WHEC UPDATE

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

August 2010; Vol. 5, No. 8

Interest in this annual issue of Good Governance seems to grow apace, with a certain emotional longing for a better world, and *peaceful coexistence.* Is the fantasy of good governance something we all yearn for, shelter from a world that seems increasingly dysfunctional, even chaotic? This issue of WHEC Update is dedicated to that all-important expertise: leadership. I have observed that one of the most overlooked but important qualities of great leadership is one's courage and willingness to do what is – unpopular. Unarguably, one of the greatest leaders in U.S. history, at the time of his leadership, continually suffered vehement opposition and may have been one of the most unpopular people ever to serve in his position. His name is Abraham Lincoln, consistently ranked by scholars as one of the greatest of all U.S. presidents. The Great Abe lost elections for several different political offices before finally being elected president by one of the lowest popular margins in history. Yet, because he was willing to do what was unpopular, taking deliberate stands on conscience, enduring malicious public abuse and loss of friends, power and prestige, he became the man who "saved the Union" and emancipated slaves. Where would we be today if he had only done what was popular? This willingness to go against the majority, to do what is right and make the tough calls is not only an important leadership trait for a president, but also for a CEO, entrepreneur, team leader, community or neighborhood leader, or the leader of a family. We call someone a *leader* when he or she is willing to do what others are not, even when – and may be most especially when – the right thing to do might not be what is popular.

You can either follow a paint-by-number-kit approach to life, do what everybody thinks you should do and stay within the accepted lines, or you can decide you want to create a masterpiece and start with a blank canvas. It might not ever turn into a masterpiece, but the only way you can hope for a masterpiece is starting with a blank canvas. The notion that entrepreneurship could be not only a business idea, but a life idea – is intriguing. To become a great leader, one must become a great person. You cannot lead others until you have first learned to lead yourself.

Higher education for women in the developing countries and in some cultures is an unpopular and neglected issue. Attaining economic and social progress in the developing world requires the creation of a new cadre of highly educated women leaders who will act as agents of change. My hope is that these women will become the missing link in development programs that face implementation challenges. Even when adequate financial resources are available, the lack of skilled leaders has often prevented effective development. We hope our project **WomensHealthSection.com** on WHEC Global Health Line will expand their occupational networks and improve their professional prospects to fulfill the priceless gift of their potential. The role of female education in advancing development has never been question, but it is clear that higher education is a potent and often overlooked weapon in the battle against poverty. It is time for the world to invest in universities dedicated to producing the next generation of women who can lead us to equality and prosperity. Leadership calls for suffering and struggle. Effective leaders build relationships – deeper relationships lead to stronger leadership.

Are you an effective leader?

The Unpopular View Of Leadership

Rita Luthra, MD

Your Questions, Our Reply:

Where does the money go that the U.S. spends on health care that other countries don't?

Healthcare Spending and Utilization: A small percentage may go for inefficiencies and to insurance company profits and executive salaries, but the majority of the money pays for a long list of things that American citizens seem to have come to expect:

- Easy access to sophisticated diagnostic tests, including MRIs and CT scans;
- Shortest waiting time for elective surgery in the world;
- Widest choice of physicians and hospitals;
- Easy accessibility to joint replacement;
- High access to renal dialysis, particularly in older patients and in patients with co-morbidities;
- Easy access to cancer screening and treatment (although a 50% reduction in all cancer cases would only increase life expectancy in the average American by 1.4 years);
- Greater access to health care provided to elderly Americans and Americans at the end their lives who may have poor prognoses.

Furthermore, the U.S. by custom and law has permitted a litigious climate to develop that has significantly increased the cost of medical care due to the practice of defensive medicine by physicians and the payment of high malpractice premiums. Many health experts believe that health care in the U.S. is expensive because most Americans are isolated from the direct purchase of health care and even the knowledge of many health care costs. Because of this, most Americans seem to consume health care as if it were free.

