

Original Article

The Role of Community Health Workers in Improving Maternal and Child Health Outcomes in Pakistan: A Qualitative Discourse Analysis

Laiba Fatima¹, Muhammad Uzair¹, Sahar Khalil¹, Arshia Memon¹, Mustafa Bashir¹, Sibghat Ullah¹, Alina Shaukat¹, Noor Ullah¹, Sift Ali¹, Abdul Basir¹

¹ Health Services Academy, Islamabad, Pakistan

*Corresponding author: Muhammad Uzair, rmuboss123@gmail.com

ABSTRACT

Background: Maternal and child health outcomes in Pakistan remain influenced by structural barriers, sociocultural norms, and limited access to healthcare services. Community health workers (CHWs), particularly Lady Health Workers, play a key role in bridging the gap between communities and the health system. However, the mechanisms through which they influence health behaviors are not fully understood. **Objective:** To explore perceptions of CHWs' roles in maternal and child health, and to identify barriers and facilitators affecting their effectiveness within community settings. **Methods:** This qualitative endline study used in-depth interviews and focus group discussions with CHWs, mothers, and community members. Data were analyzed using thematic analysis to identify key patterns in communication, trust, and healthcare practices. **Results:** Five major themes emerged: CHWs as health educators, facilitators of maternal healthcare access, promoters of preventive child health practices, trusted community members, and actors constrained by systemic barriers. Trust, cultural familiarity, and repeated interaction were key mechanisms influencing care-seeking behavior, while structural challenges such as workload, supply gaps, and institutional limitations reduced effectiveness. **Conclusion:** CHWs contribute to maternal and child health through socially embedded mechanisms of communication and trust. Strengthening their impact requires improved system support, resource availability, and integration within primary healthcare services. **Keywords:** Community health workers; maternal health; child health; qualitative research; Pakistan; primary healthcare

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INTRODUCTION

Maternal and child health remains a persistent public health challenge in Pakistan despite decades of policy attention and expansion of primary healthcare services. Although maternal and neonatal indicators have improved over time, preventable deaths, delayed care-seeking, low service uptake in some underserved areas, and persistent inequities continue to affect women and children disproportionately, particularly in rural communities and low-income urban settlements. These outcomes are shaped not only by limitations in service availability, but also by wider social determinants including poverty, low female autonomy, restricted mobility, gendered household decision-making, poor health literacy, and uneven access to skilled maternal and newborn care. In such contexts, the gap between formal health policy and actual maternal and child health practices is often determined by what happens within households and communities rather than health facilities alone.

Community Health Workers (CHWs), especially Pakistan's Lady Health Workers (LHWs), occupy a critical position within this gap. As community-based frontline workers, they provide household-level education, preventive counseling, basic maternal and child health support, referral guidance, and continuity between families and the primary healthcare system. Their contribution extends beyond service delivery in a narrow technical sense. Because they are embedded within local social networks,

they are often the first point of contact for women seeking information about pregnancy, breastfeeding, immunization, child illness, hygiene, nutrition, and family planning. Their effectiveness therefore depends not only on what services they provide, but on how they are perceived, trusted, and negotiated within local cultural and gendered environments.

Existing literature has shown that CHW-led and community-based maternal and newborn health interventions can improve antenatal care utilization, skilled care-seeking, birth preparedness, immunization coverage, and selected neonatal outcomes when implemented with adequate support, supervision, and referral linkages. In Pakistan, the LHW programme has long been recognized as a cornerstone of community-oriented primary care, particularly for women and children in underserved populations. However, evidence from programme and health systems research also suggests that CHW effectiveness is constrained by irregular supplies, administrative overload, weak supervision, limited career progression, low remuneration, and the broader fragility of service delivery systems. Quantitative and programme-level studies have been useful in documenting service roles and broad outcomes, but they do not fully explain how CHWs are experienced within communities, how trust is built or eroded, how advice is negotiated within households, or how gender norms, myths, religious understandings, and social hierarchies shape maternal and child health decisions in everyday life.

