WHEC UPDATE
Briefings of worldwide activity of Women's Health and Education Center (WHEC)
February 2016; Vol. 11, No. 2

Annual Project Report

What does it mean to stay true to the name of the United Nations? The term, United Nations, first emerged from a declaration signed in January 1942 by 26 allies fighting against Germany and Japan. The signatory Governments pledged not to sign separate peace agreements and to commit themselves to a maximum war efforts. 21 more countries would sign the declaration by the end of the war. Only States that had the United Nations Declaration received an invitation to the United Nations Conference on International Organization in the San Francisco Civic Center that began on 25 April 1945. Although the war was not yet won, delegates from the Allied nations gathered in San Francisco to create the Charter of the United Nations. At key-moments, mid-size nations like Canada played a vital role in shaping the workings of the United Nations. Mid-size nations often steered the United Nations behind the scenes, reconfigured the dynamics of decision-making, and acted as crucial intermediaries to unite nations.

Mid-size nations even proved vital in sowing the seeds for United Nations specialized agency (World Health Organization) at this San Francisco Conference. Only medical doctors from Norway, Brazil and China attended the conference as delegates. Rather than a resolution, these physicians managed to pass a declaration calling for the establishment of international conference on health. Over the next few years, that conference developed into the World Health Organization (WHO), officially founded in 1948 and headquartered in Geneva.

The history of the United Nations tells us more than just how the Organization emerged. It shows the dynamics of the Organization and its ability to adapt swiftly to changing circumstances. It is a story of cooperation across traditional enmities, which often played out behind the scenes and through little-known individuals. Over the past 70 years, the United Nations has stood out for its surprising flexibility and adaptability. We hope those qualities continue to strengthen the Organization in the future.

A strong and vital health workforce is an investment in health for today and the future. The ultimate goal is a workforce that can guarantee universal access to health care to all citizens in every country. The country coordinating mechanism model has potential to encourage new and innovative alliances among partners in recipient countries, drawing on the active participation of civil society and the private sector. Such broad membership might help to improve the quality of funding proposals, increase information-sharing and trust between planners and healthcare workers and contribute to a strong sense of shared ownership.

The Women's Health and Education Center (WHEC) and its non-profit entity The Women's Health and Education Organization, Inc. (WHEO, Inc.) had the honor to launch this e-learning project / publication (http://www.WomensHealthSection.com) in association with the Department of Public Information of the United Nations on 24 October 2002. We are embarking on a new era in medicine and healthcare. Our mission is to make evidence-based medicine available to national and international audience. To reach the global community and to serve national and international needs, the text is available in six languages: Arabic, Chinese, (US) English, French, Russian, and Spanish. The syllabus of our project is designed to stress common, everyday health-care issues in women's health. Most of all, however, we hope that the contents will motivate future research that will further enhance the understanding of reproductive health. Education is the best gift in life both to give and to receive. The main purpose of **WomensHealthSection.com** is to provide a platform for the international exchange of experience, ideas and opinion on public health with special focus on Women's Health and Health Development.

Join the movement!

A Time for Bold Initiatives
Rita Luthra, MD

2015 In Review - A Vision

The 2015 year in review gives a glimpse of what can be achieved when we all work together. The unity of all member states of UN to invest in the future of our planet by unanimously adoption of the Sustainable Development Agenda to extreme poverty is bold and much needed initiative. This is the foundation to improve maternal and child health worldwide.

With 2015 the start of the five-year commitment to the Sustainable Development Goals (SDGs), this new Reproductive Health Action Plan reaffirms the Women's Health and Education Center's (WHEC's) commitment to helping countries mobilize the financing and the technical expertise they will need to achieve the target of Millennium Development Goal (MDG) # 5: to reduce maternal mortality and achieve universal access to reproductive health by 2030.

Healthcare providers and policy makers will find our articles and forums useful and helpful in improving women's health and status in both industrialized and developing countries. We welcome comments and suggestions from all those working for Safe Motherhood. Even though each country has its unique culture, economics and politics—they all share similar developmental challenges. This whole world is a developing country -- some have a longer way to go than others.

