WHEC UPDATE

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

November 2009; Vol. 4, No. 11

People often tell me they think I have a great job being able to get inside all these National and International projects and programs we feature in *WHEC Update*. I quite agree, but may be not for the reasons most would think. I will admit that my love for International Health and Development were a contributing factor for this publication and our e-learning project in Women's Health and Health Development. It is meeting with people from different parts of the world and learning from everyone's perspectives is the most interesting feature for me. As professional and community leaders, healthcare providers have unlimited opportunities to become involved in and have a positive impact on local, national, and international communities and organizations. Volunteerism generally has been defined as time and effort devoted to helping others without regard for compensation for charitable, educational, social, or other worthwhile purposes. In the United States between the years 2005 and 2007, the average volunteer rate was 27.2% per year. To put this in perspective, in 2007 approximately 61 million people dedicated 8 billion hours of volunteer service. The United Nations Volunteers (UNV) program is the volunteer arm of the UN system, supporting peace, relief and development initiatives in nearly 150 countries. As a volunteer-based program, UNV is both unique within the United Nations family and in its scale as an international undertaking. As healthcare providers, we can improve and affect the lives of hundreds and thousands of people every year. As community members, we have the potential to influence thousands, even millions, of lives. As community leaders we have the ability to inspire other people to be involved in supporting worthy causes and to truly make a positive difference in the community.

Involvement in the community may extend to non-medical areas too. Improving safe walking paths; building safe housing; donating food, clothing, and shelter; or participating in other safety initiatives to help families are ways to volunteer and make a significant impact on the local community. All of these efforts directly or indirectly improve women's health. Another form of volunteerism is philanthropy. Contributing to organizations that affect women's health, education and status may come in the form of a financial contribution or in the form of helping to organize or solicit donations. Volunteering for international organizations also can include donating time and expertise or needed supplies, finances, and resources. The positive influence one could have in community and nationally is a strong motivation for volunteering. It is important for healthcare providers to consider the type of impact they would like to have on their communities and likewise the type of organizations or programs that might fit these goals. Volunteering outside the daily work routines often revitalizes a commitment to medicine while serving as a much needed resource to the community. We have the potential to make a significant positive impact on women's health in local communities, professional organizations, as well as the international community. My sincere thanks to all who have graciously contributed to the educational program: **WomensHelthSection.com.** Its popularity has not only grown because this is a much needed service, but also because the great job our writers and editors do in sharing the latest scientific research, planning and in many cases, years of hard work that result in the *practice guidelines* that grace our pages.

Serving Underserved Women

Rita Luthra, MD

Your Questions, Our Reply:

What decisions or actions are taken on the basis of health indicators? Who uses the health indicators and how?

Relevance of Health Indicators: A health indicator is useful if decisions based on the measurements taken contribute to improvement in the work of health personnel and consequently in the effectiveness and efficiency of the system. Indicators are quantitative measurements, generally including a numerator and a denominator, although some measure only a number of events and have only a numerator. No indicator should be defined which is not used in connection with taking action. Once an indicator has been accepted as appropriate, it has to be further defined in order to make it operational. The frequency of data collection should be determined by the urgency of the decision to be made or the speed of change in the measured variable.

The health indicator should first be analyzed and used for decision-making by the staff collecting and reporting the data. The specific action to be taken on the basis of the indicator should be confirmed and the decision criteria should be recorded in clinic or managerial procedures. Relationship between indictor and a target are – it is a common practice to set targets because the gap between measurement and objective helps decision-making. For example, targets are normally set in districts for the number of children in a new cohort aged under one year which must be fully immunized within a year. However, not all targets can be expressed as indicators.

Group processes for use in guiding national indicator selection have been devised and applied at the national policy, central program and district service levels for the steps proposed above and for identifying essential indicators related to priority health problems, services and resources.

About NGO Association with the UN:

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

FAO – Food and Agriculture Organization
For a world without hunger

The Food and Agriculture Organization of the United Nations leads international efforts to defeat hunger. Serving both developed and developing countries, FAO acts as a neutral forum where all nations meet as equals to negotiate agreements and debate policy. FAO is also a source of knowledge and information. We help developing countries and countries in transition modernize and improve agriculture, forestry and fisheries practices and ensure good nutrition for all. Since our founding in 1945, we have focused special attention on developing rural areas, home to 70 percent of the world's poor and hungry people. The Food and Agriculture Organization of the United Nations (FAO) is working with its Members and the entire international community for achievement of the Millennium Development Goals. These eight goals - each with specific targets and indicators - are based on the United Nations Millennium Declaration, signed by world leaders in September 2000. They commit the international community to combating poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women.

