Lady health workers: A positive step towards women health in Pakistan

By Hafsa Shaheen, Pakistan

Pakistan is in a crucial stage regarding awareness among women about their health issues and pregnancy especially in the teen age. In such a critical situation, lady health workers (LHWs) are a appreciable step towards women health. They visit door to door to reach women and children to educate them on various health related issues. Though there are about 90,000 LHWs but still the number is not sufficient enough to meet the requirement as witnessed by teen mothers because there is no awareness among them about child birth in early age and gap between children. Pregnancy at early age may risk the life of mother and the newborn. Pakistan’s Maternal Mortality Rate is 276 out of 100,000 live births and the Infant Mortality Rate is 76 out of 100,000 live births. Delay in pregnancy and gap in child birth in teen age can be achieved with the use of contraceptives. Off all one-third couples use contraceptives and 37% don’t have family planning information. Dr. Yasmeen Sabeeh Qazi pointed out that following the guidelines of family planning is the best way to get familiar and use of contraceptives methods to overcome mother and child mortalities at early age. There is great potential for an impact on maternal, newborn, infant and child health in Pakistan as 67% of non-first births are spaced less than 36 months apart. According to Mamtaz Ali Shah, the secretary of Sindh Population Welfare “These health workers are selected by organizations on the basis of their educational standards which is rather impractical as the literacy rate in rural areas is 17%.” Approximately 16 percent of the women bear children in their teen age (ages 15 and 19 years). 35% of currently married women are older than 34 years of age, 37% of infants under six months of age are breast fed and modern contraceptive use is low at 21.7% overall. Different NGO’s are working now for the progress of women health issues and training of LHWs in different cities. It seems a great initiative in the field of women health and decreasing rate of early teenage mothers. In this case Dr. Marilyn Wyatt, the wife of US Ambassador Cameron Munter, met with trained them how to save lives of poor LHWs at a health house in Jhelum and all over Pakistan. The U.S. government is doing much work in the field of women reproductive health and raising awareness about women’s participation in labor force.

Sources
From Our Correspondents

BOTOX - The wonder toxin

By Jagritee Sharma, USA

The term Botox instantly brings vanity to mind. However, health professionals swear by it. Recently, Botox was approved by United States Food and Drug Administration to treat urinary incontinence. It is the seventh condition that Botox has been approved to treat since the drug first arrived on the market. Botox gained widespread publicity after it was launched as a wrinkle reducer in 2002.

Botulinum toxin is a protein produced by the bacterium Clostridium botulinum and is considered the most powerful neurotoxin ever discovered. Although it is a lethal naturally occurring substance, it can be used as an effective and powerful medication. In 1950s, researchers discovered that minute quantities of Botulinum toxin type A resulted in decreased muscle activity in overactive muscles. Botulinum has the capability to block the release of acetylcholine from the neurons. This effectively weakens the muscle for a period of three to four months. Thus, botulinum acts by paralyzing muscles for a short period of time.

Although the most widespread use of Botox in the US is in cosmetics (as of 2007, 4.6 million procedures have been done in the US according to the American Society of Plastic Surgeons), it is currently used in the treatment of spasms (sudden, abnormal, involuntary muscular contraction) and dystonias (abnormal tone of any tissue) by weakening involved muscles, for the 60-70 day effective period of the drug. The approved conditions treated by Botox include:

1. Cervical dystonia (a neuromuscular disorder involving the head and neck)
2. Blepharospasm (excessive blinking)
3. Severe primary axillary hyperhidrosis (excessive sweating)
4. Strabismus (squinting)
5. Achalasia (failure of the lower esophageal sphincter to relax)
6. Migraine and other headache disorders
7. Urinary incontinence (new addition)

Urinary incontinence is caused by overactivity of bladder which leads to an inability to store urine. Botox is injected directly into the bladder, thereby relaxing it and this offers more muscle control and less incontinence to patients. One injection may help control incontinence for up to 10 months, the FDA said.

In two clinical trials involving 691 patients with incontinence due to spinal cord injury or multiple sclerosis, Botox resulted in a significant reduction in weekly incontinence episodes, compared to a placebo group, the FDA said. The most common adverse effects were urinary tract infection and urinary retention.

Botox sales reached about $1.5 billion worldwide in 2010, roughly split between cosmetic and therapeutic purposes. According to Caroline Van Hove, company spokeswoman, Botox can treat “anything from writer’s cramp to anal fissure to Parkinson’s disease. That’s why we say it’s a pipeline in a vial‖. The drug has been studied for more than 100 medical conditions and counting.

Sources


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From Our Correspondents

Enhancing access to health care: the National Health Insurance Scheme in Ghana

By Dina Danso-Abeam, Ghana

In 2003 the government of Ghana took a step further in development to improve health care in the country by implementing the national health insurance scheme (NHIS). The aim of the scheme was to provide basic health-care services to persons resident in the country. Seven years down the line, Ghanaians are boastful – amidst other shortfalls of the insurance – of a better and improved health care, thanks to the scheme.

Health system of Ghana - back in time

The first post-independence government in Ghana, led by Kwame Nkrumah, implemented a cost-free healthcare system for all Ghanaians. However, as a direct consequence of declining cocoa and gold prices coupled with skyrocketing oil prices in the 1980s, the country found itself mired in debt. Despite these difficulties, the government at the time considered itself responsible for ensuring that all citizens get access to healthcare in a way that was affordable to all until the IMF and the World Bank were approached for financial assistance. The recommendations and conditions stipulated by these institutions to serve as a panacea to Ghana’s ailing economy at the time, i.e. cutting back spending on social services, proved successful in helping the government to effectively service its domestic and overseas debts but ultimately made access to healthcare for the ordinary Ghanaian expensive. This was as result of the introduction in 1992 of a cost recovery mechanism into health establishments in the country. This system was infamously referred to as the ‘cash and carry system’. It was aimed at fully recouping the cost of drugs in all government health facilities and reducing to the barest minimum unnecessary hospital visits by patients. But its impact on Ghanaians was ultimately negative. Many were those who were simply priced-out of access to health care.

