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

Policy is a frame of mind, a strategy, or a sense of direction. Policy is rarely made on paper; it is a continuously changing mix of people and ideas. For one who has worked much on the theory and practice of change from systems of hierarchy to systems of equity, 24 October 2002 will never be forgotten. 2014, marks a milestone in the life of our initiative – ***WomensHealthSection.com*** – to improve maternal and child health. It is remarkable that with such a diverse membership of The Working Group and without a formal constitution, our initiative has managed to serve 226 countries and 13 million subscribers every year. And it remains true to its original mission in promoting the United Nations (UN) development agenda.

I see The Women's Health and Education Center (WHEC) as a symbol of the quest for and an essential element of the democratization of international relations of the UN and of the UN system. It is a vehicle to give a voice and influence to women and children, all over the world. The overwhelming majority of this section of society remains marginal on the world scene and does not have individually the power or importance to be heard and paid attention to. And even less to have an impact on what happens in world affairs.

The history of ***WomensHealthSection.com*** is intertwined with that of the United Nations. This is a transformative time for the human family – an era of technological innovation, inroads against diseases, gains in literacy and life expectancy and unprecedented global connectivity. But progress has not benefited everyone equally. Too many people suffer exploitation, lack fundamental freedoms and access to education and good health services are either not available or denied.

Education for all and health for all are complex yet historic and hugely important tasks for this new century. A more inclusive and robust partnership framework will be essential. Our initiatives, I hope, play a crucial role in making the world a better place to live. And new goals will not be accomplished without a visionary method for bringing together all sources of financing, technology, innovation and research. People also need to be freed of the impacts of armed conflicts (which affect women and children the most); violence and insecurity, which often have roots in social and economic deprivation and inequalities. Upholding good governance, human rights and the rule of the law and freeing people from fear and want are inseparable. This cannot be done single-handedly; however, we need international cooperation and good will.

The Group of ***WomensHealthSection.com*** will continue to evolve. There will always be new and emerging challenges. Currently it must address the perfect storm of our human existence and formidable combined challenges of healthcare financing, internet security and endemic financial and economic crisis. For that it will need an enhanced operational and institutional support in recognition of what it can contribute for the better of health and humanity in the next 50 years. The solutions to development has to be diversified and that a "one size fits all" or the "equal gain solution" are no longer possible or even feasible given the current global economic, social and ecological diversity and domestic capacities. Interestingly, the North-South divide is much less pronounced in the area of health and human rights, because many countries from the South as well as the North regard respect for health for all as key condition for a nation's capacity to flourish politically and economically.

That is how health and education is supposed to be: Personal, Passionate, Professional and Affordable.

Let us make every mother and child count!

The Group of ***WomensHealthSection.com*** @ 12

Rita Luthra, MD

Your Questions, Our Reply

What are community-based health-care teams to support patient-centered medical homes in USA? What is the purpose of this insurance reform?

Patient-Centered Medical Home for Women: The U.S. Congress wanted to develop and test different delivery systems that would improve outcomes and efficiency and reduce costs, as part of its effort to extend better healthcare to more individuals with the amount of money we now spend on health care in the United States. One of these options is the patient-centered medical home. The law points the way for patient-centered medical homes for women in the Medicare and Medicaid programs. The law creates the Innovation Center within the Centers of Medicare and Medicaid services with broad authority to test, evaluate, and adopt systems that foster patient-centered health care, improve quality, and contain costs in Medicare, Medicaid, and Children's Health Insurance Program. Models that can be tested include the following:

- Patient-centered medical homes, including one that address women's unique health needs;
- Transition from fee-for-service to salary-based payment;
- State all-payer payment systems;
- Health care management for chronic conditions and care coordination models.

Within Medicaid, states can require beneficiaries with two or more chronic conditions or with one chronic condition and at risk for a second one to designate a qualified a health care provider as their medical home. Obstetrics and Gynecologic practices are eligible to participate, and participating practices would be eligible for additional reimbursement.

Federal funding is available to states for the development of community-based health care teams to support patient-centered medical homes run by primary care practices. These teams may include specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health care providers, and physicians' assistants. Primary care practices in this program function as patient-centered medical homes and are responsible for addressing patient personal health care needs. The teams link the patient-centered medical home to community support services for those patients. Eligible obstetric and gynecologic practices can qualify as primary care practices, and obstetricians and gynecologists are eligible to be specialist members of the community-based health care teams.

