WHEC UPDATE
Briefings of worldwide activity of Women's Health and Education Center (WHEC)
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Shaping the Future

Most low- and middle-income countries face financing pressures if they are to adequately address the recommendations of the Global Strategy for Women's, Children's and Adolescent's Health. Negotiations between government ministries of health and finance are a key determinant of the level and effectiveness of public expenditure in the health sector. Yet ministries of health in low- and middle-income countries do not always have a good record in obtaining additional resources from key decision-making institutions. This is despite the strong evidence about the affordability and cost-effectiveness of many public health interventions and of the economic returns to investing in health. Almost all low- and middle-income countries are seeking to achieve universal health coverage, yet most are also experiencing increased financial pressures as a result of rising rates of often expensive-to-treat and chronic non-communicable diseases. Many countries are losing access to external development finance as they move into middle-income status.

How much low- and middle-income countries spend from their own resources, and how well they spend them, is a key determinant of the outputs and outcomes of women's, children's and adolescents' health. There is no consensus about the amount or proportion of national income to spend on health good outcomes for maternal health, can be achieved even in low-income settings. Nevertheless, government expenditure on health is often low in absolute and relative terms in many low- and middle-income countries. Sixty-three high-burden, low- and lower-middle-income countries are eligible for support under the recently launched global financing facility in support of the *UN Secretary-General's Every Woman Every Child global strategy.* Yet in 48 of these countries the government's expenditure on health in 2013 was less than US$ 50 per capita, with eight countries spending less than US$ 10 per capita, and as low as US$ 4 per capita in Myanmar. Only nine countries have achieved the target of allocating 15% of national budget to the health sector which was agreed to by many low-income governments in 2001. Eight countries, including highly populated India and Pakistan, allocated less than 5% of total government expenditure to health.

It is indeed our privilege to collaborate with *UN Secretary-General's Every Woman Every Child global strategy* and in our publications – ***WomensHealthSection.com*** and ***WHEC Update***, our editorial board calls for papers and point of view on this topic. Effective action on women's, children's and adolescents' health will always involve adequate and effective public expenditure in the health sector. A key aspect determining this will be the capacity of a health ministry to present coherent investment plans to the ministry of finance.

The factors we have identified are sufficiently broad-based that they can be applied in virtually any setting and any country. We recognize, however, that applying these attributes may be difficult in fragile and conflict-affected states, where basic data may be missing and lines of authority and responsibility may be blurred. Furthermore, while many of the attributes also apply to engaging with bilateral and multilateral development partners, other issues may then arise, including the requirement for ministries of health to demonstrate that development partners' resources are an addition to, rather than a substitution for, government's own expenditure efforts. While we focus on what ministries of health can do, we also recognize that ministries of finance too have a responsibility to improve prioritization, planning and resource allocation. *The Global Strategy for Women's, Children's and Adolescents' Health* already provides an overarching policy framework and strategy for improving the health outcomes of women, children and adolescents.

Investing in Women's Children's and Adolescent's Health

Rita Luthra, MD

Your Questions, Our Reply

How can health ministries present persuasive investment that is also the guideline for women's, children's and adolescents' health? Are there any frameworks?

Key Funding Attributes: A starting point for the ministry of finance will be how the ministry of health's proposals can specifically contribute to broader national development objectives. Improving health and saving lives has, of course, intrinsic value. However, the health ministry needs to also specifically demonstrate how, where, when and at what cost investments in health directly contribute to broader priority national objectives and not just to health goals, important as they may be. There are many arguments that the ministry of health can make, depending on the country. For example, investments in health, including family planning, have been shown to contribute directly and indirectly to favorable demographic trends, better learning outcomes, higher worker productivity and greater household savings and investment, and therefore to better longer term economic growth, often at low per capita cost.

Second, the ministry of finance will usually want to see that the proposed expenditure is an investment yielding substantial outputs and outcomes, and not simply a cost, with a focus on inputs and expenses. Proposals that can demonstrate measurable outputs and outcomes in ways that are affordable, feasible, financially and institutionally sustainable, cost-effective or even potentially cost-saving, and yield economic returns on investment in a wide range of settings are more convincing than budget proposals that focus just on inputs.