Many analysts dubbed it an inhumane system of health care considering that even accident victims and the disabled were denied medical treatment if they did not make out-of-pocket payments at the point of use. Detention of many lactating mothers, in maternity wards due to their being unable to pay hospital fee debts accumulated during the course of delivery, was commonplace and an extremely disturbing occurrence. Many of such mothers had no option than escaping from their hospital beds, leaving their newborns behind, in hopes of sourcing for money by any means for the purpose of paying hospital fees.

The cash and carry system achieved its objectives to a certain degree. Its introduction helped the then government save a big chunk of the annual budgetary allocation for health for other development projects. But it led to deepening poverty and a multitude of loss of human life that could have been saved by modern medical practices. Abolishing it was therefore a step in the right direction.

Providing financial risk protection – National Health Insurance Scheme (NHIS)

Ghana embraced the NHIS to exempt members from paying cash at the point of care and relieve members from the problem of converting asset to cash especially in case of catastrophic illnesses, among other benefits. The scheme covers about 95% of primary cases that are reported in Ghanaian healthcare institutions including related drugs for their treatments. Since its inception, there have been improvements in the scheme such as inclusion of some diseases that were originally not covered by the scheme, expansion of NHIS drug list to include more drugs under the scheme as well as given accreditation to more private healthcare providers. Furthermore, recently, processing of claims made by service providers and refund periods have been substantially reduced while erroneous clinical practices and abuse of the scheme by all stakeholders have also seen a significant reduction as a result of a clinical audit process that took off in 2010. These changes have saved millions of cedis for the NHIS. After its successful implementation, the scheme has been commended by world renowned organizations like the World Bank, United Nations Development Programme (UNDP) and the World Health Organization (WHO).

What is left to consider

Ghana’s National Health Insurance Scheme has been touted as a laudable project. However, there are factors that threaten the sustainability of this enviable scheme these include (i) partisan politics (ii)organizational hitches and (iii) lack of formally trained and experienced health insurance personnel. More so, a majority of the populace: the poor, the elderly, women and rural residents who were unable to afford the cash-and-carry system are still unable to afford the subscription fees of the scheme. To ensure sustainability and strengthening of the NHIS, it should be the responsibility of every government to identify new sources of generating revenue for the national health insurance fund. A combination of health education, publicity of the NHIS as well as enforcement of the national health insurance act to the letter would serve as a catapult in coaxing every Ghanaian to subscribe to the scheme. Measures to train and retain more health care and health insurance professionals must also be vigorously pursued.

Sources


From Our Correspondents

The Birmingham Conference

By Zafar Hashim, UK

The annual Birmingham conference was jointly hosted by the West Midlands Workforce Deanery and the Centre for Research in Medical and Dental Education (CRMDE), University of Birmingham on 19 May 2011. The theme of this year’s conference was “assessing trainees in the workplace: issues and opportunities.” The conference included the following:

Keynote presentations

Changing assessment culture: The challenges of workplace based assessment

Professor V. Wass discussed the current understanding of formative assessment in a summative setting especially in the context of workplace based assessments.

Assessing medical trainees for the workplace: a researcher’s perspective: How are the right doctors chosen?

Dr I. Davison gave a good account of the processes that are used in the selection and assessment of doctors e.g. examinations, workplace based assessments and selection interviews.

Poster presentations

1. Is self-assessment a valid method for assessing technical skills in Orthopaedic surgery? Self-assessment is it a threat or opportunity?

Mr M. Morgan stressed upon the importance of self-assessment which, at present is ignored in surgical training and deserves to be given more importance.

2. Learning by immediate feedback—a process to enhance learning.

This was a study conducted on 3rd year medical students at the Birmingham University. The findings clearly indicated that topic based immediate feedback process potentiated the learning of majority of the students in a tutorial setting but not to a great extent in case of lectures and bedside teaching.

3. A foundation trainee’s handover to medical students

This was a poster presenting the experience at the Royal Wolverhampton Hospital about a six page handover sheet created by foundation doctors for medical students to help them optimise their learning and training opportunities when they start work. This handover sheet could be developed further for subsequent years in training and customised for other specialities as well.

4. SCRIPT: An online learning resource to assess prescribing practice for doctors in training

This poster presented an innovative e-learning toolkit; Standard Computerized Revalidation Instrument for Prescribing and Therapeutics (SCRIPT). This tool aims at improving the prescribing practices of junior doctors. It has 39 learning modules each of which includes a pre-test, learning materials and a self-administered test. Both trainees and tutors are provided access to the system enabling monitoring of progress and identifying any weakness early.

The role of formative and summative assessment in work based learning:

This was an hour long workshop aimed at exploring the role of feedback in work-based learning and assessment. Further, it included a simulated assessment exercise about the use of formative and summative assessments.

In short, the conference was a very well organised event with a large number of healthcare professionals (who are actively involved in teaching and training in their respective institutions) from different parts of the United Kingdom presenting very innovative ideas that will go on and shape the teaching and training of medical students and doctors in the UK in the future.

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