WHEC UPDATE

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

June 2011; Vol. 6, No. 6

Achieving Global Health

We all at **Women's Health and Education Center (WHEC)** are grateful to you for your support, friendship and contributions in helping us create this e-Health Resource in reproductive health, which is serving healthcare systems in 220 countries and territories, including US Education. We look forward to collaborate with you to attain our common goals. The social conditions in which people are born, live and work are the single most important determinants of good health or ill health, or a long and productive life, or a short and miserable one. Resource distribution – from the rich to poor and the healthy to the sick – offering a logical pathway on how redistribution of resources can take place in society is essential. "Shared health governance" where researchers, health insurers, governments, health professionals and citizens work together to build consensus around health priorities – including the legislative process, coalition building, citizen participation and commitment should be the health capability paradigm. Adopting a theory of "incompletely theorized agreement" in which the constituent members of society do not need to agree on every element to reach consensus about key health goals should be acceptable. Priorities would include child and maternal health, alleviating hunger, and supply of safe drinking water. If society ensures health capabilities, individuals have a corresponding obligation to take personal responsibility. Individuals have an obligation to use their "health agency" to pursue good health, for example, by eating nutritional foods, engaging in physical activity and complying with medical advice. For this to happen, of course, governments must structure and build environment to make it easy to choose healthy behaviors – such as making fruits and vegetables accessible and affordable. It is good to imagine a world where society maximizes health and closes the health gap; where all constituent members can build consensus and coalitions; and where individuals accept personal responsibility. Yet, societies still often fail to ensure basic survival needs and universal health care. Constituent members often fail to agree on health priorities, regretfully acting in their self-interest rather than the common good. And often individuals find it exceptionally hard to eat a nutritious diet, exercise and engage in safe sex.

Health has special meaning to individuals and communities at large. Good health is necessary for human well-being, providing intrinsic value for comfort, contentment and pursuit of joys of life. But good health does more than that. It is important to allow individuals to exercise a range of human rights – both civil and political (e.g. physical integrity, personal security, political participation), social and economic (e.g. employment, education and family life). Just as important, health is necessary for well functioning societies. If a population does not have a decent level of health, it is very difficult to ensure economic prosperity, political participation, collective security and so forth. The International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by 160 countries, confers on all human beings the core entitlements essential to human fulfillment, e.g. the rights to work, social security, family life, education and participation in cultural life. Although all are vital, the ICESCR's guarantee of "the right to everyone to the enjoyment of the highest attainable standard of physical and mental health" may be the most fundamental. All people should have access to the means to avoid premature death and preventable morbidity. Even if achieving health and health equality are exceedingly difficult, it is reassuring to know that there are scholars striving for social justice. Nothing is more important for the world's population than the passionate pursuit of health and social justice. "Good policy for health" is needed for health justice instead of "good health policy" and supporting "health-in-all-policies" approach, recognizing that the health sector is not the only contributor to good health, is the way forward.

Health and Social Justice

Rita Luthra, MD

Your Questions, Our Reply

What are your core policy messages for the UN inter-governmental decision-making?

Repositioning Maternal, Newborn and Child Health: The requirement for countries to formulate Poverty Reduction Strategy Papers (PRSPs) as a precursor to debt relief and the shared commitment to the Millennium Development Goals (MDGs) have cemented the links between pro-poor policy and maternal, newborn and child health (MNCH) priorities. What does it take to encourage national leaders to act to ensure the health rights of mothers and children - rights to which they are committed? There is extensive knowledge of the technical and contextual interventions required to improve maternal, newborn and child health. In contrast, little is known about what can be done to make national political leaders give it their sustained support. The international community knows how to put things on the global policy agenda - the MDGs are proof of that - but there is a lot more to learn about how to bridge the gap between global attention and national action, and on how to maintain attention spans long enough to make a difference. Political-will first requires information on magnitude, distribution and root causes of the problems that mothers and children face, and on the consequences, in terms of human capital and economic development, of failing to confront them effectively. Maternal, newborn and child health can boast a large network of advocates at the international level that has done much to produce and disseminate such information. Considerable progress has also been made in developing a battery of interventions, to demonstrate their cost-effectiveness, and to share that knowledge. Finally, much has been done to emphasize the need for a wide range of interventions to be implemented simultaneously at household level, in communities, and through health centers and hospitals.

