WHEC UPDATE

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

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Throughout the ages, humans have been driven by a need to explore, discover and advance the understanding of human health. Although, the art and science of human health have evolved enormously, our sense of wonder at the world around us remains constant. Today, our need to know, and our demand for the latest information are satisfied with the help of computer technology and Internet. The work you are holding in your hand is the definitive guidelines for the new century. It describes a world of cutting edge research and you will experience the excitement of exploring the various research projects in the pages of **WomensHealthSection.com**. The culmination of years of painstaking and dedicated labor by the editorial / Working Group has made it possible. It is filled with intellectually stimulating information and compelling photography and graphics, and the text guides you through fundamentals of standards and quality of medical care. These papers offer a greater understanding of the latest technologies that allow us to detect and cure diseases in early stages – the world in ways our ancestors never imagined. You may have logged on to **WomensHealthSection.com** for its utility – just to look up a topic in reproductive health and continued on with your day. You may want to refer to it for research, study or business. If so, the clear organization and the comprehensive index will make it easy for you to quickly find what you need. Nevertheless, when the human-need to explore stir within you, we invite you to take the time to sit back and let this Initiative inspire you on a fascinating journey of the intellect and imagination. We are confident you will find it a rewarding experience. More demands and more pressure; less time and fewer resources – medical practice today is full of challenges. Welcome to a place where your opinions are exchanged. Voice your opinions. And we are all friends here at Women's Health and Education Center (WHEC).

What to do about domestic policy? Health care reform in USA is a priority people have in mind when they talk about economic insecurity. Here again, there is a conjunction between a real national problem and a particular political dilemma for conservatives. Conservatives tend to think that the root cause of the health-care mess lie in World War II, when employers offered health coverage to their workers as a way of evading wage controls. After the war, the Internal Revenue Service (IRS) validated this arrangement by making employer-provided health insurance deductible. Employees now had an incentive to get their insurance through their job, rather than seeking a higher wage and buying their own insurance policy. They also had an incentive to get insurance that covered routine medical expenses, rather than paying for those expenses out of pocket and using insurance only to deal with catastrophes. Technological development and the aging of the population would have caused costs to rise anyway, but this set-up exacerbated the trend. To contain costs, employers had to call in outsiders – HMOs – to impose limits on patients and doctors. There, in the nutshell, is almost everything we dislike about modern American health care. It can be very good, but it is more expensive than it is worth; more bureaucratic too. Intelligent resistance to single payer cannot, however, rest on a defense of a status quo that looks ready to collapse into it. Distinctively conservative answers to popular anxieties are needed. More and more politicians and strategists believe that the way to head off national health insurance is to propose a market-friendly mandate. But probability would answer the most widespread popular concern about health care, and might make it possible to enact further reforms, in the direction of – a market in health care. To mandate insurance would require a definition of the minimum package of benefits that insurance has to include. It might be worth putting up with the imposition if it really did close the door to socialized medicine.

The Home Front

Rita Luthra, MD

Your Questions, Our Reply:

What is meant by 'human rights'? Are human rights accepted universally?

Human Rights – General Introduction: Human beings are born equal in dignity and rights. These are moral claims that are inalienable and inherent in all human individuals by virtue of their humanity alone. These claims are articulated and formulated in what today we call human rights, and have been translated into legal rights, established according to the law-creating processes of societies, both national and international. The basis of these legal rights is the consent of the governed, that is, the consent of the subjects of the rights. The values of dignity and equality of all members of the human race, like many other basic principles which underlie what today we call human rights, can be found in virtually every culture and civilization, religion and philosophical tradition. Nevertheless, the idea of rules common to all citizen dates back many centuries. No tradition denies the existence of fundamental human well-being the flourishing of which requires respect for the most important human needs. Some dispute, however, what this means in practice. Human rights are nevertheless a way of establishing a minimal understanding of what human well-being means, and thereby draw a line which the disputes should not cross. No dispute should justify the loss of innocent lives, make rape acceptable, or allow a government to starve its population. No disagreement can justify the disappearance of those with whom we disagree.

