WHEC Update

Briefing of worldwide activity of the Women's Health and Education Center (WHEC)

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New Perspectives

The insufficient participation of women in formal conflict prevention at the peace table is an important area of United Nations Security Council resolution 1325 (2000). This remains poorly implemented. The significant contribution and strong role of women in local mediation and conflict prevention initiatives continue to be largely unrecognized and weakly supported. Thus, since 2010, the African Union (AU) Panel of The Wise – already with a mandate to draw the public's attention to largely overlooked issues, has considered ways to strengthen the participation of women and youth. At the peace table this raises awareness of the impact of war and sexual violence against women and children.

Each year, 1.4 million people worldwide lose their lives to violence. For every person who dies because of violence, many more are injured and suffer from a range of physical, sexual, reproductive and mental health problems. Violence places a massive burden on national economies, costing countries billions of US dollars each year in health care, law enforcement and lost productivity. The Women's Health and Education Center (WHEC) works with partners to prevent violence through scientifically credible strategies.

Increasingly, violence, physical and mental injuries in post-conflict areas are being recognized as important public health problems. Along with this recognition comes a pressing need to develop capacity in injury prevention and control. Prevention efforts require multidisciplinary approaches and a variety of trained professionals. A public health approach to building capacity for injury prevention and control requires enhancing knowledge, developing skills, and enabling systems in which injury prevention and control efforts are supported.

Capacity building needs include those related to human resources, institutional and infrastructural capacity, and networks and partnerships. The WHEC is working in all three of these domains to help build capacity for violence and injury prevention. Two priority needs in the human resources area are training and skills development. To address training, WHEC has collaborated with a global network of experts from iconic institutions in USA and abroad, to develop a modular violence and injury prevention control curriculum.

The Global Campaign for Violence Prevention (GCVP) aims to raise awareness about the problem of violence and emphasize the crucial role that public health can play in addressing its causes and consequences. It also seeks to ensure a coordinated international response. Our team at WHEC seeks to gather and disseminate what is known as well as develop new ideas and approaches to pragmatically and effectively address these issues within a development context. Our team also contributes to the mission of reducing poverty and improving economic growth by promoting an improved understanding of the role of the campaign within the development context and promoting effective, practical strategies to reduce and prevent conflicts, crimes and violence.

Our global network at WHEC is a network of UN Member States, international agencies and civil society organizations working to prevent violence. We share an evidence-based public health approach that targets the risk factors leading to violence and promotes multi-sectoral cooperation.

Building global commitment to violence prevention – join our efforts – we welcome everyone.

Violent Conflicts and Health Development

Rita Luthra, MD

Your Questions, Our Reply

What is The Panel of The Wise? What is its role in preventing violent conflicts in Africa? Is it successful?

Violent Conflicts and Women and Children: The first Panel of the Wise was appointed in 2007, five years after the Peace and Security Council (PSC) Protocol came into force and roughly three years after the inauguration of the PSC in May 2004. The fact that it was one of the last pillars to begin the implementation of African Peace and Security Architecture (APSA) is, in many important regards, symptomatic of prevailing dominance of a reactive, rather than preventive conflict management approach by the institution.

The Panel of The Wise turned 10 in 2017. The first Panel of the Wise (2007-2010) primarily oversaw the operationalization of its mandate and transformation of its modalities of operation into realities on the ground. Members of the first African Union Panel of the Wise were from: Algeria (North Africa), São Tomé and Principe (Central Africa), Tanzania (East Africa), South Africa (Southern Africa), Benin (West Africa).

The tenure of the second Panel of The Wise (2010 – 2014) demonstrated by centrality of this mechanism, which is characterized by an expanding portfolio of activities, the development of closer relations with other institutions within the Union. The Panel and its secretariat became key in the development of the now traditional “Cairo Retreats”, in acting as a mediation support unit within the Commission by facilitating training, capacity-building and knowledge generation, among others, to the Union’s Special Envoys, Special Representative and mediators on the ground. Members of the second African Union Panel of The Wise were from: Algeria (North Africa), DRC (Central Africa), Tanzania (East Africa), Zambia (Southern Africa), Ghana (West Africa).