We believe; Americans would have a more realistic approach to health care spending if they were actually aware of how expensive specific health care services were, or if they were responsible for paying a greater portion of their own health care.

About NGO Association with the UN:

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

UNHCR – UN Refugee Agency
MDGs and Refugees

At the Millennium Summit in New York in September 2000, the largest gathering of world leaders in history, heads of states and governments adopted the UN Millennium Declaration. This committed their nations to a new global partnership to reduce extreme poverty and also set out a series of targets, all with a deadline of 2015, that have become known as the Millennium Development Goals (MDGs). These were to eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to develop a global partnership for development. UNHCR monitors how refugees and other people of concern are included in this process and how much progress has been made in achieving the MDGs. The UN refugee agency is also a member of the Inter-Agency and Expert Group on MDG Indicators, which produces an annual report on the progress made towards the Millennium Development Goals.

Public Health Equity in Refugee and Other Displaced Persons Settings: Addressing concerns about public health equity in the context of violent conflict and the consequent forced displacement of populations raises operational and ethical issues for the United Nations for High Commissioner for Refugees (UNHCR). Priorities of service delivery, the allocation choices, and

the processes by which these choices are arrived at are now coming under renewed scrutiny in the light of the estimated two million refugees who fled from Iraq since 2003. This discussion document explores key questions of cost and equity as they arise in the context of providing health services to a number of refugee and other populations of concern to UNHCR including those from Iraq. Interviews were conducted with a number of informed and experienced humanitarian practitioners at field, country, and headquarter levels. These interviews helped frame major operational questions that need to be addressed including the status of health care delivery as a relative priority for UNHCR, allocations of resources for health between and within different populations, and strategies for transition and exit. These important operational questions now faced by UNHCR can to some extent be clarified by reference to relevant ethical theory. A review of the literature suggests that public health equity issues confronting the humanitarian community can be framed as issues of resource allocation and issues of decision-making. The ethical approach to resource allocation in health has been developed primarily within the context of one nation-state and requires taking adequate steps to reduce suffering and promote wellbeing, with the upper bound being to avoid harming those at the lower end of the welfare continuum. Deliberations in the realm of justice and capabilities theory suggest that disparities across nation-states may be acceptable, provided that those who have less are not miserable.
Details: http://www.unhcr.org/4bdfe1699.html

Collaboration with World Health Organization (WHO):

Sixty-third World Health Assembly
Date: 17–21 May 2010
Location: Geneva, Switzerland

WHO was established 62 years ago to promote health and ease the burden of disease worldwide. The Organization takes direction for its goals and priorities from the 193 Member States it is designed to serve. Each year, senior health officials from all these Member States come to Geneva to participate in the World Health Assembly. It is at the Health Assembly that WHO's work is reviewed, new goals are set, and new tasks assigned.

The process at the annual World Health Assembly – At the Health Assembly two main types of meeting are held, each with a different purpose:

- Committees meet to debate technical and health matters (Committee A), and financial and management issues (Committee B), and approve the texts of resolutions, which are then submitted to the plenary meeting.
- Plenary is the meeting of all delegates to the World Health Assembly. The Health Assembly meets in plenary several times in order to listen to reports and adopt the resolutions transmitted by the committees. The Director-General and Member States also address the delegates at the plenary.

In addition, technical briefings are organized separately on specific public health topics to present new developments in the area, provide a forum for debate and to allow for information sharing.

The Sixty-third World Health Assembly this year had a long and complex list of health challenges and responses to review. In this section, we brought daily notes on the major public health issues that were being debated during this year's session. The Sixty-third session of the World Health Assembly took place in Geneva during 17–21 May 2010. At this session, the Health Assembly discussed a number of public health issues, including:

- Implementation of the International Health Regulations (2005);
- Monitoring of the achievement of the health-related Millennium Development Goals;
- Strategies to reduce the harmful use of alcohol; and
- Counterfeit medical products.

