Introduction

The National programme for Family Planning and Primary Health Care, better known as the Lady Health Workers Programme was initiated by the Government of Pakistan in 1994. As signatories of the Primary Health Conference in Alma Ata, the government adopted a community health workers programme which aligned well with the Primary Health Care approach which advocated that healthcare must be in accordance with the socio-cultural and socio-economic attributes of a society for it to be effective. (Hafeez et al 2011,p. 210) The program aimed to reduce the high rates of maternal and infant mortality in Pakistan. The Lady Health Workers (LHWs) are recruited from within the community they serve and act as an intermediary between the community and the formal health system. Women are required to be residents of the community, be acceptable in the eyes of the community and must have at least completed middle school. It is preferable if the women being recruited as Lady Health Workers are themselves married. There are about 48,000 lady health workers in Punjab. (Dghs.punjab.gov.pk, 2017)

A Lady Health Worker is expected to register all eligible couples, counsel couples of reproductive age about family planning methods, keep checks on pregnant women and their nutrition, provide treatment for basic ailments and refer patients to the formal health system, encourage breastfeeding, promote use of iodized salt and provide medication that they receive from the government. Lady Health Workers are also required to take part in polio immunisation campaigns. (Hafeez et al 2011,p. 211) Each Lady Health Worker is responsible for providing her services to 100 to 150 households, each of which she is required to visit at least once a month. In addition to her work, LHWs also have to manage their own families and households. Despite a general improvement in health indicators in areas where Lady Health Workers serve, they remain underpaid and overworked. Although the notification of their regularization was issued in July

2012, it did not come into effect until September 2016 and that too after numerous strikes by Lady Health Workers all over Punjab. This essay seeks to explore how Lady Health Workers assert their agency and negotiate a space for themselves in the face of the challenges and restrictions they face as women at both work and home. We will examine how these women balance their household responsibilities with paid work. In addition to this, we will look at how these women have mobilized throughout the years as workers against the state with a multitude of demands including regularization, timely payment of salaries and payment of previous dues that the government owes to them.

Literature Review

Most of the research done regarding Lady Health Workers in Pakistan is focused on evaluating the effectiveness of the Lady Health Workers Programme as whole (Hafeez et al 2011; Afzal et al., 2016; Rogers et al., 2017)

A lot has been written on the role of the Lady Health Workers Programme in rural areas with regards to contraceptive use and treatment of sexually transmitted infections. (Douthwaite and Ward, 2005; Khalil, Chang and Naeem, 2016) Douthwaite and Ward's study concluded that women who were being served by Lady Health Workers were more likely to use reversible contraception because use of contraceptives was higher in districts where the Lady Health Workers Programme was implemented . The study showed that many women who would normally not approach a health centre due to cultural restrictions of *purdah* were brought into the fold of family planning through Lady Health Workers. (2005, pp. 119-121) Khalil et al. assessed

knowledge of sexually transmitted infections among Lady Health Workers. The found that about 59% of the Lady Health Workers in their sample were able to define what a sexually transmitted infection was. Khalil's research concluded that there were gaps in the knowledge of Lady Health Works with regard to sexually transmitted infections. (Khalil, Chang and Naeem, 2016, p. 3375)

A cluster-randomised trial was used to gauge the effectiveness of Lady Health Workers in dealing with perinatal depression within communities. The intervention group had trained Lady Health Workers visit households with depressed women. In the control group, Lady Health Workers who had not yet received their training were sent to the households of depression patients during their everyday routine. The intervention group (trained LHWs) was different from the control group (untrained LHWs) in that it had lower incidences of diarrhoea and higher immunization against diseases. (Task Shifting, 2009, p. 185-186) This research indicates that LHWs end up fulfilling the role of a mental health counsellor in addition to that of a confidante and medical professional.