The idea that the rights of human being should be elaborated and protected has been gradually transformed into written norms. During the 19th century this principle was adopted by a number of independent States, and social and economic rights also began to be recognized. Despite the recognition accorded to human rights in national constitutions, these rights were sometimes curtailed or eliminated by legislation or by arbitrary means, and perhaps generally, by informal social mechanism. Moreover, human rights, in spite of their status as legal rights, were often violated by States themselves. Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality. Despite several decades of international action devoted to development, the gap between rich and poor, at both international and national levels, continues to widen.

We believe, everyone has duties to the community in which alone the free and full development of his / her personality is possible. In the exercise of his / her rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

About NGO Association with the UN:

UN Partner on Millennium Development Goals (MDGs)
A Gateway to the UN System's Work on MDGs

WHO – World Health Organization
Health and development

In September 2000, the largest-ever gathering of Heads of State ushered in the new millennium by adopting the Millennium Declaration. The Declaration, endorsed by 189 countries, was then translated into a roadmap setting out goals to be reached by 2015. The eight Millennium Development Goals (MDGs) build on agreements made at United Nations conferences in the 1990s and represent commitments to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation. The MDGs are framed as a compact, which recognizes the contribution that developed countries can

make through trade, development assistance, debt relief, access to essential medicines and technology transfer. Some of WHO's work is tied directly to one MDG, for example, WHO's work on HIV/AIDS. Other work touches not one specific goal, but several at the same time, for example, WHO's work on strengthening health systems. This website provides easy access to information on WHO activities on the MDGs. It also includes recent publications on the topic. Highlights High-Level Forum on the Health Millennium Development Goals
More information

Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more. Many factors influence health status and a country's ability to provide quality health services for its people. Ministries of health are important actors, but so are other government departments, donor organizations, civil society groups and communities themselves. For example: investments in roads can improve access to health services; inflation targets can constrain health spending; and civil service reform can create opportunities - or limits - to hiring more health workers. WHO's work on 'Health and development' tries to make sense of these complex links. It is concerned with the impact of better health on development and poverty reduction, and conversely, with the impact of development policies on the achievement of health goals. In particular, it aims to build support across government for higher levels of investment in health, and to ensure that health is prioritized within overall economic and development plans. In this context, 'health and development' work supports health policies that respond to the needs of the poorest groups. WHO also works with donors to ensure that aid for health is adequate, effective and targeted at priority health problems. This website provides an update on WHO activities in the area of health and development, including recent publications, reports of country work and information on training courses and capacity-building activities.

Collaboration with World Health Organization (WHO):

International Health Regulations (IHR) (2005)

The IHR (2005) entered into force on **15 June 2007**. Since 15 June 2007, the world has been implementing the International Health Regulations (2005). This legally-binding agreement significantly contributes to international public health security by providing a new framework for the coordination of the management of events that may constitute a public health emergency of international concerns, and will improve the capacity of all countries to detect, assess, notify and respond to public health threats. Countries that are States Parties to the Regulations have two years to assess their capacity and develop national action plans followed by three years to meet the requirements of the Regulations regarding their national surveillance and response systems as well as the requirements at designated airports, ports and certain ground crossings. The International Health Regulations (IHR) are an international legal instrument that is binding on 194 countries across the globe, including all the Member States of WHO. Their aim is to help the international community prevent and respond to acute public health risks that have the potential to cross borders and threaten people worldwide. In the globalized world, diseases can spread far and wide via international travel and trade. A health crisis in one country can impact livelihoods and economies in many parts of the world. Such crises can result from emerging infections like Severe Acute Respiratory Syndrome (SARS), or a new human influenza pandemic. The IHR can also apply to other public health emergencies such as chemical spills, leaks and dumping, or nuclear melt-downs. The IHR aim to limit interference with international traffic and trade while ensuring public health through the prevention of disease spread. The IHR, which entered into force on 15 June 2007, require countries to report certain disease outbreaks and public health events to WHO. Building on the unique experience of WHO in global disease surveillance, alert and response, the IHR define the rights and obligations of countries to report public health events, and establish a number of procedures that WHO must follow in its work to uphold global public health security. The IHR also require countries to strengthen their existing capacities for public health surveillance and response. WHO is working closely with countries and partners to provide technical guidance and support to mobilize the resources needed to implement the new

rules in an effective and timely manner. Timely and open reporting of public health events will help make the world more secure.
Details: http://apps.who.int/gb/ebwha/pdf_files/WHA59/WHA59_2-en.pdf