The common project that can bring together the interests and preoccupations of the MNCH programs, as well as those of sector managers and health care providers, is that of universal access to care for mothers and children, embedded within an overall strategy of universal access for the whole population. Presenting MNCH in terms of progress towards universal access to care is not only a question of language. It frames the health of mothers, newborn babies and children within a broader, straightforward political project that is increasingly seen as a legitimate concern and is the subject of a wide social debate: responding to society's demand for the protection of the health of all its citizens. In poorest countries, where large numbers of people are excluded from access to health care, financial protection is often absent. The limited supply of "free" services is usually tax-based and under-funded. Current estimates show that out-of-pocket expenditure in these countries is between two or three times the total expenditure by government and donors, a substantial proportion of these out-of-pocket expenses being captured by commercial providers or through the payment of informal fees. The latter have become a major obstacle which has prevented the poor from accessing scarce public services, with the unpredictability of the cost compounding their reluctance to seek care.

Making the most of transitory financial protection mechanisms - as countries expand their health care networks, they often also supplement the limited coverage of public or quasi-public health insurance (social health insurance based on taxation, or mixed systems) through a multitude of voluntary insurance schemes: community, cooperative, employer-based and other private schemes. These usually proved limited financial protections from catastrophic expenditure, support equality in the distribution of spending, and facilitate the provision of affordable quality care to the enrolled population. In countries where the health care network is well developed, and exclusion from access to care is limited to a relatively marginal group, the need to generalize financial protection persists, also for the non-excluded. Historical patterns of financial management - incremental adjustments of the recurrent program budgets, supplemented by donor-funded projects - have often been slow to adapt to initiatives aimed at scaling up universal access to health care. Funding flows have not only to increase; they have to be channeled in a different way.

About NGO Association with the UN

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

Letter from United Nations Secretary-General Ban Ki-moon Introducing the Global Strategy for Women's and Children's Health

Each year, millions of women and children die from preventable causes. These are not mere statistics. They are people with names and faces. Their suffering is unacceptable in the 21st century. We must, therefore, do more for the newborn who succumbs to infection for want of a simple injection; for the young boy who will never reach his full potential because of malnutrition. We must do more for the teenage girl facing an unwanted pregnancy; for the married woman who has found she is infected with the HIV virus; and for the mother who faces complications in childbirth.
Together we must make a decisive move, now, to improve the health of women and children around world. We know what works. We have achieved excellent progress in a short time in some countries. These range from family planning and making childbirth safe, to increasing access to vaccines or treatment for HIV and AIDS, malaria, tuberculosis, pneumonia and other neglected diseases. The needs of each country vary and depend on existing resources and capacities. Often the solutions are very simple – clean water, exclusive breastfeeding, nutrition, and education on how to prevent poor health are only a few examples.

The Global Strategy for Women's and Children's Health meets this challenge head on. It sets out the key areas where action is urgently required to enhance financing, strengthen policy and improve service delivery.

These include:

- Support to country-led health plans, supported by increased, predictable and sustainable investment.
- Integrated delivery of health services and life-saving interventions – so women and their children can access prevention, treatment and care when and where they need it.
- Stronger health systems, with sufficient skilled health workers at their core.
- Innovative approaches to financing, product development and the efficient delivery of health services.
- Improved monitoring and evaluation to ensure the accountability of all actors for results.

I thank the many governments, international and non-governmental organizations, companies, foundations, constituency groups and advocates who have contributed to the development of this Global Strategy. This is a first step. It is in all our hands to make a concrete difference as a result of this plan. I call on everyone to play their part. Success will come when we focus our attention and resources on people, not their illnesses; on health, not disease. With the right policies, adequate and fairly distributed funding, and a relentless resolve to deliver to those who need it most – we can and will make a life-changing difference for every woman and every child.

Collaboration with World Health Organization (WHO)

The WHO agenda

WHO operates in an increasingly complex and rapidly changing landscape. The boundaries of public health action have become

blurred, extending into other sectors that influence health opportunities and outcomes. WHO responds to these challenges using a six-point agenda. The six points address two health objectives, two strategic needs, and two operational approaches. The overall performance of WHO will be measured by the impact of its work on women's health and health in Africa.

1. Promoting development: During the past decade, health has achieved unprecedented prominence as a key driver of socioeconomic progress, and more resources than ever are being invested in health. Yet poverty continues to contribute to poor health, and poor health anchors large populations in poverty. Health development is directed by the ethical principle of equity: Access to life-saving or health-promoting interventions should not be denied for unfair reasons, including those with economic or social roots. Commitment to this principle ensures that WHO activities aimed at health development give priority to health outcomes in poor, disadvantaged or vulnerable groups. Attainment of the health-related Millennium Development Goals, preventing and treating chronic diseases and addressing the neglected tropical diseases is the cornerstones of the health and development agenda.

