WHEC UPDATE

A Newsletter of worldwide activity of Women's Health and Education Center (WHEC)

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Happy Holidays from all of us at Women's Health and Education Center (WHEC).

Like *democracy* or *justice*, *science* is a word exhausted by its examples. We can not reconcile our understanding of the human mind with any trivial doctrine about the manner in which the brain functions. If science stands opposed to religion; it is not because of anything contained are either the premises or the conclusions of the great scientific theories. In science, as in so many other areas of life, faith is its own reward. It is said in Hebrew 11:1 "Faith, is the substance of things, hoped for, the evidence of things not seen". The relationship between science and religion has all the tension of a courtship between well-matched peers. The two disciplines have danced around each other, making the necessities of social status of women and health into science, at least since the early 20th century, when, with a combination of talent and nerve, pioneers began to redefine women's healthcare. The two disciplines have continued to share challenges. Multiculturalism, as a concept, is still relevant in 2008 and is crucial in social debates concerning cultural diversity, healthcare and citizenship. The educational thrust of *WHEC Update* and **WomensHealthSection.com** highlights the importance of the concept of multiculturalism, and encourages continued debates into its usage and applicability to education and health systems of today. Between the past failures and future promises, racism and racial discrimination are a clear effort to the fundamental truth that "all human beings are born free and equal in dignity and rights". We need a common approach to eradicate racial discrimination and we need a common agenda. Fortunately, we have one. From its inception in 1945, the United Nations has led an unrelenting fight against racism and racial discrimination. The framework for the Organization's work in that area was the declaration in the permeable to its Charter on the question of human rights: "We the peoples of the United Nations determined …. to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small, and …. to practice tolerance and live together in peace with one another as good neighbors".

We hope this challenges us to open our hearts with compassion and wisdom. Our mind creates our life. Spiritual cure is an understanding which allows us to begin to see illness and disease in a broader perspective. It directs the attention of mind to the special wisdom of cures that cause permanent healing to take place. Spiritual practices are not magical or miraculous but rather help a person to understand the real causes of health and happiness. The benefit you receive is determined by your motivation and by the quality of your mind. There appears to be certain common elements in almost all cultures which enable individuals to periodically change their everyday mode of thinking. Through our emotional attachments, our social feelings, our ideological beliefs, our sensory contacts, we are constantly diverting our thinking toward external factors. Any attempt to redirect this outwardly directed consciousness requires a different mental process. We are literally *what we think*. The type of thinking which elicits the relaxation-response is the best to achieve good physical and mental health. We do not view religion in a mechanistic fashion simply because a religious prayer brings forth this desired physiologic response. Rather we believe these age-old prayers are one way to remedy an inner incompleteness and to reduce inner discord. There are many aspects of religious beliefs which have lot to do with the relaxation and peace. Mind / body approach and forgiveness training are the most effective ways to relieve the tensions of modern-day living. It might help us to achieve richer, healthier and more productive life. The religions should illuminate us and help us find the path of love and peace. The choices we make and the lives we lead are driven by the values we hold. "You are what your deep driving desire is. As your desire is, so is your will. As your will is, so is your deed. As your deed is, so is your destiny" - from the Upanishads. We are the *sole authors* of our character.

Science & Religion

Rita Luthra, MD

Your Questions, Our Reply:

Why health economics is important? How markets function? What is particular about markets for health services? Who pays for what?

Understanding of Health Economics … The Sequel: We are all economists – when we work, buy, save, invest, pay taxes, and vote. It repays us many times over to be good economists. Economic issues are active in our lives every day. However, when the subject of economics comes up in conversation or on the news, we can find ourselves longing for a more sophisticated understanding of the fundamentals of economics. In every country (and in many sub-national structures such as states and provinces), health economics plays, or should play, an important role in critical policy and operational decisions.

These decisions include:
a. The appropriate role of government, markets and the private sector in the health sector;
b. resource allocation and mobilization functions critical to addressing equity and efficiency of public spending;
c. resource transfer mechanisms to hospitals and health care providers and the incentive systems that underlie them;
d. organizational structures at the system level and the linkages between the levels;
e. organizational structures at the facility level;
f. mechanisms to change behaviors of the population at large and health system providers in order to achieve better health.

