



WHEC Update

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

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Sustainable Development

People often face difficult decisions about their health and may later *regret* the choice that they made. However, little is known about the extent of decision-regret in health care or its predictors. When we consider regret in medicine, we typically think of the feelings that follows a poor clinical outcome. The possibility of regret shadows in almost every medical decision, which a patient makes. At each step, from choosing a doctor or a hospital to accepting a diagnosis, embracing a prognosis, and selecting or declining a treatment, there is an element of uncertainty, and therefore a risk of regret. Disappointment is an unavoidable aspect of making difficult choices. Sometimes the results fall short of what we hope for. Regret, with in its core of self-blame, can be one of the greatest burdens in a patient's life.

As physicians, we are acutely aware of the element of uncertainty in medicine, but we less often recognize its close companion, **regret**. Regret in all its forms can be a powerful undercurrent; moving patients to act in ways that may baffle us. We should recognize that anticipated regret can leave a patient mired in decisional conflict, unable to choose. To lessen the possibility of future experienced regret, we as doctors can try to reduce the emotional temperature, and when feasible, avoid having patients make their decisions while they are in a hot state. Except in the most urgent circumstances, physicians can set in motion a deliberate process, exploring all treatment options to avert process regret.

Regret is typically viewed as a negative emotion. It is notable that existing patient regret scales have largely failed to assess for a positive impact of regret. However, awareness of regret can be positive or functional, a potent force in modifying behavior and enhancing decision-making. As physicians, we can help our patients make better decisions by understanding the power of regret, in all its forms.

Yet despite the centrality of regret in medicine, studies have largely failed to capture the complexity and consequences of this emotion. Furthermore, many of the proposed instruments for measuring patient regret fail to differentiate disappointment from regret. As practicing physicians, and as longtime writers and editors, we realized that although physician regret was occasionally discussed in the context of malpractice litigation, the important subject of patient regret was never directly raised in our training and is still largely absent from the curriculum.

Our writers explored this issue on **WomensHealthSection.com**, our analysis was that the experience of a poor outcome does not always result in regret. Researchers describe "process regret" that occurs, for example, when patients do not consider information about all available choices before making-a-decision. Even more unexpected to us as physicians was the observation that a good outcome does not always prevent regret. Researchers have described regret that is related to the patient's role in the decision process. For example, when another person heavily influences the choice of treatment and the patient adopts a more passive stance, "role regret" may arise.

Psychology research in other domains has provided some insight into the genesis of regret in medicine. Imagine the feelings of two different investors in the wake of a dropping stock price? An "active" investor had recently bought shares, whereas a "passive" investor had simply retained the stock he held. Although these studies involved money, similar experiments have addressed various medical situations including cancer screening and treatment, prenatal testing, and elective surgery.

Always remember – language of kindness is understood by all, there is no substitution for this.

The Power and Complexity of Regret in Medicine

Rita Luthra, MD



Your Questions, Our Reply

What is the extent of decision-regret among health care providers, especially in primary care settings and their patients? What are the identifying risk factors associated with regret?

Shared Decision-Making: Over the past two decades, a growing international movement to increase patient involvement in healthcare decisions and development of various decision support interventions has taken shape. However, many healthcare decisions are challenging, and negative experiences during or after decision-making can lead patients to have regrets about the choices that were made. Evidence suggests that decision regret is a common phenomenon in healthcare and that it can reach high levels for some medical decisions. Decision regret is associated with lower satisfaction with care, negative experiences with the healthcare system, and reduced quality of life. As such, it is increasingly viewed as an important patient-reported outcome measure as well as a proxy measure for the quality of healthcare decisions.

Assessing decision regret is particularly important in the context of primary care. For many patients, the clinical encounter with their family physician is the first point of contact with the healthcare system. This is where they learn about health issues, have their problems assessed and diagnosed, and consider steps they can take to preserve or improve their health. Primary care providers offer care across the lifespan, manage all but the most uncommon or unusual conditions, and ensure continuity and coordination of care provided at other levels of the healthcare system or by other professionals. Primary care thus encompasses the widest possible spectrum of health conditions and is the forum where the greatest number and diversity of medical decisions take place, making it a very relevant clinical context for the study of decision regret.