The third Panel of the Wise (2014 – 2017) devoted significant efforts to the facilitation and provision of mediation functions to political dispute processes very high on the agenda of the AU PSC, as well as the UN Security Council, advancing the women, peace and security agenda by convincing the AU Assembly to permanently mainstream women’s participation in the APSA structure, through the establishment of the African Network of Women in Conflict Prevention and Peace Mediation (FemWise).

We advocate at least four key actions to be taken by the AU Commission:

1. The establishment of the Office of the Special Envoy on Women, Peace and Security;
2. The launch of the AU five-year Gender Peace and Security Program GPSP);
3. The implementation of an Open Session of the Council on Women, Peace and Security;
4. The launch of the African Network of Women in Conflict Prevention and Peace Mediation (FemWise).

The Panel of the Wise’s role in preventing the outbreak of violent conflicts in Africa was meant to provide information and analysis on the experiences, to date, of an important pillar of APSA. The objective was to discuss the gradual institutionalization of the Panel over the last 10 years and provide reflections that can inform the Panel’s operations in the future. An understanding of the Panel of the Wise begins with its legal and normative dimensions as well as the modalities governing its operations, in additions to the rationale, some would say philosophy, underpinning the institutionalization of this structure within the African Union, it is in the domain of action, of operations, that the real value and potential of the Panel can be reflected upon.

Join the efforts!

United Nations at a Glance

The Permanent Mission of Eritrea at the United Nations

Eritrea became UN Member State on 28 May 1993. it joined the United Nations in 1993, as a full-fledged member; soon after it had achieved its independence through 30 years of liberation.

Eritrea, officially the State of Eritrea, is a country in the Horn of Africa, with its capital at Asmara. It is bordered by Sudan in the west, Ethiopia in south, and Djibouti in the southeast. The northeastern and eastern parts of Eritrea have an extensive coastline along the Red Sea. The nation has a total area of approximately 117,600 km^2 (45,406 sq. miles) and includes the Dahlak Archipelago and several of the Hanish Islands. Its toponym *Eritrea* is based on the Greek name for the Red Sea, which was first adopted for Italian Eritrea in 1890.

Eritrea is a multi-ethnic country, with nine recognized ethnic groups in its population of around 5 million. Most residents speak languages from the Afroasiatic family, either of the Ethiopian Semitic languages or Cushitic branches. Among these communities, the Tigrinyas make up about 55% of the population, with the Tigre people constituting around 30% of inhabitants. In addition, there are many Nilo-Saharan-speaking Nilotic ethnic minorities. Most people in the territory adhere to Christianity or Islam.

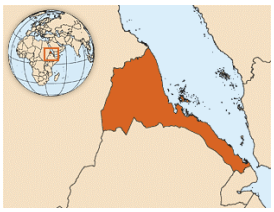
Eritrea is a member of the African Union, the United Nations, and Intergovernmental Authority on Development (IGAD), and is an observer in the Arab League alongside Brazil, Venezuela, India and Turkey. On 1 January 1980, Italy set the boundaries of Eritrea and ruled it as a colony until 1941, when the British defeated the Italians in Africa and took over the administration. After the Italian defeat in World War II, Britain administered Eritrea. Following a decision by the United Nations, Eritrea was federated in 1952, with a certain amount of autonomy. However, during the federation with Ethiopia, Emperor Haile Selassie's government systematically violated the rights granted by the UN.

General Economy: The Eritrean Government is currently engaged in creating a modern, technologically advanced and internationally competitive economy where private enterprise is the driving economic force. Historically Eritrea has been a trading nation with its strategic location and accessibility to the markets of the Middle East and Africa.