A qualitative approach is therefore necessary because maternal and child health behavior is not determined by knowledge alone. Women's care-seeking, feeding decisions, acceptance of immunization, family planning discussions, and use of referral services are deeply influenced by beliefs, fears, interpersonal trust, power relations, and the acceptability of health messages within local social worlds. Understanding these dimensions requires attention to lived experience, language, and the meanings participants attach to CHW interactions. It is especially important in Pakistan, where community-level maternal and child health practices are often negotiated through family elders, husbands, religious understandings, and local norms around modesty, mobility, and childbirth.

This study was designed to qualitatively examine how CHWs are perceived within maternal and child health service delivery in Pakistan and how their role is enacted at the interface of households, communities, and the health system. Using in-depth interviews and focus group discussions, the study explores how CHWs are viewed by community members, how they facilitate maternal and child healthcare practices, what barriers and enabling factors shape their work, and how their role is experienced beyond formal policy descriptions. The objectives of the study were to explore stakeholders' perceptions of the role of CHWs in improving maternal and child health outcomes, to identify cultural, institutional, and structural barriers and facilitators affecting their effectiveness, and to understand how trust, communication, and community embeddedness shape the acceptability and potential sustainability of CHW-led maternal and child health support in Pakistan.

MATERIALS AND METHODS

This study employed an interpretative qualitative design using in-depth interviews and focus group discussions to explore how community health workers contribute to maternal and child health outcomes in Pakistan and how their role is understood by those who deliver, receive, and oversee community-based care. A qualitative approach was selected because the study aimed to examine perceptions, lived experiences, communication practices, and the sociocultural conditions that shape maternal and child health behavior, rather than to quantify service outputs or test statistical associations. The study focused particularly on the work of community health workers, including Lady Health Workers, in relation to antenatal care, facility-based delivery, preventive child healthcare, breastfeeding, immunization, referral practices, and maternal health counseling within underserved communities.

The study was conducted in Pakistani communities where CHW programmes were actively engaged in maternal and child health service delivery, especially in rural and low-income settings where access to formal care is often constrained. These contexts were selected because CHWs in such settings often

function as the principal link between households and the primary healthcare system. Before submission, the final manuscript should specify the exact study locations, district or provincial setting, and the dates of data collection so that readers can judge contextual relevance and transferability.

Participants were selected purposively to ensure inclusion of individuals with direct experience of maternal and child healthcare communication and service use. The sample included community health workers, pregnant women or mothers of young children, and community members involved in maternal and child health-related decision-making. Where applicable, policymakers or programme personnel responsible for community health implementation may also be included if they contributed directly to the data corpus. Purposive sampling was used to capture information-rich perspectives across different stakeholder groups and to allow exploration of variation in experiences and perceptions. The final manuscript should clearly report the number of interviews and focus group discussions conducted, the number of participants in each category, eligibility criteria, who approached participants, the setting of recruitment, and whether any eligible participants declined to participate.

Data were collected through semi-structured in-depth interviews and focus group discussions using interview guides developed from the study objectives and the existing literature on community-based maternal and child health care. The guides were designed to explore participants' perceptions of CHW roles, trust in CHW advice, communication around antenatal care, facility delivery, immunization, infant feeding, family planning, referral behavior, and the structural barriers affecting CHW practice. Interviews and group discussions were conducted in local languages spoken by participants, and these should be explicitly named in the final manuscript. All sessions were audio-recorded with participant permission, supported by field notes documenting non-verbal cues, contextual observations, and reflections relevant to interpretation. For transparency and reproducibility, the final manuscript should state the approximate duration of interviews and FGDs, the typical group size for FGDs, whether discussions were conducted in private community settings, and whether guides were piloted before formal data collection.

All audio recordings were transcribed verbatim and, where necessary, translated into English for analysis. To preserve meaning and contextual nuance, the transcription and translation process should be described clearly in the final version, including whether bilingual researchers reviewed transcripts for accuracy and whether translated excerpts were checked against the original language. All transcripts were de-identified prior to analysis, and any potentially identifying information was removed to protect participant confidentiality. Audio files, transcripts, and field notes were stored securely and accessed only by the research team.

The study incorporated reflexive qualitative practice by recognizing that the researchers' disciplinary backgrounds, assumptions, and interactions with participants could shape data collection and interpretation. Because qualitative findings are co-produced through the research process, the final manuscript should explicitly describe who conducted the interviews and FGDs, their professional training, whether they had any prior relationship with participants or the local health system, and what steps were taken to minimize interviewer influence and interpretive bias. These steps may include reflexive memoing, team discussion of assumptions, repeated reading of transcripts, and collaborative review of codes and themes.