Research on the programme's operation in rural areas included a study that examined how Lady Health Workers' mobility was affected by gendered norms in the rural community they belonged to and how their mobility within their community affected the number of visits to households that they were responsible for. The study comprised of a mixture of qualitative and quantitative methods that included semi-structured questionnaires for 803 women residing in the community , in-depth interviews with 21 Lady Health Workers across the Attock district and 27 in-depth interviews with women residing in the community. The findings indicated that a Lady Health Worker was more likely to visit households that were a part of her *biradari* because they encountered greater difficulties once they moved out of their *biradari* with men sometimes

following them and mocking them. Lady Health Workers circumvented restrictions on their mobility by allowing members of the community to visit her house for diagnosis of problems and medicines. Similarly women in those households were more likely to be satisfied with the services a Lady Health Worker provided if the Lady Health Worker belonged to the same *biradari* as the household in question. The study also indicated that the Lady Health Workers suffered a decrease in their status because they had to move in spaces occupied by unrelated men.(Mumtaz, 2012)

Similarly, another study looked at both rural and peri-urban settlements in Sindh and Punjab to see if the Lady Health Workers' induction into paid labour had empowered them and caused any changes with regards to their position both in the household and the larger community. This research found that women who were recruited as LHWs increasingly took an active role in household decisions with one of the women interviewed by the writer even taking on the role of a community leader after becoming a Lady Health Worker. Even when employment as a Lady Health Worker did not lead to any substantial increase in influence, Lady Health Workers gained access to knowledge resources through their training and shared the information with other women in their community. One of the women interviewed for this study did not use contraceptives until after she had received her training as a Lady Health Worker. The study states that there were intermittent protests by lady health workers in 2002 in Nawabshah and other areas. The movement of Lady Health Workers has consolidated itself since then organising around non-payment of salaries, the burden of additional duties of immunisation campaigns and regularization of their service as government employees. The movement led to a nationwide boycott of polio drives by Lady Health Workers. (Khan, 2011)

Parallels of the Lady Health Worker Programme can be found in other countries in South Asia and Africa where Community Health Workers, both male and female, are recruited to spread awareness and prevent spread of communicable diseases. The Nepalese Government began its Community Health Volunteer Programme in 1970 to tackle maternal morbidity and maternity with around 50,000 women health workers working in all districts of Nepal. Similarly, India has more than 300,000 health guides across the country trying disseminate awareness on hygiene and proper sanitation and encouraging vaccinations.(Hossain, 2004)

We examined a study on Community Health Workers in rural KwaZulu-Natal, South Africa. The Community Health Workers were responsible for providing health-related services and support to households especially those where people were infected with both HIV and Tuberculosis. The Community Health Workers expressed dissatisfaction at the situation because they were being provided inadequate support from the Department of Health in terms of supplies they required for their workbooks, pens, bandages, gloves and first aid kits. Many of the respondents of the study complained about the low stipend they received especially because the households they served had come to expect some sort of financial support. Some of them said that they could not bear the emotional strain of looking after those who were sick and dying and one of the respondents said she would quit work soon.(Suri, Gan and Carpenter, 2007)

Community health workers elsewhere in the Global South have also mobilized against poor working conditions. An example of this would be the two week long strike by health workers in Mombasa County in Kenya over non-payment of their salaries by their County. The health workers also cited the lack of pharmaceutical and non-pharmaceutical supplies as a reason for protesting. The protests resulted in a noticeable decline in outpatient attendance. A similar

strike in South Africa led to a decrease in patients visiting the hospital by as much as 63%. (Njuguna, 2015)

Unlike most of the prior research done on the Lady Health Workers which focuses on the effectiveness of the programme itself, our research revolves around the toll their work takes on the Lady Health Workers themselves. In addition to this, our research also differs in that it focuses on Lady Health Workers in an urban setting and is more qualitative than the research mentioned above which allowed us to explore the deeper meanings and explanations behind the Lady Health Workers' Movement.

Methodology

The research was qualitative in nature and the method used to unearth data about LHWs was in depth semi-structured interviews and participant observation. The methodology was chosen because we wanted to see the impacts of the LHW program on the personal lives of LHWs and whether they managed to gain some agency and we were able to do that through in-depth interviews asking them about their family life, their relationships with community members, etc. and participant observation allowed us an insight into their professional life. Saima, Amna and Maria were the three Lady Health Workers we interviewed apart from the four other community members. They were all married or widowed women who had been working as lady health workers for more than 10 years.The sampling technique we employed was snowball sampling and was based on convenience since the field site was near Nawal's residence and that made it much easier to access, since Saima who was also our key informant and our gatekeeper

further introduced us to other lady health workers. We met Saima through a personal contact who resides in the area, whose house Saima would visit in her duty as a LHW.

The sample size was 7; 3 lady health workers along with 4 members of their community. The field site was Nadirabad, near Bhatta Chowk in Lahore. Nadirabad is an area with narrow streets; people from lower middle class and working classes reside there. We visited both relatively bigger houses to interview community members and other relatively smaller ones too, so were able to observe the class variation firsthand. For participant observation, we followed the Lady Health Worker, Saima around Nadirabad as she went door to door and to schools in order to administer polio drops to children under the age of five.