Yet surprisingly few studies have investigated decision regret in primary care. Out of 59 multi-centers-studies examining the extent and predictors of decision-regret related to healthcare decisions, we identified only five studies conducted in family medicine practices. Specifically, authors assessed the extent of decision regret related to decisions about hormone replacement therapy, cardiovascular disease prevention, use of antibiotics for acute respiratory infections, and treatment choices for diabetes. In three of these studies a low mean level of decision regret was observed among participants, but in two studies (on hormone replacement therapy and diabetes decisions) authors reported relatively high levels of regret. None of the five studies examined risk factors contributing to decision regret in their primary care patients, nor did they examine whether decision regret varies across the multiple types of healthcare decisions that take place in primary care.

The review of literature suggested, while it is reassuring that most patients report relatively low levels of decision regret in primary care settings where the bulk of healthcare services are delivered, further research is needed to identify valid and reliable cut-off points for distinguishing clinically significant regret and its impact on patient health.

One ideal measure for identifying decisional conflict in clinical settings is the SURE (Sure of myself; Understanding information; Risk-benefit ratio; Encouragement) tool. Our experience has shown most primary care patients experience relatively low levels of decision regret after their consultations with family physicians, although higher decision regret was found when patients experienced higher decisional conflict. Decisional conflict during consultations can be addressed with effective decision support interventions aiming to foster SDM, such as patient decision aids.

Further research is needed to explicitly examine the trajectory of decision-regret over time in primary care and other health care settings and to identify its clinically significant effects. Therefore, we suggest estimating the extent of decision-regret experienced by primary care patients and other health care providers to examine the factors associated with regret.

Tuesdays @ UNDPINGO

A Strategy for Development

https://outreach.un.org/ngorelations/sites/outreach.un.org/files/article_files/chat_17_april_2018-rsvp.pdf



Why do child marriages still exist in today's world?

Their rights, their future

Child Marriage is a deep-rooted issue especially in rural communities. It is time to focus on these issues and get stricter laws. Let us join forces to eradicate it.

End Child Marriage – We Welcome everyone

A Call for Action

Moderator: Jaslin Kaur, Co-Founder, RefuGirl

Speakers: Helen Belachew, Gender and Development Manager, Programmes Division **UNICEF**; Luz Maria Utrera, Fundacion Luz Maria and Upasana Chauhan @ Women's Health and Education Center (**WHEC**)

Concept Note:

17 April 2018, why we are still unable to end child marriages? It's 2018 and even today 1 in 5 girls in this world are said to be married before they turn 18. Child marriage is a grave threat to the lives and prospects of young girls. It violates their rights, denies them of their childhood, disrupts their education, jeopardizes their health, and limits their opportunities. If there is no reduction in child marriage, the global number of women married as children will reach 1.2 billion by 2050.

In the most recent **UNICEF** release of data concerning Child Marriage and estimated 16% of girls aged 15-19 are currently married. Among that data ¼ adolescent women in West and Central Africa are in unions / living together.

There are many concerning biological facts related to child marriages, pregnancies and childbirths.

Please visit: <http://www.womenshealthsection.com/content/obs/obs002.php3>

How does WHEC address these issues globally?

- Providing aid to global networks to create more awareness on child marriage at the grassroots and rural areas because governmental regulation cannot reach effectively in these areas.
- Providing more access to quality education not only to the girls but mothers as well to empower the whole family.
- Make more stricter laws and severe punishments to end the child marriages.
- **Support UNICEF's work** in reducing child marriage by connecting with the grassroots and local non-profits working at the grass roots level.
- Through use of international networks WHEC will continue its work to prevent child marriage via community activism. In coordination with other ECOSOC and DPI organizations to reduce all gender- based violence.

We hope to see this mission by 2030 becomes a reality, and gender equality a precedent. Join the efforts. There are no strangers @ WHEC – only the friends you haven't met.