Suggested Reading: http://www.eritrea-unmission.org/

Collaboration with World Health Organization (WHO)

WHO | Eritrea



Country Cooperation Strategy

Health and Development challenges

In 1994, Eritrea formulated and implemented socioeconomic development policies and strategies that concentrated not only on rebuilding and rehabilitating war-damaged and destroyed economic and social infrastructure but also on formulating numerous national economic and social development plans. The macroeconomic policy of the Government identifies human capital formation through education and health as the main strategy for long-term national development. Substantial progress has been made in the health sector.

- Infant mortality rate decreased from 72 deaths per 1,000 livebirths in 1995 to 48 deaths and 42 deaths in 2010, which is lower than sub-Saharan Africa's average of 105;
- Under-five mortality rate dropped from 136 deaths per 1,000 livebirths in 1995 to 93 deaths in 2002 and 63 deaths in 2010 compared with the sub-Saharan African average of 151;
- Total fertility rate decreased from 6.1 in 1995 to 4.8 in 2002 and 2010, which is below the sub-Saharan African average of 5.4;
- Maternal mortality ratio declined from 998 per 100,000 livebirths in 1995 to 486 in 2010;
- Proxy HIV incidence in the 15-24 years age group decreased from 2.1% in 2003 to 0.28% in 2011
- Malaria morbidity and mortality were reduced by 74% and 83% respectively in 2012 compared with the year 2000 levels;
- Estimated TB incidence decreased from 243 per 100,000 population in 1990 to 97 per 100,000 population in 1990 to 97 per 100,000 population in 2011

Health Financing

The total cost of the Health Sector Strategic Plan 2012-2016 is estimated at US $ 418,404,847 mostly to be funded by the Government, which is the main source of financing of health services in the country. The Government is responsible for building and maintaining health infrastructure; training, recruitment and remuneration of health personnel; and procurement and distribution of essential medicines. The central Government allocates resources for health as a lump sum during the annual budgeting cycle. Provision of health care to the population is generally free with a normal fee charged for registration. The UN agencies, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTM), Global Alliance for Vaccines and Immunization (GAVI) and a few bilateral organizations contribute to health care financing in the country mostly through specific programs for disease control and maternal/child health, among others.

Suggested Reading: http://www.who.int/countries/eri/en/

Bulletin Board

Authorship & Policy

…Continued

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Authors may submit supplemental digital content to enhance their article's text and to be considered for online-only posting. Supplemental digital content may include the following types of content: text documents, graphs, tables, figures, graphics, illustrations, audio and video. Cite all supplemental digital content consecutively in the text. Provide a legend for supplemental digital content at the end of the text. List each legend in the order in which the material is cited in the text. The legends must be numbered to match the citations from the text. Include a title and a summary of the content.

For audio and video files, also include the author name, videographer, participants, length (minutes), and size (MB). Authors should ensure that patients are not identifiable in the digital content unless they obtain written consent from the patients and document that they have obtained consent in the cover letter submitted with the manuscript.

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Stand-Alone Video Gallery

The editors encourage the submission of videos for inclusion in the Journal’s Stand-Alone Video player. These videos will undergo review before being posted online, and authors must sign the Journal’s license for publication agreement form.

All video destined for the Stand-Alone Video player must be encoded in Flash Video (.FLV) format. This format allows for embedded, streaming playback through the Journal’s website. No other file formats are supported at this time. If you are interested in submitting a video for consideration, please contact our editorial office.

Collaboration with UN University (UNU)

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

Displaced Communities and the Reconstruction of Livelihoods in Eritrea

Since large-scale programmes of post-war resettlement and reintegration are costly, it is important to learn the lessons of the resettlement programme started after the end of Eritrea's liberation war in 1991. Eritrea's system of land tenure largely facilitated resettlement (although long-term environmental problems may emerge), social capital built during the war was a positive resource, and the state's legitimacy was another positive factor despite the shortage of skills, and fragmented help from the donors. Those who self-settled generally did better than those who settled under government schemes: this implies that helping self-settlement is more cost-effective than direct government help-an important lesson for the future. The success of returnees in reconstructing their livelihoods depends upon the resumption of sustainable development activities in settlement areas. Assistance is most effective and equitable when provided on a community-wide basis, bringing benefits to the entire population of areas where returnees settle.

