and on social media, and align itself with other public sector unions. Most importantly, the union has been successful in gaining public approval for Muslim lower- and middle-class women to protest visibly on the streets during sit-in protests. To be sure, this is not the case for other women's movements in Pakistan, which are usually led by upper-middle- and upper-class women who are seen as Western feminists and divorced from the realities of the everyday Pakistani people.

Yet, as my dissertation depicts, LHWs continue to face an uphill battle given their identity as women working on an internationally funded healthcare initiative. As a result, LHWs have

been targets of sexual assault by groups that want to police women's mobility, and have also been targets of shootings by groups who do not want any Western intervention. Moreover, their negotiations with the Government of Pakistan must be negotiated continuously to ensure they are paid on time, given promotions and pay raises, among other demands.

Subsequently, my research challenges the notion that health outcomes are the product of "personal choices" alone and investigates the impact of social and institutional variables on health behaviors. Using qualitative data from multiple rounds of interviews, participant observations, and focus groups, I have drawn a framework to examine the structural and cultural dimensions of an internationally funded healthcare initiative in a developing country. This research, therefore, has direct relevance to the COVID pandemic and vaccination efforts and speaks to the invisible labor of vaccination, and the social complexities of reaching unvaccinated rural populations.

Moving forward, I plan to explore how the religiosity of female community workers impacts the healthcare services they provide. While religiosity and medical care might seem at odds from a Western perspective, religiosity is tool female healthcare workers employ in rural Pakistan use for social protection and as a persuasion tool in vaccinations. Future work will also tease out how international development agencies are different from global health projects, given that the latter has a more sophisticated framework that includes gender in their planning.

Concomitantly, I also want to explore how the different components of GPEI—specifically WHO and Rotary International—approach a healthcare crisis differently given that one is a subsidiary organ of the UN while the latter is a philanthropic organization. Do the different interests of the two organizations impact the initiative in a postcolonial nation differently and, if so, in what ways?

APPENDIX (METHODS)

Setting, Participants, Data & Methods

The research was conducted in ten settlements around metropolitan cities in South Punjab in three rounds of interviews between 2015-2019. While the first settlement was chosen through knowing a local LHW in the area, subsequent settlements were selected through snowball sampling. I spoke with thirty women in one-on-one interviews and in focus groups. Of these thirty women, fifteen were LHWs providing basic healthcare services including polio vaccine deliveries and antenatal healthcare. Interviews were conducted in the privacy of women's homes for those who were home-based workers. With LHWs, I spoke to them while they worked in the clinic and accompanied them on their door-to-door checkups, and sometimes also followed them into their homes.

LHWs are assigned to a local health facility called a Basic Health Unit (BHU). BHUs have a limited staff and infrastructure, comprising of LHWs, their supervisors called Lady Health Supervisors (LHSs), a Lady Health Visitor (LHV) who has her own examination room at the BHU, and finally a medical doctor (MD), who had the highest authority at the BHU. Occasionally there was also a nutritionist. BHUs also have a small pharmacy and a basic delivery room. Among the medical staff, LHWs are the largest group and are considered to be at the lowest rung of the public healthcare system. They are also the only ones who do not see patients at the clinic like an LHV or MD, Instead, LHWs come to the BHU daily to mark their attendance and during monthly meetings at the BHU, create a rotation plan to visit a few of the households assigned to them each day.

After their daily rounds, LHWs go home around mid-day, where they are accessible to community members any time of the day, as needed. For this reason, LHWs' homes are designated

as a “health house,” wherein a room is dedicated to community members who can visit at any time to seek immediate medical attention. Their schedules change during vaccination campaigns when they must work into the evenings to achieve vaccination targets.

Access into the field was made possible by driving 3-5 hours outside of metropolitan city limits and then walking to the villages, which were mostly off-road. The setting of these villages was quite diverse: alongside rivers, on rocky hills or overlooking agricultural land. Most homes were makeshift and were made of aluminum, wood scraps, straw, and cardboard. Subsequently, basic infrastructure such as roads, electricity, running water was scarce. Settlements closer to the city, and closer to clinics with LHWs were built with more permanent materials including brick and mortar and had pathways—though often not paved roads—and electricity in some homes. A few of the makeshift homes had a small solar panel to charge a cell phone and/or provide light.

Initially, the first two village settlements were chosen at random by driving into the outskirts of the city and walking around nearby homes to see if anyone would talk to me. Unlike metropolitan cities, women in these rural settlements were quite open to inviting me into their homes and speaking with me, some with the intentions of selling their livestock or handicrafts, while others who did not mind sitting down and having a casual chat. Thereafter, snowball sampling helped to connect with additional participants who lived nearby, with both LHWs and home-based workers, in other village settlements, sometimes an hour or so away by foot to a 2-4 bus ride away.

