WHEC UPDATE
Briefings of worldwide activity of Women's Health and Education Center (WHEC)
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Lessons From The Field

I love my job. My passion for Global Health was a contributing factor in creation of this publication; however, it is the writers, editors and publishers amaze me – the vision and creativity they possess. I offer my sincere thanks to their contributions. Tell us your idea for changing the world. Every journey starts from somewhere; our started 11 years ago in Springfield, Massachusetts (USA). ***WomensHealthSection* 2.0** – practicing medicine in the age of googling, friending and tweeting, is the reality of today. The Internet has changed how clinicians practice medicine and interacts with patients. Physicians routinely use the Internet as a clinical tool, for example, searching for medical information, utilizing Internet-based medical records, and communicating with patients and colleagues via e-mail and secure platforms within electronic medical record systems. Physician scientists also utilize the Internet to register and recruit for research studies. Such applications of the Internet are widely accepted aspects of 21st-century medical care. Other Internet applications, such as social networking websites (Facebook, Twitter, Google+, LinkedIn, etc.) have the potential to fundamentally change the nature of relationships in the medical encounter and pose new challenges for clinicians to define appropriate professional boundaries.

In 2013, our survey found that 82% of American adults use the Internet and 80% of users searched for health or medical information online. Seeking health information online was the third most popular online activity among survey respondents, with 44% looking specifically for information about health professionals. Some physicians are taking steps to respond to their patients' online postings or inquiries, for example, asking patients to sign contracts promising not to post comments to public websites prior to initiating a treatment relationship, a move that has been criticized as censorship. Privacy limitations of social networking sites challenge the basic tenets of confidentiality and limit their use clinically.

Healthcare providers must place their patients' interest above their own. If they search for a patient or interact online, they should do so in service of the patient's best interest and not out of their own curiosity or prurient desires. They should avoid complicated dual relationships that would be outside their primary role and should recall their implied public role or personas in their given positions as well. We believe the risks of clinicians interacting with patients on social networking outweigh the benefits at this time. Posting and searching for information online can sometimes be clinically effective, as long as confidentiality and professional ethics are fully considered on a case-by-case basis. Health care providers can rely on traditional principles of professional ethics for guidance in many Internet clinical scenarios, particularly confidentiality and fidelity (or role morality). Health care providers have an obligation not to disclose information provided in a physician-patient relationship without consent. If a physician were to search for a patient online or accept an online friendship from a patient, any information gleaned would be based on information initially obtained in the framework of patient-physician relationship (that is, physicians would not be able to search for the patient without the patient's name, a piece of protected health information in the physician-patient relationship). As such, the principle of confidentiality would have physicians keep private all information subsequently discovered online. They might even ask the patient's permission before documenting information discovered online in the electronic record, which might then be released to third parties.

In Project Development, just like in business and just like in life, the best teacher of all is: failure. Another lesson we have learnt on this road is that – never let failure predetermine your future. Our initiative ***WomensHealthSection.com*** marks its 11th birthday on 24 October 2013 and serves 13 million subscribers every year in 225 countries. We hope to continue to provide this very important service to the healthcare providers and patients all over the world. We are thrilled by its success.

Let's do this.
The Amazing Journey
Rita Luthra, MD

Your Questions, Our Reply

What is ***WomensHealthSection* 2.0**? What health care providers can learn and expect from searching online for patient information and for educational purposes? Will this **2.0** initiative be open to general public to post their opinions?

The WomensHealthSection 2.0: A central feature of this initiative is the potential for increasing contact, both direct and indirect, between the patient and healthcare providers both before and after the in-person visit. Healthcare providers and patients can learn more about each other indirectly (and covertly) via online information, thus bringing non-clinical material into a clinical context. In the past, some of this information might have been available in non-electronic format but would have been more difficult to access. The easily available and permanent nature of information on the Internet contributes to its effects on interpersonal relationships. Online healthcare provider-patient encounters permit a closeness and accessibility to physicians that might enhance trust and relationships, but they could also lead to complicated and dual relationships. Becoming a "friend" on Facebook, for example, might imply "friendship", which is a role separate from the traditional healthcare provider-patient relationship.

Thus, online accessibility has the potential to deepen and improve medical care as well as to threaten traditional professional boundaries established to protect the best interests of patients. In this era of evidence-based medicine, which helps guide healthcare providers' clinical behaviors, doctors have little to no evidence about how online interactions might improve or harm medical care. A technological generation gap persists, as the most senior clinicians are inexperienced with new technologies, limiting the availability of mentorship. Women's Health and Education Organization, Inc. (WHEO, Inc.) in collaboration with WHEC had released recommendations to guide healthcare providers on the profession use of social media and the Internet, focusing primarily on preserving patient confidentiality and upholding public trust in the medical profession, in 2012. They are called for personal responsibility and the practice of professional appropriateness when using online information and interactions. These guidelines offer practical advice for physicians in an effort to maximize benefit to and minimize risk of harm to patients.

