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

Remote teaching (Internet communication) in low-resource settings, where faculty time is limited and access to visiting faculty is sporadic, is feasible, effective, and well-accepted by both learners and teachers. This is the experience and conclusion of our initiative ***WomensHealthSection.com***. Using video Internet communication to teach and evaluate surgical skills in low-resource settings is also beneficial, as concluded by our initiative. We hope to expand the availability and access to our e-Health platform in up-coming years to low- and middle-income countries and areas.

Surgical skills training outside the operating room has become a routine part of residency training in the United States and continues to expand as an important part of residency curriculums. In resource-limited countries, where there are often few trained surgeons to care for a large population, it is often difficult to meet surgical training need with on-the-job learning. The global burden of surgical diseases have been increasingly recognized as a significant issue, and although shown to be a cost-effective area of intervention, has not been a priority in global health. One of the limitations of training in Africa, as with many resource-challenged countries, is ratio of skilled attending surgeons to number of patients served, as well as the number of trainees. Inadequate access to health care is a significant factor that contributes to decreased life expectancy for pregnant women. Improving the care available by increasing the level of surgical skills acquisition and number of skilled providers fits with the Millennium Development Goal 5 of decreasing maternal mortality. Additionally, it is also identified in Africa, that skill acquisition as an area of critical importance, stating that – the capacity of training is insufficient to meet the human resource training is insufficient to meet the human resource needs for maternal and newborn health. Some of the medical officers at the district hospital or health centers in low-resource settings have no skills for maternal and newborn care, despite the critical role they are expected to play at this level. Internet teaching modality could provide a mechanism for participating in global health training without travel and reduce the teaching burden on already strained local faculty.

There are several potential advantages to learning basic surgical skills in a laboratory setting. Simulation allows for repetitive and deliberate practice, rather than observatory learning. Errors can be tolerated and corrected in a skill session. Additionally, developing and solidifying basic skill level and, thus, improved learning when in the operating room. To make a skills training program more sustainable and available, the use of remote teaching is a viable option. This potentially allows faculty, residents and students who are not able to travel to participate in global health education. The ability to improve basic surgical skills through remote teaching should not be over-looked. There are several challenges with this type of teaching programs. To perform this successfully, reliable (fast) Internet access is essential. The difference in time zone makes scheduling a challenge and requires some planning and commitment on both sides and sometimes a local physician facilitator, may not be possible in all settings. Overall, it is encouraging to show that our e-Health platform is making a difference in low- and middle-income countries and settings. We believe that this basic technology can be applied to many different surgical skills and teaching modalities. With the use of Internet cameras to help guide arm movement and body mechanics, there are many more potential surgical applications (ultrasonography and laparoscopy) and other learning opportunities (remote case discussion, Morbidity and Mortality conference). Teachers and interns enjoy the remote teaching method and are interested in exploring additional applications.

This type of teaching is good way to foster ongoing application collaboration and to help us build a meaningful relationship between developing and developed countries with significant geographic constraints.

Video Internet Teaching – A Sustainable Development

Rita Luthra, MD

Your Questions, Our Reply

How can we improve health care for unauthorized (undocumented) immigrants in United States of America? Are there any health programs for unauthorized immigrants in USA?

Health Status and Unauthorized Immigrants: This population is less likely than other residents of the United States of America to have health insurance. Providing access to quality health care for unauthorized immigrants and their children, who often were born in the United States and have U.S. citizenship, is essential to improving the nation's public health. Health care professionals can play an important role in improving access to needed health care for unauthorized immigrants by: helping society understand the importance and wide-spread benefit of universal health care access for all U.S. residents, regardless of immigration status; advocating for local, state, and national policy and legislation to secure quality, affordable coverage for all and advocating for programs that serve unauthorized immigrants, such as increasing funding for the Title X family planning program and encouraging states to accept the Medicaid expansion or extend meaningful insurance coverage to low-income and vulnerable populations.

The United States of America has been called a nation of immigrants. As of 2011, approximately 13% of the U.S. population, 40 million people, was born outside of the United States. Approximately 11.3 million individuals living in the United States are unauthorized (i.e. they either entered the country illegally or have expired visas). Most immigrants (53%) came from Latin America and the Caribbean, one half of whom were born in Mexico. In addition, approximately 28% are from Asia, 12% from Europe, 4% from Africa, 2% from North America, and less than 1% from Oceania. Women account for nearly 47% of this population and children account for 10%. Children who are U.S.-born citizens, although eligible for public health insurance by virtue of this citizenship status, are more likely to be uninsured when their parents have unauthorized status. Most unauthorized immigrants live in poverty and have low rates of health insurance coverage.