Health economists can contribute to better decision-making. Long term capacity building efforts, through degree programs in universities, should develop the human capital needed in health economics to address needs. But short- and medium-term needs cannot be met through deeper human capital investments through universities. Furthermore, health economists, even when they exist and are well trained, are not always part of decision-making structures in ministries of health. A clear gap exists
for training and empowering, policy and operational decision makers on how health economics can contribute to strengthening the effectiveness of health systems by efficiently and equitably addressing the needs of the population.

We suggest; training of healthcare providers is essential in Health Economics and it should be a part of the Continuing Medical Education Initiative courses. This will be a helpful tool to develop understanding on the relevance and recommendations of women's health and economic empowerment initiative in every country. This is essential to expose healthcare providers to potential contribution of health economics to decision making in the health sector. We shall continue the expert series on Health Economics with UNU – WIDER in 2009.

About NGO Association with the UN:

Millennium Development Goals (MDGs): A note to the reader – Charting progress towards the MDGs

The Millennium Declaration, signed by world's leaders of 189 countries in 2000, established 2015 as the deadline for achieving most of the Millennium Development Goals. The majority of MDG targets has a baseline of 1990, and is set to monitor achievements over the period 1990-2015. This report presents an assessment of progress midway through the process, based on data available as of June 2007. Since more data are now becoming available for the period after 2000, data for 2000 are also presented whenever possible, to provide a more detailed picture of progress since the Declaration was signed. The basis for this analysis is based on regional and subregional figures compiled by the Inter-Agency and Expert Group on MDG Indicators. In general, the figures were obtained through weighted averages of country data – using the

population of reference as a weight. To ensure comparability across countries and regions, the data are those used by international agencies within their area of expertise (see inside front cover for a list of contributing organizations). For each indicator, one or more agencies were designated to be the official data providers and to take the lead in developing appropriate methodologies for data collection and analysis. Data are typically drawn from official statistics provided by governments to the international agencies responsible for the indicator. This is done through a mechanism of periodic data collection. In the case of data on employment, for example, the International Labor Organization collects labor force indicators from labor ministries and national statistical offices in every country; in the area of health, the World Health Organization gathers administrative records and household survey data on major diseases from ministries of health and national statistical agencies around the globe. To fill frequent data gaps, many of the indicators are supplemented by or derived exclusively from data collected through surveys sponsored and carried out by international agencies. These include many of the health indicators, which are compiled for the most part from Multiple Indicator Cluster Surveys and Demographic Health Surveys. In some cases, countries may have more recent data that have not yet become available to the specialized agency in question. In other cases, countries do not produce the data required to compile the indicator, and the responsible international agencies estimate the missing values. Finally, even when countries regularly produce the necessary data, adjustments are often needed to ensure international comparability. The United Nations Statistics Division maintains the official website of the Inter-Agency and Expert Group on MDG Indicators and its database – accessible at mdgs.un.org – containing the aggregated data as well as the country data series as provided by all partner agencies. The database also presents the detailed metadata on the calculation of the indicators and the methodologies used for regional aggregations. Aggregated figures are used in this report to provide an overall assessment of regional progress under the eight goals and are a convenient way to track advances over time. However, the situation in individual countries within a given region may vary significantly from the averages presented here.

Building stronger statistical systems the availability of good statistics and the capacity of governments, donors and international organizations to systematically measure, monitor and report on progress in all social and economic spheres are at the heart of development policy and the achievement of the MDGs. Reliable data at the national and local levels are indispensable to informing policies, identifying and measuring the effectiveness of key interventions, and monitoring progress. Since periodic assessment of the MDGs began over five years ago, a number of initiatives have been launched to address the needs of developing countries to strengthen their capacity to produce, analyze and disseminate data. A major step in this direction was the 2004 endorsement of the “Marrakech Action Plan for Statistics - Better Data for Better Results, An Action Plan for Improving Development Statistics,” by the Second International Roundtable on Managing for Development Results, comprising aid recipients and donor stakeholders.

