For Freedom from Hunger's MAHP project in West Bengal, India, the microfinance institution BANDHAN is developing an informal health education system to teach people how to take control of their own health and how to access health services in their communities. This effort is combined with an emergency health loan.

Freedom from Hunger's programme in Burkina Faso, called Réseau des Caisses Populaires du Burkina (RCPB), is testing a health-savings product in which participants put money into a medical savings account and receive cards listing their balance.

> "The goal is to turn an out-of-pocket payment to a pre-payment system, which is not linked to your health condition and not linked with whether you use health services or not."
>
> *Ke Xu, a health economist at WHO.*

Participants can take these cards to a local clinic or pharmacy and receive health services or prescriptions, and the money from the appointment is automatically deducted from their account. This way, Reinsch says, patients don't have to worry about showing up with cash.

In neighbouring Benin, Freedom from Hunger is working with the non-profit Association Pour la Promotion et l'Appui au Développement de Micro-Entreprises (PADME), which is looking at a programme combining credit with education based on Freedom from Hunger's model.

Participants, mostly women, are given a micro-loan to start a business, but periodic meetings — at which they make their loan payments — double as education sessions covering health, nutrition, family planning and sound business practices, according to Freedom from Hunger's web site.

Such programmes can learn from previous attempts to address health-care financing issues.

For instance, Michael Kent Ranson studied a programme in Gujarat, India, run by the Self-Employed Women's Association's Medical Insurance Fund.

He looked at what effect reimbursing all or part of the costs of hospitalization had on poor families and found that health insurance reimbursement more than halved the percentage of what he termed "catastrophic hospitalizations", that is, those that cost more than 10% of annual household income, and of hospitalizations that resulted in impoverishment.

This system helped to protect the poor, but problems remained. For one, health-care expenses even after coverage were still often catastrophic; for another, programmes that exclude the wealthy collect limited premiums and may not be sustainable. Ranson also noted that the amount of money spent on hospitalization may have been skewed by items that don't carry receipts, such as bribes and gifts for health-care personnel.

In Cambodia, the health ministry, in conjunction with UNICEF and Médecins Sans Frontières (MSF), tried to address the problem of so-called informal payments, which add hidden costs to medical care that aren't reimbursable by insurance.

It did this by formalizing those payments and making them part of the official process, which meant they were covered. In addition, such informal payments were prohibited, but in return, health-care workers got a bit more money.

With the blessing of Cambodia's health ministry, MSF and UNICEF set up the Health Equity Fund, administered by an NGO specialized in the area, to step in and pay for health care for those who couldn't.

It turned out that, according to an analysis of such a fund in Sotnikum, Cambodia, published in *Health Policy and Planning* in 2004, the Health Equity Fund's main strength lay in preventing expenditures by encouraging people to seek care before catastrophic illness. ■

Theresa Braine, *Mexico City*

Pakistan, Afghanistan look to women to improve health care

Women health workers have been vital in improving the health of women and children in Pakistan. Inspired by its neighbour's experience, Afghanistan is embarking on a similar programme to encourage women to work in the health sector.

Khalda Perveen ventures where trained doctors rarely dare to go. She is among more than 90 000 Lady Health Workers who are working to increase health awareness and improve child and maternal health across Pakistan, particularly in poor rural areas where three-quarters of the country's population live.

"In remote areas where there are no doctors, Lady Health Workers perform an important role: we go to areas where other health professionals won't go," Perveen, 29, said. "But still some people don't accept us and think that as women … we shouldn't be working."

Run by the Pakistani government's National Programme for Family Planning and Primary Health Care, the Lady Health Workers scheme was launched in 1994 to reach out to remote, tribal communities where strict adherence to social and religious customs has long hampered women's ability to work as health workers and seek health care.

Similar traditions exist across the border in war-torn Afghanistan, where maternal and under-five child mortality are high. More women — an estimated 1600 per 100 000 — die in childbirth than in any other country, bar Sierra Leone, according to WHO. Child mortality is also among the world's highest. According to WHO's most recent estimates, 257 children in Afghanistan die out of every 1000 born.

Afghanistan has much work to do after two decades of conflict and neglect — particularly during the 1992–96 civil war and subsequent Taliban reign — left the country's health system in tatters.

Now the country is embarking on a programme similar to that of the Lady Health Workers that is credited with significantly improving health care across Pakistan.

Paul Garwood

Shaban Rafik (in blue), a 20-year-old Lady Health Worker, consulting women in the town of Chikar in Pakistan which was badly affected by the October 2005 earthquake.

Great distances from homes to health centres, widespread illiteracy that limits educational and employment aspirations of women, and tribal customs that forbid women to work or be visited by male heath workers compound difficulties faced by many Afghan and Pakistani women and children seeking health care.

Due to these barriers, few women use services that are provided by health facilities staffed by male health workers. A 2002 survey found that only 40% of Afghan basic health facilities employed female health-care providers.

That is why Nagis, an Afghan woman aged in her 30s and who uses just one name, gave birth at home recently to a daughter who died several days later. She said that during her pregnancy she couldn't go to the clinic in her village of Rabat, north of the Afghan capital of Kabul, because there were no female doctors or midwives there.

"It is generally considered taboo here for men to treat women," Nagis said.

Pakistan has been tackling the barriers to women receiving basic health care by training an army of Lady Health Workers to raise health awareness among communities that are cut off from hospitals and health centres by social barriers and distance, Dr Zareef Khan, Deputy National Coordinator for the programme, said in an interview with the *Bulletin*.

