



WHEC Update

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

December 2019; Vol. 14. No. 12

A Grand Collaboration

Happy Holidays from all @ the Women's Health and Education Center (WHEC)

As 2019 ends, we @ WHEC turn our attention to those who contribute to the uniqueness of our community and our initiatives with the United Nations (UN) and the World Health Organization (WHO). On that note, we would like to take this opportunity to extend our best wishes to you and your family for a happy, safe and peaceful holiday season.

In 2002, when I had accepted this challenging project with UN DPI (Department of Public Information) to plan and develop, e-Health platform with special focus on maternal child health – honestly, I was terrified, scared, very scared and extremely scared. While I was just getting comfortable in my private practice in Western Massachusetts, taking on additional responsibility with the burden of full-time practice of obstetrics and gynecology, was a daunting undertaking. But it was a dream of mine from childhood to work with the United Nations (UN) and the World Health Organization (WHO). I just could NOT resist. I had to go into full throttle, no matter how scared and how tired I was.

Luckily, I had a support system and friends like you. In the last 18 years I had the pleasure of working with the finest physicians, nurses, journalists and technology experts, who guided me on this path. There were few bumps (quite a few, actually) in the road, but the mistakes and misfortunes teach us lot more than the successes. I was lucky to have you all on my side. In 2008, when The Women's Health and Education Center (WHEC) was accepted as *NGO in Special Consultative Status with Economic and Social Council of the United Nations* – I think that was the moment I knew I was going to be okay. My friends at UN and WHO have accepted me, and I was not as scared to develop a global information system anymore. My mother was my best supporter and cheer-leader of mine. She had inspired me to continue on this rough-terrain. I am glad this acceptance letter in 2008 came a week before she passed away. Goodbye is never a fun word or easy to say, but I know she was happy about this accomplishment of mine, and she will be peaceful wherever she was going. This gave me satisfaction.

Your friendship and support has made this web-learning project a great success. Our media channels can be accessed in 227 countries and territories, in all the Member States of the UN and in all the Member States of the WHO. We look forward to work with anyone who is interested in improving maternal and child health. We welcome everyone! Join us....

Writing *WomensHealthSection.com* and *WHEC Update* and serving as Editor-In-Chief taught me something different. One: don't be afraid to be who you are. Two: everything great started with an idea and taking step number one. Finally, three: it's okay to be little nervous (a lot nervous). It has been a very challenging and a very demanding experience. No regrets contentment.

This month, readers, go for that big goal, that big picture, that big idea, and that big project – you have passion for. Imagine students in developing countries and the United States, Europe and developing countries simultaneously reviewing the same medical curriculum and learning from each other (**Internet Classrooms to improve maternal and child health**). Tackle that big dream. Ignore the doubt in your head and follow the joy in your heart. Happy holidays, I hope 2020 is a lucky one.

We the peoples of the United Nations

New Technologies and Information Systems: But Where To?

Rita Luthra, MD



Your Questions, Our Reply

How can multilateralism survive in the era of Internet and Artificial Intelligence (AI)? What is the role of AI in health sector?

Innovating to improve maternal and child health: The Civil Society Organizations (CSOs) and the Non-Governmental Organizations (NGOs) community is extremely varied. New ideas and approaches are being tested all the time. Change is a constant factor in our lives. I welcome this. However, in the arena of peace, education-for-all, health-for-all, and fair development-for-all, it is essential the activities of The State, IGOs (Intergovernmental Organizations), CSOs, NGOs The U.N. should be complementary, or at least compatible. I believe that the time has now come to tackle these problems so that we can act together more effectively to promote our common agenda. This is WHEC's expectations.

Market analyst predict that intelligent machines, programed to think and reason like the human mind, will revolutionize health care in the very near future. In fact, proponents of the transformative power of AI usually give two examples: self-driving cars and the delivery of health care. AI is a new frontier for the health sector. As so often happens, the speed of technological advances has outpaced our ability to reflect these advances in sound public policies and address a number of ethical dilemmas. Many questions do not yet have answers and we are not yet sure we know all the questions that need to be asked. Much of the enthusiasm for the use of smart machines to improve health care reflects the perspectives of wealthy countries and well-resourced private companies. We need a broader perspective. The initiatives of WHEC look at potential benefits, risks, and ethical dilemmas in the context of several worldwide trends that shape priority to improve maternal and child health and healthcare delivery systems.