Collaboration with World Health Organization (WHO):

World Health Report 2008
Primary Health Care: Now More Than Ever

As nations seek to strengthen their health systems, they are increasingly looking to primary health care (PHC) to provide a clear and comprehensive sense of direction. The World Health Report 2008 analyses how primary health care reforms, that embody the principles of universal access, equity and social justice, are an essential response to the health challenges of a rapidly changing world and the growing expectations of countries and their citizens for health and health care. The Report identifies four interlocking sets of PHC reforms that aim to: achieve universal access and social protection, so as to improve health equity; re-organize service delivery around people's needs and expectations; secure healthier communities through better public policies; and remodel leadership for health around more effective government and the active participation of key stakeholders. This Report comes 30 years after the Alma-Ata Conference of 1978 on

primary health care, which agreed to tackle the "politically, socially and economically unacceptable" health inequalities in all countries. Much has been accomplished in this regard: if children were still dying at 1978 rates, there would have been 16.2 million child deaths globally in 2006 instead of the actual 9.5 million. Yet, progress in health has been deeply and unacceptably unequal, with many disadvantaged populations increasingly lagging behind or even losing ground.

Meanwhile, the nature of health problems is changing dramatically. Urbanization, globalization and other factors speed the worldwide transmission of communicable diseases, and increase the burden of chronic disorders. Climate change and food insecurity will have major implications for health in the years ahead thereby creating enormous challenges for an effective and equitable response. In the face of all this, business as usual for health systems is not a viable option. Many systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a strong sense of preparedness for what lies ahead. Fortunately, the current international environment is favorable to a renewal of PHC. Global health is receiving unprecedented attention. There is growing interest in united action, with greater calls for comprehensive, universal care and health in all policies. Expectations have never been so high. By capitalizing on this momentum, investment in primary health care reforms can transform health systems and improve the health of individuals, families and communities everywhere. For everyone interested in how progress in health can be made in the 21st century, the World Health Report 2008 is indispensable reading. Details: http://www.who.int/whr/2008/whr08_en.pdf

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Collaboration with UN University (UNU):

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Fiscal Policy for Poverty Reduction, Reconstruction, and Growth

Growth, poverty reduction, and social peace are all undermined when public expenditure management and taxation are weak and when the fiscal deficit and public debt are not managed successfully. And large-scale aid and debt relief cannot work without a good fiscal system. The macroeconomic frameworks of many poor countries are improving, but fiscal policy's full potential will not be realized until good and accountable expenditure and taxation systems are built. Good fiscal policy can raise economic growth through well-chosen public investments provided that the spending is large enough. Growth itself increases the tax base generating the potential for higher public spending on poverty reduction. Fiscal reform can be a tool for peace when an unfair distribution of spending and taxation generates grievances that turn violent. Overall, fiscal policy reveals more about the political priorities underpinning a country's development strategy than any other area of policymaking.

Aid Can Not Be Effective Without a Good Fiscal System: Fiscal policy is central to the continuing debate over aid effectiveness. The pioneers of development economics in the 1950s and 1960s assumed that the basic structures of public expenditure management and taxation that we take for granted in rich countries would not take too long to establish themselves in post-independence Africa and Asia. However, they were sorely disappointed in many of the new African states (and in some of the Asian ones as well). In the 1970s poverty reduction was, for the first time, placed at the forefront of development; aid was intended to help governments meet basic needs, but the assumption was again made that the associated pro-poor public spending would not be too difficult to organize. Pessimism set in with the 1980s and aid flows became organized around highly controversial programs of structural adjustment, including fiscal reforms that often included crude mechanisms to curb public spending and bring fiscal deficits down (frequently resulting in

unnecessary cuts in already low levels of pro-poor spending). By the 1990s aid lending had created a fiscal burden of debt-service that took resources away from development and poverty spending, and the Heavily Indebted Poor Counties (HIPC) Initiative together with the Multilateral Debt Relief Initiative (MDRI) are as a result freeing up 'fiscal space' (see the companion volume Debt Relief for Poor Countries, edited by Tony Addison, Henrik Hansen, and Finn Tarp, also published by Palgrave Macmillan for WIDER). Towards the end of the decade a start was made in shifting away from project aid and towards budgetary support, as country 'ownership' came into vogue. This trend continues today, although it periodically stumbles over the governance dimensions of fiscal policy—not least in countries reconstructing from conflict and those in unstable regions such as the Horn of Africa and Africa's Great Lakes region. Taxing and spending decisions are inherently political and therefore conflictual (some violently so). But weak institutions may fail to implement plans effectively, and macroeconomic shocks can overturn the best-crafted of spending programs.