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Collaboration with UN University (UNU):

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

Understanding the African Growth Record: the Importance of Policy Syndromes and Governance

The current paper, first, finds that although the post-independence growth of African economies has fallen substantially below that of other regions, this comparative evidence is less than uniform across time and countries. Second, it uncovers total factor productivity as the primary culprit underlying the generally dismal growth record. Third, reflecting recent evidence, the paper finds that 'policy syndromes' represent a major culprit explaining the growth performance, with their absence accounting for nearly 3.0 percentage point rise in the annual per capita GDP growth via increases in TFP. Finally, the paper finds that governance exerts positive direct and indirect impacts on growth; the latter is via the potential ability of governance to achieve a syndrome-free regime.

Most countries of Sub-Saharan Africa (SSA) attained political independence from colonial rule in the late 1950s through mid-1960s. Since 1960, economic performance of this region has substantially lagged behind that of other regions of the world. Nonetheless, the performance has been rather episodic, with the economies of African countries growing fairly strongly until about the late 1970s, when the region's GDP growth began to decline substantially, falling short of population growth. Many countries of Africa1 have, however, exhibited increasingly strong growth since the mid-1990s. In 2007, for instance, the GDP growth of SSA economies averaged 5.8 per cent, a rate that was comparable to those in other regions of the world. Some 26 African countries, representing 70 per cent of the SSA population and 78 per cent of the GDP, grew by at least 4.0 per cent per year on average. Indeed, since 1995, the annual growth rates of these countries have averaged 6.9 per cent, a rate that is comparable to that of India, for instance, whose growth averaged 6.7 per cent over the same period. At the same time, however, about one-third of African countries registered growth rates that averaged 2.1 per cent. In sum, not only has the African growth record been episodic over time, but has also varied substantially across countries.

The poverty picture: The above overall historically low SSA economic growth is reflected in the dismal poverty picture over the last 25 years. Based on World Bank (2007) data, the proportion of the population earning less than US$1 decreased only slightly from 42 per cent in 1981 to 41 per cent in 2004. Over the same period, this measure of poverty fell substantially for South Asia (SAS), as a reference region, from 50 per cent in 1981 to 31 per cent in 2004, so that the relative SSA/SAS poverty rate gap increased steadily by nearly 50 percentage points. The resurgence in growth in Africa has brightened the poverty picture somewhat during the last decade or so. Indeed, the rates of poverty reduction in SSA and SAS have been comparable since the mid-1990s, falling by 4 and 5 percentage points, respectively, between 1993 and 2004. Similarly, the poverty rate measured at the US$2 standard fell by 4 percentage points and 5 percentage points for SSA and SAS, respectively. There appears, then, to have been a reversal in course for the poverty rate in SSA since the mid-1990s, mirroring the growth pattern. Thus, understanding the growth record should be useful not only in its own right, but also in terms of charting the course of human development as reflected by changes in the poverty rate, for instance.

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

Universal Declaration of Human Rights:

All human beings are born with equal and inalienable rights and fundamental freedoms. (Continued)

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

To be continued…..

Top Two Articles Accessed in July 2009:

1. Mental Health Promotion in Schools;
   http://www.womenshealthsection.com/content/gynmh/gynmh002.php3
   Authors: Rhona Birrell Weisen, Consultant with the Program on Mental Health and John Orley, Manager of the Program in the Division of Mental Health and Prevention of Substance Abuse, World Health Organization, Switzerland.

2. Vulvodynia; http://www.womenshealthsection.com/content/gyn/gyn005.php3
   WHEC Publications. Special thanks to the physicians who reviewed the paper and the editorial board for compiling it.