Many countries where the majority of health facilities lack such basics as electricity and running water – it would be hard to sell these countries on the advantages of AI when even standard machines for analyzing patient samples or sterilizing equipment cannot run for want of electrical supplies. Any discussion of the potential of smart machines to revolutionize the delivery of health care must be alert to these huge gaps in basic capacities. At the same time, it is observed the ubiquitous presence of smart phone even in the most resource-constraint settings. Schools may not have toilets or latrines. Children may not have shoes. But smart phones are ready to hand. Given the significant shortage of health workers, the application of AI to healthcare could potentially reduce some of the burden on overloaded health staff. This is one advantage: revolutionary new technologies will certainly meet some resistance from the medical profession, but not, for the time being, because they threaten jobs. Given the power of super computers and super-chips to mine and organize huge amounts of data, it is easy to envision a number of applications of AI in the health sector.

In the midst of all this exciting potential, several reasons for caution:

First; medical decisions are complex; they depend on context and values such as care and compassion. Machines will never be able to imitate genuine human compassion.

Second; machines can aid the work of doctors, organize, rationalize, and streamline the processes leading to a diagnosis or other medical decision, but AI cannot replace doctors and nurses in their interactions with patients.

Third; we must consider the context and what it means for the lives of people. What good does it get an early diagnosis of skin or breast cancer if a country offers no opportunity for treatment, has no specialists or specialized facilities and equipment, or if the price of medicines is unaffordable for both patients and the health system?

In short, the potential of AI in healthcare is huge, but so is the need to take some precautions.



United Nations at a Glance

Permanent Mission of India to the United Nations

India became UN Member State on 30 October 1945



India, official name the **Republic of India**, is a country in South Asia. It is the seventh largest country by area, the second most populous country, and the most populous democracy in the world. Bounded by the Indian Ocean on the south, the Arabian Sea on the southwest, and the Bay of Bengal on the southeast, it shares land borders with Pakistan to the west, China, Nepal and Bhutan to the north, and Bangladesh and Myanmar to the east. Indian cultural history spans more than

4,500 years.

Its capital: New Delhi; largest city: Mumbai; official languages: Hindi and English; religions: Hinduism 79.8%, 14.2% Islam, 2.3% Christianity, 1.7% Sikhism, 0.7% Buddhism, 0.4% Jainism, 0.9% others. A pluralistic, multilingual and multi-ethnic society, India is home to 1.3 billion people. It is also home to a high diversity of wildlife in a variety of protected habitats.



India is among the original members of the United Nations that signed the Declaration by United Nations at Washington on 1 January 1942 and also participated in the historic UN Conference of International Organization at San Francisco from 25 April to 26 June 1945. As a founding member of the United Nations, India strongly supports the purposes and principles of the UN and has made significant contributions to implementing the goals of Charter, and the evolution of the UN's specialized programs and agencies. Independent India viewed its

membership at the UN as an important guarantee for maintain international peace and security, India stood at the forefront during UN's tumultuous years of struggle against colonialism and apartheid. India's status as a founding member of the Non-Aligned Movement and the Group of 77 cemented its position within the UN system as a leading advocate of the concerns and aspirations of developing countries and the creation of a more equitable international economic and political order. India is today at the forefront of efforts on UN reform, including expansion of the Security Council in both the permanent and non-permanent categories to reflect contemporary realities.

Since 2015, India has made Agenda 2030, a cornerstone of the development policies. During the last 5 years, a large number of flagship programs have been implemented with the aim to empowering the vulnerable segments of our society and improve inclusion access multiple dimensions. According to UNDP – Reports between 2000 – 2016, 271 million people were lifted out of multi-dimensional poverty. 300 million bank accounts, a majority for women, were opened during the past five years. 320 million women were handed over cooking gas-stoves, thereby freeing them from the oppression of cooking on wood and bio-fuels with adverse health impacts. India is committed to provide housing for all by 2022 – 15.4 million houses were completed and handed over during the past five years under the PMJAY – (Rural) and another 10 million completed in urban centers. All villages – 100% have now been electrified and 80 GW of renewable energy capacity has been installed.