Publisher: UNU-WIDER; series: UNU Policy Brief; Volume: 05/2006. Authors: Tony Addison, Alan Roe, and Matthew Smith; Publication date: June 2006
Sponsors: The governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Ministry for Foreign Affairs), Norway (Royal Ministry of Foreign Affairs), Sweden (Swedish International Development Cooperation Agency-Sida) and the United Kingdom (Department for International Development).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page of WomensHealthSection.com)

Point of View:

Recording patient responses in low-income countries: does the tool make a difference?

Delivery of health information and health services in low-income countries can be improved when information and communications technology (ICT) is used in culturally appropriate ways. ICT offers many benefits, including access to online resources, electronic data collection, electronic storage and retrieval of patient data, etc. However, there may be social and cultural barriers to acceptance of the technology. Age, gender, class, education level, national or regional culture, level of urbanization, and political climate can all be potential barriers to acceptance. In addition, technology may be feared because it is unknown or because it is brought in by outsiders. Careful understanding of social and cultural contexts is needed to avert such unintended negative effects. My colleagues and I are conducting research to understand the social and cultural barriers to accepting ICT in healthcare settings in low-income countries (1). Our studies evaluate the acceptability and impact of handheld computers, mobile phones, websites, and other ICT in healthcare settings. If you are interested in these ideas, we welcome your input and collaboration.

Reference: 1. Bulletin of the World Health Organization;
http://www.who.int/bulletin/volumes/86/10/08-054668/en/index.html

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United Nations Charter:

We the Peoples of the United Nations …. United for a Better World
(Continued)

CHAPTER XVIII
AMENDMENTS
Article 108
Amendments to the present Charter shall come into force for all Members of the United Nations when they have been adopted by a vote of two thirds of the members of the General Assembly and ratified in accordance with their respective constitutional processes by two thirds of the Members of the United Nations, including all the permanent members of the Security Council.
Article 109
1. A General Conference of the Members of the United Nations for the purpose of reviewing the present Charter may be held at a date and place to be fixed by a two-thirds vote of the members of the General Assembly and by a vote of any nine members of the Security Council. Each Member of the United Nations shall have one vote in the conference.
2. Any alteration of the present Charter recommended by a two-thirds vote of the conference shall take effect when ratified in accordance with their respective constitutional processes by two thirds of the Members of the United Nations including all the permanent members of the Security Council.
3. If such a conference has not been held before the tenth annual session of the General Assembly following the coming into force of the present Charter, the proposal to call such a conference shall be placed on the agenda of that session of the General Assembly, and the conference shall be held if so decided by a majority vote of the members of the General Assembly and by a vote of any seven members of the Security Council.

CHAPTER XIX
RATIFICATION AND SIGNATURE
Article 110
1. The present Charter shall be ratified by the signatory states in accordance with their respective constitutional processes.
2. The ratifications shall be deposited with the Government of the United States of America, which shall notify all the signatory states of each deposit as well as the Secretary-General of the Organization when he has been appointed.
3. The present Charter shall come into force upon the deposit of ratifications by the Republic of China, France, the Union of Soviet Socialist Republics, the United Kingdom of Great Britain and Northern Ireland, and the United States of America, and by a majority of the other signatory states. A protocol of the ratifications deposited shall thereupon be drawn up by the Government of the United States of America which shall communicate copies thereof to all the signatory states.
4. The states signatory to the present Charter which ratify it after it has come into force will become original Members of the United Nations on the date of the deposit of their respective ratifications.