Goal 1 relates directly to hunger, which is the primary global issue of concern for FAO. Some developing countries have made impressive gains in achieving the hunger-related targets, but many are falling behind. For more information on the prevalence of hunger worldwide, see The State of Food Insecurity in the World, 2008, published annually by FAO.

Iraq: The Food and Agriculture Organization of the UN (FAO), which is responsible for the agricultural component of the Oil-for-Food Program, is making all efforts to save the winter

harvest, especially in Iraq's three northern governorates, which account for much of the country's cereal production. According to FAO, farmers in Iraq are in urgent need of spare parts and fuel for combine harvesters and tractors for the upcoming spring harvest, estimated at between 1.5 million and 1.7 million tons of grain. At the beginning of April 2003, FAO launched an $86 million emergency campaign to help secure crop and livestock production and improve agricultural productivity. The appeal is envisioned to fund six other projects meant to: protect harvest; increase food production; prevent outbreaks of animal diseases; ensure water supplies in rural areas; and coordinate relief efforts. FAO also needs funds to improve, plan and coordinate food security activities in collaboration with other UN agencies and non-governmental organizations and to monitor their impact on the nutritional status of the population. Some $20 million of the appeal are for three emergency projects to secure the grain harvest and the spring and fall plantings. As any disruption of water would damage crops and livestock production, the FAO appeal also includes provision for pipes, pumps, drills and technical expertise required to set up emergency water supplies and repair damaged irrigation networks, if needed. A $9.8-million project is designed to support the country's 4,000 poultry farms, another essential source of the animal proteins missing from the food basket.

Collaboration with World Health Organization (WHO):

Preparing the Health Work Force

This chapter is about preparation: getting it right at the beginning; giving the right training to the right people to create an effective workforce for the delivery of health care. It focuses on the entry of health workers into the workforce and on the health training institutions – schools, universities and training colleges – which provide them with the knowledge and competencies for the jobs they will be required to do.

Workforce entry: the right mix
Preparing the health workforce to work towards attainment of its health objectives represents one of the most important challenges and opportunities for health systems. Going beyond the traditional notion of skill mix, this chapter extends the concept of mix to include: how many people are trained (numbers); the degree to which they reflect the socio-cultural and demographic characteristics of the population (*diversity*); and what tasks the different levels of health workers are trained to do and are capable of performing (*competencies*). Maintaining a reasonable balance in terms of numbers, diversity and competencies of the health workforce requires a thorough understanding of the driving forces and challenges that shape health and education systems as well as labor markets. This understanding, however imperfect, can be used as a guide to policies and possible actions related to training and recruitment.

The “pipeline” for recruitment: The process that leads to health workers’ entry into the workforce can be seen as one by which individuals progress through educational institutions and graduate with specific skills or degrees that facilitate their recruitment by employers to the health workforce. This “pipeline” spans primary, secondary and tertiary education institutions and health services facilities that produce a range of workers from auxiliaries to technicians and professionals. Along the pipeline, criteria for entry to training institutions, attrition while training, and the markets for recruitment determine how many and what types of individuals move forward to become health workers. A focus on health training institutions and the markets for recruitment yields insights on how to manage entries to the health workforce in line with performance objectives. Details: http://www.who.int/whr/2006/06_chap3_en.pdf

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Collaboration with UN University (UNU):

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

Access to Land and Land Policy Reforms

The objective of this research and policy brief is to analyze different mechanisms of access to land for the rural poor in an era when redistribution through expropriative land reform is largely inconsistent with the forces of the political economy. The roads of access to land which are explored are intra-family transfers, access through community membership, land sales and rental markets, and government programs including decollectivization and land-market assisted land reform. The array of instruments is vast, and each can be subjected to specific policy interventions to make them more effective for sustainable poverty reduction.