Permanent Mission of India to the UN

New York Details: <https://www.pminewyork.gov.in/>

Collaboration with World Health Organization (WHO)

WHO | India



Health Situation

- Polio has been eliminated. Yaws, guinea worm and maternal and neonatal tetanus have been eliminated. Leprosy stands eliminated at the national level and the country is rapidly moving ahead to eliminate kala-azar, lymphatic filariasis, leprosy and malaria.
- India has a high burden of communicable, including non-communicable diseases (NCDs), maternal and neonatal conditions and a rising burden of mental health and injuries.
- Premature mortality from NCDs accounts for 75% of total mortality among 30-69 years old.
- While India recorded an impressive 70% reduction in maternal deaths and 66% reduction in deaths of children under-5 years of age between 1990-2015, the maternal mortality ratio (MMR) of 167 and infant mortality rate (IMR) of 43 is still high.
- Immunization coverage in 2015 was 62% among 12-23 months old. Coverage rates have improved in 2016 and are further improving with intensified Mission Indradanush, which aims to reach 90% by the end of 2018.
- Revised TB incidence from 2.2 to 2.8 million/year and TB mortality from 220,000 to 480,000 per year indicate that India has 27% of global burden and 34% of TB mortality.
- India has the third highest malaria burden in the world with 1.16 million cases in 2017.
- Wide health inequity exists within and among states. For example, MMR in Kerala was 61 compared to 300 in Assam (2015), and girls in India have higher prevalence of undernourishment than boys.
- The country has a high proportion of sex selective abortion. In 2016, India ranked 125th in gender equality, with Gender Equality Index of 0.530

Health Policies and Systems

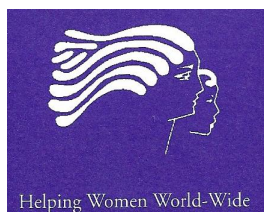
- India is a fast-growing economy, GDP doubled between 2000 to 2014 with a projected growth of over 7% for this fiscal year.
- Rural population is 67% (2015), urbanization is fast increasing with 2.4% annual growth.
- India has made progress in health. Life expectancy is now 68 years; it was 33 in 1947.
- Government expenditure on health is around 1% of GDP. This has resulted in inadequate financial protection in health and high out of pocket – more than 62% of spending on health by Indians represents out of pocket and around 60 million people are pushed into poverty.
- Inequity in socioeconomic dimensions is a challenge to India's development.
- Air pollution is a rising concern.
- India has become the “pharmacy of the world”, contributing to access to good quality and affordable medical products for India itself and beyond its borders. It is consistent with the PM initiative “Make in India.”

Cooperation for Health

- A multisectoral approach is key to effective CCS implementation. As the lead UN agency for health, one of WHO's important role is to lead collaborations and partnerships with a range of health and non-health partners to maximize synergies and ensure health goals are at the forefront.
- WHO works closely with UN agencies within and outside the country such as UNAIDS, UNICEF, UNDP, and UNFP.
- WHO will actively seek new partnerships to leverage the health agenda and will work with civil society to ensure public participation.

Details: <https://www.who.int/countries/ind/en/>

Bulletin Board



Terms of Use

....Continued

Preservation of Immunities

Nothing herein shall constitute or be considered to be a limitation upon or a waiver of the privileges and immunities of The WHEC, which are specifically reserved.

General

The WHEC reserves its exclusive right in its sole discretion to alter, limit or discontinue the Site or any Materials in any respect. The WHEC shall have no obligation to take the needs of any User into consideration in connection therewith.

The WHEC reserves the right to deny in its sole discretion any user access to this Site or any portion thereof without notice.

No waiver by The WHEC of any provision of these Terms and Conditions shall be binding except as set forth in writing and signed by its duly authorized representative.

- **UN Document; Reference 3310**
<http://www.womenshealthsection.com/content/Reference-3310-UN-Document.pdf>
- **WHEC By-Laws; available @**
<http://www.womenshealthsection.com/content/documents/WHEC-By-Laws.pdf>
- **WHEC Global Health Line (WGHL); available @**
http://www.womenshealthsection.com/content/cme/WHEC_Global_Health_Line.pdf
- **Partnership for Maternal Newborn and Child Health (World Health Organization); available @**
http://www.womenshealthsection.com/content/documents/PMNCH_Membership_Since_2011.pdf
- **Every Woman Every Child Global Strategy; available @**
<http://www.everywomaneverychild.org/commitment/womens-health-and-education-center/>

Contact us: *We look forward to hearing from you!*

<http://www.womenshealthsection.com/content/whec/contact.php3>



Promoting Maternal and Child Health Worldwide – We Welcome Everyone

Dedicated to Women's and Children's Well-being and Healthcare Worldwide



Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics
Research)

Expert Series on Health Economics

A Short History of India's Economy

This paper is a short history of the Indian economy since 1968. India today is a changed country from what it was half a century ago, when Myrdal published his *Asian Drama*. The stranglehold of low growth has been broken, its population below the poverty line has fallen markedly, and India has joined the pantheon of major players globally. This paper analyses the economic policies and the politics behind this transformation; and uses that as a backdrop to take stock of the huge challenges that lie ahead.