Third, a ministry of finance will be more confident about allocating additional resources if the ministry of health provides evidence that it is already making good use of its existing resources. A finance ministry may concede that the health ministry requires additional funding, but may be reluctant to allocate additional funds if it knows or perceives, for example, that public health facilities are irregularly staffed or underused; that there has been under-expenditure in the health budget in previous years; or that there are inefficiencies in procurement or cases of waste and corruption. The World Health Organization (WHO) notes that around 20–40% of health expenditure globally could be freed up through eliminating 10 preventable sources of waste and inefficiency in the health sector. A World Bank report estimated that in Cambodia savings could exceed US$ 50 million a year or one-third of government health spending (the equivalent of 0.4% of gross domestic product), through more efficient purchasing of pharmaceuticals, medical equipment and supplies.

Fourth, the ministry of health can make a stronger case if it can specifically demonstrate that the requested expenditure is part of a coherent investment plan, with resources allocated strategically to where they will achieve the highest impact and value for money. The ministry of finance will expect an accurate and transparent estimate of various costs, including the capital costs, recurrent costs and, most importantly, opportunity costs – that is, what benefits are being foregone if the health ministry's recommended intervention is adopted, including the cost of doing nothing.

Fifth, ministries of finance are usually interested in saving money and reducing costs. Health ministries can therefore help their case if they demonstrate that expenditure on health is not just cost–effective but can also be cost-saving to government and to households.

Sixth, it helps if health ministries can argue when and how market failures in health require public expenditure. Market failures occur when markets do not allocate resources in a way that maximizes overall welfare. In the health sector, this can justify public expenditure.

Seventh, an effective health funding proposal is one that identifies, and where possible quantifies, where there are mutual gains for both the ministry of finance and the ministry of health. Increasing taxation on tobacco – recently described as the "single best health policy in the world" – is one example.

Eighth, presenting a strong plan for the implementation, management and evaluation of health programmes is important. Some ministries of health, and their development partners, place emphasis on the upstream strategic planning but pay less attention to the downstream realities of procurement, health-worker salaries, supply-side readiness and other key aspects of scaling up implementation in practice.

Ninth, strengthening the information and evidence base for policy and programming is important in budget proposals. Ministries of health already collect input-focused data, such as salaries and the number of professional training workshops. Collecting and analyzing output and outcome indicators and the incremental costs of scaling up programmes, can better inform policy and programming decisions with the ministry of finance.

Finally, ministries of health need to be cautious about advocating earmarked (hypothecated) taxes: for example, proposing an increased tax on tobacco and alcohol products for health reasons but asking for the additional revenue be used to fund health-related services such as health promotion. Such taxes do have some justification from a political economy perspective

We at WHEC support interventions that simultaneously achieve both efficiency and equity in women's, children's and adolescents' health.

United Nations At A Glance

Permanent Mission of the Union of the Comoros to the United Nations

Comoros became Member State of the United Nations on 12 November 1975

Comoros Mission History:

The Permanent mission of the Comoros to the United Nations is also accredited to the United States, Canada and Cuba. The Ambassador is appointed by the President of the Union and presents its credentials to the countries of representation, in according the practice defined in the Vienna Convention on Diplomatic Relations.

Current information is posted on the official web sites of the United Nations and of the receiving and accrediting States:

United Nations Protocol and Liaison Service

Union of Comoros

Peacebuilding Commission

Comoros becomes 20th Member of IOR-ARC

The Union of Comoros was today inducted into the Indian Ocean Rim-Association for Regional Cooperation as its 20th member. The membership of the Comoros Islands, an archipelago of four islands and several islets located in the western Indian Ocean, was unanimously approved by the 19 members states of the IOR-ARC at its Ministerial meeting held here.

The United States also began its participation as "dialogue partner." (11/2012)

Click here to read more recent news, communications and press releases

Details: https://www.un.int/comoros/

Collaboration with World Health Organization (WHO)

WHO | Comoros

Health Situation

Life expectancy at birth has improved, from 54 years in 1991 to 67.6 in 2012. Although there are some signs of improvement in the situation of maternal and child health, as evidenced by a reduction in maternal, infant and child mortality, much remains to be done to achieve the health-related MDGs, address socioeconomic disparities between the islands, and narrow the gap between rural and urban areas and between the sexes, which are the factors underlying these statistics. The epidemiological situation continues to be dominated by acute respiratory infections and malaria, despite the fact that malaria prevalence in the Comoros fell by more than 98% in 2013.