2. Fostering health security: Shared vulnerability to health security threats demands collective action. One of the greatest threats to international health security arises from outbreaks of emerging and epidemic-prone diseases. Such outbreaks are occurring in increasing numbers, fuelled by such factors as rapid urbanization, environmental mismanagement, the way food is produced and traded, and the way antibiotics are used and misused. The world's ability to defend itself collectively against outbreaks has been strengthened since June 2007, when the revised International Health Regulations came into force.

3. Strengthening health systems: For health improvement to operate as a poverty-reduction strategy, health services must reach poor and underserved populations. Health systems in many parts of the world are unable to do so, making the strengthening of health systems a high priority for WHO. Areas being addressed include the provision of adequate numbers of appropriately trained staff, sufficient financing, suitable systems for collecting vital statistics, and access to appropriate technology including essential drugs.

4. Harnessing research, information and evidence: Evidence provides the foundation for setting priorities, defining strategies, and measuring results. WHO generates authoritative health information, in consultation with leading experts, to set norms and standards, articulate evidence-based policy options and monitor the evolving global heath situation.

5. Enhancing partnerships: WHO carries out its work with the support and collaboration of many partners, including UN agencies and other international organizations, donors, civil society and the private sector. WHO uses the strategic power of evidence to encourage partners implementing programs within countries to align their activities with best technical guidelines and practices, as well as with the priorities established by countries.

6. Improving performance: WHO participates in ongoing reforms aimed at improving its efficiency and effectiveness, both at the international level and within countries. WHO aims to ensure that its strongest asset - its staff - works in an environment that is motivating and rewarding. WHO plans its budget and activities through results-based management, with clear expected results to measure performance at country, regional and international levels.
More on women's health and health in Africa

Bulletin of the World Health Organization; Complete list of contents for Volume 89, Number 6, June 2011, 393-468

Collaboration with UN University (UNU)

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

Growth, Inequality, and Poverty Reduction in Developing Countries: Recent Global Evidence

The study presents recent global evidence on the transformation of economic growth to poverty reduction in developing countries, with emphasis on the role of income inequality. The focus is on the period since the early/mid-1990s when growth in these countries as a group has been relatively strong, surpassing that of the advanced economies. Both regional and country-specific data are analyzed for the US$1.25 and US$2.50 level poverty headcount ratios using the most recent World Bank data. The study finds that on average income growth has been the major driving force behind both the declines and increases in poverty. The study, however, documents substantial regional and country differences that are masked by this 'average' dominant growth story. While in the majority of countries growth was the major factor behind falling or increasing poverty, inequality, nevertheless, played the crucial role in poverty behavior in a large number of countries. And, even in those countries where growth has been the main driver of poverty reduction, further progress could have occurred under relatively favorable income distribution. For more efficient policy-making, therefore, idiosyncratic attributes of countries should be emphasized. In general, high initial levels of inequality limit the effectiveness of growth in reducing poverty while growing inequality reduces poverty directly for a given level of growth. It would seem judicious, therefore, to accord special attention to reducing inequality in certain countries where income distribution is especially unfavorable. Unfortunately, the present study also points to the limited effects of growth and inequality-reducing policies in low-income countries.

The current paper has examined the poverty reduction performance in developing countries during the more recent period of relatively rapid growth globally. Using the most recent comparable data from World Bank (2009), we first presented evidence on GDP growth, income growth, and poverty reduction since the 1980s for the various regions of the world: EAP, EECA, LAC, MENA, SAS, and SSA. The regional evidence is provided for two periods: 1981 to mid-1990s and mid-1990s to the present, with a focus on the latter strong growth sub-period. Also examined is a global sample of 80 countries for which available data would permit reasonably comprehensive country comparative analysis.

The paper finds that, except for EECA, poverty measured at both the US$1 (US$1.25 2005 PPP adjusted income) per day and US$2 (US$2.50 2005 PPP-adjusted income) per day decreased for all regions during the entire 1981–2005 period. Similarly, with the exception of MENA, all regions exhibited greater poverty declines in the latter sub-period. Two regions, EECA and SSA, showed increases in poverty rates during the earlier sub-period. However, poverty has declined for all regions since the mid-1990s. The above 'average' results are in concert with previous studies that extol the dominant virtues of growth (e.g., Dollar and Kraay 2002). While analytically appealing, however, this growth dominant story is inadequate, for we have also documented herein major differences across countries globally. In some sense, our findings are consistent with Ravallion's (2001) that looking beyond the averages can uncover country-specific differences in what happens to inequality during growth. We have gone a step further, however, by estimating the implications of such differences for poverty reduction by region and for a large number of countries, using the most recent poverty dataset from the World Bank. The current results suggest that adopting the appropriate pro-poor growth strategies requires some understanding of idiosyncratic country attributes. After all, policies are by and large country-specific, and the present study does indeed find that there are substantial differences in the abilities of countries to translate economic growth to poverty reduction, based on their respective inequality and income profiles. By shedding light on this transformation process by country these findings, at least, provide a 'roadmap' for undertaking country studies to uncover the underpinning idiosyncratic

factors. Understanding such country-specific profiles is crucial in crafting polices for most effectively achieving poverty reduction globally.