Cultural Diversity is now the norm in each and every country. Women's Health and Education Center (WHEC) respects the rights of patients, colleagues and the communities. We plan development together. In this forum we are all equals, working towards a common goal -- to improve maternal and child health worldwide.

WomensHealthSection.com -- Knowledge that touches patients; is a vision for the Globalized World. The use of information science and telecommunications to support the practice of medicine when distance separates the caregiver from the patient is the way forward to make medical care more affordable and more accessible in every country. A strong and vital health workforce is an investment in health for today and the future. It has profound effect on all the Citizens of the World, and political, social, economic systems. We welcome everyone.

It is indeed our pleasure to submit to you the **UN Document:** **E/2015/NGO/2**

http://www.womenshealthsection.com/content/documents/UN-Economic-and-Social-Council-Statement-E-2015-NGO-2.pdf **published by Economic and Social Council**

Create a Page/Space on ***WomensHealthSection.com*****!**

Get the Big Picture!

It served **14 million** readers / subscribers in 227 countries and territories with an average of about 1.4 million visitors / subscriber, per month, in 2015 with links to about 85,000 websites. On average 112,000 files, 7,600 URLs and 18,600 pages were accessed every month. It expanded from 22 to 28 sections and we hope to continue to grow. In the spirit of growth in this digital age, it was upgraded in 2015 for global dissemination. We have rearranged content so that it is easier for you to find what you need.

We welcome your feedback and hope you find the Journal to be useful – a continuing mission.

Top 15 Countries out of 227 Countries and Territories, where ***WHEC Global Health Line / WHEC Net Work*** is accessed frequently: USA; Canada; China; Australia; Argentina; Russian Federation; Saudi Arabia; Belgium; U.K.; Germany; Venezuela; Spain; India; Mexico; and France.

Top 5 Groups out of 25 groups for educational purposes: US Educational; US Commercial; US Government; US Military and International (Int).

Top 5 User Agents out of 1,001: Microsoft (MSIE 8.0, 6.0 and 9.0); Google (Googlebot / 2.1 and / imgres); Yahoo (Yahoo! Slurp and Yahoo! Slurp China); MSN (msnbot-media); bingbot/2.0

Top 5 most popular sections out of 28: 1) Obstetrics; 2) WHEC Update; 3) Gynecologic Oncology; 4) Gynecology; 5) Healthcare Policies and Women's Health.

Top 10 most read comprehensive review articles out of 230 Practice Bulletins: 1) End of Life Decision Making; 2) Psychiatric Disorders During Pregnancy; 3) Female Sexual Dysfunction; 4) End-of-Life Care: Pain Assessment and Management ; 5) Stillbirth: Evaluation and Management ; 6) Medical Liability: Risk Management; 7) Medical Liability: Tort Reform; 8) Medical Liability: Coping With Litigation Stress 9) Sexual Violence 10) Bone Health: Osteoporosis Prevention Strategies.

Beneficiaries: Visitors of *WomensHealthSection.com* (more than 120 million readers / subscribers worldwide so far and growing fast…)

Dedicated to Women's and Children's Well-being and Health Care Worldwide

Your Questions, Our Reply

How can a truly universal post-2015 agenda be achieved? How should the post-2015 framework be implemented?

Promote Sustainable Development: In order for the post-2015 framework to have an impact, universality is essential. A non-universal framework would make it very difficult to hold Governments to account to meeting the targets to which they have agreed. Therefore, we need a global set of shared indicators that motivate action and allow for cross-country comparison. At the same time, however, a universal framework must still be context sensitive. This can be achieved through more context-specific indicators that complement the universal set of global indicators and that are agreed upon at a national or even regional level. Furthermore, unless stated within the universally agreed targets, benchmarks and the pace of progress should be defined at the national level.