The campaign started with 8000 workers in 1994 and now has 92 000 across the country. By the end of 2006, 100 000 workers will be in the field and a further 10 000 should be introduced by 2008.

Khan, an architect of the health worker scheme, said Pakistan's high maternal and infant mortality forced the government to improve the delivery of health services to the population.

Prospective workers do three months in-class training to learn how to provide basic health services, such as family planning, immunization, hygiene, and maternal and child health. Then they do a further 12 months' work experience in the community, before being sent to a village in the area where they come from.

"Pakistan's health system is unable to cater for all the population in rural areas. In some areas, the closest basic health unit is seven kilometres from someone's house," Khan said.

> "In remote areas where there are no doctors, Lady Health Workers perform an important role: we go to areas [where] other health professionals won't go."
>
> *Khalda Perveen, a Lady Health Worker in Pakistan.*

But the Lady Health Workers programme provides at least one worker in every village with a population of at least 1000 (or 150 households).

A. H. Jokhio, H. R. Winter and K. K. Cheng found in their study published in the *New England Journal of Medicine* in 2005 that perinatal and maternal deaths decreased significantly when female health workers helped train birth attendants and connected them to formal health services.

"I am very happy in the work that I am doing because I am raising awareness and working for humanity," said Sajda Yacoub, who has been a Lady Health Worker in Pakistan for 12 years.

Efforts to introduce similar programmes in Afghanistan are taking shape, but WHO predicts that it could be eight years before enough Lady Health Worker-equivalents are in place.

WHO's representative in Afghanistan, Dr Riyad M. F. Musa Ahmad, said maternal health-care services are unequally distributed throughout the country and most women, especially from rural areas, have little or no access to health care when they are pregnant and give birth.

In some remote Afghan areas, female doctors and community health workers have been introduced to provide obstetric and gynaecological care, Ahmad said.

Afghanistan's Ministry of Public Health, with the support of partners including WHO and UNICEF, is training community midwives and female community health workers to serve in the country's rural areas, where 77% of the population lives.

> "My presence here has encouraged more women to come [to this health clinic] … They feel more comfortable dealing with female doctors."
>
> *Dr Wahida Jalal Marzada, the first female doctor at a health clinic in the district of northern Salang, Afghanistan.*

Based on population data and government targets, Afghanistan needs up to 10 000 midwives to deliver babies and manage life-threatening complications, according to Ahmad. In 2002, Afghanistan had only 467 midwives.

The new initiative's aim is to train 1200 midwives annually so the 10 000 target can be reached in no more than eight years.

Afghanistan also needs between 22 000 and 84 000 female community health workers, similar to Pakistan's Lady Health Workers, but to date just 5000 male and female workers have been trained.

"My presence here has encouraged more women to come [to this health clinic]," says Dr Wahida Jalal Marzada, who last year became the first female doctor at the northern Salang district's health clinic. "They feel more comfortable dealing with female doctors." ■

Paul Garwood, *Islamabad*

Paul Garwood

Sajda Yacoub, who has been a Lady Health Worker in Pakistan for 12 years.

Maternal health care wins district vote in Uganda

One district in Uganda has dramatically reduced the number of womens' deaths due to pregnancy and childbirth. Now the government is considering how to extend the same level of maternal care to women to the country's remaining 75 districts.

When Dr Godfrey Egwau, a consultant obstetrician at Soroti Regional Referral Hospital's maternity unit, stood for parliament in February, voters knew that if he won he would move to the capital, Kampala, about 280 km away.

Women in Soroti district weighed this and overwhelmingly voted for his opponent. Egwau, who dreamed of going into politics, lost the election.

Many associate Egwau with the high standard of maternal care provided here. He is proud of the district's record, but says the good work is not his achievement alone.

"When I stood for parliament in the last elections, they refused to vote for me, saying 'this is our good doctor, he cannot go!' It's true, we have succeeded, but we need to move away from individualization," Egwau said.

Many women across Uganda give birth without knowing whether they are HIV positive.

But pregnant women, like Connie*, who come to the Soroti hospital receive routine HIV counselling and testing. Of some 500 admissions a month, 30–40 test positive and are provided with treatment to prevent transmission of HIV from mother to child.

When the 22-year-old mother's result was positive, she was given medicine to prevent her from infecting her daughter, counselling, and she was put on antiretroviral (ARV) treatment.

> "Our rule is simple: for each mother there must be a baby to go back with and for each baby, there must be a mother to go back home with."
>
> *Dr Godfrey Egwau, a consultant obstetrician at Soroti Regional Referral Hospital.*

Since February 2005, life-saving ARV medicines have been provided free to patients in Uganda who are HIV positive.

Soroti district became the test ground for a pilot of the WHO programme, Making Pregnancy Safer (MPS) from 2001 to 2004, the central principle of which is to make skilled care available for every birth. Since then, the district has continued to provide this high level of maternal care. Thousands of women like Connie have benefited.

Uganda is one of many countries taking the MPS approach, including Bangladesh, Bolivia, Kenya, India, Indonesia, the Lao People's Democratic Republic, the Republic of Moldova, the Philippines, Timor-Leste, the United Republic of Tanzania and Zambia.

"The success of the Making Pregnancy Safer initiative in Uganda

* not her real name