Data were analyzed using thematic analysis. Analysis began with repeated reading of transcripts to achieve immersion and familiarity with participants' accounts. Initial codes were then generated from segments of text relevant to perceptions of CHW roles, health education practices, care-seeking behavior, trust, preventive child health, sociocultural barriers, and structural constraints within the health system. These early codes were reviewed, compared, and grouped iteratively into broader categories and themes that captured patterned meanings across the dataset. Thematic interpretation focused on how participants understood the role of CHWs, how CHW communication influenced maternal and child health practices, and what contextual factors enabled or limited their effectiveness. To improve analytic

transparency, the final manuscript should report whether coding was conducted manually or with software, how many researchers participated in coding, whether a shared codebook was developed, and how disagreements in coding or interpretation were resolved through discussion and consensus. If an audit trail, coding memos, or theme matrices were maintained, these should also be reported.

Trustworthiness was addressed through methodological and participant triangulation across interviews and focus groups and across different stakeholder categories, including CHWs and community members. Credibility was strengthened through iterative reading of transcripts, close comparison of accounts across participant groups, and theme refinement through team discussion. Dependability and confirmability were supported by documenting analytic decisions during coding and theme development. Transferability was enhanced by grounding interpretation in the social and service-delivery context of community-based maternal and child health in Pakistan. If member checking, peer debriefing, or negative case analysis were undertaken, these should be explicitly stated in the final manuscript rather than implied.

Ethical approval was obtained from the relevant institutional review body prior to data collection. All participants were informed about the aims of the study, the voluntary nature of participation, their right to withdraw at any point, and the measures taken to maintain confidentiality and anonymity. Informed consent was obtained before interviews and focus group discussions, including permission for audio recording. Because maternal and reproductive health topics may involve private or sensitive experiences, efforts were made to conduct data collection in settings that supported privacy and respectful participation. The final manuscript should include the name of the approving ethics committee and the approval reference number.

RESULTS

Analysis of the in-depth interviews and focus group discussions revealed that community health workers (CHWs), particularly Lady Health Workers (LHWs), occupy a central and socially embedded role in maternal and child health (MCH) practices within underserved communities. Across participant groups—including mothers, CHWs, and community members—CHWs were consistently described not only as service providers but as trusted intermediaries who translate health knowledge, facilitate care-seeking, and negotiate health decisions within households. At the same time, participants highlighted structural and institutional constraints that limit the effectiveness of CHWs despite their recognized importance.

Five interrelated themes emerged from the analysis: (1) CHWs as health educators and translators of health knowledge; (2) facilitation of maternal healthcare access; (3) promotion of preventive child healthcare practices; (4) trust, familiarity, and community embeddedness; and (5) systemic and institutional barriers constraining CHW effectiveness.

Theme 1: CHWs as Health Educators and Translators of Health Knowledge

Participants across most interviews and focus group discussions described CHWs as the primary and most accessible source of maternal and child health information within the community. Mothers frequently reported that CHWs played a key role in explaining pregnancy-related risks, nutrition, hygiene, and newborn care in ways that were understandable and culturally appropriate. This educational role appeared strongly in narratives from both mothers and CHWs.

A mother explained:

“Before she started coming, we did not know when to go for check-ups. She explains in simple words—like when the baby is moving less or if there is swelling, then we should not wait. Now we understand these things.” (MWRA, Rural Punjab)

CHWs also described actively correcting misconceptions and traditional beliefs that could negatively affect maternal health practices. This function of “knowledge translation” was particularly important in contexts where informal advice from elders or community norms conflicted with biomedical recommendations.

“Many women believe they should eat less during pregnancy so the baby stays small. I tell them this is not correct. I explain that good food makes both mother and baby strong, not weak.” (CHW, Rural Sindh)

Across the dataset, this theme was prominent in discussions of both maternal and child health practices, suggesting that repeated, personalized communication at the household level plays a key role in shaping health awareness and behavior.

Theme 2: Facilitating Access to Maternal Healthcare Services

The facilitative role of CHWs in linking communities to formal healthcare services emerged strongly across participant accounts. This theme was raised across most stakeholder groups and was particularly prominent in discussions related to antenatal care (ANC) and institutional delivery.