Although a renewed and strengthened global partnership for mobilizing the means of implementation is necessary, the implementation of the post-2015 framework should not overlook the many existing global initiatives to build more peaceful societies. For example, the Geneva Declaration – endorsed by over 100 States – aims to achieve measurable reductions of armed violence in conflict and non-conflict settings. Presented and widely endorsed at the Fourth High-Level Forum on Aid Effectiveness in Busan, Republic of Korea, the "New Deal for Engagement in Fragile States" proposes five key peacebuilding and State-building goals as a focus for cooperation between 19 conflict-affected States, development partners and international organizations. Indeed, through this New Deal process, conflict-affected States are sharing to pilot the use of 34 common indicators to measure progress across five peace goals, which can inspire and inform the post-2015 indicator framework. In addition to these global processes, there is a wide range of national-level initiatives and experiences from which other countries will be able to draw as they plan their own paths to meeting the targets in Sustainable Development Goals (SDGs) 16. In this regard, creating partnerships and enabling cross-country learning should be a key component of implementation.

The post-2015 development framework represents a once-in-a-generation opportunity to ensure multilateral action – grounded in development and focused on people – to prevent violent conflict.

Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels. Achieve gender equality and empower all women and girls. Ensure healthy lives and promote well-being for all at all ages.

We have been given an opportunity to establish and ambitious, equitable development agenda for the next 15 years. Global political processes are on track to deliver a meaningful outcome which could be transformative for global health. As we forward, stakeholders must hold Governments accountable to fulfil their promises for a substantial agreement, and begin working together to implement SDGs.

Join conversation @ ***WomensHealthSeciton.com*** and ***WHEC Global Health Line.***

United Nations At A Glance

Permanent Mission of the Kingdom of Cambodia to the United Nations

Became Member State of the United Nations on 14 December 1955

Cambodia, officially known as the Kingdom of Cambodia and once known as the Khmer Empire, is a country located in the southern portion of the Indochina Peninsula in Southeast Asia. Its total landmass is 181,035 square kilometers (69,898 sq mi), bordered by Thailand to the northwest, Laos to the northeast, Vietnam to the east, and the Gulf of Thailand to the southwest.

With a population of over 15 million, Cambodia is the 70th most populous country in the world. The official religion is Theravada Buddhism, practiced by approximately 95 percent of the population. The country's minority groups include Vietnamese, Chinese, Chams, and 30 hill tribes. The capital and largest city is Phnom Penh, the political, economic, and cultural center of Cambodia. The kingdom is a constitutional monarchy with Norodm Sihamoni, a monarch chosen by the Royal Throne Council, as head of state. The head of government is Hun Sen, who is currently the longest serving non-royal leader in South East Asia and has ruled Cambodia for over 25 years.

The foreign relations of Cambodia are handled by the Ministry of Foreign Affairs under H.E. Hor Namhong. Cambodia is a member of the United Nations, the World Bank, and the International Monetary Fund (IMF). It is a member of the Asian Development Bank (ADB), ASEAN, and joined the WTO in 2004.

In 2005 Cambodia attended the inaugural East Asia Summit in Malaysia. Cambodia has established diplomatic relations with numerous countries; the government reports twenty embassies in the country including many of its Asian neighbors and those of important players during the Paris peace negotiations, including the US, Australia, Canada, China, the European Union (EU), Japan, and Russia. As a result of its international relations, various charitable organizations have assisted with social, economic, and civil infrastructure needs.

While the violent ruptures of the 1970s and 1980s have passed, several border disputes between Cambodia and its neighbors persist. There are disagreements over some offshore islands and sections of the boundary with Vietnam and undefined maritime boundaries and border areas with Thailand. Cambodian and Thai troops have clashed over immediately adjacent to the Preah Vihear temple, leading to a deterioration in relations

The Judgment of the International Court of Justice (ICJ) In The Hague on 15 June 1962

The Court

By nine votes to three: finds that the Temple of Preah Vihear is situated in territory under the sovereignty of Cambodia; finds in consequence,

By nine votes to three: That Thailand is under an obligation to withdraw any military or police forces, or other guards or keepers, stationed by her at the Temple, or in its vicinity on Cambodian territory;

By seven votes to five: That Thailand is under an obligation to restore to Cambodia any objects of the kind specified in Cambodia's fifth Submission which may, since the date of the occupation of the Temple by Thailand in 1954, have been removed from the Temple or the Temple area by the Thai authorities.

