Gender and Class Inequities Among Female Healthcare Workers in Pakistan: Breaking the Glass Ceiling

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Abstract: This article is part of a larger book project that examines the polio eradication initiative in Pakistan from an intersectional lens of gender, class, and labor. In this paper, I showcase how class can play an essential role in the tone of the discrimination felt by female healthcare workers. I draw from my longitudinal interviews conducted between 2015-2022 in South Punjab, Pakistan, to compare the experiences of female medical doctors (medical officers or MOs) and lady community health workers LHWs, who work alongside the healthcare workforce to show why an intersectional must be adopted to understand the complexities of gender and class at the workplace in Pakistan.
Keywords: Pakistan, global health intervention programs, gender and labor, community health workers, state and development, polio eradication

Introduction

The Pakistan (publicly funded) healthcare system perpetuates gender and class inequities among female healthcare workers (Khan, 2019). To understand the everyday sexism and classism experienced by women, we must contextualize gender and class. Women globally perform most of the world's care work, often informal and unpaid, and sociocultural and religious norms reinforce the site of this work primarily in the home, including in Pakistan. Even when women engage in paid and formal work, they are impacted by gendered expectations (Acker, 1990; 2006).

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, overcrowding of women in female-dominated occupations [which] lowers their wages and enables employers to profit from this cheap labor" (Ali, 2000, p. 1). In addition to being exploited for labor, women are subject to varying levels of harassment from their male colleagues. Mirza's (1999) research showcases the everyday sexism and harassment of women in

middle-level positions in the urban city of Lahore, as well as tactics they must use 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 did not have to leave their offices to do outside work. One such occupation is in healthcare, particularly in the government, as my respondents told me that working in the government brought more legitimacy.

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 law was a crucial step, it was not implemented, despite Pakistan being a signatory to many international documents advocating for women's rights.

Pakistan's (public) healthcare system

Pakistan's healthcare system is rooted in a colonial legacy, which perpetuated unequal power distribution between the British and natives in colonial India (Kumar, 1998). Today, patriarchal and patrilocal norms (see Jejeebhoy and Sathar 2001) persist, and access to the highest positions in the healthcare administration remains inaccessible to most—such that the highest positions that once were limited to the British remain circumscribed to mostly men from largely privileged backgrounds. Jalal (1991) adds that women have little choice, especially because gendered inequalities are reinforced by Islamic morality and Islamic policing through military takeovers of the government. While women have opportunities to work in the healthcare field, the work of Lady Health Workers (LHWs) rests upon the gendered expectation of women being nurturing, in line with literature that shows healthcare as being a gendered occupation (see Zimmerman and Hill, 2006). Additionally, female community health workers (Lady Health Workers or LHWs) are also hired in Pakistan as they can access parts of a (female) patient's home that a male worker usually cannot when abiding by strict Islamic norms, which is important, especially in remote spaces of Pakistan where the *purdah*, the practice of women not being seen by men they are unrelated to) is observed.

At the core of the public healthcare facilities is the Lady Health Worker Program, which employs female workers at the community level to provide primary care in rural areas too far from major hospitals. LHWs, at the lowest rung of the public healthcare system, are trained for

15 months to provide postnatal care and identify symptoms of common illnesses. They are also the frontline workers during the Polio eradication campaigns, going door to door to administer polio drops to eligible children (Khan, 2011; Ahmed, 2020).

LHWs are assigned to Basic Health Units (BHUs), a 1-2 room clinic with an attached pharmacy serving nearby communities as a hospital. In rural places like parts of Southern Punjab, where I conducted my interviews, BHUs were instrumental in allowing marginalized people unable to access healthcare to more prominent hospitals in cities. At these BHUs, medical officers, or MOs, head the operation. MOs are physicians in the government sector whom I was told must complete the first few years upon being hired into government service in BHUs before being promoted to more specialized public-funded hospitals in cities. Most MOs in my fieldwork were women. Unlike LHWs, whose work often involves going door-to-door during polio vaccinations and doing postnatal checkups, MOs do not leave the BHU to see patients. Outside of working hours, LHWs' homes are also designated as 'health houses' wherein community members can seek their help around the clock.