We have seen that land tenure largely facilitated resettlement (although long-term environmental problems may emerge), social capital built during the war has been a positive resource, and the state’s legitimacy has been another positive factor despite the shortage of skills, and fragmented help from the donors. Three policy implications stand out. First, those who self-settled generally did better than those who settled under government schemes: this implies that helping self-settlement is more cost-effective than direct government help – an important lesson for the future. Second, the success of returnees in

reconstructing their livelihoods depends upon the resumption of sustainable development activities in settlement areas – therefore a multifaced development program should be implemented in the areas of return.

Further donor resources are needed to reinforce government efforts. Longstanding problems remain. One of the most important is food-security; much of the population relies on food aid except in years of exceptional rainfall. The capacity of many rural areas to absorb additional populations will be limited unless Eritrea's dependence on rainfall is reduced through the construction of dams, micro-dams and the spread of water conservation practices. But such investment must also be combined with supportive land-tenure policies, so that communities have an incentive to sustainably manage land and common property resources. Hence, urgent consideration must be given to further tenure reform, another illustration of the importance of reform to equitable reconstruction. Many challenges therefore remain.

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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)

Eritrea

Eritrea is in the grips of one of its worst droughts recorded in recent history. A recent analysis by famine experts shows a rapid decline in the purchasing power of the poor, resulting in extreme food shortages for many. Some additional 300,000 metric tons of food aid are urgently needed to meet the country's needs this year.

The effects of drought continue to deepen in Eritrea. Distress signs are mounting: increased malnutrition, selling off livestock, livestock deaths, drying-up of wells and traditional water sources, increases in the price of local grain and the scarcity of food in markets in remote areas.

Complementary education programme puts children back to school in Eritrea

In a sustained effort to provide primary education for all, a UNICEF-supported programme of Complementary Elementary Education (CEE) is attempting to reach the children and young adults in Eritrea who had initially missed the opportunity to attend school. The primary targets for the CEE programme are children aged 10 to 14, with a specific focus on girls.

"Girls at this age are eyed for marriage, and the boys are expected to do serious tasks, which would generate additional income for the household," says Bekit Hussien, administrator at the Jengerjiba CEE. "Thanks to the sensitization by the government, parents have now started to send their children to this center from a place as far an hour walking distance."

Zahra Ahmed, 12, is one of the girls enrolled in level one of the programme. Intently copying an equation from the blackboard, she doesn't seem to mind at all that the classrooms have no benches. Holding her notebook tight to her chest, Zahra says proudly: "I can read and write now. I will write a letter when my mom needs one. I am happy when teachers take us to the reading corner to read stories for us."

UNICEF support

Ismael, one of the successful students on track to finish primary education through this programme, will complete his third level of CEE this year. He walks for two hours to get to class each day without complaint, because he dreams of becoming a doctor, and no distance, however great, will deter him from his goal. "I once went to attend to my mother who was in hospital," says Ismael. "My uncle told me then that I would be [able] to treat sick people if I finish school."

Working with the Ministry of Education, UNICEF provides furniture, materials and exercise books for the learning centres. Though conditions may be challenging here, hope and ambition resonate far beyond the tough environment of Jengerjiba. Matter-of-factly printed in the corner of one classroom are the words, "There is no darkness like ignorance."

Suggested Reading: http://www.ungei.org/infobycountry/eritrea.html

To be continued….

Two Articles of Highest Impact, February 2018

1. Marijuana and Pregnancy Implications;
   http://www.womenshealthsection.com/content/obs/obs035.php3
   WHEC Publications. Special thanks to our writers and editors for compiling the review. Funding provided by WHEC Initiatives for Global Health.