The next 25 years

Peering into the distant future is not easy for any discipline, and economics is no exception. The discipline has reached a maturity whereby short-term forecasts – predicting the effects of today's interventions over the next weeks, months, or even a year – have gained some credibility and this is what provides the foundation for modern monetary and fiscal policy. With the arrival of big data analysis and improved techniques for mathematical modelling, there should be improvements in the power of forecasting over longer horizons. But we are not there yet. Moreover, the intertwining of economics with politics and societal norms and habits makes long-term forecasting hazardous. With these caveats in place, it is time, to indulge in some of the joys of speculation about what the next 25 years may look like for India.

First, agriculture as a share value-added in GDP has over the last 50 years become quite decline in its production can cause food inflation, large welfare losses among the poor, and even political instability. Therefore, agriculture as a sector will continue to need nurture.

Second, while technology will eventually create a global challenge that will affect India as well, for some time still to come India will be able to take advantage of its cheap labor and boost its manufacturing sector, which is a powerful absorber of labor. But to nurture this sector more investment is needed in infrastructure, the reduction of bureaucratic costs, and also good macroeconomic policy, because a wrong exchange rate policy can blight the nation's scope for greater manufacturing exports. The nation will need new investments in this.

Third, and a closely related problem, is the matter of inequality. If the working classes are not endowed with more creative skills, there is the danger that, even if India continues to grow, all its growth will be concentrated at the top end. This will be problem for India for some time to come. While the growth story has been exemplary, various indicators show that growth has not been distributed well across society.

The world can get there, and India can play a leadership role in ushering in such an age. With its early investment in the political institutions of democracy, secularism, and openness to idea, as well as in good universities and institutes of higher learning, including science and engineering, and in its more recent improvements in savings and investment rates, India, with its enormous size, has the potential to be in the front line. There are policy corrections to be made, there are pitfalls to be avoided, as discussed in this paper, but with all those caveats, the prospects look good for what lies ahead.

Publisher: UNU-WIDER; Author: Kaushik Basu; Sponsors: The Institute is funded through income form an endowment fund with additional contributions to its work program from Finland, Sweden, and the United Kingdom as well as earmarked contributions for specific projects from a variety of donors.

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)

India | Background

Economic growth in India has been strong over the past decade, especially in the information technology sector. But significant disparities remain, based on class, caste, gender and geography. The United Progressive Alliance coalition government, which came into power in May 2004, has pledged to emphasize social development as part of its National Common Minimum Program. It seeks to eliminate some of the inequalities in Indian society by reducing poverty, increasing public spending on education, speeding the delivery of health services, and improving nutrition and food safety.



With one upper primary school for every three primary schools, there are not enough upper primary centers even for those children who complete primary school. For girls, especially, access to upper primary centers becomes doubly hard. Several states have undertaken innovations to make schools more child-friendly and in the development of child-friendly assessment tools. Exercises in the assessment of teacher training and teacher effectiveness and the development has been the adoption of The Meena Communication Initiative as a learning and advocacy tool by the Ministry of Education at national and state levels.

Barriers to girls education

Major barriers to girls education include:

- Many rural children have been left behind by migrating parents or have been sent by themselves into urban areas for education.
- Basic education is free but not compulsory. Many schools in the south were closed due to political unrest in the 1990s and have yet to reopen.
- Traditional views that devalue education are prevalent.
- Turnover of teachers and instructors is high.



UNGEI in action

UNGEI has been formally launched, but girl's education initiatives are ongoing: Key initiatives of the Women's Health and Education Center (WHEC) in India in collaboration with UNGEI and other UN System's programs are:

- Addressing school and classroom environments, teaching-learning processes, teacher support and school-community linkages.
- Education analysis and research.
- Accelerating the implementation of the communication strategy for girls' education at the national and state levels and integrated districts.
- Administering child-friendly learning assessment tools.
- Strengthening policy dialogue on issues related to education and stronger service delivery of educational intervention for working children.

Partners

Partners include the Government of India, Australian Government Overseas Aid Program, CARE, European Union, ING-Vysya Foundation, Swedish International Development Cooperation Agency and UK Department for International Development, in addition to other NGOs, donors and the joint UN system.

Details: <http://www.ungei.org/infobycountry/india.html>

To be continued....