Discussion: <https://outreach.un.org/ngorelations/content/dpi-ngo-chat-series-why-do-child-marriages-still-exist-todays-world-17-april-2018>



United Nations at a Glance

Permanent Mission of Ethiopia at the United Nations

Ethiopia became UN Member State on 13 November 1945



Ethiopia, officially the Federal Democratic Republic of Ethiopia, is a country located in the Horn of Africa. It shares borders with Eritrea to the north and northeast, Djibouti and Somalia to the east, Sudan and South Sudan to the west, and Kenya to the south. With over 102 million inhabitants, Ethiopia is the most populous landlocked country in the world and the second-most populous nation on the African continent.

It occupies a total area of 1,100,000 sq. kilometers (420,000 sq. mi), and its capital and largest city is Addis Ababa. There are 90 individual languages spoken in Ethiopia. Most people in the country speak Afroasiatic languages of the Cushitic or Semitic branches. English is the most widely spoken foreign language and is the medium of instruction in secondary schools. In 1995 Constitution of Ethiopia, Amharic is recognized as the official working language of the Federal Government.

Ethiopia's governmental system was a monarchy for most of its history. Ethiopia was one of the nations to retain its sovereignty from long-term colonialism by a European colonial power. Many newly-independent nations on the continent subsequently adopted its flag colors.

Ethiopia was also the first independent member from Africa of the 20th century League of Nations and the United Nations. Ethiopia and Eritrea use the ancient Ge'ez script, which is one of the oldest alphabets still in use in the world. A majority of the population adheres to Christianity (mainly the Ethiopian Orthodox Tewahedo Church and P'ent'ay), whereas around a third follows Islam (primarily Sunni).

Ethiopia is the place of origin of the coffee bean, which was first cultivated at Kefa, one of the 14 provinces in the old Ethiopian administration. Ethiopia has the most UNESCO World Heritage Sites in Africa. Additionally, the country is one of the founding members of the UN, the Group of 24 (G-24), the Non-Aligned Movement, G-77 and the Organization of African Unity. Its capital city Addis Ababa serves as the headquarters of the African Union, the Pan African Chamber of Commerce and Industry, the United Nations Economic Commission for Africa.

In Ethiopia rural women lag-behind in access to land property, economic opportunities, and financial assets. Women farmers perform 75% of farm labor but hold only 18.7% of agricultural land in the country. The SDG-F has been working in the regions of Oromo and Afar and using a multifaced approach to generate gender-sensitive agricultural extension services, support the creation of cooperatives, promote the expansion of women-owned agribusiness and increase rural women's participation in rural producer associations, financial cooperatives and unions.

Joint Development Programs

Joint Development Programs are very helpful avenue for UN coordination. In 2012, UN Women partnered with other UN entities in implementing 104 joint programs around the world. One in **Ethiopia** brought us together with the UN Population Fund, the UN Development Program, UNICEF, UNESCO and ILO. Grounded in support for the Government's national development plan, the program prioritizes education and economic empowerment for women and girls.

Partnership for Sustainable Development Goals (SDGs)

<https://sustainabledevelopment.un.org/partnership/partners/?id=166>

Collaboration with World Health Organization (WHO)

WHO | Ethiopia



According to United Nations Development Program (UNDP), in 2010 Ethiopia ranked 174 out of 187 countries with comparable data in Human Development Index (HDI). In the same year, according to the World Bank (WB), total health expenditure, as a percentage of GDP, was 4.9%.

Economic growth, income distribution, geographical difference, education, gender, food and nutrition behavior, lifestyle-related factors, environmental factors related to water and sanitation, waste management, food safety and

air quality are some of the major determinants that have direct impact on health outcomes of different socioeconomic groups of a country.

Ethiopia recognized the profound effect of the social determinants of health (SDH) on health and its overall development endeavors.