2. Uterine Cancer: A Modern Approach to Surgical Management;
   http://www.womenshealthsection.com/content/gyno/gyno027.php3
   WHEC Publications. Special thanks to Dr. Tashanna K. N. Meyers, Assistant Professor of Obstetrics and Gynecology; Tufts University School of Medicine, for serving as reviewer and helpful suggestions.

From Editor's Desk

A Perception Change Project

Contraception: Access, Perception and Task-sharing

Worldwide there is poor access to family planning services due to inadequate numbers of health workers or their uneven distribution. Enabling additional cadres of health workers to provide family planning services through competency-based training, is essential.

Globally, governments, civil society, multilateral organizations, donors, the private sector, and the research and development community have committed to enable 120 million more women and girls to use contraceptives by 2020. Furthermore, the Sustainable Development Goals (SDGs) aim to meet 75% of the global demand for contraception by 2030. To meet these goals, national programs will need to

bring together many components, including social and behavior change, a gender and rights perspective, commodities, and quality service provision by adequately trained health providers. Many countries have already enabled mid- and lower-level cadres of health workers to deliver a range of contraceptive methods, utilizing these cadres either alone or as part of teams within communities and/or health care facilities.

Contraception is an inexpensive and cost-effective intervention, but health workforce shortages and restrictive policies on the roles of mid- and lower-level cadres limit access to effective contraceptive methods in many settings. Expanding the provision of contraceptive methods to other health worker cadres can significantly improve access to contraception for all individual couples.

The Women's Health and Education Center (WHEC) recognizes task sharing as a promising strategy for addressing the critical lack of health care workers to provide reproductive, maternal and newborn care in low-income countries. Task sharing is envisioned to create a more rational distribution of tasks and responsibilities among cadres of health workers to improve access and cost-effectiveness.

Task shifting: It refers to process of delegation or rational distribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications to make more efficient use of the available human resources for health. Reorganizing the workforce in this way through task shifting usually presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded.

Task sharing: It refers to an expansion of the levels of health providers who can appropriately deliver health services. The term is used to emphasize the common performance of the entire clinical task, or key components of it, among teams of different cadres of health workers. Tasks are not taken away from one cadre and given to another, but rather that additional cadres are given the capacity to take on identified tasks. Task sharing enables this expansion to lay and mid-level healthcare professionals – such as nurses, midwives, clinical officers and community health workers – to safely provide clinical tasks and procedures that would otherwise be restricted to higher level cadres. It can be a vital strategy in overcoming the shortage in overcoming the shortage of higher level providers in many settings. Even in well-resourced health systems, task sharing can offer a means of providing services more efficiently, more cost effectively and in a less medicalized environment.

Our recommendations and suggestions

To optimize health worker roles to improve access to key maternal and newborn health interventions through task shifting and task sharing:

- General counseling and sharing information on contraception;
- Distribution of condoms (male and female), other barrier methods;
- Initiation and distribution of combined oral contraceptives, progestin only oral contraceptives, and emergency contraception;
- General instructions for using Standard Days Method, TwoDay Method®, and Lactational Amenorrhea;
- Delivery of injectable contraceptives using a standard syringe with needle for intramuscular injection or for subcutaneous injection;
- Insertion and removal of Intra Uterine Devices (IUDs);
- Insertion and removal of contraceptive implants;
- Provision of tubal ligation;
- Provision of vasectomy.

Recommended Program Actions and Research Actions

Implementation of sound international and national strategies to increase the number of skilled health workers trained and allowed to provide family planning services, with specific focus on underserved areas and population groups, is of utmost importance.