Two Articles of Highest Impact, November 2019

Editors' Choice – Journal Club Discussions

Fully open-access with no article-processing charges

Our friendship has no boundaries. We welcome your contributions.

1. Chronic Kidney Disease and Pregnancy;
<http://www.womenshealthsection.com/content/obsmd/obsmd020.php3>
WHEC Publications. Funding: WHEC Global Initiatives are funded by a grant from an anonymous donor. Join us at WHEC Global Health Line for discussion and contributions.
2. Learning and Innovation Network for Knowledge and Solutions (LINK);
<http://www.womenshealthsection.com/content/heal/heal024.pptx>
WHEC Publications. Funding: WHEC Global Initiatives are funded by a grant from an anonymous donor. Join us at WHEC Global Health Line for discussion and contributions.

Partnership for Maternal, Newborn & Child Health (World Health Organization) PMNCH Member

Worldwide service is provided by the WHEC Global Health Line



From Editor's Desk

New Initiatives, New Collaborations, New Directions

Medical Tourism: Globalization of the Healthcare Marketplace



Medical tourism has become a US \$ 60 billion a year business and is growing by 20% a year (*The Lancet*). India alone will welcome about 1.2 million foreign patients to its hospitals in 2020 and expected to pump about \$ 3.2 billion into that country's economy. Medical tourism is fundamentally different from the traditional model of international medical travel where patients generally journey from less developed nations to major medical centers in highly developed countries for medical treatment that is unavailable in their own communities. The term medical tourism does not accurately reflect the reality of the patient's situation or the advanced medical care provided in these destinations.

Medical travel is projected to expand globally in the next decade. Citizens in the United States of America, for instance, already receive significant volumes of services abroad, both for urgent and elective procedures. The growth in medical travel is largely due to improved availability of health technology,

decreasing costs for travel and advertising by companies wishing to attract patients. Medical tourism has been described as “travel across international borders with the intention of receiving some form of medical treatment. This treatment may span the full range of medical services, but most commonly includes dental care, cosmetic surgery, elective surgery and fertility treatment.”



Many foreign hospitals have already become accredited by the US Joint Commission, which assesses and accredits healthcare organizations in the USA. Through its subsidiary the Joint Commission International (JCI), the Joint Commission accredits international healthcare facilities and also provides educational and consulting services to hospitals around the world. As of September 1st 2018, there are 34 JCI accredited hospitals in India.

Medical services in India are particularly affordable, with prices as low as 10% of those in the United States. A number of countries in Central and South

America have developed strong reputations for cosmetic and plastic surgery, bariatric procedures, and dental care. India, Malaysia, Singapore, and Thailand are well-established medical tourism destinations that have become popular for patients seeking cardiac surgery and orthopedic surgery. Several highly developed nations including, Belgium, Canada, Germany, Israel and Italy are attracting foreign patients under the banner of medical tourism, offering sophisticated modern care with careful attention to patient preference, service and satisfaction.

Quality and Safety in Medical Tourism

Faced with the choice of many medical institutions in diverse countries, medical tourists may find it very difficult to identify well-trained physicians and modern hospitals that consistently provide high-quality care. Some medical tourism agents, particularly those with backgrounds in healthcare, may be helpful resources for patients in making appropriate choices. Accreditation by the JCI, which has accredited more than 150 facilities in 25 countries, and/or the International Organization of Standardization may provide a useful point of reference for patients selecting offshore medical facilities.

Concerns have been voiced regarding the risk of complications resulting from travel and vacation activities in the postoperative period. The management of postoperative complications that occur after a patient returns from an offshore medical facility, and the consequent costs of this care, are difficult issues that remain unresolved.

The Response to Medical Tourism

The medical community in developed countries has started to recognize medical tourism as a real phenomenon that involves the profession, practitioners, and patients. The United States Senate Special Committee on Aging held hearings on the issue of medical tourism in June 2006 and called for a task force of experts to explore the impact and safety of lower-cost healthcare abroad. In several states, Blue Cross Blue Shield sells insurance policies that enable or encourage patients to have expensive surgical procedures at low-cost offshore medical facilities.

It is increasingly apparent that medical tourism is changing the healthcare landscape in industrialized and developing countries around the world, and there is every reason to believe that this trend will continue to evolve. Effective research in medical tourism as a global phenomenon requires consideration of all three domains, with the overall goal of improving access, quality of care, and health equity.