The insurance practices of charging women more than men for equivalent coverage in U.S. ended on January 1, 2011. This change should hopefully make insurance more affordable for our patients. The law allowed insurers in the individual health insurance and the small group markets to vary premiums only for age, geographic location, family size, and tobacco use, but not by gender.

It has long been recognized that our nation's health care system, in U.S., is badly in need for improvements. Our per capita spending is too high; too few Americans have, can afford, or can find good health care insurance coverage; there is too much waste and bureaucratic red tape; and preventive health care is too low a priority.

We all at WHEC support patient-centered medical homes for women. Join our efforts

Every Woman & Every Child event during the 69th regular session of the UN General Assembly

25, September 2014, It was indeed a pleasure to attend breakfast meeting for **UN MDG Advocates** in the morning and in the afternoon this high level segment at 69th UN General Assembly on invitation of UN Secretary General BAN Ki-moon at Trusteeship Council, UN Headquarter.

The purpose of this briefing is to update Missions from UN Member States on global progress on the health MDGs, in particular women's and children's health and the Secretary-General's high-level *Every*

Woman Every Child event on September 25, as well as related health events around the week of the 69th Session of the UN General Assembly. To view the concept note click here. To view the invitation click here

MDG Advocacy Group and the Roll Back Malaria Partnership, in its Breakfast Session showcased the successes of the eight MDGs to deliver a healthier, equitable and more sustainable future, and launched the MDG Advocates' Leaders Report, on 25 September 2014, in the margins of the 69th Session of the UN General Assembly. Our efforts for MDG # 5 (Improve Maternal Health) were recognized and I thank you for the collaboration.

15 years ago this was just a "pipe dream"; now it is a reality. The MDG Advocates' Leaders Report, Accelerating Action: Global Leaders on Challenges & Opportunities for MDG Achievement, can be accessed at the below link:

http://www.mdgleaders.org/

The commitments of Women's Health and Education Center (WHEC) can be accessed from the link below:

http://everywomaneverychild.org/commitments/csos-ngos/women%E2%80%99s-health-and-education-center

The 69th Regular Session of the United Nations General Assembly convened at UN Headquarters on Tuesday, September 16, 2014. The General Debate opened on Wednesday, September 24, 2014 with high-level statements from Heads of State.

Partnering for Results: Delivering for Every Woman & Every Child Within A Generation High Level Event to advance the Global Strategy for Women's and Children's Health:

This event took place on Thursday, September 25 at UN Headquarters from 3:00-5:00pm. To watch the event on webcast click the link below. Featured speakers include the Rt. Hon. Stephen Harper, Prime Minister of Canada and Mrs. Graça Machel, Board Chair of the Partnership for Maternal, Newborn and Child Health. To view the concept note click at link below:

http://everywomaneverychild.org/news-events/events

A promise fulfilled!

United Nations At A Glance

Permanent Mission of India to the UN

India's engagement with the institutions of modern multilateral diplomacy began when, on 28 June 1919, India signed the Treaty of Versailles which ended the First World War. Article 1 of the Treaty created the League of Nations, the precursor of the United Nations. India was a founder member of this organization, as well as of the International Labour Organization, which was created by the Treaty of Versailles, in 1922, India became one of the permanent members of the Governing Council of the ILO, a position it has maintained to this day.

India was among the original members of the United Nations that signed the Declaration by United Nations at Washington on 1 January 1942 and also participated in the historic UN Conference of International Organization at San Francisco from 25 April to 26 June 1945. As a founding member of the United Nations, India strongly supports the purposes and principles of the UN and has made significant contributions to implementing the goals of the Charter, and the evolution of the UN's specialized programmes and agencies

Independent India viewed its membership at the United Nations as an important guarantee for maintaining international peace and security. India stood at the forefront during the UN's tumultuous years of struggle against colonialism and apartheid. India's status as a founding member of the Non - Aligned Movement and the Group of 77 cemented its position within the UN system as a leading advocate of the concerns and aspirations of developing countries and the creation of a more equitable international economic and political order.