Mothers described how CHWs encouraged them to attend antenatal check-ups and helped negotiate these decisions within family structures, especially where mobility or decision-making autonomy was limited.

“I was not planning to go to the hospital because it is far, but she kept reminding me and even told my mother-in-law that check-ups are necessary. Then my family agreed.” (MWRA, Rural Punjab)

CHWs also emphasized their role in identifying danger signs and facilitating timely referrals. Their influence was not limited to providing information but extended to persuasion, reassurance, and ongoing follow-up.

“When I see any danger signs, I immediately tell the family not to delay. Sometimes they hesitate, but I explain the risk and convince them to go to the hospital.” (CHW, Semi-urban Punjab)

This theme highlights how CHWs act as mediators between households and healthcare systems, particularly in contexts where geographic, economic, or sociocultural barriers limit direct access to services.

Theme 3: Promotion of Preventive Child Healthcare Practices

Preventive child healthcare, particularly immunization and infant feeding, was another major area where CHWs were perceived to have a sustained influence. This theme appeared frequently in interviews with mothers and CHWs and was moderately reflected in broader community discussions.

Mothers described how CHWs addressed fears and misconceptions surrounding vaccination, often reframing immunization as a protective and necessary practice.

“At first I was afraid of vaccines because people say children get sick after it. But she told me it protects the child from bigger diseases, so now I complete all vaccinations.” (Mother, Rural Sindh)

In terms of infant feeding, CHWs were described as promoting exclusive breastfeeding and correcting traditional practices such as early introduction of water or other substances.

“She told me not to give anything except mother’s milk for six months. Before that, elders used to say give water or honey, but now I follow what she taught.” (MWRA, Rural Punjab)

These findings suggest that CHWs play a critical role in shaping preventive health behaviors through repeated counseling and culturally sensitive communication. The influence of CHWs in this domain appeared to operate through ongoing interaction rather than one-time health messaging.

Theme 4: Trust, Familiarity, and Community Embeddedness

Trust emerged as a central mechanism underpinning the effectiveness of CHWs across all themes. This theme was strongly expressed across nearly all participant groups and appeared to be a key factor influencing the acceptance of CHW advice.

Participants consistently emphasized that CHWs were trusted because they belonged to the same community, shared similar cultural norms, and communicated in familiar language.

“We trust her because she is from our own area. She understands our problems and speaks like us. We feel comfortable asking her anything.” (MWRA, Rural Sindh)

Mothers also highlighted that CHWs provided a safe and non-judgmental space to discuss sensitive issues such as pregnancy, reproductive health, and family planning.

“We cannot talk openly about these things with doctors, but with her we can discuss everything—even family planning—because she listens and does not judge.” (Mother, Semi-urban Punjab)

Compared to formal healthcare providers, CHWs were perceived as more approachable and accessible, suggesting that relational trust and social proximity are critical to effective health communication in community settings.

Theme 5: Structural and Institutional Barriers Constraining CHW Effectiveness

Despite the strong recognition of their role, participants across multiple groups highlighted significant structural and institutional challenges affecting CHW performance. This theme appeared most strongly in CHW narratives but was also reflected in community and stakeholder accounts.

CHWs frequently described heavy workloads and administrative burdens that limited their ability to focus on community engagement.

“We have too many tasks—polio, reports, surveys, visits. Sometimes paperwork takes more time than actually talking to women.” (CHW, Rural Punjab)

In addition, gaps in supply chains and weak health system support were reported to undermine the effectiveness of CHW efforts, particularly when referrals could not be completed or services were unavailable.

“Sometimes we advise women, but medicines or facilities are not available. Then people think we are not helping, even though the problem is not from our side.” (CHW, Rural Sindh)

Participants also noted limited professional recognition and gender-related challenges, particularly in engaging male decision-makers or navigating sociocultural restrictions.

“We work in the field every day, but still people do not see us as professionals. Also, sometimes it is difficult to talk to male family members about health decisions.” (CHW, Rural Punjab)

These findings indicate a clear tension between the perceived importance of CHWs and the constraints imposed by systemic limitations, suggesting that improvements in training, logistics, and institutional support are necessary to enhance their effectiveness.