Who should have access to land? What is the optimum definition of property rights and use rights in each particular context? Is government intervention justified to influence who has access to land and under what conditions? These questions remain, in most developing countries, highly contentious. It is indeed the case that land is all too often misallocated among potential users and worked under conditions of property or user rights that create perverse incentives. As a consequence, investments to enhance productivity are postponed, and responses to market incentives are weakened; many poor rural households are unable to gain sufficient (or any) access to land when this could be their best option out of poverty; land remains under-used and often idle side-by-side with unsatisfied demands for access to land; land is frequently abused by current users, jeopardizing sustainability; and violence over land rights and land use is all too frequent. With population growth and increasing market integration for the products of the land, these problems tend to become more acute rather than the reverse. As a result, rising pressures to correct these situations have led many countries to reopen the question of access to land and land policy reforms. While large scale expropriative and redistributive land reforms are generally no longer compatible with current political realities, there exist many alternative forms of property and use rights that offer policy instruments to alter the conditions of access to land and land use. A rich agenda of land policy interventions thus exists to alter who has access to land and under what conditions for the purposes of increasing efficiency, reducing poverty, enhancing sustainability, and achieving political stability.

Historically, the most glamorous path of access to land has been through state-managed coercive land reform. In most situations, however, this is not the dominant way land was accessed by current users and, in the future, this will increasingly be the case. Most of the land in use has been accessed through private transfers, community membership, direct appropriation, and market transactions. There are also new types of state-managed programs of access to land that do not rely on coercion. For governments and development agents (NGOs, bi-lateral and international development agencies), the rapid decline in opportunities to access land through coercive land reform should thus not be seen as the end of the role of the state and development agents in promoting and altering access to land. The following paths of access to land in formal or informal, and in collective or individualized ownership can, in particular, be explored: (1) Intra-family transfers such as inheritances, inter-vivo transfers, and allocation of plots to specific family members; (2) access through community membership and informal land markets; (3) access through land sales markets; and (4) access through specific non-coercive policy interventions such colonization schemes, decollectivization and devolution, and land market-assisted land reform. Access to land in use can also be achieved through land rental markets (informal loans, land rental contracts) originating in any of these forms of land ownership. Each of these paths of access to land has, in turn, implications for the way land is used. Each can also be the object of policy interventions to alter these implications of land use. The focus of this policy brief is to explore each of these paths and analyze how to enhance their roles in helping increase efficiency, reduce poverty, increase equality, enhance sustainability, and achieve political stability.

Publisher: UNU – WIDER; Authors: Alain de Janvry and Elisabeth Sadoulet; Series: WIDER Policy Briefs;

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

Point of View:

United Nations 62nd Annual DPI/NGO Conference

The United Nations 62nd Annual DPI/NGO Conference, "Disarm Now! For Peace and Development" was hosted in Mexico City from September 9 to 11, 2009. Five representatives from the NGO – Women's Health and Education Center (WHEC) attended the Conference. It addressed weapons of all kinds: nuclear arms, weapons of mass destruction, cluster bombs, landmines, chemical and biological weapons, conventional weapons, small arms and light weapons. More than 740,000 people are killed by armed violence annually. The majority of deaths, 490,000 - occur outside war zones. In the past 20 years, two million children have been killed and another six million have been permanently disabled. 60 million children are currently not in school, but are in conflict areas, according to UN statistics. Countless other people have been threatened, displaced, raped, and suffered human rights abuses as a result of armed violence. Weapons are the single greatest factor in food instability, destabilizing society, preventing development, and feeding the flames of civil war.

Global spending on military is $1.4 trillion. The United States spends half of this, which is seven times more than China, the next largest spender on military. There are 20,000 nuclear weapons in the world today. The number of nuclear weapons worldwide peaked in the mid 1980's at around 70,000 warheads. Several thousands are kept in high alert – ready to be launched in minutes. Nine states possess nuclear weapons: United States, Russian Federation, United Kingdom, France, China, India, Pakistan, Democratic Peoples Republic of Korea, and Israel. Non-nuclear states are understandably threatened. A Brookings Institute study in 1998 put the overall cost of US nuclear weapons program between 1940 and 1998 at over $5.5 trillion. The US spends $30 billion a year just to maintain its stockpiles of nuclear weapons. The US Department of Energy reports that weapons activity have resulted in the production of more than 104 million cubic meters of radioactive waste. Nuclear weapons create the twin crisis: economic and environmental. They are not a deterrent to war. They did not stop war.