Key development cooperation achievements, opportunities and challenges

Opportunities / achievements

1. Potential funds on areas including health/Emerging global health initiatives;
2. Ethiopia has signed the global IHP compact and developed a country compact which has been signed by WHO among 11 partners;
3. The Joint Financial Agreement (JFA) has paved the way for the existence of a pooled fund managed by the Government (MDG pooled fund);
4. Annual Review Meetings where federal and lower levels of the health systems with partners review performance of health system in the past and agree on the coming year's plan;
5. New partners supporting the health agenda (e.g. Australia);
6. Joint missions (Government and partners);
7. Launching of one UN fund;
8. Three UN joint programs underway.

Challenges

1. Global financial crisis;
2. Harmonization and alignment commitments;
3. Strengthening of monitoring and follow-up capacity;
4. Expanding and developing new partnerships in health.

Civil Registration and Vital Statistics (CRVS)

A well developed and functioning registration system ensures the registration of all vital events including births, marriages and deaths and issues relevant certificates as proof of such registration. Civil registration promotes efficient government planning, effective use of resources and aid, and more accurate monitoring of progress towards achieving the Sustainable Development Goals.

Details: <http://www.who.int/countries/eth/en/>

71st World Health Assembly, May 21 – 26, 2018

Geneva, Switzerland

The World Health Assembly is the decision-making body of WHO. It is attended by delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the World Health Assembly are to determine the policies of the Organization, appoint the Director General, supervise financial policies, and review the approve the proposed programme budget. The Health Assembly is held annually in Geneva, Switzerland.

Media Centre: www.who.int/mediacentre/events/governance/wha/en/

The Global Health 50/50 Report



The Global Health 50/50 Report, the first of its kind, provides a comprehensive review of the gender-related policies of 140 major organizations working in and/or influencing the field of global health. The initiative is focused at the intersection of several SDGs, including health, gender equality, inequalities and inclusive societies and institutions.

The seven domains examined were:

- Public statement of commitment to gender equality;
- Gender defined in institutional policies and consistent with global norms;
- Programmatic policies in place to guide gender-responsive action;
- Sex-disaggregated data collected and reported;
- Workplace policies and practices with specific measures to promote gender equality in place;
- Gender parity in governing bodies and senior management;
- Gender of the head of the organization, and of the governing body.

Suggested Reading: <http://globalhealth5050.org/report>



High-Level Political Forum 2018

HLPF 2018; 9-18 July

Open Invitation

The meeting of the high-level political forum on sustainable development in 2018 convened under the auspices of the Economic and Social Council will be held from Monday, 9th July, to Wednesday, 18 July; including the three-day ministerial meeting of the forum from Monday, 16 July, to Wednesday 18 July 2018. The theme will be “Transformation towards sustainable and resilient societies.”

SDG Learning Workshop Session on Tuesday 10 July, 10.00 AM – 01.00 PM

Title: *Effective tools employed by Major Groups and other Stakeholders in the 2030 Agenda implementation, follow-up and review.*

The list of presenters in this group are the following:

- Abibimman Foundation – African Civil Society tools

- Centre for International Sustainable Development Law – legal tools to support the realization of SDGs 15 and 6
- CIVICUS: World Alliance for citizen participation – civil society participation tools, Human Right Index
- Women's Health and Education Center (WHEC) – its Learning and Innovation Network for Knowledge and Solutions (LINK)
- World Family Organization and UNAPMIF – Budgetary alignment with sustainable development policies
- World Federation of Engineering Organizations (WFEO) – Infrastructure and technology

WHEC Global Health Line, launched on 4 July 2013, which is serving in 227 countries and territories, about 14-15 million subscribers every year, can help further the Sustainable Development Goals (SDGs). According to the World Health Organization (WHO), at least 1,600 women will die or permanently disabled today, due to pregnancy and childbirth. And this is 2018. Skilled attendant means successful outcomes. We wish to develop Essential Knowledge Platform in Maternal and Child Health, such as, <http://www.WomensHealthSection.com>

WHEC Global Health Line (WGHL), through its Learning and Innovation Network for Knowledge and Solutions (LINK), aims to catalyze collaborative networks – cutting across disciplines, sectors, and borders – that seek science and technology-based solutions to development challenges.

Join us for an interesting and intriguing discussion. We hope to see you there.