To prevent harm, legal and economic frameworks for medical travel are needed. The current lack of regulation in medical tourism creates risks for patients due to a lack of oversight and variable standards of

practice. Legal frameworks need to clarify liabilities for adverse events and ensure equality of access for the local population, to ensure they are not negatively affected by medical tourism.



In The News

Protect Human Rights



The term “human rights” was mentioned seven times in the UN’s founding Charter, making the promotion and protection of human rights a key purpose and guiding principle of the Organization. In 1948, the Universal Declaration of Human Rights brought human rights into the realm of international law. Since then, the Organization has diligently protected human rights through legal instruments and on-the-ground activities.

How does the UN promote and protect human rights?

High Commissioner for Human Rights; The Office of UN High Commissioner for Human Rights (OHCHR) has lead responsibility in the UN system for the promotion and protection of human rights. The office supports the human rights components of peacekeeping missions in several countries and has many country and regional offices and centers. The High Commissioner for Human Rights regularly comments on human rights situations in the world and has the authority to investigate situations and issue reports on them.

Human Rights Council

The Human Rights Council, established in 2006, replaced the 60-year-old UN Commission on Human Rights as the key independent UN intergovernmental body responsible for human rights.

Human Rights Treaty Bodies

The human rights treaty bodies are committees of independent experts that monitor implementation of the core international human rights treaties.

What legal instruments help the UN protect human rights?

The International Bill of Human Rights

The Universal Declaration of Human Rights (1948) was the first legal document protecting universal human rights. Together with the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, the three instruments form the so-called International Bill of Human Rights. A series of international human rights treaties and other instruments adopted since 1945 have expanded the body of international human rights law.

What other UN offices and bodies are responsible for protecting human rights?

- Security Council;
- Third Committee of the General Assembly;
- Various other UN Bodies – Economic and Social Council (ECOSOC), UN Permanent Forum on Indigenous Issues (UNPFII);
- Secretary-General;

- UN Peace Operations;
- Commission on the Status of Women (CSW) – it is the principal global intergovernmental body dedicated to the promotion of gender equality and the advancement of women. UN Women, established in 2010, serves as its Secretariat.

Details: <https://www.un.org/en/universal-declaration-human-rights/index.html>



“Women’s Work” Unpaid and Overworked

Raising women’s participation in the economy can bring large benefits for all of society: it can boost economic growth, strengthen macro stability, help economies diversify, and help tackle income inequality. Despite some progress, large gender gaps remain. As much as half of the world’s work is unpaid. And most of it is done by women. This imbalance not only robs women of economic opportunities. It is also costly to society in the form of lower productivity and forgone economic growth. It

follows that a fairer allocation of unpaid work would not only benefit women but would also lead to more efficient work forces and stronger economies. For these reasons, reducing gender imbalances in unpaid work is part of the United Nations Sustainable Development Goals.

Time is not money

Across different countries, women disproportionately do more hours of unpaid work than men.



Source: United Nations Sustainable Development Goals.

Note: Data are from most recently available year.

Examples of unpaid work include cooking, cleaning, fetching food and water, and caring for children and the elderly. These tasks are not counted as part of economic activity because they are difficult to measure based on values in the marketplace. Yet their economic value is substantial, with estimates ranging from 10 to 60% of GDP.

There are large differences across countries.

Unpaid work declines as economic development increases.

INTERNATIONAL MONETARY FUND

Engines of liberation

Policies can help reduce and redistribute unpaid work. In developing economies, measures to improve water supply, sanitation, electricity, and transportation are critical to free women from low-productivity tasks.

Governments need to ensure access to education and healthcare for women. Without proper human capital, women's possibilities in the labor market are very limited. According to UNESCO, 130 million school-age girls are not in school. It is only a matter of providing the services, but also guaranteeing their use. Many families in Pakistan choose not to send girls to school because of security concerns. Enshrining women's rights in law could help to reshape social institutions and values that prevent access to education and healthcare. Family-friendly policies also help. Many Nordic countries invest heavily in early childhood education and care, which allows for high enrollment and fosters women's ability to return to work after giving birth.

https://www.youtube.com/watch?time_continue=13&v=5FmbL_IjILM&feature=emb_logo

Art & Science

Art that touches our soul

Unforgettable Memories

of

UN Headquarter in Geneva, Switzerland (July 2013)



A meeting place,
A magical place.
Where the lake mirrors the sky in glassy completion;
Where the earth gives way to water;
Where different cultures surrender to their smallness.
A fleeting moment in a temporary existence,
This moment is met, again and again, in a place that
– transcends time and cultures.

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

<http://www.WomensHealthSection.com>