The rate of HIV/AIDS prevalence remains low at 0.025%. There were 79 recorded cases of tuberculosis in 2005, 67 in 2006 and 56 in 2007, with a cure rate of 90%. There were 120 newly detected cases of leprosy in 2005, 121 in 2006 and 111 in 2007. Arboviruses continue to affect the population, and non-communicable diseases are also a major concern; in 2008, 25.4% of the population had high blood pressure, 4.8% had diabetes and 25.9% had high cholesterol. Neonatal mortality, malaria, diarrheal diseases caused by drinking untreated water, poor food quality, environmental effects and climate change are all causes of morbidity and mortality, particularly in women and children.

Cooperation for Health

The Comoros have very few bilateral partners, which puts the country at a disadvantage in terms of mobilizing financial support for the health system. France provides health sector assistance through a project financed by the French Agency for Development (AFD). Following the 2009 Doha conference on development in the Comoros, there has been a marked improvement in the level of support from Arab countries, particularly in the area of infrastructure. However, the harmonization and alignment of this support presents a real problem given the absence of effective mechanisms to coordinate assistance.

The usual partners among the specialized agencies of the United Nations system (WHO, UNICEF and UNFPA) nonetheless allocate considerable resources to supporting the development of the health sector. The proportion of technical and financial support from WHO is decreasing relative to that provided by other partners, thus impacting its leadership role as the pre-eminent partner in the Comoros.

The United Nations Development Assistance Framework (UNDAF) for 2015-2019 has recently been drafted, with the vision statement “Going Forward United in Action”; the national sustainable development strategy for the period 2015-2019 has still to be adopted. The Comoros CCS has been extended to ensure harmonization and alignment with national policies and strategies, thereby facilitating alignment with the 3rd generation CCS.

Details: http://www.who.int/nutgrowthdb/database/countries/com/en/

Bulletin Board

UN Document E/2014/NGO/53

Join our efforts – we welcome everyone!

Economic and Social Council

*E/2014/1/Rev.1, annex II.

Statement submitted by Women's Health and Education Organization, a non-governmental organization in consultative status with the Economic and Social Council.

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 30 and 31 of Economic and Social Council resolution 1996/31.

Health-care providers usually have interest or passion in a particular global issue or a particular region of the world. Preparing the next generation of health-care providers in the international arena, deepening their knowledge and improving the skill set for a career in global health and global governance are needed. The programmes expose health-care providers to both the academic training and practical knowledge necessary for developing a career trajectory that will focus the passion of health-care providers and actualize their desire to have an impact on national and international health-care policies. The programme is building the capacity to care.

The Women's Health and Education Center's (WHEC's) website offers 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 making medical care more affordable and more accessible in every country.

International development has moved beyond charity. It has reached a new, globally competitive stage, bringing with it enormous strategic and economic implications for all the nations and citizens of the world in the years ahead.

The challenge and opportunity are here.

Let us make every mother and child count!

Details: http://www.womenshealthsection.com/content/documents/UN-Economic-and-Social-Council-Statement-E-2014-NGO-53.pdf

Collaboration with UN University (UNU)

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

The Challenge of Small Island Developing States

A vital part of WIDER's research agenda has in recent years focused on the challenges faced by Small Island Developing States (SIDS) – a group of countries and territories often neglected in the mainstream development discourse. Understanding the challenges faced by SIDS is important, particularly given the impact of global crises and natural disasters on their development prospects. In many ways, SIDS are bearing the brunt of crises in climate, food and finance and their responses and efforts at building resilience may provide valuable lessons for other countries and regions. In this article, we provide a brief overview based on three journal special issues and sections emanating from the WIDER research project on Fragility and Development, dealing with the core concerns of SIDS.

A Diverse Group

SIDS is a diverse group in a number respects – in fact the United Nations currently classifies 52 countries and territories as Small Island Developing States (SIDS). More than 50 million people live in these countries. Forty-three of them are located in the Caribbean and the Pacific regions. The group includes countries that are relatively rich by developing country standards, such as Singapore and Bahamas, but also some of the poorest countries in the world, including Comoros, Haiti, Kiribati and Timor-Leste.