Possible limitations of our research may be that our key informant Saima took us to the houses of community members and was sitting right in front of the respondents when they answered questions about how Lady Health Workers had impacted their personal lives so their answers may have been influenced by her presence. Limitations of the research also include that our sample size was rather small due to their busy schedules.

Another limitation could have been the presence of family members. For example, while interviewing Maria, her husband was sitting right next to her, watching TV, as she complained about his lack of empathy for her. His presence could possibly have led to her not opening up about certain issues in detail even though she seemed to be quite honest and bold about her opinions. Our own positionality as young female researchers impacted the way we got access in the community and interviewed women. Us being students made it all the more easier because Saima's own daughters were university students too and had conducted research thereby our presence was not questioned. People in the community also mistook us for her daughters.

Findings

Lady Health workers were trained for 6 months before they could start practising. They visit 15 houses per day, to help the women in the community deal with their reproductive care, and to check up on the health of their young children. They leave their houses at 8:30 in the morning to go house to house to perform their duty. They have to provide a monthly report of their work to their supervisor. Hence their work requires careful documentation- from recording the menstrual cycles of women to noting down which children have been given polio drops, vaccinations and injections. The supervisors also keep checking on them to see if they are doing their duties. In order to allow them to keep a check, LHWs have to mark the walls of the houses they have covered with chalk. Saima mentioned that it was LHWs who allowed government hospitals to get filled up with patients since they are the ones who created awareness about these low-cost hospitals because earlier, the community majorly relied on midwives or private clinics which were not always equipped for all sorts of medical procedures. This also allowed infant mortality rate to decline. Their work also has checks and balances in the form of photos that the LHWs have to send over through a phone application to their supervisors or basic health units of them administering polio drops or injections. The members of the community that had been interviewed had expressed gratitude for the Lady Health Workers as it has made their lives easier in the sense that visits to the doctor or clinics have been reduced and they feel at ease discussing their sexual lives with the lady health workers.

Reproductive Health

LHWs provide couples with contraceptives like condoms and IUDs only after they have had 2 children. Lady Health Workers did not intervene before the couple had two children because if a new bride did not have children soon after her marriage, her mother-in-law might create problems because marriage's primary purpose was perceived to be procreation. Lady Health Workers saw themselves interfering in "God's blessings" if they intervened before 2 children had been born. After the couple has had one or two children, the Lady Health Workers advise them to space out their next child's birth by at least 3 years.

Maria mentioned that she gives condoms and contraceptives when couples have completed their family that is when they have had 2 boys and 2 girls. In the case of accidental pregnancies too, they direct the women towards abortion clinics after the consent of their husbands.They advise women to avoid getting their deliveries done by midwives and instead go to hospitals and Saima, almost always accompanies them to the hospital at the time of delivery. The development discourse regarding population control and contraceptives was targeting the poorer women to convince them to use birth control in order to reduce poverty. Post the Cairo conference, the reproductive health agenda took a backseat, with the focus shifting to development.

The Millennium Development Goals focused particularly on improving maternal health and child mortality as a way of reducing poverty. (Harcourt, 2009, p.51). The focus was not on sexual and reproductive rights where women could exercise their choice, and decide if and when they wanted to have children. The LHWs would only introduce birth control to women who had

given birth to two children and not to newly married women or even young women so they served a similar purpose of reducing poverty in families as Saima suggested, “When they cannot afford children and continue to have children, I advise them against it but if they can afford to feed more children then I don’t interfere much.” Even abortion is only advised if the family does not have the resources and means to raise another child therefore showing that it is less about emancipating women and more about meeting financial needs and reducing poverty. Underlying this approach to Lady Health Workers and population control are Neo-Malthusian assumptions. Additionally, focusing only on women’s reproductive care reduced the focus of healthcare on perceiving women as reproductive bodies and that takes away from women’s wider social and economic roles (Harcourt, 2009, p.50). In the cases of infertility, Saima elaborated that mother-in-law’s are quick to blame the daughter-in-law’s and tell their sons to get remarried and/or to divorce their wives, however LHWs have increased awareness about male infertility and advise them to get the men checked too.