Details: http://www.cambodiaun.org/

Collaboration with World Health Organization (WHO)

WHO | Cambodia

Health Situation

Cambodia has observed a significant improvement in health status of the population due to the strong economic growth in the past several years; particularly in infant, child and maternal mortality as well as in continuing decline in HIV prevalence and deaths by malaria. However, the improvement in neonatal mortality has been much slower, and the issues of the inequality still persists between rural and urban areas as well as among different socio-economic groups including women, the poor, migrant workers, unregistered population, and ethnic minorities. Substantial progress has been made towards meeting the targets set out in the Cambodia MDGs (CMDGs) where all the CMDG 4, 5, 6 efforts are on track to meet these goals by 2015. Progress to improve nutrition has been slower than expected, with under-nutrition contributing to more than 6,400 child deaths annually and 40% of children under 5 are stunting. New health challenges are also emerging, notably Non-communicable diseases (NCDs) epidemic and growing rates of injuries such as road accidents.

Among others, tobacco is considered to be one of the biggest risk factors for developing NCDs, whereas around 30% of adults is estimated to be daily tobacco users. While Cambodia has made a strong progress in communicable disease control, one of the remaining challenging is emerging infectious diseases where Cambodia has the highest numbers of cases of avian influenza H5N1 subtype (47 cases between 2005 – 2013) globally. Cambodia is committed to developing the core capacities required by the International Health Regulations (IHR) by June 2014. Good progress has been made in surveillance and response to outbreaks, however development of “point of entry” has lagged behind.

Cooperation for Health

Cambodia has enjoyed high levels of financial support from the international community over the last decade, where health and HIV have been priority sectors. Aid for health rose to US $ 199 million in 2010. The health sector in Cambodia has been described as complex and fragmented, with at least 30 partners active in the sector and large numbers of NGOs. Cambodia’s mechanisms for aid coordination have continued to expand and strengthened, and there is explicit commitment to development effectiveness at the highest level of government as seen in the monitoring of the Busan agenda implementation. An effective Technical Working Group – Health (TWG-H) with broad representation from government, multilateral and bilateral agencies, and NGOs has been established for information sharing and policy discussion in the health sector.

Details: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_khm_en.pdf?ua=1

Bulletin of the World Health Organization; Complete list of contents for Volume 94, Number 2, February, 77–156

Point of View

Our Graduates Making a Difference at Regional, National and International Levels

Rajasthan (“Land of Kings”) is India’s largest state by area. It is located in Western part of the country. The state was formed on 30 March 1949 when Rajputana (the name adopted by the British Raj) was merged with India. Its capital and largest city is Jaipur. Today, the State has 10 medical colleges affiliated with The Rajasthan University of Health Sciences. Sardar Patel Medical College (SPMC) is the second medical college in the state. It opened its doors to the 45 students (first batch) in April, 1959. The college was named in honor of a highly venerated freedom fighter, Sardar Patel, whose statesmanship brought about a merger of diverse princely states (as many as 19, who constitutionally could have enjoyed independent status) into one big state, that is Rajasthan.