India is today at the forefront of efforts on UN reform, including expansion of the Security Council in both the permanent and non - permanent categories to reflect contemporary realities

Historical perspective: Decolonization and Apartheid

26 June 1945: Signing of UN Charter, Sir A Ramaswami Mudaliar, signing the UN Charter at San Francisco

The purposes of the UN Charter include promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion. This was by no means an easy quest. In 1945, when the UN Charter was signed, more than 750 million people lived in colonies. India was in the forefront of the struggle against colonialism, apartheid and racial discrimination. This struggle transformed the lives of millions of people in Africa and Asia.

Charter provisions on Non - Self Governing Territories were given a new thrust when the UN adopted the landmark 1960 Declaration on the Granting of Independence to Colonial Countries and Peoples. India was a co - sponsor of the Declaration. The Declaration solemnly proclaimed the necessity of bringing to a speedy and unconditional end, colonialism in all its forms and manifestations.

The following year, the Special Committee on the Implementation of the Declaration on Decolonization was established to study, investigate and recommend action to bring an end to colonialism. India was elected the first Chairman of the Decolonization Committee. As a member of the Committee of 24, as it came to be called, India has ceaselessly struggled for an end to colonialism. India also took up the decolonization issue in the Trusteeship Committee, the Special Committee on Non - self Governing Territories and the Fourth Committee.

India was amongst the most outspoken critics of apartheid and racial discrimination in South Africa, being the first country to have raised the issue in the UN (in 1946). India played a leading role in the formation of a Sub - Committee against Apartheid set up by the General Assembly. When the Convention on Elimination of all forms of Racial Discrimination was adopted in 1965, India was among the earliest signatories. India also contributed generously to UN Funds for assistance to victims of apartheid and for revitalization and economic regeneration of Africa and remains a fervent supporter of Africa's development and aspirations

Details: https://www.pminewyork.org/index.php

Collaboration with World Health Organization (WHO)

WHO | India

Country Cooperation Strategies at a glance

India is the world's largest democracy, the second most populous country in the world (1.21 billion people according to the provisional figures of the 2011 census) and the tenth largest economy (with a gross domestic product of US$ 1377.3 billion) in 2009. India has undergone extraordinary socioeconomic and demographic changes. The population pyramid has evolved with increases in both the very young and in the ageing population, as well as an urbanization process with megacities and expanded shanty towns. The urban population increased 4.6- fold between 1951 and 2001 compared to only a 2.8-fold increase in the total population. Between 1980 and 2011 India's Human Development Index improved by 1.6% annually from 0.344 to 0.547, and yet the country ranks 124th out of 187 countries with comparable data

Health and Development

India accounts for 21% of the world's global burden of disease.

- India is home to the greatest burden of maternal, newborn and child deaths in the world. Infant mortality rate declined from 83 per 1000 live births in 1990 to 44 per 1000 live births in 2011 and maternal mortality ratio reduced from 570 per 100,000 live births in 1990 to 212 in 2007–2009. However, both remain high in comparison to other BRICS countries.
- Though, impressive advances have occurred in addressing communicable diseases such as the significant progress towards polio eradication, rapid changes in India's society and lifestyles have led to the emergence of non-communicable diseases, which are already responsible for two-thirds of the total morbidity burden and about 53% of total deaths (up from 40.4% in 1990 and expected to increase to 59% by 2015).
- Gender issues are of great concern. The worrying proportions of selective gender abortion became even more visible with the 2011 census; the female-to-male sex ratio in the 0–6-year age group declined steeply from 0.945 in 1991 to 0.914 in 2011. The Gender Equality Index (GEI) in India is 0.748, well below, for example, China (0.405) or Sri Lanka (0.599). In 2008, India ranked 122nd in gender equality among 168 countries.
- India is losing more than 6% of its GDP annually due to premature deaths and preventable illnesses, according to a 2010 World Bank report.
- Total expenditure on health is 4.2% of GDP. Of this, current public expenditure is only 1.1% of GDP. Over 70% expenditure is out of pocket (and majority at point of service). The country's per capita health spending has risen from US$ 21 in 2000 to US$ 44 in 2009 (with government expenditure within it increasing from US$ 6 to US$ 13). However, India remains among the five countries with the lowest public health spending levels in the world.
- Out-of-pocket payments have increased, with impoverishment of nearly 2.2% of population taking place annually due to catastrophic illness-related expenditure. Hospitalization for major illnesses is a major cause of indebtedness, especially for those living below the poverty line.