The Affordable Care Act (ACA) of 2010 specifically excludes unauthorized immigrants from coverage by Medicare, Medicaid, and The Children's Health Insurance Program (CHIP), or from purchasing health insurance through state market-places. Citizens or lawfully present children of unauthorized parents, however, are eligible to purchase coverage through state marketplaces, for premium tax credits and lower copayment, and for Medicaid or CHIP. In July 2012, the Obama administration announced a new policy, called Deferred Action for Childhood Arrivals, which allows unauthorized youth who meet certain criteria to apply for a 2-year deferral from deportation. Immigrants granted Deferred Action for Childhood Arrivals status are considered "lawfully present". However, in August 2012, the Obama administration released an Interim Final Rule specifying that Deferred Action for Childhood Arrivals-eligible individuals, despite their "lawfully present" status, are excluded from expanded coverage under the ACA, Medicaid, and CHIP.

Our experts suggest – the ACA does not extend care coverage for unauthorized immigrants, because Disproportionate Share Hospital payments will decrease under the ACA, it is imperative that states accept the Medicaid expansion option, otherwise health care resources available to care for these individuals will be even further compromised. The Women's Health and Education Center (WHEC) and its non-profit entity The Women's Health and Education Organization (WHEO, Inc.) supports a basic health care package for all women, without regard to immigration status, and helps achieve this by promoting universal access to health insurance for all individuals in the United States and advocating for the elimination of barriers to existing federal programs, including Medicaid.

We believe, supporting the safety-net system and provision of care in the inpatient and outpatient setting for the uninsured is the way forward.

United Nations At A Glance

Bosnia and Herzegovina and the United Nations

The Socialist Federal Republic of Yugoslavia was an original Member of the United Nations, the Charter having been signed on its behalf on 26 June 1945 and ratified 19 October 1945, until its dissolution following the establishment and subsequent admission as new Members of Bosnia and Herzegovina, the Republic of Croatia, the Republic of Slovenia, The former Yugoslav Republic of Macedonia, and the Federal Republic of Yugoslavia.

The Republic of Croatia was admitted as a Member of the United Nations by General Assembly resolution A/RES/46/238 of 22 May 1992.

The Republic of Bosnia and Herzegovina was admitted as a Member of the United Nations by General Assembly resolution A/RES/46/237 of 22 May 1992.

The Republic of Slovenia was admitted as a Member of the United Nations by General Assembly resolution A/RES/46/236 of 22 May 1992.

By resolution A/RES/47/225 of 8 April 1993, the General Assembly decided to admit as a Member of the United Nations the State being provisionally referred to for all purposes within the United Nations as "The former Yugoslav Republic of Macedonia" pending settlement of the difference that had arisen over its name.

The Federal Republic of Yugoslavia was admitted as a Member of the United Nations by General Assembly resolution A/RES/55/12 of 1 November 2000.

On 4 February 2003, following the adoption and promulgation of the Constitutional Charter of Serbia and Montenegro by the Assembly of the Federal Republic of Yugoslavia, the official name of "Federal Republic of Yugoslavia" was changed to Serbia and Montenegro.

In a letter dated 3 June 2006, the President of the Republic of Serbia informed the Secretary-General that the membership of Serbia and Montenegro was being continued by the Republic of Serbia, following Montenegro's declaration of independence.

Montenegro held a 21 May 2006 referendum and declared itself independent from Serbia on 3 June. On 28 June 2006 it was accepted as a United Nations Member State by General Assembly resolution A/RES/60/264.

UN Data: http://data.un.org/CountryProfile.aspx?crName=Bosnia%20and%20Herzegovina

Collaboration with World Health Organization (WHO)

WHO | Bosnia and Herzegovina

The role of a WHO/Europe country office is to respond to requests from the host country to support policy-making for sustainable health development, taking a holistic health-system approach. This includes providing guidance, building up local relationships to implement technical cooperation, making standards and agreements, and ensuring that public health measures are coordinated and in place during crises.

The WHO Country Office, Bosnia and Herzegovina was established in October 1992 in Sarajevo to continuously support health authorities and partners in Bosnia and Herzegovina in improving population health through evidence-based, sustainable public health interventions.

The Office is the focal point for WHO activities in Bosnia and Herzegovina. The country team consists of 7 people, including 3 professionals with background in public health and health management.
The priorities for the Country Office are set out in the biennial collaborative agreement between WHO/Europe and the host country. The Office implements the agreement in close collaboration with national institutions and international partner agencies.

Priorities for joint work are set out in the biennial collaborative agreement (BCA) between WHO/Europe and Bosnia and Herzegovina for 2014–2015.

Global direction

This BCA is aligned with WHO's Twelfth General Programme of Work for 2014–2019, which establishes priorities for the Organization's work and an overall direction for the 6-year period beginning January 2014. In so doing, it reflects the 3 main areas of WHO reform: programmes and priorities, governance and management.