Mobilisation

Mobilization of women has been characterised often through the distinction Molyneux identified between practical and strategic gender interests. Practical gender interests relate to issues that women encounter in the roles allocated to them by the sexual division of labour. When women organize around practical gender interests, they organize not as women but as mothers, workers , citizens and peasants. Strategic gender interests are those interests that seek to change the conditions women live in and challenge their subordination. Practical gender interests

are derived from women's lived experiences while strategic gender interests are deductively derived. Molyneux's distinction has been utilised by Sonia Alvarez to characterise different women's movements in Latin America as either feminine (relating to practical gender interests) or feminist (those that relate to strategic gender interests). Chinchilla argues that feminism must play the role of linking feminine and feminist movements. This distinction is slightly problematic because movements organizing around strategic gender interests tend to be associated with either upper class women or women living in the Global North while movements that center on practical gender interests are associated with the Global South. (Ray and Korteweg, 1999, pp.48-50)[Office1]

The distinction between strategic and practical gender interests may not always be very clear. Ray and Korteweg refer to the Madres de la Plaza who initially organized as mothers of missing individuals but later included women's rights and other human rights issues into their agenda too. (1999, p.51) This can also be seen in the Lady Health Workers' movement over the years[Office2] . The movement can be perceived as a movement around practical gender interests of the Lady Health Workers. Although they organised initially as workers asking for regularization of their jobs, payment of salaries, increase in salaries and payment of dues that were owed to them, these women have managed to subvert some of the limitations the society has imposed on them as women. Maria and Saima had not received their salaries for the last month. The only salary they had been paid in the last 5 months was 16,000 Rupees and less than the 17,000 Rupees they had been promised. The Health Department still owed the Lady Health Workers dues from the increment that they were supposed to get starting 2013. However, the women had managed to succeed to a great extent in getting their pays raised.

Saima informed us that during last year's strikes, women from all over Punjab would gather either in Lahore or Islamabad and spend the entire day protesting outside either the Punjab Assembly, the Lahore Press Club or the National Assembly. Lady Health Workers spent days and weeks away from their homes and families in a different city protesting for better conditions. The strikes inadvertently ended up improving the Lady Health Workers' mobility; they would travel large distances without any of their male relatives and often, like Saima, would choose to go away despite their families' disapproval and mostly on their own funds. Saima said that she spent around 8000 Rupees from her own income to cover the food and travel costs of going to Islamabad for a strike. Despite never using feminist terminology, the Lady Health Workers ended up doing many things during the protests that challenged prevailing gender roles. The women spending days at the site of the protests for the cause meant that these women were interacted in public spaces outside their community more than they would in their daily lives. Hence, despite beginning as a movement where women organized as workers, they did manage to gain greater agency and mobility as women. The greater visibility of these women in the public eye because of their mobilization cannot be ignored. The Lady Health Workers may not themselves acknowledge it or perceive it this way, but their movements did end up spilling over into feminist consciousness. (Ray and Korteweg, 1999, p.51)

Naila Kabeer defines empowerment as a process of change where one goes from not being given the right of choice to acquiring the ability to make one's choices.The ability to make a choice is conceptualized in terms of three dimensions- resources, agency and achievement. (1999; pp. 436-337) Kabeer talked about how achievement is often measured in terms of the immunisation of a woman's children and her access to healthcare because a woman who could

make decisions in her household would also assert herself in seeking non-routine healthcare for herself and her children. Empowerment was also measured in terms of change in the time women spent in market-related work ; the greater the time a woman spent in market-related work, the greater her empowerment. (1999, 451-453) However, in the in-depth interviews we conducted, particularly with Maria, revealed that induction into formal paid work had done little to empower them in this sense. Maria told us that after she had completed middle school and could not continue her education, the prospect of working as a lady health worker was very exciting to her and one of the very few opportunities available to her in village. However, Maria's induction into formal work had not caused a change in her or her children's health. One of Maria's children had passed away years ago and Maria said that despite advising the pregnant women in her community to eat well and take their prenatal medicines on time, she herself would not take her medicines for weeks at a time. Saima said that before her recruitment as a Lady Health Worker, she would not leave her house even to buy her own clothes but now she was outside most of the day. With regards to time spent on market-related activity, Saima could be considered empowered, but it must be taken into account that Saima's children were all grown and her husband had passed away which meant that she could afford to spend less time on household work. With Saima and Amna, there were no significant differences in terms of their access to health and power in decision-making compared to their lives before recruitment which showed that paid work was not necessarily empowering in this case.