For the past 30 years the geographically wide, densely populated and enormously varied Republic of India has made remarkable efforts in the field of health. The list of initiatives include the adoption of a National Health Policy in 1983; the 73rd and 74th Constitutional Amendments devolving power to local institutions in 1992; the National Nutrition Policy in 1993; the National Health Policy, the National Policy on Indian System of Medicine and Homeopathy and Drug Policy in 2002; the introduction of simple health insurance schemes for the poor in 2003; and the inclusion of health in the Common Minimum Programme

of Government in 2004. More recent achievements include the commitments to implement the National Rural Health Mission (NRHM) and proposals to achieve universal health coverage (UHC).

The High Level Expert Group (HLEG) on UHC constituted by the Planning Commission of India met in October 2010, with the mandate of developing the UHC framework for the 12th Five-Year Plan of the Government of India. The Group submitted its detailed report in October 2011, the salient recommendations of which have been accepted by the Steering Committee of the Commission and communicated to the parliament.

Details: http://www.who.int/countries/ind/en/

Bulletin of the World Health Organization; Complete list of contents for Volume 92, Number 10, October, 697-772

Collaboration with UN University (UNU)

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

The risks to education systems from design mismatch and global isomorphism: Concepts, with examples from India

The incredibly low levels of learning and the generally dysfunctional public sector schooling systems in many (though not all) developing countries are the result of a capability trap (Pritchett et al. 2010). Two phenomena reinforce persistent failure of schooling systems to produce adequate learning outcomes. One is the mismatch between system design—the allocation of activities across organizations and mechanisms of accountability—and the insights of the 'new institutional economics' from principal agent models and contract theory. In particular, many education systems attempt to manage teaching and learning as a 'thin' or 'logistical' activity that can be managed with top-down control and an emphasis on compliance. The reality is that teaching is a 'thick' or 'implementation intensive' activity that performs better when teachers and operators of schools are given performance standards, have multiple in-depth accountability channels, and are given greater autonomy. The second phenomena that facilitates persistent failure is global isomorphism on enrollment and inputs (Meyer et al. 1977; Boli et al. 1985; Meyer et al. 1997). That is, the field (in the sense of Bourdieu 1993) of global education has produced a near exclusive emphasis on enrollments and duration in school, adequacy of physical inputs, and formal qualifications that allowed, perhaps encouraged, national systems to ignore completely performance on child-learning (of any type, measured in any way). I conclude with a comparison in India of the national governments recent efforts in basic education which have been almost exclusively isomorphic.

India and other South Asian countries are deep into a learning crisis. Their public sector systems are failing to produce children anywhere near ready for the twenty-first century. I argue that two of the possible explanations of this state of affairs are that (a) the mismatch between the system design that could produce effective schooling organizations and the actual design of the system and (b) that external pressures have been for enrollment and input isomorphism that simply assumes achieving forms and thin inputs can produce the desired outcomes. This ideology is deeply embedded into the major reform efforts of the national government of India as reflected in the Right to Education Act, the design, implementation, monitoring and evaluation of SSA and the data collected in DISE. There is no evidence to date that this approach can, or will, improve the most important aspects of the schooling experience or the learning outcomes of Indian children.

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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/)

United Nations Girls' Education Initiative (UNGEI)

The Effort to Advance the Global Strategy
(Continued)

India | Background

Economic growth in India has been strong over the past decade, especially in the information technology sector. But significant disparities remain, based on class, caste, gender and geography. The United Progressive Alliance coalition government, which came into power in May 2004, has pledged to emphasize social development as part of its National Common Minimum Programme. It seeks to eliminate some of the inequalities in Indian society by reducing poverty, increasing public spending on education, speeding the delivery of health services, and improving nutrition and food security.

With one upper primary school for every three primary schools, there are not enough upper primary centers even for those children who complete primary school. For girls, especially, access to upper primary centers becomes doubly hard. The gross enrolment ratio in primary education has increased, with much of the growth attributable to increased enrolment of girls. Serious concerns exist with respect to quality of education due to high drop-out rates and poor learning achievements. Although there is improvement in the ratios of girls to boys in primary, secondary and tertiary education during the past decade, they are far from reaching the goal of parity. And girls belonging to marginalized social and economic groups are more likely to drop out of school at an early age.