WHO's programme budget for 2014–2015 was strongly shaped by Member States, which reviewed and refined the Organization's priority-setting mechanisms as well as the 1 managerial and 5 technical categories in which its work is now structured.

Regional context

The BCA further reflects the European policy framework for health and well-being, Health 2020, adopted by the WHO Regional Committee for Europe at its 62nd session in 2012.

Health 2020 is an innovative roadmap, which sets out the Regional Office's new vision and strategic health priorities for the coming years. Health 2020 aims to maximize opportunities for promoting health and reducing health inequities. It recommends that Member States address population health through whole-of-society and whole-of-government approaches. It emphasizes the need to improve overall governance for health and suggests paths and approaches for more equitable, sustainable and accountable health development.

Health 2020 was informed by the latest evidence and developed in broad consultation with technical experts, Member States, civil society and partner organizations.

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

Bulletin of the World Health Organization; Complete list of contents for Volume 93, Number 5, May, 285-360

Collaboration with UN University (UNU)

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

Consociational settlements and reconstruction: Bosnia in comparative perspective, 1995-present

The small country of Bosnia-Herzegovina, with a population of less than four million, has received a substantial amount of aid from the international community since the war in 1991-95. This aid can be considered in two categories: (i) direct intervention by internationals in brokering and then supporting the Dayton Peace Agreement of 1995, and (ii) funding for a variety of projects to aid Bosnia's democracy,

infrastructure, and economy. Both types of aid were crucial to making peace possible, and the need for some support remains. However, aid cannot reconcile all of the difficult logical problems that can emerge in the governance of mixed states. The Dayton Agreement was intended to end a fierce and bloody war, but it also became the default setting for consociational governance institutions. Consociationalism is intended to institutionalize voice for each group and relies heavily on cooperation between elites. Many critics argue that the agreement is not suited to long-term governance structures, but changes to these institutions that could be accepted by all parties have been elusive

This paper examines Bosnia with some comparative insights from Northern Ireland. Both places were extremely fragile in the immediate aftermath of their brokered peace negotiations and consociational institutions, in Bosnia in 1995 and Northern Ireland in 1998. Bosnia in particular was the recipient of a large amount of international aid. While this aid was crucial to the initial state-building effort, the problems Bosnia now faces are due to its consociational governance structure. Some of the group-based aspects of consociationalism are at odds with individual rights, a problem which cannot be addressed by aid alone.

In this contribution, author has argued that Bosnia provides an interesting example of direct and funded aid, because it has been one of the most-funded interventions per capita in history. This aid was indeed crucial to setting the country on a firm foundation and to establish its consociational state structures. The fact that the state has not collapsed again into violence nearly 20 years after the settlement is a sign of this success, especially in light of the number of negotiation attempts required to get to the 1995 Dayton Agreement. In the short term, international aid has been crucial to this success. However, in the long term, some of the governance tensions inherent in the consociational structures of the Dayton Agreement have emerged, but these cannot be addressed by aid alone. They constitute logical problems that must be resolved by means of negotiation and organic involvement of the population. The fact that the Northern Ireland Good Friday Agreement has some similar (though not as many) tensions illustrates that the consociational contradictions are not simply Bosnian problems, but rather reflect some of the fundamental institutional tensions between group-based decision-making structures and individual human rights.

Publisher: UNU-WIDER; Author: Sherrill Stroschein; Sponsor: UNU-WIDER gratefully acknowledges specific programme contributions from the governments of Denmark (Ministry of Foreign Affairs, Danida) and Sweden (Swedish International Development Cooperation Agency—Sida) for ReCom. UNU-WIDER also gratefully acknowledges core financial support to its work programme from the governments of Denmark, Finland, Sweden, and the United Kingdom.

(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)

Global Partnership for Education (GPE)

The Global Partnership for Education is the only multilateral partnership devoted to getting all children into school for a quality education.

Established in 2002, the Global Partnership for Education is comprised of close to 60 developing countries, donor governments, international organizations, the private sector, teachers, and civil society/NGO groups.

One of our five strategic objectives for the 2012-2015 period is to promote girls' education. Our approach is to ensure that "all girls in GPE-endorsed countries successfully complete primary school and go to secondary school in a safe, supportive learning environment".

GPE partners work together to:

- Increase gender parity and enrollment overall;
- Provide strong incentives as well as technical and financial support to developing country partners to include gender analysis and strategies in their education plans;
- Support the enrollment of out-of-school girls into primary school and lower secondary school; and
- Ensure that girls make the crucial transition from primary to secondary school.

GPE results in girls' education since 2002 include:

- GPE partners have helped enroll approximately 10 million girls in school since 2003 (2013 Results for Learning Report);
- 69 per cent of girls in GPE countries now finish primary school, compared to 56 per cent in 2002 (upcoming 2014 Results for Learning Report);
- 14 GPE partner countries now have as many girls as boys completing primary school or are close to this goal; 14 countries have more girls than boys completing primary school (2013 Results for Learning Report); and
- The number of girls out of school has dropped by 47 per cent over the last decade (2002 – 2012) (upcoming 2014 Results for Learning Report).