Details and logistics: <https://sustainabledevelopment.un.org/hlpf>

Bulletin Board

Privacy Policy

Your privacy on the Internet is of utmost importance to the Women's Health and Education Center (WHEC). This privacy statement describes WHEC's policy concerning the gathering and sharing of visitors' information through the WHEC web site. It applies to all "WHEC sites" -- that is, all sites within the "womenshealthsection.com" domain name.

What information does WHEC collect?

Normal web site usage: In general, you can browse the WHEC site without telling us who you are or revealing any personal information about yourself. The only information we gather during general browsing is from standard server logs. These include your IP (Internet Protocol) address, domain name, browser type, operating system, and information such as the web site that referred you to us, the files you download, the pages you visit, and the dates/times of those visits.

Collection of personally identifiable information

If you register for a newsletter, log on to certain WHEC sites, request information, provide feedback, join a discussion group or join an electronic mailing list, you will be asked to provide personal information such as your name, postal address and e-mail address. This information is collected only with your knowledge and permission and is kept in various WHEC databases. WHEC sites with specific requirements to collect personal information may publish a privacy policy specific for that site. In these cases, the site-specific policies will be complementary to this general WHEC privacy policy but will give additional details for that site. Joining electronic discussion groups may mean that other participants of the discussion group (including non-WHEC employees) will see personal information that you have volunteered. For open discussion groups, this information will be public.

What does WHEC do with the information it collects?

Normal web site usage: The information gathered during general browsing of the "womenshealthsection.com" domain is used to analyze trends and usage of the WHEC site and to improve the usefulness of the site. It is not connected with any personal information.

To be continued...



Collaboration with UN University (UNU)

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

Maternal and neonatal services in Ethiopia

Measuring and improving quality

Ethiopia has invested in hospital quality improvement for more than a decade and this tool was integrated into existing quality improvement mechanisms within lead hospitals, with potential for scale-up to all government hospital. Significant improvements in quality of intrapartum care were detected from baseline (June-July 2015) to follow-up (February-March 2016) in targeted hospitals. The overall mean quality score rose from 65.6 (standard deviation; SD: 10.5) to 91.2 (SD: 12.4) out of 110 items ($P < 0.001$).

The method was feasible, requiring total of 3 days and two to three trained data collectors per hospital visit. It produced data that detected substantial changes made during 8 months of national hospital quality improvement efforts. With additional replication studies, this tool may be useful in other low- and middle-income countries. Summary of main lessons learnt

- The tool and process for assessing quality of intrapartum care in hospitals in Ethiopia was feasible to implement, requiring 3-day site visits by two or three data collectors.
- The process produced data sensitive enough to detect significant changes made during less than 1-year of national quality improvement efforts by the Ethiopia Hospital Alliance for Quality.
- Informed by the World Health Organization's service availability and readiness assessment instrument, the tool provided a feasible approach to identify gaps and opportunities for improvements in quality.

The process met several key challenges. First, due to constraints of staffing, cost and time, the authors were unable to measure patient outcomes and had to depend on combination of direct observation and chart reviews to obtain data. Often charts were incomplete, which was noted; more complete medical records would facilitate more precise quality measurement efforts. Second, the process required substantial financial and time investments and the authors could only accomplish the site visit for 18 hospitals. Third, clinical observations may have overestimated the use of quality processes, given that people may alter their behavior when they know they are being observed. The linking of performance, as measured by this process, to financial rewards for top performing and most improved hospitals was reported to have motivated hospitals to understand and improve their quality data. The process also helped to highlight clear gaps on which to focus future national quality improvement efforts by the medical services directorate and health ministry.

Publisher: UNU-WIDER; Authors: Maureen E. Canavan, Marie A. Brault, Dawit Tatek, Daniel Burssa, Ayele Teshome, Erika Linnander, Elizabeth H. Bradley; Sponsors: The Institute is funded through income from an endowment fund with additional contributions to its work programme from Denmark, Finland, Sweden, and the United Kingdom.