From Editor's Desk:

Centers for Disease Control and Prevention (CDC), USA

Considerations Regarding Novel H1N1 Flu Virus in Obstetric Settings

This document has been developed to provide guidance for prevention and management of novel H1N1 flu infection in inpatient and out-patient obstetric settings. Severe illnesses among pregnant woman and infants have been reported in this outbreak, although the epidemiology and spectrum of illness among pregnant woman and infants are not fully understood at this time and are under investigation. Prevention of infection with novel influenza A (H1N1) virus in pregnant women and infants is the highest priority message in this guidance. Healthy pregnant women should have access to prenatal care and labor and delivery services in settings where they can be separated from persons who are ill or potentially ill with novel H1N1 flu infection. In addition, a cautious approach to the management of neonates with ill mothers is recommended which includes isolation and close observation. Recommendations are interim, based on current knowledge of the novel H1N1 flu outbreak in the United States, and may be revised as more information becomes available.

Treatment and chemoprophylaxis

Early treatment with influenza antiviral medications is recommended for pregnant women with suspected influenza illness. Clinicians should not wait for test results to initiate treatment since these medications work best if started as early as possible after illness onset. The currently circulating novel influenza A (H1N1) virus is sensitive to the neuraminidase inhibitor antiviral medications zanamivir (Relenza®) and oseltamivir (Tamiflu®), but is resistant to the adamantane antiviral medications, amantadine (Symmetrel®) and rimantadine (Flumadine®). Oseltamivir is given orally and results in systemic absorption; by contrast, zanamivir is given by inhalation and results in lower systemic absorption. Oseltamivir and zanamivir treatment and chemoprophylaxis regimens recommended for pregnant women are the same as those recommended for adults who have seasonal influenza. Pregnancy should not be considered a contraindication to oseltamivir or zanamivir use. Pregnant women appear to be at higher risk for severe complications from novel influenza A (H1N1) virus infection, and the benefits of treatment or chemoprophylaxis with oseltamivir or zanamivir outweigh the theoretical risks of antiviral use. Although a few adverse effects have been reported in pregnant women who took these medications, no relation between the use of these medications and those adverse events has been established. More information on influenza antiviral medications is available at: CDC Interim Guidance on Antiviral Recommendations for Patients with Novel Influenza A (H1N1) Virus Infection and Their Close Contacts.

United Nations Conference on Trade and Development (UNCTAD)

Commission on Science and Technology for Development
Report on the eleventh session (26-30 May 2008)

Technology and Logistics: The objective of the Division on Technology and Logistics (DTL) is to enhance the economic and development and competitiveness of developing countries – in particular Least Developed Countries (LDCs) – through efficient trade logistics services, transit transport systems, increased access to and sustainable utilization of information and communication technology, and training and capacity-building programs for local institutions. This is done through analytic work, intergovernmental policy dialogue and implementing technical cooperation and training and capacity building programs. The Division consists of three Branches and hosts the United Nations Commission on Science and Technology. Commission on Science

& Technology for Development (CSTD) is a subsidiary body of the Economic and Social Council (ECOSOC). The Commission provides the General Assembly and ECOSOC with high-level advice on relevant science and technology issues. UNCTD is responsible for the substantive servicing of the Commission. At its eleventh session (United Nations, New York 2008), CSTD reviewed the progress made in the implementation of the outcomes of the World Summit on the Information Society. The session included a ministerial segment, in which 13 Member States were represented at the ministerial level (Angola, Burkina Faso, Dominican Republic, Iraq, Jordan, Lesotho, Malaysia, Pakistan, Philippines, South Africa, Switzerland and Tunisia). Participants also included the heads of international and regional organizations of the United Nations system or their representatives; representatives of the African Union, the Organization for Economic Cooperation and Development, the African Development Bank and Islamic Development Bank; and representatives of civil society and of business entities such as Alcatel, Cisco Systems, Inc., Intel Corporation, Nokia Siemens Networks, Tunisie Telecom, iBurst South Africa and Tata Consulting Services. Details of the session can be accessed at: http://www.unctad.org/en/docs/ecn162008d5_en.pdf

Special Thanks:

WHEC thanks Dr. Laurence B. McCullough, PhD, Associate Director for Education, Professor of Medicine and Medical Ethics, Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, TX (USA) for his contribution, support and friendship to the project. It is indeed our privilege to work with you. Thanks again.

Words *of* Wisdom:

True merit, is like a river; the deeper it is, the less noise it makes.

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