The Health Assembly also discussed the program budget, administration and management matters of WHO. Details: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_J3-en.pdf

Bulletin of the World Health Organization; Volume 88, Number 8, August 2010, 561-640 Table of contents

Collaboration with UN University (UNU):

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

The Great Transformation 1989-2029: Could It Have Been Better? Will It Be Better?

Over 1.8 billion people, from Central Europe to East Asia, have been involved in the great systemic transformation to market economy, civic society and democracy. The process has brought mixed fruits. The diversification of the current situation is a result of both the legacy from the past and the different strategies and policies executed in particular countries over subsequent periods. These polices have been based on different assumptions and followed the advice of alternative schools of economic thought. Consequently, theoretical lessons as well as policy implications can be learned from this vast experience. The term, *emerging markets*, commonly used (and misused to refer to the post-socialist reality without necessary reflection), was not created to describe the new, complex economic reality of countries under systemic transformation. Another neoliberal concept, the term is related to the expansion of the neoliberal model of capitalism, lasting over the same time as the now twenty-year episode of post-socialist transformations. These 'emerging' markets are not appearing, evolving and maturing market economies, civic societies or political democracies but emerging new fields of economic activity, particularly speculation, for the richer part of the world, the one which 'emerged' long ago as a capitalist economy and has institutionally and financially matured to become so strong and affluent that it can—and will—use that affluence also elsewhere, in addition to its traditional fields of domination. Considering the map of the world before 1989 with the division as it existed then, the situation called for the non-market part of the world to 'emerge' and open up for capital penetration. That, in turn, was and still is possible only through the transformation from a socialist planned economy to capitalist market economy.

In conclusion, answering the questions: *Could it have been better? Will it be better?*, it must be said that yes, it obviously could have been better—to various extents in various countries, in various fields for particular individuals and social groups. It could have been better if the objectives had been more accurately defined and the systemic transformation had not been perceived as a self-contained aim but rather as an instrument to achieve a more superior goal—fast socioeconomic development to enable the country to make up for its historical lags. *Will it be better?* In the absolute sense, of course yes. In the next two decades of transformations, the level of production and consumption will double and in some cases even triple. In twenty years, will GDP per head in the new post-socialist member countries of the EU be around 50,000 $PPP? This is not very probable with regard to all the 100 million people residing in this part of Europe, but it is possible that certain countries and regions (more and more often, one needs to think in terms of regions, not countries), will able to achieve economic success. The conclusions derived from the preceding years, should help to reduce the gap between potential possibility and actual reality for the next two decades, 2010-29. However, even in 2029, just as in 1989 and in 2009, there will be people who will answer the question, *When at last will it be better?* With the sarcastic retort: *It's been already…*

Author: Grzegorz W. Kolodko; Publisher: UNU-WIDER; Sponsor: UNU-WIDER acknowledges the financial contribution to the conference by the Finnish Ministry for Foreign Affairs and the continued support to the research program by the governments of Denmark (Royal Ministry of

Foreign Affairs), Finland (Ministry for 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:

How can civil society contribute to make cities healthier?

Globalization in urban areas has generated a new geography of inequality, poverty, unemployment, social exclusion, and inadequate housing. Creating healthy cities involves working toward large-scale changes by addressing these broader determinants of health. Addressing these determinants means focusing on creating and sustaining equity in access to appropriate and ecological: physical infrastructure (such as housing, transportation, and water, sanitation and solid waste disposal); social, educational and health services; nutritious, healthy and secure food sources; participatory local governance; and social networks that create and sustain social capital. There is a long litany of health issues that are particularly egregious in urban settings, such as: violence and unintentional injuries; harmful use of alcohol, tobacco and other drugs; vector-transmitted diseases; mental health, stress and social isolation; road safety; infectious diseases; non-communicable chronic diseases and their risk factors; infant mortality; air and noise pollution; water, hygiene & solid waste disposal; and urban disasters and emergencies, among others.