Details of the paper can be accessed from the link of UNU-WIDER on CME Page
<http://www.WomensHealthSection.com/content/CME>



United Nations Girls' Education Initiative (UNGEI)

The Effort to Advance the Global Strategy (continued)

Ethiopia: Background



Ethiopia, with a population of 75 million, has many ethnic groups speaking different languages or dialects. The country is no stranger to environmental and political crises, including drought, famine and border conflict. In 1988, the Government adopted an Education Sector Development Program (ESDP), and primary school net enrolment rates have increased considerably. Enrolment of girls has particularly gone up, and gender gap has narrowed.

Barriers to girl's education

Social and cultural factors affecting girls: Parental and societal attitudes, as well as traditional practices, such as child marriage, dowry system and female genital mutilation/cutting. A shortage of conducive learning environments; school often lack girl-friendly facilities, such as sanitary latrines and clean water. Long distances to schools and unsafe roads, resulting in parents keeping daughters at home to protect them from sexual abuse and other violence.

UNGI in action

UNGEI was launched in 2005. The partnership known as Partnership for Girls Education aims at promoting girls' education at the primary level and accelerating the ongoing initiatives, with an emphasis on marginalized areas.

Key Initiatives

- Advocacy and social mobilization;
- Creating conducive learning environment through child-friendly schools;
- Construction of schools near communities, e.g. Alternative Basic Education Centers.

Partners

Ministry of Education, Save the Children Alliance, UNESCO, UNICEF, USAID, Women's Standing Committee in Parliament, regional education bureaus, Girls' Education Department at the Regional Education Bureau, the Regional Women's Affairs Office in the Prime Minister's Office and regional women's associations.

UNGEI within other national and international framework

Fast Track Initiative (FTI), Poverty Reduction Strategy Papers (PRSPs) and sector-wide approaches to planning (SWAP's); Common Country Assessments (CCAs), and UN Development Assistance framework exist at the national level. Details: http://www.ungei.org/infobycountry/ethiopia_758.html

To be continued....

Two Articles of Highest Impact, April 2018

1. The Apgar Score; <http://www.womenshealthsection.com/content/obsnc/obsnc002.php3>
WHEC Publications. Funding provided by WHEC Initiatives for the Global Health.

2. Newborn Screening Program in the United States;
<http://www.womenshealthsection.com/content/obsnc/obsnc003.php3>
WHEC Publications. Funding provided by WHEC Initiatives for the Global Health.



From Editor's Desk

The Perception Change Project

Understanding Poverty



The World Bank Group is committed to fighting poverty in all its dimensions. We use the latest evidence and analysis to help governments develop sound policies that can help the poorest in every country improve their lives.

We face big challenges to help the world's poorest people and ensure that everyone sees benefits from economic growth. Data and research help us understand these challenges and set priorities, share knowledge of what works, and measure progress.

Fewer people live in extreme poverty than ever before. Even as the world's population has grown, the number of poor has gradually fallen. In 1990, almost 4 in 10 people were living under the international extreme poverty line of \$ 1.90 a day. In 2013, that figure had fallen to just over 1 in 10. But that still represents more than 767 million people. Poverty remains unacceptably high. (Source: World Bank)

Let's Talk Development:

Doing research for advocacy (which is a large part of my job) is a balancing act. The pressure to come up with clear findings and "killer facts" that speak to policy-makers can easily tip over into something much more questionable. Some "political truths" diverge even further from reality. And simple narratives are precisely what stick in people's heads, improve policy, change attitudes and bring about change (hopefully for better not worse). And yet, this is what we call '**a zombie statistic**': often quoted but rarely, if ever, presented with a source from which the number can be replicated. We have such questionable "facts" because existing poverty data makes it hard to have a clear picture of the true gender dimensions of poverty.

- Poverty's effects on women: No, 70% of the world's poor aren't women – but that doesn't mean poverty isn't sexist. What we know from existing data is that women account for about 50%, not 70% of the world's extreme poor. Poverty, is generally measured at the household level – meaning that if a household lives in extreme poverty, we assume that everyone under that roof lives at the same level of deprivation. However, evidence and common sense tell us that this is rarely the case; women, children, people with disabilities, and elders, for example, often receive smaller portion of food or have less invested in their education and health.