Exact guidelines and recommendations from medical organizations and institutions will ultimately fail to keep up with the ever-changing pace of technology, the Internet and their impact on clinical practice. As soon as the "rules" for healthcare providers are perfected, those rules will have yielded to the next generation of technological innovation. It seems two options exist: Avoid Internet encounter or go back to basic ethical principles of professional-patient relationships. Some patients and physicians might choose complete avoidance. But this would come with costs, both personal (not being able to enjoy the benefits or amusements of new technologies) and professional (social networking might improve health care relationships and outcomes, but physicians would not know if they have chosen not to try). In the future, it might be considered unethical *not* to search for or engage with patients online if doing so would lead to improved outcomes.

Our **2.0** Initiative is only available to Institutions and Government agencies/entities in 225 countries, to participate, at this time. We hope you explore this opportunity to serve your patients and colleagues all over the world.

Endings and beginnings @ ***WomensHealthsection.com***

United Nations At A Glance

Brazil and the United Nations

Brazil, a founding member of the United Nations, has historically held the importance of multilateralism at the center of its foreign policy. As we increase our participation at the UN, we have also deepened our debate with the public and with other diplomatic representations.

To assist in that aim, we have collected on this website our main statements at UN Headquarters, contact

information for our staff, as well as other pages and links on Brazilian foreign policy, history, society and culture. The website is continually updated with new information and is intended to be a valuable tool for understanding Brazil's positions on the main topics of the multilateral agenda.

The Security Council's engagement with the issue of Women and Peace and Security has greatly contributed to our common efforts to improve the lives of women in conflict situations around the world. The resolutions adopted by the Council have not only created a comprehensive body of norms and tools, but have also stimulated discussion, self-criticism and progress on the protection and promotion of women´s rights.

Today we focus our attention on one of the most appalling aspects of the Women and Peace and Security agenda: the problem of sexual violence in conflict. The challenge when discussing this scourge is to translate our sorrow and outrage into practical action capable of bringing real change.

Only an integrated approach, that combines a stronger focus on prevention, the fight against impunity and better support to victims can help us fight sexual violence in conflict in an effective and decisive manner.

http://www.un.int/brazil/#

Collaboration with World Health Organization (WHO)

WHO | Brazil

Country Cooperation Strategy at a glance

The Federative Republic of Brazil has a total land area of 8.5 million km². The country comprises 26 states, the Federal District, and 5,560 municipalities. These administrative divisions have special and standing commissions, shared responsibilities, as well as political, fiscal, and administrative autonomy. Brazil is a presidential federal republic. In 2010, the projected population of Brazil is estimated to be 193 252 604 inhabitants with 2 938 214 births and a crude birth rate of 15.20 per 1000 inhabitants. This is a decrease of 400 000 births as compared to in 2005. The GDP per capita in 2006 (based on year 2000 values) was R$ 12 688.00 (around US$ 5830), varying between R$ 6029 (us$ 2770) in the northeastern region and R$ 16 912 (US$ 7772) in the southeastern region. Brazil’s Human Development Index (HDI) has also been increasing: from 0.788 in 2003 to 0.80 in 2007.

Health situation: The country is undergoing a process of epidemiological transition in which Non-communicable diseases and external causes (acts of violence) are progressively outpacing infectious and parasitic diseases. The Brazilian health system is made up of a complex network of public and private institutions that provide, finance, and manage health services; produce and distribute health inputs and research; train human resources in health; and regulate, legislate, and oversee the health system.

The Unified Health System (UHS or SUS as per its acronym in Portuguese) is exclusively responsible for providing health coverage to 78.8% of the Brazilian population, and is the primary network of public health institutions that provide, finance, and manage health services. The remaining 21.2% of the population, which are covered by the Supplementary System, is also entitled to access the health services provided by the UHS. In addition to these functions, the UHS is also responsible for health surveillance, disease control, and regulation of the health sector. The Family Health Strategy is the country’s primary instrument for providing basic care to the population. In 2005, the Family Health Strategy covered 73 million people (40% of the population) in 4,837 cities through 22,683 multidisciplinary health teams.

Facilitating access to essential pharmaceutical drugs is part of basic care, and is provided through special financing mechanisms and government-owned “people’s pharmacies” (farmácias populares).