The Pan American Health Organization (PAHO), Regional Office for the World Health Organization, works provides technical support and backstopping to the countries of the Americas (the Western Hemisphere). This collaboration includes the above-mentioned issues related to urban health in order to promote healthy urbanization. PAHO has been working with countries to facilitate the creation of healthy and supportive settings (municipalities, schools, workplaces, etc.), which has been one of the most frequently and successfully applied health promotion strategies in the Region during the past three decades. This approach is based on the belief that determinants of poverty and equity, and their influence on health, can be addressed through the creation of sustainable public policies and laws, development of supportive environments, establishment of public-private partnerships, strengthening of networks, and the promotion of active participation of municipal and local governments in health promotion and development. Healthy settings interventions and policies build strongly on community, population, economic, social/cultural, environmental and institutional assets. Using the settings approach, PAHO has developed the Healthy Municipalities, Cities and Communities (HMC) Strategy. This strategy was introduced in the 1990s is currently implemented in 18 of the 35 countries and 3 territories of the Americas. The main objectives of the HMC Strategy are: (1) To promote health, together with people and communities, in settings where they study, work, play, love, and live; (2) Establish and strengthen a social pact among local authorities, community organizations, and public and private sector institutions; and (3) use local planning and social participation in management, evaluation, and decision-making. In order to create healthy cities we must all work together – the public sector, private sector, and civil society - with one unified vision. With this common goal, we can each in our own way work toward creating broad-level change in order to promote health in an appropriate and sustainable way in urban settings across the globe.
Review: http://www.paho.org/whd2010

By Marilyn Rice
Senior Advisor in urban health and determinants of health
Pan American Health Organization/World Health Organization
Washington, DC; USA
e-mail: ricemari@paho.org

Constitution Of The World Health Organization:

(Continued)

CHAPTER VI – THE EXECUTIVE BOARD

Article 24
The Board shall consist of thirty-four persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established pursuant to Article 44. Each of these Members should appoint to the Board a person technically qualified in the field of health, who may be accompanied by alternates and advisers.

Article 25
These Members shall be elected for three years and may be re-elected, provided that of the Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty-two to thirty-four the term of office of the additional Members elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one Member from each regional organization in each year.

Article 26
The Board shall meet at least twice a year and shall determine the place of each meeting.

Article 27
The Board shall elect its Chairman from among its members and shall adopt its own rules of procedure.

Article 28
The functions of the Board shall be:
(a) To give effect to the decisions and policies of the Health Assembly;
(b) To act as the executive organ of the Health Assembly;
(c) To perform any other functions entrusted to it by the Health Assembly;
(d) To advise the Health Assembly on questions referred to it by that body and on matters assigned to the Organization by conventions, agreements and regulations;
(e) To submit advice or proposals to the Health Assembly on its own initiative;
(f) To prepare the agenda of meetings of the Health Assembly;
(g) To submit to the Health Assembly for consideration and approval a general program of work covering a specific period;
(h) To study all questions within its competence;
(i) To take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular it may authorize the Director-General to take the necessary steps to combat epidemics, to participate in the organization of health relief to victims of a calamity and to undertake studies and research the urgency of which has been drawn to the attention of the Board by any Member or by the Director-General.

Article 29
The Board shall exercise on behalf of the whole Health Assembly the powers delegated to it by that body.

To be continued…..

Top Two Articles Accessed in July 2010:

1. Breast Cancer Risk Assessment;
   http://www.womenshealthsection.com/content/gyno/gyno018.php3
   WHEC Publications. Special thanks to Genetic Counselors on the panel for helpful suggestions and priceless support in preparing the review.

2. Obesity in Pregnancy;
   http://www.womenshealthsection.com/content/obsmd/obsm013.php3
   Authors: Dr. Robert M. Silver, Chief Maternal and Fetal Division, University of Utah Health Sciences Center, Salt Lake City, UT (USA) and Dr. Jeanette Chin, Clinical Instructor, Department of Obstetrics and Gynecology, University of Utah Health Sciences Center, Salt Lake City, UT (USA).