Although in the beginning, the college was short of space, equipment, laboratories, furnishings and other paraphernalia, it was not short of trained and experienced staff that was recruited by the personal efforts of the founder principal from different parts of India. All of them were imbued with a missionary zeal to give their best to the students. After taking training in the advanced methods of teaching and research in the U.S.A. and United Kingdom, some of our young bright faculty members, who had returned to SP Medical College, felt unhappy at the sorry state of medical education in Rajasthan. They wanted SPMC to keep pace with the latest trends in medical education. Slowly and steadily they worked for shifting the teacher-centered coaching towards student-centered pedagogy. The formal lectures were reduced; group discussions, tutorials, and bed-side teaching were substantially increased. Exposure to patients was advanced by a year. Vertical and horizontal co-ordination between various subjects was attempted with greater gusto and implemented wherever feasible. Over a period of time, clinical and para-clinical quizzes replaced the archaic techniques of making a pill or a mixture or emulsion or dissecting a frog in the lab. Greater emphasis was placed on the theme of primary health care, health promotion and disease prevention. Nomenclature of the subject of Hygiene was changed to Preventive and Social Medicine in order to highlight the role of the environmental and societal factors in disease, and community-based teaching was introduced from the first year and continued throughout the educational program. These changes of far-reaching importance were effected over time and they stimulated analytical skills and fostered life-long learning skills.

SPMC graduates, educated as they were in an atmosphere of advanced academia mixed with humanitarianism proved their worth in the national and international spheres. They have occupied positions of great importance in the government, university, industry and international organizations and have made contributions of sterling value in their respective fields. Their achievements, attainments and accomplishments have been embodied in a coffee-table book titled 'SPMC ALUMNI REMINISCE'. This book also describes the struggles they made, challenges they faced and obstructions they overcame to make a niche for themselves in medical world.

It is interesting to mention here that SPMC, starting with the intake of only 45 students, has now an intake of 250 students for under-graduate course (M.B.B.S.), 63 for postgraduate degrees and 19 for post-graduate diplomas. Super-specialization (D.M.) courses have also been started in some subjects. Thus this college started 66 years ago is now playing a very important role both in the fields of medical education and health care in the country. Thus a long way SPMC has come but a long way it has yet to go. And it will, because in the mind of its alumni, faculty and students the following dictum is permanently etched: "*Where there is a will, there is a way; where there is no way we will make one".*

Details: http://medicaleducation.rajasthan.gov.in/bikaner/index.asp
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Collaboration with UN University (UNU)

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

Clustering, competition, and spillover effects in Cambodia

- There is significant evidence of productivity spillovers associated with the clustering of informal firms in Cambodia;
- Formal and manufacturing firms, however, do not experience the advantages of agglomeration economies due to pressure from direct competitors;
- Benefits derived from improvements in productivity as a result of the clustering of economic activity of firms in Cambodia most often do not outweigh the negative effects of competition created by nearby firms.

What types of businesses benefit or suffer due to geographic clustering? Data available from Cambodia on competition and spillovers—at both village- and commune-level—is useful to answer a number of

questions about the effects of clustering and the possible benefits or drawbacks of encouraging the concentration of industries in specific zones in developing countries.

Is firm productivity enhanced by clusters?

In Cambodia, firm clustering at both village- and commune-levels is usually indicative of higher measured firm productivity. However, data also reveal that a large number of competing firms operating within the same sector at either village- or commune-level can have a negative impact on the productivity of firms. In other words, increased competition created by the clustering of similar economic activities in one zone often results in a decrease in productivity as competitive pressures begin to take a toll on individual firms, eventually resulting in lower revenue levels for a given input level.

Does the impact of clustering differ depending on industry and firm size in Cambodia?

While businesses are generally more productive in more densely populated clusters, the manufacturing and service sectors do not benefit from clustering in the same way—service sector firms perform better in agglomerations of economic activity where they are located closer to target customers; manufacturing firms experience more pronounced effects of competition and thus must often diversify their customer bases by targeting larger areas. The subsequent diversification of manufacturing customer bases may be hindered due to high transport costs or a lack of relevant market information.

The majority of Cambodian firms are quite small, with most employing less than 10 people. Despite this, there does not appear to be a substantial difference between the effects of competition experienced by small firms compared to those confronting larger industrial firms.