However, the tone of such discrimination differed across the socioeconomic class lines of the two groups. It is these class-based differences, I contend, that must be contextualized to understand the lack of solidarity across female health workers in various posts in the larger hierarchy of Pakistan's health care system.

Methods overview

The research presented in this paper is part of a larger book project (see Ahmed, 2020) that emerged from my doctoral dissertation. I visited parts of South Punjab, Pakistan, in 2015 and initially conducted interviews with 30 LHWs. Since then, I have visited the field to conduct follow-up interviews annually (except for 2020) with 22 of the LHWs I initially interviewed. The latest round of interviews was in December 2022, and the number of interviews since 2015 is 85 in total, of about an hour each over the last eight years. I have also interviewed 5 MOs and had informal conversations with several government employees in the state health department, four Pakistan-based members of Rotary International, and two local members of the World Health Organization. I conducted all interviews in English, Urdu, and Punjabi and primarily used my notebook to jot down field research notes (see Emerson, 1995) and direct quotes, as most respondents were wary of me using a voice recorder.

I translated and transcribed the data using MS Word, though I have used Dedoos in recent rounds of follow-up interviews. During the analysis, names were changed to protect the confidentiality of participants. The analysis was done through line-by-line and axial coding using Word's highlight and comment features to note patterns in speech, behavior, and cultural norms. In the initial rounds of interviews, I wrote memos to understand and draw out meanings to my findings, considering existing research and attempt better explain the rationale for the observed patterns and revisiting the recordings and field notes.

Gender & Class at the Workplace

Crenshaw (1989) stresses the importance of intersectionality to contextualize the effect of racism and sexism that impacts Black women in particular ways compared to white women and Black men. I use this framework of intersectionality in my research to argue that socioeconomic differences between LHWs and MOs create varied experiences of gendered discrimination in the workplace. Furthermore, my data reveals that the lack of solidarity between the two groups can also be traced back to class differences.

I also use Acker's (2006) inequality regime as an added dimension to understanding the discrimination that happens at the workplace in Pakistan's public healthcare system. While both female worker groups face gendered discrimination, only the LHWs have created a labor union to give them a stronger representation to demand better working conditions from their employer, the state. In contrast, MOs do not similarly experience inequalities or have unions like the LHWs. For instance, during visits, I was frequently told by LHWs in my research that MOs appeared disengaged and disinterested in their work, perhaps due to being stationed at a BHU, which is usually not equipped with much staff or medical tools and is generally in rural and peri-urban settings.

One MO, Ayesha, expressed her dissatisfaction during a tea break, saying, "My entire family thinks I am in some dump, and I am!" When discussing the LHWs, most MOs seemed critical, often calling them uneducated and unruly. LHWs, too, commented on MOs not having the best interest of LHWs, mainly because they would be posted elsewhere within a couple of years. Additionally, LHWs complained that MOs would divert patients to private clinics run by MOs, where patients could be charged higher fees that go directly into the MOs' pockets.

A stark contrast in the socioeconomic positions between the LHWs and MO further consolidates the differences in treatment and perception of gendered discrimination by both groups. Ayub & Siddiqui's (2013) book investigating attrition rates of LHWs in Pakistan's Khyber Pakhtunkhwa province also highlights doctors' lack of trust and respect for LHWs. LHWs must request paid sick leave and/or be paid on time.

In my observations and interviews, I found that while both groups face discrimination, they face these differently due to socioeconomic differences. For example, the rule for LHWs to be married before they can be hired from a functional perspective is for the LHWs' safety—that married women are assumed to be more protected than their single counterparts. It also allows for LHWs to "cash in on their in-laws' contacts and respectability," as one MO explained to me. On the other hand, a female MO need not be married to be hired.