Of the thirty interviews conducted, twenty were in rural areas that did not have built roads, direct access to a school or a major hospital. These settlements were usually between three to five hours of a drive away from the closest city and had to be accessed via foot where roads were no

longer available. In peri-urban areas, families considered themselves to live within the city, citing their close proximity to paved roads, hospitals and brick-and-mortar schools.

Interviews were done in Urdu, Punjabi, and some Saraiki. I also spoke with three doctors and two government employees in the Punjab Health Department to get a sense of the chain of command between the various actors. Of the thirty women (LHWs and home-based workers) I interviewed, I did follow-up interviews every year for four years for three months every summer, with twenty-two who had not moved since my earlier rounds of interviews. One-one-one interviews were semi-structured, and questions asked in focus groups were open-ended.

Communication was not difficult, as I speak two of the most common languages in the area, Urdu and Punjabi, with native fluency. Additionally, I am also ethnically and culturally Punjabi and was born and raised in Lahore, Pakistan, for most of my life. Still, there were stark differences primarily along the lines of class that set me apart from the participants, despite my best efforts. Participants were eager to talk about themselves and their lives after learning about my research project and my status as a student. Being a female researcher was a key factor to get access into women's homes and workplaces and have candid conversations with them. In most interviews, participants referred to me as their older sister (*baji*) or daughter (*beta* or *beti*) by the end of our conversations in the first meeting, which is not an unusual custom, and further increased trust during follow up conversations.

Of all the interviews and observations in both groups, only three interviews were recorded because participants were uncomfortable to speak with a recorder in front of them. Thus, I relied primarily on field notes, quickly jotting down phrases verbatim, and occasionally asked my interviewees to repeat themselves if I missed something, which they did not seem to mind.

Questions were semi-structured and began with asking what women do every day, the nature of their relationship with their relatives, especially with their mother-in-law, daughter(s), and husband. Responses comprised of what women thought of themselves both as individuals and in the larger group they identify themselves to be in, and their strategies to be successful mothers, wives, daughters, and sisters. In follow up interviews, I asked similar questions and tracked changes in answers and/or situations for the women to chart differences over time.

In my participant observation notes, I paid close attention to the nonverbal communication between my conversation partner and her observers. These observations were helpful to understand how women recognized and reinforced (local meanings of) power and space to those within themselves as individuals, the collective and outsiders (Emerson 1995). During the analysis, names were changed to protect the confidentiality of participants.

I translated and transcribed the data in MS Word. The analysis was done through line-by-line and axial coding using the highlight and comment features. Upon finding patterns in speech, behavior and cultural norms, I wrote memos to understand and draw out meanings to my findings in light of existing research and attempt better explain the rationale for the observed patterns and revisited the recordings and field notes.

During the collection of my data, I found myself exhibiting some particular code-switching and buffering myself to get better access to my subjects. The following are memos written after reflection of my time in the field:

Memo 1

> During one of my fieldwork interviews, I was invited to an older cousin's home for dinner, who lived in the area. Her husband is a government employee surgeon and I thought he might know some people for my research, so I accepted. It was a bit awkward because she kept on bringing up the subject of me turning down her brother for marriage, despite it being one of her mother's last wishes before she passed.

At one point, while we were talking, her husband entered the room. Without much thinking, I quickly put my dupatta over my head. We exchanged hellos and he left soon after. Later that evening, my cousin remarked about how she was so impressed and taken aback when I put my dupatta over my head when her husband entered. *Mujhe boat pasand aya jab Sarah nay sar per dupatta liya [I really liked it when Sarah put her dupatta on her head]* is something she often repeats to other people when talking about me, perhaps as a testimony for my character and character, as if to imply that it is untainted despite having lived abroad and alone for so many years.

I was not raised in a conservative household, and grew up instead watching my mother go to work where she gave orders to men in her office. She also never wore a dupatta over her head, nor ever asked me to. While there were a couple of girls who starting wearing a scarf in my class of thirty-five girls, this was never a majority. Yet, some part of me internalized that wearing a dupatta at the very least was "morally good," and it stuck with and came back to me when I was working in the field, outside of cities and especially in rural areas where nearly all women, except for a few female doctors I met in the field, wore a dupatta on their head.
Wearing a dupatta over the head is perhaps also associated as backward and conservative—in bad light—among liberal educated elites that I grew up with and still maintain contact with. At another occasion, when I was walking in old Lahore, I once again put on a dupatta over my head, convincing myself I did so because I did not want to invite stares from men. My companion, a male colleague, another graduate student who belongs to the liberal educated elite class, was taken aback and remarked (in English), "You know you don't have to wear that, right?"