Lessons from Cambodia

There is significant evidence of productivity spillovers associated with the clustering of informal and service sector firms in Cambodia. However, competition in clusters can exert significant negative effects on formal and manufacturing firms and prevent them from reaping the benefits of agglomeration economies often touted in developed countries.

- Policy efforts should focus on removing constraints that prevent formal firms from reaping the benefits of clustering;
- Reducing the imposed costs of competition within clusters will allow manufacturing firms to become more productive

The inflexible nature of formal firms restricts them from adapting and competing effectively with competitive pressures. Manufacturing firms, on the other hand, are challenged with finding broader customer bases when there is greater competition within their specific clusters; challenges from competitors and registration expenses prohibit them from enhancing productivity. Future clustering policies must therefore focus on the removal of the cost base of the formal and manufacturing firms that form the basis of a healthy industrial sector.

(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)

Cambodia

After decades of war and civil strife, Cambodia has enjoyed relative peace for the past several years and is steadily rebuilding its shattered infrastructure, society and economy

Given the destruction wrought by years of terrible conflict, recovery has been slow – Cambodia is still one of the poorest countries in Asia, with some 34 per cent of its people surviving on less than US$ 1 a day. Nearly half of all Cambodian children are malnourished, and one in eight dies before their fifth birthday, largely due to preventable causes. More than half of Cambodia's 13 million people are under the age of 18, and ensuring that they will grow up to be healthy, educated adults ready to fully contribute to the sustainable development of their country remains a major challenge.

Yet Cambodia is making progress towards that goal. Nearly 90 per cent of children now enter primary school, with girls enrolling at almost the same rate as boys. Although Cambodia still has one of the highest HIV/AIDS prevalence rates in Asia, this rate has fallen by nearly one-third since 1997. Stepped up efforts in law enforcement for child protection have resulted in over 750 sex tourists and paedophiles being arrested and prosecuted in recent years for the sexual abuse of children. And the country's development efforts are now being guided by new sector-wide strategies and policies in the areas of poverty reduction, health, education and nutrition.

Child-friendly schools give Cambodian children a boost

At the crack of dawn, the school day swings into motion in Trapaing Chhouk School, several kilometers down a dirt track from the nearest town. By 6 a.m., students are already streaming in the front gate. Some come on foot, others on bicycles. Many are carrying branches or large chunks of bark to be used as firewood. They have come early for breakfast. Student volunteers scoop heaps of rice, lentils and green vegetables into bowls, which the children then take outside or to their classrooms. It's simple fare that goes a long way in this rural region, where many families still struggle to feed themselves.

New opportunities for children

The morning meal at Trapaing Chhouk is the result of a partnership between UNICEF and the World Food Programme. It's also a key component of the Child Friendly School initiative, which aims to get all children into class by the age of six and improve the quality of education nationwide.

A child-friendly school actively identifies excluded children, gets them enrolled in school and acts in the interests of the 'whole' child – including his or her health, nutrition and overall well-being.

Beyond simply increasing enrolment numbers, UNICEF hopes improved schools will provide new opportunities for Cambodia's next generation. In a country where fewer than 20 per cent of girls are enrolled in secondary school, achieving these goals is a daunting task that requires cooperation from many organizations. "The fact that we have support not just from the World Food Programme and UNICEF but from the whole UN country team to increase children's participation in education is very important," said UNICEF's Representative in Cambodia, Rodney Hatfield. "In my opinion, that's the UN at work."

Details: http://www.ungei.org/infobycountry/cambodia_107.html

To be Continued……..

Top Two-Articles Accessed in January 2016

1. Uterine Cancer: A Modern Approach to Surgical Management;
   http://www.womenshealthsection.com/content/gyno/gyno027.php3
   WHEC Publications. Special thanks to Tashanna K.N. Myers, MD, FACOG; Assistant Professor of Obstetrics and Gynecology; Tufts University School of Medicine; Gynecologist Oncologist at Baystate Health, Springfield, MA (USA) for serving as reviewer and helpful suggestions in compiling this review.