Emotional Labour in the workplace

The Lady Health Workers since they operate in a local community, become a known figure there. They are looked up to issues that are not related to health care too. They have to perform emotional labour for the women whose houses they go to. Saima mentioned that she often has to go to houses and listen to the mother-in-laws whine about their daughter-in-laws and then listen to the daughter in law's side of the story too**.** Maria said that they function as the *'raazdars'* of every woman in the community and keep with them what one person says about the other and if the daughter-in-law is talking to the LHWs in their room about contraceptives or family planning, they don't share it with the mother-in-laws. Saima is a key figure in the community and besides going to all the houses of the area, she almost performs the duties of a counselor. She also helps the community members with matchmaking, family issues, issues of schools and tuitions and she gives the women advice. Therefore her work entails her to perform emotional labour for the women of the community too. A number of women from the community were migrants. A community member, Fatima, informed us that she had come from Chitral and had not known Urdu at all, and the presence of Saima and her intervention brought a lot of support for her since she was quite young when she had moved to Nadirabad post her marriage and initially, her husband would communicate her health related problems to Saima but then she became better versed in Urdu and developed a bond with Saima. Saima mentioned how she advised Fatima what tuitions and school to send her children to. This is one way in which Lady Health Workers would also deal with the anxieties and distress of migrant women who were more or less clueless about the new area they had moved to.

Hochschild's work revolves around the emotional labour performed by flight attendants (Theodosius 2008, pg 13). Emotion management requires emotion work, she emphasized on how

private and public feelings differ and draws on Erving Goffman's work about the roles people play in life which is much like a theatre, emotional labor in the private realm where one has to act depending on what is emotionally due to a person (Theodosius 2008 pg 15). However, in this case we see this emotional labor being extended to the private sphere of work too. Individuals take part in emotion work by drawing on imagination and memory, feelings can then be used to produce appropriate responses (Theodosius 2008, pg 19). Hochschild talks about how emotional labor is also used in the public sphere for commercial purposes, where air hostesses are hired by being carefully selected (Theodosius 2008, pg 20) Women who are older and married are preferred as Lady Health Workers possibly because of the amount of emotional labour that the job requires. Nursing and professions of health care requires the consideration of the emotions of the patients. (Theodosius, 2008. p. 29). The fact that LHWs are women chosen from within the community makes it easy for them to relate to the problems of the women in the community and their experience allows them to give others life advice.

Care Work and the Second Shift

Saima, was a widow currently, and had only started work as a LHW when her children were grown up and in college so she had little to do in terms of child care, but the fact that she could only start working after her children were old enough to take care of themselves shows that women have to often choose between working outside the home and childcare. Although she did not have any child care work to perform, she still had to make '*handi roti'* as she put it, at Fajar every morning before leaving for work. Maria was a lady health worker with 3 children, she had to work out of necessity while being sick during her pregnancy. She has been working as a Lady

Health Worker for over twenty years. First, she worked as a Lady Health Worker in her village in Okara but ever since her marriage 12 years ago, she has been working in Nadirabad.

She had heard about the job vacancy when she was sick herself but she applied for the job. Her youngest child is a 2 year old boy, and the oldest a 10 year old girl and she was currently 3 months pregnant. She also had another job of selling clothes so working two jobs, during a rough pregnancy along with household work and childcare. She often has to take her 2 year old son along to work, on polio drives,etc. She said it did not disrupt her work because her child was smart. She complained about her husband turning his face the other way and going back to sleep when she asked him to help out with getting the children ready in the morning while preparing food for the children. She expressed a lot of resentment at her husband not dividing household work and childcare. She compared her premarital life as a lady health worker to her post marital life and she stated that her life was far easier before her marriage when she did not have to take care of the house and could perform her duties well. She said at work she is constantly worried about whether her children have come back from school, have had food, etc. Her eldest daughter, who is the 4th grade, who would make *roti* for herself. She also complained about having to miss out on the affection of her children since she was busy all the time and their father got all the love.

She also sadly expressed dissatisfaction with her life, lamenting about her inability to sleep at night and not being able to reach a conclusion regarding her situation. Instead of her husband stepping in to help her with childcare and housework, her children feel sympathy for their mother and sometimes her daughter would miss her school to take care of the 2 year old son when Maria would be out on her duty. She stated that she rebuked her husband multiple times by

reminding him that the children are his responsibility too but it had no effect on him. While leaving,she grimly said, *"Majbooriyan nahi khatam hoti, insaan khatam hojaata hai"*.