In such moments, I feel like I sometimes shift in and out of these understandings of what being a "good" and "moral" woman means, especially if it means I can slip in effortlessly to get access to interviewees. Nagar (2000) remarks that in rural areas of India, female activists steer clear from Western portrayals and projects of feminism because it can isolate them from locals, who might not echo a sentiment/attitude they feel is foreign.

My positionality as a woman, and especially unaccompanied, also became obvious in my interactions with men, particularly government employees, which I reflect on in another memo:

Memo 2

During an interview with an officer in the district health office (DHO), I was writing notes trying to understand the chain of power of the public health system, and how LHWs fit in this hierarchy. The DHO (officer) seemed very unimpressed with my research topic (this was quite a common sentiment) but obliged to help because of the "connection" I came in with, which was through one of the international agencies (ROTARY). Access to people and their knowledge is heavily dependent upon the reference that gets you in the door. Growing up as a child of a government employee in a very high posting, I could sit in my mother's office and (more) junior officers would report to her office to help me for a project, should I needed. In such cases, I was "madam's daughter," thereby erasing some identify factors such as gender, appearance, et cetera, which were at the forefront of my conversations in my fieldwork as I did not want to get access in these spaces from that privileged place, especially if it meant isolating myself from my participants (see Emerson on going bottom-up and never top-down so you don't isolate your participation).

In this context, the entire conversation the DHO and I had was riddled with an obvious power imbalance, as well as of course the gender and age dynamic. At one point, the officer looked over my notes, exasperated and pulled my notebook from my hands, turned over to a new page and began scribbling a new hierarchy. "You aren't taking the right notes, here, let me help you," he said. After a very brief explanation, he invited me to dinner at his house where he could explain it better (I did not answer and did not go), and then had one of the female doctors who was reporting to his office to get a holiday to sit in the back of the room and "answer any other questions" I might have.

This experience was very different from with LHWs. At one point, a LHW looked over my notes that were problematic because I was quoting in Urdu what she had said. She blushed and looked incredulous that I had copied down something she said verbatim (recall: recorders

seemed to make participants nervous and I tell participants I will be writing notes and ask them to repeat some quotes I thought would be good for my research. She smiled and would slow down when I was writing. The experience was very different from that with the DHO. LHWs were also aware of the power/class imbalance between them and I, despite my best efforts to mitigate the differences with the choice of clothes, shoes I made. However, the socioeconomic class differences were obvious from my clean Urdu accent, representative of going to a private school growing up, as well as me writing notes in English. LHWs and female participants in general were much more approachable and encouraging than male participants.* Even when LHWs complained about not having enough monetary compensation for the work they did, and that they often had to pay for work-related travel from their own pockets, I would commonly be given a water bottle or a soft drink as a hospitable gesture that I had to accept.

The gender and power dynamic was quite apparent in my fieldwork. AT BHU's, there was an obvious tension between LHWs and the MO (medical officer, usually a female doctor from the city who is posted for a year as per protocol to a BHU, often set in rural areas). My presence became quite problematic for this tension between the LHWs and MOs, as the latter would think I was her peer, given we were both "educated" and from the city. I would often have to politely refuse as this would isolate me from my participants. In other instances, LHWs would tell me

*at one point a male participant made a snide remark about my appearance, for example, telling me I should eat less. At another point, I had another man tell me I should sit at home and get married instead of doing this strenuous work for nothing. One military person I was introduced to said: "This kind of research is for a degree not a useful research. This kind of research is done at home."

Memo 3 (2019)

One of the maids working for an upper level Air Force officer remarked that at the end of the day, her employer was a woman, and that because she showed too much arrogance and confidence (thereby making her appear to be more masculine and hence unattractive), she had lost the appeal and attraction of her husband who now worked abroad. Upon this anecdote, she told me that "no matter how high up you go, you are still a woman, and therefore very

replaceable to a man [her husband]. *Aadmi ka kya hai? Osay do, teen, aur auratein miljayein gi. Isliyay, baji, main yeh hadayat doongi aapko k agar aapka* husband *naraz ho, chup Ker kay onki sunlo. Aadmi chahta hai osay sunay, agay mat bolay."*

What's it to a man [if his wife leaves him]? He can get a second or even third wife. This is why, madam/sister, I will give you an advice that if ever your husband gets mad, you should stay quiet and listen to him. Men only want someone to listen to them, and not talk back."

Here too, the woman acknowledges that 1) a woman's status, no matter how high up in ranking by virtue of her career (in the case of her employer) or education (in my case), does not add to her status because at the end of the day, she is a woman. And a woman in this society needs a man/husband. Secondly, she also depicts a somewhat universal story and advice on how to work with, and not go against, a man's ego/anger, not acknowledging the emotional labor and toll it would take on the woman herself, perhaps because it is more important she have a man/husband than the repercussions she has to face in order to keep one.

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