Synthesis of Findings

Taken together, the findings suggest that CHWs contribute to maternal and child health through a combination of educational, relational, and facilitative roles. Their influence appears to operate through repeated interaction, culturally grounded communication, and the trust they build within communities. At the same time, their effectiveness is closely linked to the broader health system context, particularly the availability of services, institutional support, and resource continuity.

Across the dataset, CHWs were consistently positioned as a bridge between communities and the healthcare system, but this role was shown to be both socially embedded and structurally constrained. These results highlight that improving maternal and child health outcomes in such settings requires not only strengthening CHW capacity but also addressing the systemic conditions within which they operate.

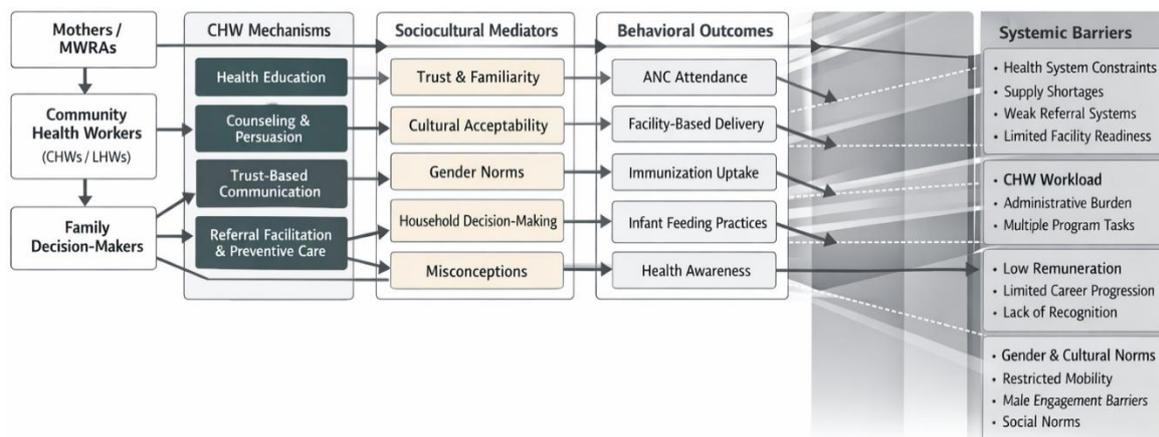


Figure 1. Conceptual pathways illustrating how community health workers influence maternal and child health outcomes, with cross-cutting systemic barriers.

This figure 1 presents an interpretative model derived from qualitative thematic analysis. It illustrates how interactions between community health workers (CHWs), mothers, and family decision-makers activate key mechanisms including health education, counseling, trust-based communication, and referral facilitation. These mechanisms operate through sociocultural mediators such as trust, cultural acceptability, and gendered decision-making, influencing maternal and child health behaviors including antenatal care attendance, institutional delivery, immunization uptake, and infant feeding practices. Cross-cutting systemic barriers—such as workload burden, supply limitations, institutional constraints, and gender norms—are depicted as side barriers that disrupt or weaken these pathways. The model represents qualitative patterns and does not imply quantified relationships.

DISCUSSION

This study provides an in-depth qualitative understanding of how community health workers (CHWs), particularly Lady Health Workers (LHWs), are perceived and experienced within maternal and child health (MCH) service delivery in Pakistan. The findings highlight that CHWs function not only as providers of basic health information but as socially embedded agents who shape health behavior through trust, repeated interaction, and culturally grounded communication. Their influence appears to operate through relational mechanisms—particularly trust, familiarity, and social proximity—rather than through technical authority alone.

The role of CHWs as health educators and translators of knowledge aligns with existing literature demonstrating that community-based interventions improve maternal and neonatal health outcomes by increasing awareness and promoting preventive practices. However, this study adds qualitative depth by showing how health education is not simply delivered but negotiated within local belief systems. Participants' accounts suggest that CHWs actively reinterpret biomedical messages into culturally acceptable forms, particularly in relation to maternal nutrition, breastfeeding, and immunization. This supports prior evidence indicating that culturally sensitive communication is essential in contexts where traditional beliefs and informal advice networks strongly influence maternal health practices.