Who is responsible for armed violence, conflict, and disarmament? Is it the governments, the manufacturers, the dealers, the users, the media, civil society, or all of these? Armed violence affects all societies, and impedes human social and economic development. There will be no sustainable development globally until there is disarmament. We need to disarm now, respect life, and let all people around the world enjoy peace and security. Civil society is a key player in achieving disarmament. The NGO Declaration on Disarmament and Development, adopted at the 62nd Annual DPI/NGO Conference in Mexico City, was circulated as a document of the UN Security Council on 18 September 2009 by Ambassador Claude Heller, Permanent Representative of Mexico to the United Nations.

By Sharon L. Wallenberg
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Administrative Assistance for WHEC Initiatives for Global Health
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Universal Declaration of Human Rights:

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

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right of security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

To be continued…..

Top Two Articles Accessed in October 2009:

1. HELLP Syndrome: Diagnosis and Management;
   http://www.womenshealthsection.com/content/obs/obs013.php3
   Author: Dr. Baha M. Sibai, Professor and Chairman, Department of Obstetrics and Gynecology, University of Cincinnati, Ohio (USA)

2. H1N1 Influenza in Pregnancy;
   http://www.womenshealthsection.com/content/obsidp/obsidp008.php3
   WHEC Publications. Special thanks to WHO, CDC and NIH for the contributions. Special thanks to our consultants in Infectious Diseases for reviewing the manuscript.

From Editor's Desk:

ABOUT THE "MAKING HEALTH SYSTEMS WORK" WORKING PAPER SERIES
The "Making Health System Work" working paper series is designed to make current thinking and actual experience on different aspects of health systems available in a simple and concise format for busy decision makers. The papers are available in hard copy and on the WHO health systems website.

Working paper 10:
Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and Management in Low-Income Countries

This report is based on deliberations from an international consultation on strengthening leadership and management as an essential component to scaling health services to reach the Millennium Development Goals. The consultation took place in Accra, Ghana in January 2007. The focus was on low-income countries though the principles discussed concerned leadership and management in other settings as well. The report describes a technical framework adopted by the consultation for approaching management development and sets out key principles for sustained and effective capacity building. The consultation and discussions resulting in this report involved some 80 participants from 26 countries, 20 international, regional and national management and development organizations, and 5 WHO Regional and 5 Country Offices. The draft report was circulated to all participants of the meeting. Their comments have been incorporated in the final version. The paper was prepared by Catriona Waddington (HLSP UK) with contributions from Dominique Egger, Phyllida Travis, Laura Hawken and Delanyo Dovlo (all of WHO/HQ). The International Consultation and this report were supported with funds from the Bill and Melinda Gates Foundation, Seattle, Washington, USA

RATIONALE: To achieve the health-related Millennium Development Goals, many low-income countries need to significantly scale up coverage of priority health services. This will generally require additional national and international resources, but better leadership and management are key to using these resources effectively to achieve measurable results. Good leadership and management are about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources. While leaders set the strategic vision and mobilize the efforts towards its realization, good managers ensure effective organization and utilization of resources to achieve results and meet the aims. Ministries of Finance and international donors are increasingly insisting on evidence of measurable results in health. Better leadership and management are thus critical to achieving the MDGs: they are required to demonstrate results from existing resources – and these results, in turn, make it more feasible for additional resources to be made available to the health sector. (We could call this the "virtuous circle of leadership and management strengthening".) In many low-income countries, what is really needed is managers who can lead, and leaders who can manage.

At present, a lack of leadership and management capacity is a constraint, especially at operational levels of both the private and public health sectors. This is sobering, considering the time and money spent by governments and development partners to strengthen capacity in leadership and management. Thus it is clear that these efforts have to be improved. The competencies, roles and responsibilities should be clearly defined and performance changes measured. Progress requires systematic work to determine needs and identify effective interventions; countries to implement an overall plan for developing leadership and management capacity; and international aid to be coherent in support of country plans. Details: http://www.who.int/management/working_paper_10_en_opt.pdf

Special Thanks:

WHEC thanks Dr. Maria M. Morales Suárez-Varela, Professor Titular de Universidad, Area de Medicina Preventiva y Salud Pública, Universitat de Valencia, Burjasot, Spain for her contributions, support and friendship to this educational project and program. Thanks again.

Words *of* Wisdom:

A sweet face readily attracts the mind; but a sweet tongue permanently captivates it.

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