Publisher: UNU WIDER; Author: Augustin Kwasi Fosu; Sponsor: UNU-WIDER gratefully acknowledges the financial contributions 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—DFID).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

Constitution Of The World Health Organization

(Continued)

CHAPTER XVI – RELATIONS WITH OTHER ORGANIZATIONS

Article 69
The Organization shall be brought into relation with the United Nations as one of the specialized agencies referred to in Article 57 of the Charter of the United Nations. The agreement or agreements bringing the Organization into relation with the United Nations shall be subject to approval by a two-thirds vote of the Health Assembly.

Article 70
The Organization shall establish effective relations and co-operate closely with such other inter-governmental organizations as may be desirable. Any formal agreement entered into with such organizations shall be subject to approval by a two-thirds vote of the Health Assembly.

Article 71
The Organization may, on matters within its competence, make suitable arrangements for consultation and co-operation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental.

Article 72
Subject to the approval by a two-thirds vote of the Health Assembly, the Organization may take over from any other international organization or agency whose purpose and activities lie within the field of competence of the Organization such functions, resources and obligations as may be conferred upon the Organization by international agreement or by mutually acceptable arrangements entered into between the competent authorities of the respective organizations.

To be continued……

Top Two-Articles Accessed in May 2011

1. Evolution Of Surgical Management of Breast Cancer;
   http://www.womenshealthsection.com/content/gyno/gyno004.php3
   WHEC Publications. Special thanks to Dr. Steven M. Schonholz, Medical Director, Breast Cancer Center at Mercy Medical Center, Springfield, MA (USA) for expert opinions and assistance in preparation of the manuscript.

2. Vaccines & Immunizations;
   http://womenshealthsection.com/content/documents/VaccinesImmunizations.pdf
   WHEC Publications. Adapted from 2011 guidelines for adult immunization by United States Center for Disease Control and Prevention (CDC).

From Editor's Desk

More Money for Health, More Health for the Money

With only five years left until the 2015 deadline to achieve the Millennium Development Goals, UN Secretary-General Ban Ki-moon officially launched a global effort on women's and children's health in New York on April 14, 2010. The Global Strategy for Women's and Children's Health, developed by a wide range of stakeholders, sets out how we can work together to improve the health of women and children. All partners have an important role to play: governments and policymakers, donor countries and philanthropic institutions, the United Nations and other multilateral organizations, civil society, the business community, health workers and their professional associations, and academic and research institutions. Over the past year, leaders from these fields have worked together to develop the Global Strategy.

The Global Strategy for Women's and Children's Health, launched September 22nd, at the 'Every Woman, Every Child' special event during the MDG Summit, spells out what we need to do to accelerate progress. It calls for a bold, coordinated effort, building on what has been achieved so far - locally, nationally, regionally and globally. It calls for all partners to unite and take action – through enhanced financing, strengthened policy and improved service delivery. Since the Global Effort on Women's and Children's Health was launched in April 2010, many partners have come forward with ambitious pledges to do more for women's and children's health. This summary of commitments sets out how partners will contribute to achieving better health for women and children around the world, contributing to some of the Global Strategy's key outcomes. These include saving 16 million lives by 2015, preventing 33 million unwanted pregnancies, protecting 120 millions of children from pneumonia and 88 million children from stunting, advancing the control of deadly diseases such as malaria, HIV/AIDS, and ensuring access for women and children to quality facilities and skilled health workers. Together, our pledges will ensure more health for the money, through better and more focused use of all available resources. They also represent more money for health. Today's launch represents a major step towards filling the gap between the investment needed and what is currently provided for women's and children's health – with an estimated US$40 billion in funding committed over the next five years. This funding will be measured and tracked to ensure accountability for commitments, actions and results. That this comes from such a wide range of actors is particularly significant.

In the days, weeks and months ahead – all partners are challenged to build on this initial set of commitments. Please select a category on the left to begin browsing.
Commitment by Governments: http://www.everywomaneverychild.org/commitments?cat_id=1

Words *of* Wisdom

To improve is to change; to be perfect is to change often.

– Sir Winston Leonard Spencer-Churchill (1874-1965)

****

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