Details: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_bra_en.pdf

WHO Reproductive Health Update

Ending preventable maternal deaths: the time is now

Between 1990 and 2010, maternal mortality decreased globally by nearly 50%. As 2015 approaches, attention turns to what has been achieved—and what lies ahead for the global development goals, including those for maternal and child health. As countries and international platforms engage in post-2015 planning, now is the time to envision the ending of preventable maternal deaths. An ambitious global target is to reduce maternal mortality ratios to less than 50 per 100 000 live births by 2035 and we believe that this target can be reached worldwide

Read Lancet article

Bulletin of the World Health Organization; Complete list of contents for Volume 91, Number 10, October, 719-796

Collaboration with UN University (UNU)

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

Brazil's Growth Performance: Achievements and Prospects

This paper reviews Brazil's growth performance over the last quarter of a century and discusses the main determinants of a pick-up in growth since the mid-1990s. Emphasis is placed on the policy pay-offs associated with a consolidation of macroeconomic adjustment, which is a pre-condition for sustained growth. Structural reform based on a liberalization of the county's trade and investment regimes have also generated productivity gains that have supported growth. The paper also discusses a number of policy challenges that will need to be addressed in the coming years to ensure that high growth can sustained over the longer term.

Further efforts towards increasing Brazil's growth potential should focus on two main areas. *First*, the consolidation of macroeconomic adjustment would fulfil an important framework condition for growth, a lesson that is applicable more generally to emerging market and transition economies. Effort to stem the increase in government spending would create room in the budget for much-needed investment and pave the way for a reduction in the tax take in the future, once the public debt has been reduced further. This is likely to contribute also to a fall in Brazil's high real interest rates. *Second*, effort to close the gap in educational attainment and performance in relation to the OECD area would also put Brazil in a better stead to compete in international trade. Moreover, to the extent that it raises labour productivity, continued human capital accumulation would contribute to improving further Brazil's distribution of income, which remains skewed even by Latin American standards. A less unequal distribution of income would have the additional advantage of making growth more pro-poor.

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

Brazil

With an estimated 170 million inhabitants, Brazil has the largest population in Latin America and ranks sixth in the world. In Brazil, 54 million people live below the poverty line. The child mortality rate has fallen to 29 per 1,000 live births, but remains disproportional to national production capacity and available technology. Maternal mortality continues to be a problem, although its magnitude is unclear due to a lack of consistent data despite 96 per cent of deliveries taking place in hospitals. Pre-natal care is considered to be of low quality and of unequal access to different segments of the population and regions of the country. The fight against HIV/AIDS requires special actions focused on children and youth. With 97 per cent enrolment in primary school, the educational challenge is that of quality: 1.1 million children and adolescents aged 12 to 17 are still unable to read and write; 11 per cent of children are completing eight years of primary school by age 15.

UNICEF helps launch a national alliance for universal access to quality, basic education in Brazil

The 'Commitment' is a national pact that brings together the Brazilian Federal government, the National Organization of Municipal Education Managers (UNDIME), several NGOs, private foundations and institutes, and the United Nations Children's Fund (UNICEF) in Brazil. The national alliance works with an established set of goals and projects that will be monitored year after year until 2022, when Brazil celebrates 200 years of independence.

With a primary education enrolment rate of 98%, Brazil has almost reached MDG 2: universal primary education. However, in the poorest regions, such as the North and Northeast, only 40% of children actually complete their primary schooling. And, in the more developed regions, such as the South and Southeast, this proportion rises to only 70%.

The top priorities in the area of education for UNICEF Brazil are universal access, quality basic education and ensuring that children learn successfully. UNICEF works with partners to achieve these priorities by supporting initiatives such as the 'Commitment', which guarantees children access to school, and also improves the quality of the education and teaching provided.

Nevertheless, in spite of significant progress made over the past few years, today 800,000 Brazilian children aged 7-14 are still out of school. "Of these 800,000 children, 500,000 are afro-descendants", said Marie-Pierre Poirier. "This reminds us that the challenge of promoting universalization includes the fight against exclusion, including exclusion motivated by racial and ethnic factors."

Key challenges are to ensure that children's learning needs are met, and to strengthen educational methodologies which are adapted to their local and cultural reality. In the Brazilian Semi-Arid region, for example, more than 350,000 children aged 10-14 do not attend school, and the pupils often take 11 years to finish the 8 grades of primary school. This is due in part to the lack of curricula and education content that are adapted to the day-to-day reality of the children in the region. The situation is being addressed by: adapting the teaching content and school calendar to their reality; strengthening the capacity of teachers, municipal councils, families and NGOs; providing extra-curricular activities such as sports and culture.

http://www.ungei.org/infobycountry/brazil_1104.html

To be continued……

Top Two-Articles Accessed in September 2013

1. Current Concepts in Pelvic Floor Anatomy;
   http://www.womenshealthsection.com/content/urog/urog017.php3
   WHEC Publications. Special thanks to Dr. Dr. R. K. Mittal, Pelvic Floor Dysfunction and Disorder Group, Division of Gastroenterology, University of California, San Diego VA Health Care Center, San Diego, CA (USA) for the assistance in preparing the manuscript.