- Adopt and strengthen public-private partnerships to optimize the capacity of health workers in the non-governmental (NGO) sector and to transfer skills rapidly across the health system.
- Undertake a systematic approach to standardized, competency-based training that enables health workers to provide quality family planning services, with adequate supervision and monitoring, and clear protocols for referrals.
- Trained health workers, including community health workers, providing family planning services should receive appropriate recognition, support and remuneration.
- Undertake further rigorous studies to determine the safety and effectiveness of the recommendations such as: auxiliary nurses performing IUD insertion and removal, and nurses and midwives performing male and female sterilization procedures.
- Undertake studies to evaluate the cost-effectiveness of programs of various cadres of health providers in family planning service provision.
- Carry out social science and implementation research to understand, and strengthen, the dynamics and organization of health-systems and contraceptive services delivery.

The WHEC recognizes task sharing as a promising strategy for addressing the critical lack of health care workers to provide reproductive, maternal and newborn care in all countries. We believe, it envisions to create a more rational distribution of tasks and responsibilities, perceptions and engagement about contraception in the communities and in the region.

Join the efforts.

The Partnership
for Maternal, Newborn & Child Health

H.E. Ms. Michelle Bachelet to Chair PMNCH Board

The Partnership for Maternal, Newborn & Child Health (PMNCH) is delighted to welcome H.E. Ms. Michelle Bachelet Jeria, President of the Republic of Chile, as the incoming Chair of the PMNCH Board. Ms. Bachelet is a long-time advocate for the rights of women and children in Latin America and is a medical surgeon, specialist in pediatrics. She became Chile's first female president in 2006 following a term as Health Minister, where she laid the foundation for an overhaul of the Chilean healthcare system. Throughout her two tenures as president (2006 and 2013), she prioritized women's issues and was a champion for protecting the most vulnerable. President Bachelet will conclude her presidential term in Chile in March 2018, after which she will take on this voluntary role for PMNCH, among other activities.

After her first term as President in 2010 she served as president of a joint-initiative with the International Labour Organization and the World Health Organization (WHO). President Bachelet will take up the Chair for PMNCH in April, joining us for our next board meeting expected in June 2018

We all @ The Women's Health and Education Center (WHEC) welcome Ms. Michelle Bachelet and we are looking forward to collaborating and strengthening our partnership to improve maternal and child health, worldwide.

Get Involved!

In The News

United Nations Peacekeepers: Service & Sacrifice

Since 1948, more than a million women and men have served as UN Peacekeepers. Every day, they make a tangible difference in the lives of millions of the world's most vulnerable people, and every day they save lives. They serve at great personal risk and in harsh conditions. Tragically some make the ultimate sacrifice – over 3,500 peacekeepers have lost their lives in the cause of peace.

Peacekeeping is a unique force for good, with military and police personnel from over 120 countries serving together, alongside civilian colleagues. UN peacekeepers come from diverse cultures and speak different languages but share a common purpose: the protection of vulnerable communities and the provision of support to countries struggling to move from conflict to peace. We ask peacekeepers and their families to make a great sacrifice.

Who contributes troops and police to peacekeeping?

Peacekeeping is a global partnership; it is the commitment of our Troop and Police Contributing Countries that allows peacekeeping to happen. UN peacekeeping is a unique global partnership. It brings together the General Assembly, the Security Council, the Secretariat, troop and police contributors and the host governments in a combined effort to maintain international peace and security. Its strength lies in the legitimacy of the UN Charter and in the wide range of contributing countries that participate and provide precious resources.

What peacekeeping does?

UN Peacekeeping helps countries navigate the difficult path from conflict to peace. We have unique strengths, including legitimacy, burden sharing, and an ability to deploy troops and police from around the world, integrating them with civilian peacekeepers to address a range of mandates set by the UN Security Council and General Assembly. UN Peacekeeping is guided by three basic principles:

1. Consent of the parties;
2. Impartiality;
3. Non-use of force except in self-defense of the mandate.

https://peacekeeping.un.org/en

Thank You UN Peacekeepers for your service & sacrifice

Words of Wisdom

Since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed.

- Constitution of UNESCO

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

http://www.WomensHealthSection.com