From Editor's Desk:

UN Secretary-General Launches Global Effort on Women's Health

Governments and stakeholders join in urgent effort to reduce deaths in childbirth, leading up to September Summit on Millennium Development Goals

14 APRIL 2010 | NEW YORK- With only five years left until the 2015 deadline to achieve the Millennium Development Goals, UN Secretary-General Ban Ki-moon is announcing the development of a Joint Action Plan for accelerating progress on maternal and newborn health. "No woman should die bringing life into the world," said Secretary-General Ban. "We must create a seamless continuum of care that helps to improve the health of women from pregnancy through childbirth and builds the foundation for a healthy society." Every year, more than 300,000 women and girls die in pregnancy or childbirth, and another 10-15 million suffer severe or long-lasting illnesses or disabilities caused by complications. The Joint Action Plan will bring together key partners -- including Governments, foundations, the corporate sector, civil society, and United Nations agencies -- in a targeted effort to improve the health of women and children.

The Plan highlights the central role of women's health in sustainable development, and links women's rights with safe motherhood and child survival. "A cornerstone of the Obama Administration's Global Health initiative is women and girl-centered programming that acknowledges women are the gateway to their communities," said U.S. Department of Health and Human Services Secretary Kathleen Sebelius. "Women and girls are particularly vulnerable to ill health and are comparatively underserved by health services. When women receive the care they need, their families, communities and all of society benefit." Calling for urgent and strategic efforts, the Joint Action Plan urges all stakeholders, developed and developing countries, civil society actors, private businesses, philanthropy and the multilateral system to each offer new initiatives and adopts an accountability framework that will keep maternal and child health high on the national and international development agenda.

Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5

Maternal mortality remains a major challenge to health systems worldwide. Reliable information about the rates and trends in maternal mortality is essential for resource mobilization, and for planning and assessment of progress towards Millennium Development Goal 5 (MDG 5), the target for which is a 75% reduction in the maternal mortality ratio (MMR) from 1990 to 2015. We assessed levels and trends in maternal mortality for 181 countries. We estimated that there were 342 900 (uncertainty interval 302 100–394 300) maternal deaths worldwide in 2008, down from 526 300 (446 400–629 600) in 1980. The global MMR decreased from 422 (358–505) in 1980 to

320 (272–388) in 1990, and was 251 (221–289) per 100 000 live-births in 2008. The yearly rate of decline of the global MMR since 1990 was 1·3% (1·0–1·5). During 1990–2008, rates of yearly decline in the MMR varied between countries, from 8·8% (8·7–14·1) in the Maldives to an increase of 5·5% (5·2–5·6) in Zimbabwe. More than 50% of all maternal deaths were in only six countries in 2008 (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo). In the absence of HIV, there would have been 281 500 (243 900–327 900) maternal deaths worldwide in 2008.

Interpretation: Substantial, albeit varied, progress has been made towards MDG 5. Although only 23 countries are on track to achieve a 75% decrease in MMR by 2015, countries such as Egypt, China, Ecuador, and Bolivia have been achieving accelerated progress.

Authors: Hogan MC, Foreman KJ, Mohsen Naghavi, Ahn SY, Mengru Wang, Makela SM, Lopez AD, Lozano R, Murray CJL; Publisher/Organizer: Institute for Health Metrics and Evaluation (IHME)
Details: http://www.who.int/pmnch/topics/maternal/20100402_ihmearticle.pdf

Special Thanks:

WHEC thanks Dr. Robert M. Silver, Professor of Obstetrics and Gynecology, Chief, Division of Maternal-Fetal Medicine, University of Utah Health Sciences Center (UUHSC), Salt Lake City, UT 84132 (USA) for priceless support, friendship and contributions. Thanks again.

Words *of* Wisdom:

Anyone can become angry – that is easy. But to be angry with the right person, to the right degree, at the right time, for the right purpose, and in the right way – that is not easy.

****