Ideally, we would have detailed, individual-level data to truly understand the depth and breadth of poverty among women in the world. However, given the difficulty many countries face in gathering household-level data, which can be costly and time-consuming, this will be a challenge, but one we are beginning to tackle. The good news is that despite the limitations, we can still learn a lot about the differences in poverty between men and women in the meantime.

This is the focus of a collaborative effort by UN Women and the World Bank, which uses the World Bank's Monitoring Database (GMD) to analyze gender differences in welfare at the global level. The database covers 89 countries, representing approximately 84% of the population in the developing world – or about 5.2 billion individuals.

- Breaking the cycle of poverty: The social status of one's parents is as influential today as it was 50 years ago in determining a person's future (**lottery of birth**). Is this a fair progress?

Low levels of upward mobility are particularly pronounced in the developing world, especially in sub-Saharan Africa. For example, only 12% of today's young adults (born in the 1980s) in some sub-Saharan African economies have more education than their parents, compared to more than 80% of the same generation in parts of East Asia. All the 15 economies where people's education level is most closely tied to their parents' education are developing economies.



Aspirations: when people perceive that they cannot move out of poverty, they are less likely to take necessary steps to do so – their perceptions impede their aspirations, keeping them trapped. It is critical to incorporate behavioral insights into policies and programs, to better reach those who have been left behind in the development process.

We hope to eventually replace the “zombie statistics” from above with a living, breathing, accurate understanding of the true depth of poverty among men, women and children in the world. This is not an

attempt to make poverty more gender-equal, but rather to ensure that countries' and communities' efforts do not leave anyone behind.

End Poverty Day

The world is making progress toward the goals of ending extreme poverty by 2030 and boosting shared prosperity everywhere. By focusing our resources on three areas: promoting sustainable and inclusive economic growth, investing in human capital and fostering resilience to shocks, and by measuring progress – we can get the rest of way.

End Poverty Day presents the global community with an opportunity each year to focus on our goals and to work with government and citizens, civil society, private sector and development organizations to build support for the action needed to achieve those goals.



In The News

ECOSOC Forum

Putting the money where the goals are: Development Challenges and progress

While estimates vary, it is safe to predict that the bill for implementing the Sustainable Development Goals (SDGs) worldwide will be in the trillions of dollars. The current upturn in global economy increases our chances of footing that bill, but steady sources of funding over the next 12 years – come rain or shine – must be guaranteed to achieve the SDGs by 2030. This is agenda for 3rd UN Economic and Social Council (ECOSOC) Forum in Financing for Development. The Finance Ministers and other high-level officials from the around the world will meet in New York and will present progress made in their countries towards implementing the Addis Ababa-Action Agenda – the milestone 2015 agreement on financing of the Global Goals. Representatives of multilateral organizations, international financial institutions, development banks, civil society, the business community and local authorities will also share their views and actions.



During an effective dialogue, Permanent Representatives of UN Member States will have unique opportunities to engage the Executive Directors of the World Bank and the International Monetary Fund on policy coherence in the areas of disaster risk and resilience, the taxation of the digitalized economy. Led by the Ambassadors of Jamaica and Portugal, Member States will use the Financing for Development Forum to negotiate concrete actions in the seven areas of Addis Agenda. The outcome of their discussions will inform the High-level Political Forum on Sustainable Development in July 2018. The Forum will be preceded by the SDG Investment Fair, which will make the business case for investing in sustainable development and stimulate dialogue between the

world of business and governments. Energy, agriculture, infrastructure and financial innovation will be center stage at the Fair.

SDG Investment Fair:

<http://www.un.org/esa/ffd/ffdforum/wp-content/uploads/sites/3/2017/10/2018-SDG-Investment-Fair.pdf>



Words of Wisdom

We outgrow love like other things
And put it in the drawer,
Till it an antique fashion shows
Like costumes grandsires wore.

- Emily Elizabeth Dickinson (10 December 1830 – 15 May 1886) American Poet.

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

<http://www.WomensHealthSection.com>