Sharing a Common Vulnerability to External Shocks

Despite this, all SIDS are vulnerable to economic shocks and natural hazards to a degree that few other countries or regions are. This is reflected in the volatility of SIDS GDP growth. SIDS located in the Pacific region record the lowest average and by far the most volatile GDP growth. Pacific SIDS growth rates range from 2.0 to 9.1 percent and the volatility, as measured by the coefficient of variation is more than twice that of all developing countries and the SIDS group as a whole. Volatility in GDP growth rates is also higher in SIDS located in Africa and the Caribbean, respectively, than in all developed countries.

SIDS rely heavily on trade to drive growth, hence the volatility of their growth. Work carried out for the WIDER project, for instance, shows that in the Caribbean the top five export commodities for between 70 per cent and 96 per cent of the regions' exports. This creates economic vulnerability to changes in export demand and commodity prices. Trade flows, expressed as the sum of commodity exports and imports relative to GDP, are far higher in SIDS than in all other Developing countries (DCs) and the Least Developed Country (LDCs) group. Commodity exports and imports as a percentage of GDP in any one year were no less than 95 and as high as 141 per cent, and averaged 110 per cent over the period 1980 to 2007. The equivalent numbers for all developing countries were 64, 94 and 78 per cent, respectively.

More pertinent is volatility in trade given its implications for vulnerability to external shocks. Indeed, SIDS trade is more volatile than for other developing countries. The coefficient of variation for SIDS trade relative to GDP for the period 1980 to 2007 is 10.23, compared to 7.56 and 8.80 for DCs and LDCs respectively.

In addition to export dependency, external vulnerability is accentuated by the fact that for most households in SIDS, remittances from abroad is a very important source of income. While this create a vulnerability towards global downturns , when remittance decline (as during the recent global financial crisis) it also acts as a buffer in the case of local hazards – it is often found that remittances to SIDS increase in the wake of a natural disaster.

Authors: Wim Naudé, Mark McGillivray and Amelia U. Santos-Paulino; Publisher: WIDER-*Angle*

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

Global Challenges for Adolescents

Challenges and realizing the rights of adolescents and advancing their development requires a keen understanding of their current circumstances. Using the latest available data from international surveys, supplemented by national sources and research studies where appropriate, this chapter examines the state of adolescent health and education before looking at gender and protection issues. At the international level, the evidence base on middle childhood (5–9 years) and adolescents (10–19 years) is considerably thinner than it is for early childhood (0–4 years). This relative paucity of data derives from several factors. The survival and health care of children under five years – the time of greatest mortality risk for individuals – has been at the cornerstone of international efforts to protect and care for children for more than six decades. In recent decades, vast leaps have taken place in the collection of health data, driven by the child survival revolution of the 1980s, the 1990 World Summit for Children, the Convention on the Rights of the Child and the push for the Millennium Development Goals (MDGs). Consequently, national and international health information systems for children mostly focus on the early years, concentrating on such indicators as neonatal deaths, infant immunization and underweight prevalence among under-fives. Health information on adolescents, by contrast, is not widely available in many developing countries apart from indicators on sexual and reproductive health collected by major international health surveys, particularly in the context of HIV and AIDS. Where health data on adolescence are available, it is often not disaggregated by sex, age cohort or other factors that could give much-needed details on the situation of adolescents.

Tobacco consumption and drug and alcohol use are growing health risks for adolescents

In part, injuries arise from a propensity to take risks that is a common feature of adolescence, connected with the psychological need to explore boundaries as part of the development of individual identity. Such readiness to take risks leads many adolescents to experiment with tobacco, alcohol and other addictive drugs without sufficient understanding of the potential damage to health or of other long-term consequences of addiction, such as being drawn into crime to pay for a habit.

Education presents a similar story. The decades-long international drive for universal primary education and, more recently, for early childhood development has fostered the development of indicators and analysis of education in the first decade of life. This is most welcome, and it reflects the growing and sustained commitment of international and national stakeholders to education, increasingly for girls as well as boys. The evidence base at the international level on secondary education, is far narrower. Sufficient data do not exist to determine the share of secondary-school-age children who complete education at this level globally, or to assess the quality of the education they receive. And as with health, not many developing countries can provide comprehensive disaggregated data on key quantitative and qualitative indicators.