Several states have undertaken innovations to make schools more child-friendly and in the development of child-friendly assessment tools. Exercises in the assessment of teacher training and teacher effectiveness and the development of teacher performance standards have been supported. A noted success of the girls' education movement has been the adoption of The Meena Communication Initiative as a learning and advocacy tool by the Ministry of Education at national and state levels.

Barriers to girls' education

Major barriers to girls' education include:

- Many rural children have been left behind by migrating parents or have been sent by themselves into urban areas for education
- Basic education is free but not compulsory. Many schools in the south were closed due to political unrest in the 1990s and have yet to reopen
- Traditional views that devalue education are prevalent
- Turnover of teachers and instructors is high.

UNGEI in action

UNGEI has not been formally launched, but girls' education initiatives are ongoing.

Key initiatives for girls' education

- Addressing school and classroom environments, teaching-learning processes, teacher support and school-community linkages
- Education analysis and research
- Accelerating the implementation of the communication strategy for girls' education at the national and state levels and in integrated districts
- Administering child-friendly learning assessment tools
- Strengthening policy dialogue on issues related to education and stronger service delivery of educational intervention for working children

Partners

Partners include the Government of India, Australian Government Overseas Aid Program, CARE, European Union, ING-Vysya Foundation, Swedish International Development Cooperation Agency and UK Department for International Development, in addition to other non-governmental organizations, donors and the joint UN system.

UNGEI within other national and international frameworks

Poverty Reduction Strategy Papers (PRSPs) and sector-wide approaches to planning (SWAPs); Common Country Assessments

To be continued……

Top Two-Articles Accessed in September 2014

1. Improving Maternal Health Through Education;
   http://www.womenshealthsection.com/content/heal/heal014.pdf
   UN Chronicle Publication. Special thanks to our partners, friends and supporters to collaborate with us to improve maternal and child health worldwide.

2. Current Ovarian Cancer Management;
   http://www.womenshealthsection.com/content/gyno/gyno026.php3
   WHEC Publications. Special thanks to our writers and editors for compiling the review.

From Editor's Desk

What is Every Woman Every Child?

Launched by UN Secretary-General Ban Ki-moon during the United Nations Millennium Development Goals Summit in September 2010, *Every Woman Every Child* aims to save the lives of 16 million women and children by 2015. It is an unprecedented global movement that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The effort puts into action the *Global Strategy for Women's and Children's Health*, which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children.

Why does this matter?

Every Woman Every Child provides a new opportunity to improve the health of hundreds of millions of women and children around the world, and in so doing, to improve the lives of all people. The health of women and children is critically important to almost every area of human development and progress, and directly impacts our success in achieving all of the Millennium Development Goals (MDGs), adopted by world leaders in 2000. Research has conclusively demonstrated that the health of women and children is the cornerstone of public health. Healthy women and children create healthy societies. Healthy societies, in turn, are the foundation upon which nations build successful economies and create prosperity for their people. And prosperity, as we know, is essential to political stability and social harmony.

What can be done?

Every Woman Every Child recognizes that all actors have an important role to play in improving women's and children's health. More than $40 billion was pledged at the 2010 launch, and numerous partners have made additional, and critical, financial, policy and service delivery commitments, but more help is needed. The Secretary-General is asking the international community to come together to drastically improve the health of women and children globally. This would mean saving the lives of 16 million women and children, preventing 33 million unwanted pregnancies, ending stunting in 88 million children, and protecting 120 million children from pneumonia by 2015. This is an enormous and unprecedented undertaking. The stakes are high, and the cost of failure is great. But the rewards of success are greater still. They include a better life for all of us, and a healthy future for women and children everywhere.

Please visit http://www.everywomaneverychild.org/ for more information.

Words *of* Wisdom

Motherhood

From out the front of being, undefiled,
A life hath been upheaved with struggle and pain;
Safe in her arms a mother holds again
That dearest miracle – a new-born child.
To moans of anguish terrible and wild,
As shrieks the night-wind through an ill-shut pane,
Pure heaven succeeds; and after fiery strain
Victorious woman smiles serenely mild.

Yea, shall she not rejoice, shall not her frame
Thrill with a mystic rapture! At this birth,
The soul now kindled by her vital flame
May it not prove a gift of priceless worth?
Some savior of his kind whose starry fame
Shall bring a brightness to the darkened earth.

– Mathilde Blind; German Poet (1841-1896)

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities
http://www.womenshealthsection.com/