Hochschild argued that men who help out little at home are affected by it too because of the resentment that their wives hold against them. (Hochschild, 1989:7) In the case of Maria, however, her husband sat with her during the interview but showed no concern and seemed completely unaffected by the complaints Maria was directing at him. Kabeer argues that something about the masculine identity makes it impossible for men to engage in child care and labor. In addition, Kabeer adds that women have longer working hours due to them working firstly, for the paid job that they have and then additionally performing household work (Harcourt 2009:75).

One reason why Lady Health Workers were able to to manage their work well was that they could come to and go back from their homes while moving around within the area, to check on their children or finish any pending work in the middle of their work hours. Amna also stated that, even though she does not have a husband or children, she has to cook and clean the house. She had a teaching job earlier but that required her to be at the school at all times but being a Lady Health Worker is more convenient for her, since she can come back home in the middle of duty, to check up on her elder sister who she lives with or to finish any incomplete work.
In order to ease the burden of both maintaining professional paid work and balancing it with household chores and childcare, women have to adjust the "clockwork of careers" and get work that is part time, low paid, etc. (Hochschild 1989:119). Thus women have to negotiate between the two spheres of lives without any help, often and have to run the extra mile in order to successfully perform their responsibilities.

According to Gita Sen, women are at the crossroads of production and reproduction (Harcourt,2009:72). Working women have to spend a lot of time structuring their lives in a way that allows them to maintain both their professional and personal lives. The paid work that women engage in is not necessarily empowering then, if they are not in control of their earnings and they have to negotiate between work and family. (Harcourt 2009:75). Saima complained about her children not helping her out much and she would have to cook everyday even though they were older.

Women feel strained because they are performing multiple tasks at the same time (Hochschild 1989: 9). As in the case of Maria, who would watch her 2 year old as she would go to other people's houses to do her work. Work often takes a toll on women's bodies too, through the participant observation we found that their work is physically exhausting as well as it involves walking around the whole area on foot sometimes at the expense of their own physical health. With Saima, we had to walk over to each and every house in her area. Participant observation was very insightful in this case as we were able to assess how physically draining the job must be on a daily basis. Maria, barely able to get up after sitting down like she mentioned and we also witnessed, had a lot of trouble managing her duties because it was physically challenging for during her pregnancy to move about and go from house to house. Gender hierarchies are also produced on the bodies as work can be physically strenuous for women (Harcourt, 2009: 76).

The Lady Health Workers Program also actively tries to hire women who are married as LHWs. Kabeer argues that women have a harder time and face greater resistance by their husbands (Harcourt 2009:75). Saima narrated an instance where a patient of hers sent her

husband to her place late night as she was about to give birth, and her husband was quite angry at how they would come late at night to ask for medicines or ask for help in case of deliveries. He even told her to quit her job, once. Maria, particularly mentioned how her job was very easy for her when she was in Okara and was single as compared to now, where she is barely managing to survive, financially even at the expense of her physical condition. Therefore, LHWs have to keep negotiating with their husbands in order to continue working and deal with their resistance and possible insecurities.

Saima said that she used to control her resources and her husband never used her money, even currently, she keeps her money for her personal use as her children pay for the household expenses, so whereas some Lady Health Workers did manage to gain economic independence, others like Maria had to give up all their money either to their husbands or for household expenses.

Conclusion

The Lady Health Workers had managed to negotiate a considerable space for themselves within the state-led development project they were a part of and within their community but it has not led to any radical changes within the household. All three Lady Health Workers still bore the responsibility of most of the household work in addition to to their jobs that caused them considerable physical strain because of all the walking they had to do on a daily basis. The women's recruitment as Lady Health Workers meant that they ended up performing more emotional labour with women they served who confided their problems to her. In addition to this, they had very little time to themselves because their house being a designated health house meant that members of the community would visit them at odd hours. The Lady Health Workers

have succeeded in getting most of their demands accepted but are unsatisfied because the government has failed to implement them. They have still maintained pressure on the government by participating in *dharrna* and have proved themselves a force to be reckoned with. The Lady Health Workers are a living example of why working class, third world women cannot be reduced to a mere object of development especially when these women themselves have played a vital role in improving their community's health indicators.

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[Office1]This seems to come out of the blue. Perhaps explain the protests first and then talk about theories of mobilization.

[Office2]When did this start?

[Office3]In what sense apart from increasing spatial mobility?
[Office4]Author?