The Global Partnership works closely with the United Nations Girls' Education Initiative (UNGEI) and many other bilateral and multilateral partners to move forward the girls' education agenda. UNGEI, together with the Ministry of Foreign Affairs of France, is the co-lead of the Technical Reference Group to the GPE for girls' education.

Learn more about the Global Partnership for Education: http://www.globalpartnership.org

To be Continued……..

Top Two-Articles Accessed in April 2015

1. Healthy Mother Health Infant Through Nutrition;
   http://www.womenshealthsection.com/content/obs/obs029.php3
   WHEC Publications. Special thanks to WHO, NIH, Institute of Medicine (IOM) for the contributions. We thank our reviewers for helpful suggestions.

2. Women's Health and Human Rights;
   http://www.womenshealthsection.com/content/heal/heal015.php3
   WHEC Publications. Special thanks to WHO, UNFPA and The World Bank for the contributions. Gratitude is expressed to our writers, editors and reviewers for compiling the review.

From Editor's Desk

WHO | Sustainable Development

Traditionally, this is described as development that meets the needs of the present without compromising the ability of future generations to meet their own needs (and is therefore sustainable) - as defined by the 1992 UN Declaration on Environment and Development at Rio de Janeiro. However, it is impossible to define accurately what the needs of future generations will be because we cannot know with any certainty what future inventions or changes will bring.

Health is both a resource for, and an outcome of, sustainable development. The goals of sustainable development cannot be achieved when there is a high prevalence of debilitating illness and poverty, and the health of a population cannot be maintained without a responsive health system and a healthy environment. Environmental degradation, mismanagement of natural resources, and unhealthy consumption patterns and lifestyles all have an impact on health. Ill-health, in turn, hampers poverty alleviation and economic development.

Sustainability impact assessments of trade policies are a process for assessing the impact of trade liberalization on sustainable development.

World Summit on Sustainable Development (WSSD)

At the 2002 World Summit on Sustainable Development (WSSD) held in Johannesburg, South Africa, sustainable development was reaffirmed as a central component of the international agenda. A wide range of targets and concrete commitments for action to implement sustainable development objectives were agreed and reaffirmed by governments. Health (the theme of the first plenary) was identified as one of five priority sectoral issues under the framework of the Water, Energy, Health, Agriculture and Biodiversity (WEHAB) initiative.

The major outcomes of the WSSD include a negotiated Plan of Implementation (featuring health throughout, as well as a separate chapter on health), a Political Declaration and a number of implementation partnerships and initiatives. Among the most significant achievements of the Summit was a new target to halve the proportion of people who do not have access to basic sanitation by the year 2015. This complements the Millennium Development Goal of halving the proportion of people without access to clean drinking water by 2015.

Other targets include, by 2020, to use and produce chemicals in ways that minimize significant adverse effects on human health and the environment, taking into account the precautionary principle. In the area of health promotion, there was an agreement to enhance health education with the objective of achieving improved health literacy on a global basis by 2010. There was also a wide variety of actions in the area of health care and disease control, environmental health, nutrition and lifestyle-related diseases and risks, and child health. On women's health and gender issues, it was agreed that access to health care should be consistent with basic human rights as well as religious and cultural values.

Other outcomes of the Summit included:

- Biodiversity: to cut significantly by 2010 the rate at which rare animals and plants are becoming extinct;
- Poverty: to establish a solidarity fund to wipe out poverty, "the greatest global challenge facing the world today". It was stressed that contributions to the fund are voluntary;
- Aid: recognition that a substantial increase in aid is needed for poor countries to meet agreed development goals. Rich countries are urged to give 0.7% of national income, a target first set in 1970;
- Energy: to take actions to improve access to affordable energy, but there was no agreement on specific targets to increase "substantially" the use of renewable energies, such as solar or wind

power, in global consumption. The European Union was in favor of targets but the United States and oil-producing countries were not;

- Fish: to restore depleted fish stocks by 2015 at the latest, recognizing that oceans are essential ecosystems and a critical source of food, especially in poor countries;
- Governance: recognition that good governance nationally and internationally is essential for sustainable development.

Details – Health and Sustainable Development:

http://www.who.int/mediacentre/events/HSD_Plaq_02.7_def1.pdf?ua=1

Words *of* Wisdom

Trust no future, however pleasant;
Let the dead past bury its dead;
Act-act in the living present;
Heart within, and God over head.

– H. W. Longfellow (1807-1882), from *A Psalm of Life,* American Poet and Educator

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

http://www.womenshealthsection.com/