2. Exercise During Pregnancy and Postpartum Period;
   http://www.womenshealthsection.com/content/obs/obs031.php3
   WHEC Publications. Special thanks to NIH, CDC and US Department of Health and Human Services for the contributions. We thank our reviewers for the helpful suggestion.

From Editor's Desk

Bangladesh – Bicycling "Info Ladies" bring Internet to Remote Villages

Dozens of "Info Ladies" bike into remote Bangladeshi villages with laptops and Internet connections, helping tens of thousands of people — especially women — get everything from government services to chats with distant loved ones. It's a vital service in a country where only 5 million of 152 million people have Internet access.

The Info Ladies project, created in 2008 by local development group D.Net and other community organizations, is modeled after a program that helped make cell-phones widespread in Bangladesh. It intends to enlist thousands more workers in the next few years with startup funds from the South Asian country's central bank and expatriates working around the world. D.Net recruits the women and trains them for three months to use a computer, the Internet, a printer and a camera. It arranges bank loans for the women to buy bicycles and equipment.

"This way we are providing jobs to jobless women and at the same time empowering villagers with critical information," said Ananya Raihan, D.Net's executive director. The women — usually undergraduates from middle-class rural families — aren't doling out charity. Begum pays 200 takas ($2.40) for an hour of Skype time with her husband, who works in Saudi Arabia. Begum smiles shyly when her husband's cheerful face pops up. With earphones in place, she excitedly tells him she received the money he sent last month. He asks her to buy farm land. Even Begum's elderly mother-in-law now uses Skype to talk with her son.

"We prefer using Skype to mobile phones because this way we can see him on the screen," Begum said, beaming happily from her tiny farming village in Gaibandha district, 120 miles (192 kilometers) north of the capital, Dhaka. In the neighboring village of Saghata, an Info Lady is 16-year-old Tamanna Islam Dipa's connection to social media.

"I don't have any computer, but when the Info Lady comes I use her laptop to chat with my Facebook friends," she said. "We exchange our class notes and sometimes discuss social issues, such as bad effects of child marriage, dowry and sexual abuse of girls." The Info Ladies also provide a slew of social services — some for a fee and others for free. They sit with teenage girls where they talk about primary health care and taboo subjects like menstrual hygiene, contraception and HIV. They help villagers seeking government services write complaints to authorities under the country's newly-enacted Right to Information Act.

They talk to farmers about the correct use of fertilizer and insecticides. For 10 takas (12 cents) they help students fill college application forms online. They're even trained to test blood pressure and blood sugar levels. "The Info Ladies are both entrepreneurs and public service providers," Raihan said.

Raihan borrowed the idea from Bangladeshi Nobel laureate Muhammad Yunus, who in 2004 introduced mobile phones to rural women who had no access to telephones of any kind, by training and sending out scores of “Mobile Ladies” into the countryside. That hugely successful experiment drew in commercial mobile phone operators. Now more than 92 million people in Bangladesh have cell-phone access. Nearly 60 Info Ladies are working in 19 of Bangladesh’s 64 districts. By 2016, Raihan hopes to train 15,000 women. In July, Bangladesh’s central bank agreed to offer interest-free loans to Info Ladies. Distribution of the first phase of loans, totaling 100 million takas ($1.23 million), will begin in December. Raihan said D.Net is also encouraging the large population of Bangladeshi expatriates to send money home to help Info Ladies get started.

“It’s very innovative,” says Jamilur Reza Chaudhury, a pioneer of information technology education in Bangladesh. “The project is really having an impact on the people at grass-root level.” Info Lady Sathi Akhtar, who works in Begum’s and Dipa’s villages, said she makes more at the job than she would as a school teacher. She said that after making payments on her 120,000 taka ($1,480) loan and covering other costs, she takes home an average of 10,000 takas ($123) a month. “We are not only earning money, we are also contributing in empowering our women with information. That makes us happy.”

Words *of* Wisdom

If you think you are beaten, you are.
If you think you dare not, you don’t.
If you’d like to win, but think you can’t,
It’s almost a cinch you won’t.

Life’s battles don’t always go
To the strongest or faster man;
But soon or late the man who wins
Is the one who thinks he can.

– Anon

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

http://www.womenshealthsection.com/

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