Sexual and reproductive health matters

Girls are more likely to have engaged in early sex in adolescence but also less likely to use contraception. Investing in sexual and reproductive health knowledge and services for early adolescents is critical for several reasons. The first is that some adolescents are engaging in sexual relations in early adolescence; international household survey data representative of the developing world, excluding China, indicate that around 11 per cent of females and 6 per cent of males aged 15–19 claim to have had sex before the age of 15. For girls, child marriage is also associated with an increased risk of sexually transmitted infections and unwanted pregnancies. Research suggests that adolescent pregnancy is related to factors beyond girls' control. One study undertaken in Orellana, an Ecuadorian province in the Amazon basin, where nearly 40 per cent of girls aged 15–19 are or have been pregnant, found that the pregnancies had much less to do with choices made by the girls themselves than with structural factors such as sexual abuse, parental absence and poverty.

Details for the main report: http://www.ungei.org/files/SOWC-2011-Main-Report_EN_02092011.pdf

To be continued……

Top Two-Articles Accessed in August 2016

1. Adolescent Health Care; http://www.womenshealthsection.com/content/gyn/gyn022.php3
   WHEC Publications. Special thanks for WHO, American Academy of Pediatrics (AAP), and NIH for the contributions. Financing for this series is provided by WHEC Initiatives for Global Health.

2. Genetic Counseling and Genetic Screening;
   http://www.womenshealthsection.com/content/obs/obs026.php3
   WHEC Publications. Women's Health and Education Center (WHEC) expresses gratitude to Dr. John P. O'Grady, Professor, Obstetrics and Gynecology, Tufts University School of Medicine, Medical Director Mercy Perinatal Service, for his priceless contribution in preparing the series on Genetics and The Prenatal Testing, and Dr. Frank H. Boehm, MD, Vanderbilt University Medical Center, North B1100, Nashville, TN (Boehm FH. Having a perfect child.)

From Editor's Desk

Development of Africa

The decolonization of Africa was a priority for the UN during the middle of the twentieth century. Since then, the development of the continent has become the priority. The UN's Millennium Development Goals (MDGs) have led to substantial progress, but much more work needs to be done before the hopes of the people of Africa can be fulfilled.

The United Nations continues to work through the MDGs to strengthen Africa. Progress has been made towards the attainment of many of the MDGs, in particular those on education, gender equality and the empowerment of women and combating HIV/AIDS and other diseases. Many challenges remain for Africa, including controlling the spread of the Ebola virus, which, if not contained, could negatively impact Africa's development. Significant progress has been made towards consolidating peace and security in Africa, and strengthening its democratic institutions. But tremendous work will have to be done before Africa is truly secure and at peace.

With the completion of the Millennium Development Goals, the UN is now working with Africa to chart a development path to a more sustainable future. It is cooperating with the African Union, including the New Partnership for Africa's Development (NEPAD) and the regional economic communities who developed the African Agenda 2063, a transformative 50-year development agenda initiated in 2013. To help Africa achieve more sustainable development goals, institutional support has been provided by the United Nations to the High-level Committee of African Heads of State and Government on the Post-2015 Agenda, especially in the formulation of a common African position.

Coordination support has been provided through the interdepartmental task force on African affairs and the Regional Coordination Mechanism for Africa to increase collaboration, and strengthen coherence, in delivering system-wide support to Africa. The United Nations continues to support efforts to make the African Peace and Security Architecture operational, and implement the Human Rights Strategy for Africa and improve electoral management and monitoring.

Making Africa more peaceful and secure, and promoting human rights will help create an environment in which development can flourish in the form of sustainable development. Africa can then build on the progress it has made in implementing the MDGs. It can continue to improve the lives of its people, by

taking care of their welfare and their development needs, while paying attention to the environment in which they live, so it can sustain them, and future generations.

Sustainable Development – Public and Private Partnership

Details: http://www.sdgfund.org/public-private-partnerships

Words *of* Wisdom

My days among the dead are past;
Around me I behold,
Where ever these causal eyes are cast,
The mighty minds of old;
My never-failing friends are they,
With whom I converse day by day.

With them I take delight in weal
And seek relief in woe;
And while I understand and feel
How much to them I owe,
My cheeks have often been bedewed,
With tears of thoughtful gratitude.

– Robert Southey (12 August 1774 – 21 March 1843) English poet, historian, biographer and essayist.

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

http://www.womenshealthsection.com/