2. Non-Invasive Prenatal Genetic Testing for Fetal Anomalies;
   http://www.womenshealthsection.com/content/obs/obs034.php3

WHEC Publications. Special thanks to our writers, editors and reviewers for the helpful suggestions.

From Editor's Desk

WHO | Zika Virus

Key facts

- Zika virus disease is caused by a virus transmitted by Aedes mosquitoes;
- People with Zika virus disease usually have a mild fever, skin rash (exanthema) and conjunctivitis. These symptoms normally last for 2-7 days;
- There is no specific treatment or vaccine currently available;
- The best form of prevention is protection against mosquito bites;
- The virus is known to circulate in Africa, the Americas, Asia and the Pacific.

Introduction

Zika virus is an emerging mosquito-borne virus that was first identified in Uganda in 1947 in rhesus monkeys through a monitoring network of sylvatic yellow fever. It was subsequently identified in humans in 1952 in Uganda and the United Republic of Tanzania. Outbreaks of Zika virus disease have been recorded in Africa, the Americas, Asia and the Pacific.

- Genre: Flavivirus;
- Vector: Aedes mosquitoes (which usually bite during the morning and late afternoon/evening hours);
- Reservoir: Unknown

Signs and Symptoms

The incubation period (the time from exposure to symptoms) of Zika virus disease is not clear, but is likely to be a few days. The symptoms are similar to other arbovirus infections such as dengue, and include fever, skin rashes, conjunctivitis, muscle and joint pain, malaise, and headache. These symptoms are usually mild and last for 2-7 days. During large outbreaks in French Polynesia and Brazil in 2013 and 2015 respectively, national health authorities reported potential neurological and auto-immune complications of Zika virus disease. Recently in Brazil, local health authorities have observed an increase in Zika virus infections in the general public as well as an increase in babies born with microcephaly in northeast Brazil. Agencies investigating the Zika outbreaks are finding an increasing body of evidence about the link between Zika virus and microcephaly. However, more investigation is needed before we understand the relationship between microcephaly in babies and the Zika virus. Other potential causes are also being investigated.

Transmission

Zika virus is transmitted to people through the bite of an infected mosquito from the Aedes genus, mainly Aedes aegypti in tropical regions. This is the same mosquito that transmits dengue, chikungunya and yellow fever. Zika virus disease outbreaks were reported for the first time from the Pacific in 2007 and 2013 (Yap and French Polynesia, respectively), and in 2015 from the Americas (Brazil and Colombia) and Africa (Cape Verde). In addition, more than 13 countries in the Americas have reported sporadic Zika virus infections indicating rapid geographic expansion of Zika virus.

Diagnosis

Zika virus is diagnosed through PCR (polymerase chain reaction) and virus isolation from blood samples. Diagnosis by serology can be difficult as the virus can cross-react with other flavi-viruses such as dengue, West Nile and yellow fever.

Treatment

Zika virus disease is usually relatively mild and requires no specific treatment. People sick with Zika virus should get plenty of rest, drink enough fluids, and treat pain and fever with common medicines. If symptoms worsen, they should seek medical care and advice. There is currently no vaccine available.

WHO Director-General Briefs Executive Board on Zika Virus

WHO Response

WHO is supporting countries to control Zika virus disease through:

- Strengthening surveillance;
- Building the capacity of laboratories to detect the virus;
- Working with countries to eliminate mosquito populations;
- Preparing recommendations for the clinical care and monitoring of persons with Zika virus infection; and
- Defining and supporting priority areas of research into Zika virus disease and possible complications.

Details: http://www.who.int/csr/disease/zika/en/

Zika Virus Disease: Questions & Answers

http://www.who.int/features/qa/zika/en/

Words *of* Wisdom

The woods are lovely, dark and deep.
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep.

- Robert Lee Frost, American poet (March 26, 1874 – January 29, 1963)

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

http://www.womenshealthsection.com/