There is also an apparent difference in how the administration handles requests from LHWs and female MOs. LHWs face the gendered expectation of being a good mother and daughter-in-law at home. For example, while both LHWs and MOs wait at district offices, I observed MOs being able to sit in the privacy of her superior in an air-conditioned room while waiting to ask for an approved leave from work. In contrast, LHWs wait in halls with no fans, often sitting on the floor even when there may be space inside their superior's office room. One female health worker, Kinza, said, "Sometimes they make [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]."

In contrast, discrimination against a female MO looks different, as in the case of Ayesha, who came into the office of a district health officer during my conversation with him to understand the organization of the state health department. The district health officer made us wait as he had tea and chatted with some of his other guests, making us sit in the corner, telling us we should chat till it was our turn. Ayesha told me this was common practice, and she and her coworkers were used to this. While waiting for my turn, I repeatedly watched the district officer call Ayesha *'bachi'* (young daughter) and '*beta'* (child), which seemed to be infantilizing her and her designation despite her being there for official leave approval. The tone was kinder in most of these conversations I observed between MOs and their superiors from how LHWs described their interactions.

Furthermore, despite being regularized as government employees, in my early interviews, LHWs told me that they 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, an LHW, reported, "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 is 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 care work and household chores LHWs perform (see Hochschild and Machung 1989). Although three LHWs reported having help from their mothers to take care of the kids, most LHWs reported waking 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. When I asked LHWs if their supervising MO could have been helpful, Saba said, “They [MO] do not have our interests in mind. Rather, they will tell patients to see them after hours in their private evening clinic. They do not trust us or respect us.”

To be sure, the socioeconomic differences between most LHWs and MOs are stark. Regarding education, the basic requirement for an LHW is finishing eighth grade, though I met a few LHWs who had done two master’s degrees, and some were even working on their MPhil degrees. In contrast, MOs are medical officers who must complete at least an MBBS degree to apply. In many BHUs, the differences between clothing and appearance between LHWs and MOs was also quite apparent: many MOs I saw did not cover their head and/or wore much more expensive-looking clothes and accessories than their LHW counterparts, though I did see some exceptions. As LHWs complained, many MOs told me that LHWs were incompetent in their jobs. Mehr, an MO, said, “They [LHWs] only bring us the patients when it is too late. They are just very incompetent.” Another MO, Gazala, added, “They do not even come to work half the time or do their job. It is quite stressful trying to supervise [them].”

Another possible reason LHWs do not feel that their interests are aligned with MOs is due to the latter usually being posted in a BHU for a year or so only, which is not the same as LHWs, who usually have lived in the same place for years if not decades, relying on their social capital and networks.

For these reasons, the LHW union has allied itself with other government employees in precarious working conditions and similar socioeconomic backgrounds instead of working with MOs to work against gendered discrimination against all female employees in the healthcare system. Given the time and space constraints, this collective action cannot be expanded here but will be available in a forthcoming paper and book.

Conclusion

Despite being a signatory to many international conferences and even passing a bill in 2010 to penalize harassment in the workplace, the government of Pakistan has done little to implement these laws into practice. This paper examined how female health workers in Pakistan's public healthcare system experience discrimination differently across class divisions. Class differences also create a lack of solidarity among the two groups in focus in the paper: Lady Health Workers (LHWs) and their supervisors, known as MOs (or medical officers) in the field. Through interviews and observations, I demonstrate that while both MOs and LHWs experience workplace discrimination, discrimination is a lot more overt in the case of LHWs.

Addressing gender and class inequalities in the healthcare industry requires a comprehensive approach considering the sociopolitical, historical, and cultural factors contributing to these inequalities. It gives insight into why there are divisions among female health workers across class lines. The Lady Health Worker Program is crucial to Pakistan's public healthcare system. Subsequently, addressing the disparities and challenges LHWs face is essential to ensure their well-being and effectiveness in providing healthcare services.

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