The findings also reinforce the importance of CHWs in facilitating access to maternal healthcare services, particularly antenatal care and institutional delivery. Consistent with previous studies in Pakistan and other low- and middle-income settings, CHWs were described as mediators who help overcome barriers related to distance, cost, and sociocultural restrictions. Importantly, this study highlights that facilitation is not limited to referral but involves persuasion, negotiation within households, and reassurance, especially in settings where women's autonomy is constrained. This reflects broader evidence that maternal health decisions are often influenced by family hierarchies, including husbands and mothers-in-law, and that effective interventions must engage these decision-making structures.

Trust emerged as a central theme across all participant groups and appears to be a key mechanism linking CHW communication to behavioral outcomes. Participants emphasized that CHWs were trusted because they belonged to the same community, shared cultural norms, and were accessible in everyday life. This finding is consistent with qualitative research from Pakistan and similar settings, which has shown that trust in CHWs enhances acceptability of health advice, improves communication around sensitive topics, and increases uptake of preventive services. The ability of CHWs to create safe spaces for discussion—particularly around reproductive health and family planning—further underscores their role as relational actors rather than purely clinical providers.

Preventive child healthcare practices, including immunization and infant feeding, were also strongly influenced by CHW engagement. Participants described how CHWs addressed fears and misconceptions about vaccines and corrected harmful feeding practices through repeated counseling. This reflects established evidence that community-based health workers play a critical role in improving immunization coverage and early childhood nutrition. However, the current study highlights that these practices are shaped through ongoing interaction and reinforcement, rather than one-time health messaging, suggesting that continuity of contact is essential for sustained behavioral change.

Despite these positive contributions, the study identified several structural and institutional barriers that constrain CHW effectiveness. Participants consistently described heavy workloads, administrative burden, and competing program responsibilities that limit the time available for meaningful community engagement. In addition, supply chain issues, weak referral systems, and limited facility readiness were reported to undermine the credibility of CHWs when recommended services were not accessible. These findings align with broader health systems research indicating that CHW performance is highly dependent on the strength of the supporting system, including logistics, supervision, and integration with primary care services.

Gender norms and sociocultural constraints also emerged as important factors shaping CHW effectiveness. Female CHWs often operate within environments where mobility is restricted and engagement with male decision-makers is limited, which can affect their ability to influence household-level decisions. This finding reflects existing literature on gender dynamics in Pakistan, where women's health behaviors are often mediated through family structures and social norms. Addressing these challenges may require strategies that extend beyond CHWs themselves, including male engagement interventions and community-level dialogue.

From an implementation perspective, the findings suggest that strengthening CHW programmes requires a multidimensional approach. Training should not only focus on technical knowledge but also on communication skills, cultural competence, and negotiation strategies within households. Ensuring consistent availability of medicines and referral services is essential to maintain community trust. Additionally, improving remuneration, career pathways, and professional recognition may enhance motivation and retention. Integrating CHWs more effectively into the primary healthcare system, with supportive supervision and functional referral linkages, is critical for translating community-level engagement into measurable health outcomes.

Trustworthiness and Limitations

The study employed qualitative methods to explore lived experiences and perceptions, which limits generalizability but enhances contextual depth. Credibility was supported through triangulation across participant groups, including CHWs and community members, and through iterative analysis of interview and focus group data. However, several limitations should be considered. First, participants may have been influenced by social desirability bias, particularly if recruitment was facilitated through CHWs or health programmes. Second, translation of interviews from local languages into English may have resulted in some loss of nuance. Third, the study reflects an endline perspective and does not include baseline comparison or longitudinal assessment of change. Finally, the absence of detailed

reporting on participant variation and district-level differences may limit transferability. These limitations should be considered when interpreting the findings.

CONCLUSION

Community health workers play a critical and socially embedded role in maternal and child health in Pakistan. This study shows that their contribution extends beyond service delivery to include communication, trust-building, and facilitation of health-related decision-making within households. Their effectiveness is shaped by culturally grounded interactions, repeated engagement, and their position within community social structures. However, their impact is contingent on the broader health system environment, including availability of services, institutional support, and resource continuity. Strengthening maternal and child health outcomes in Pakistan requires not only investment in CHW training and capacity, but also addressing systemic constraints, enhancing supply chains, supporting referral systems, and incorporating strategies for community and male engagement. Sustainable improvement in MCH outcomes will depend on recognizing CHWs as key actors within both social and health system domains.

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