Article 111

The present Charter, of which the Chinese, French, Russian, English, and Spanish texts are equally authentic, shall remain deposited in the archives of the Government of the United States of America. Duly certified copies thereof shall be transmitted by that Government to the Governments of the other signatory states.

IN FAITH WHEREOF the representatives of the Governments of the United Nations have signed the present Charter. DONE at the city of San Francisco the twenty-sixth day of June, one thousand nine hundred and forty-five.

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Top Two Articles Accessed in November 2008:

1. Genetic Counseling and Genetic Testing;
   http://www.womenshealthsection.com/content/obs/obs026.php3
   WHEC Publications. Gratitude is expressed to Dr. Frank H. Boehm, Professor and Vice Chairman of Department of Obstetrics and Gynecology, Vanderbilt University Medical Center, Nashville, TN (USA) for his contribution titled: The Perfect Child (Boehm FH. Having a perfect child. *Obstet Gynecol* 2007;109:444-445). Special thanks to Dr. John P. O'Grady, Professor of Obstetrics and Gynecology, Tufts University School of Medicine and Medical Director Mercy Perinatal Service, Springfield, MA (USA) for his priceless contribution in preparing the series on Genetics and The Prenatal Testing.

2. Principles of Genetic Counseling and Prenatal Diagnosis;
   http://www.womenshealthsection.com/content/obsdu/obsdu003.php3
   Author: Dr. Francis H. Boudreau, Chairman (Past), Department of Obstetrics and Gynecology, St. Elizabeth's Medical Center, Boston, MA (USA); in collaboration with Women's Health and Education Center (WHEC).

From Editor's Desk:

The White House Summit on International Development: Sustaining the New Era

The White House Summit on International Development: Sustaining the New Era took place in Washington, D.C. on October 21, 2008 with President Bush delivering the keynote speech and Secretary Rice providing opening remarks. The Summit was co-hosted by USAID, the Office of the Global AIDS Coordinator at the Department of State, the Millennium Challenge Corporation and others. The event brought together a wide range of representatives from the public and private sectors including NGOs and faith-based organizations from the United States and the developing world. Among the guests were Liberian President Ellen Johnson Sirleaf, musician and activist Bob Geldof and National Security Advisor Stephen Hadley. Amir Dossal, the Executive Director of the UN Office for Partnerships, attended the summit to join discussions related to key principles of international sustainable development, including good governance and rule of law, results-based programs and accountability, and the importance of private sector-led economic growth.

"During times of economic crisis, some may be tempted to turn inward -- focusing on our problems here at home, while ignoring our interests around the world, […] This would be a serious mistake. America is committed, and America must stay committed, to international development for reasons that remain true regardless of the ebb and flow of the markets." - President George W. Bush. For further information, please visit the official website:
http://www.whitehouse.gov/infocus/internationaldevelopment/index.html

Strengthening the UN-US Relationship - The Better World Campaign

In March 2000, the Board of Directors of the Better World Fund (BWF), under the leadership of its Chairman, Ted Turner, extended the life of the Better World Campaign (BWC) by renewing its grant for two years. This allows BWC to continue its work to strengthen the United States-United Nations relationship through direct advocacy in the United States Congress, and its education and outreach efforts across the nation. BWC continues in its mission to ensure that the United States meets its full financial obligations to the United Nations and repays its debt. There has been substantial progress on that front throughout this year and, in the immediate aftermath of the 11 September terrorist attacks on the United States, the Congress took two important steps towards "normalizing" the country's relationship with the United Nations.
Strengthening the UN-US Relationship: The Better World Campaign

Special Thanks:

WHEC thanks Dr. Michael J. Zinaman, Chairman, Department of Obstetrics and Gynecology, St. Elizabeth's Medical Center, Boston, MA (USA) for his support, friendship and assistance in the development of this project / program in women's health, education and research. We all are looking forward to a productive collaboration. We at Women's Health and Education Center (WHEC) consider St. E's as our second home. Thanks again.

Words *of* Wisdom:

The soul of community does not consist in making every inch of ground produce some profit. It is better that it should be a few dollars poorer, than that its beauty should be destroyed, the purity of its atmosphere be corrupted.

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities