WHEC
Helping Women World-Wide

WHEC Update

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

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Making A Difference

Homelessness is one of the crudest manifestation of poverty, discrimination and inequality, affecting people of all ages, genders and backgrounds. Globally, 1.6 billion people worldwide live in inadequate housing conditions, with about 15 million forcefully evicted every year, which has noted an alarming rise in homelessness in the last 10 years. Eradicating poverty is not only an ethical, but also a social, political and economic necessity. Placing people at the center of development by ensuring full participation by all is of utmost importance. Poor physical health is associated with poverty in general but seems to be more pronounced among those who are without homes. Individuals without homes often lack access to healthcare treatment. Chronic health problems and inaccessibility to medical and dental care can increase school absences and limit employment opportunities. People without home have higher rates of hospitalizations for physical illnesses, mental illness, and substance abuse than other population.

Each year between 2 – 3 million people in the United States experience an episode of homelessness (HUD-US Departments of Housing and Urban Development). **COVID-19 pandemic has made this situation worse. Homelessness is an issue that can affect anyone**. The odds of an individual in the United States becoming homeless in a given year are 1 in 194. It is estimated 1% of population in developed countries – USA, Canada and EU countries are homeless and 10% of homeless people are under the age of 15.

Over the years the face of homelessness has changed from the adult male alcoholic to an increasingly diverse population with complex medical illnesses. Despite population, the shortage of affordable housing is a major precipitating factor that can render individuals homeless who are not extremely poor. According to US Census, the prevalence of homelessness is high among military veterans, estimated in 2016 to be about 13%.

Families with children are the fastest growing segment of the homeless population (HUD, 2018). The average sheltered family was headed by a female with 2 to 3 members. 34% of the total homeless population composed of families. 50% of children without homes are under age 5. A growing number of families experiencing homelessness have school-aged and adolescent children as well. African-American families make up to 43% of homeless families. Lack of education is associated with homelessness, with 53% of homeless mothers lack a high school diploma.

Additionally, the interface between homelessness and child welfare involvement results in many children being separated from parents and the placed in foster care. These children tend not to be reported in census studies of homelessness. Children without homes have greater numbers of school absences, compromising their academic achievements as well as school adjustment and self-esteem. Healthcare for homeless-population is a challenging but an important issue that needs to be addressed. It is essential to undertake efforts to prevent homelessness, to expand community-based services, and to provide adequate healthcare for this underserved population.

Tiny House Appendix Q is a part of a larger initiative by the American Tiny House Association to gather tiny house information for every state in the USA. Most cities and towns don't already have a policy on tiny houses, whether on foundations or on wheels, so their stance on tiny houses is currently unknown. Municipalities probably won't consider whether to allow tiny houses unless someone brings it up with them. Share your opinions on **WHEC Global Health Line.**

Homelessness and Health

Rita Luthra, MD

Your Questions, Our Reply

How can we make social inclusion a reality? What exactly is Tiny-House Appendix Q? How does it affect resolving the problem of homelessness which COVID-19 pandemic has made worse?

Our Efforts – A Concept Note: In 2020, it will be 25 years since the Copenhagen Declaration set out a list of ten commitments to drive social development and social progress globally at the international and national levels. The United Nations Department of Economic and Social Affairs (UN DESA) will reaffirm the need for a people-centered approach to development and for its urgent and concrete implementation through coordinated and coherent efforts by the international community.

The Women's Health and Education Center's (WHEC's) recommendations and initiatives on how to promote poverty-reduction strategies, homelessness, improve social protection programs and affordable healthcare for vulnerable population are:

1. Preventing Homelessness;
2. For healthcare providers: Identify patients within the practice who may be homeless or at risk of becoming homeless and provide healthcare for this population without bias.
3. Improved coordination between community programs and specific healthcare services such as prenatal care, cervical cancer screening, immunizations, mental health, substance abuse, and management for sexually transmitted infections and tuberculosis.
4. Modified residency and medical student curricula to increase awareness of healthcare issues of homeless individuals and promote involvement in direct care.
5. Indexing the minimum wage locally to the cost of housing.
6. Adequate disability benefits for those who are unable to work.
7. Increase access to long-acting reversible contraceptives.
8. Achieving Universal Health Coverage (UHC). Concept Note– WHEC's Written Statement, published by CSocD for 58th Session, UN Document: E/CN.5/2020/NGO/60

http://www.womenshealthsection.com/content/documents/CSocD_2020_Written_Statement.pdf

Realizing the right to health and wellbeing of all people by acting on existing gender inequalities and their complex determinants is challenging. We all at WHEC believe, adopting this agenda will accelerate progress for all people, in all their diversities, to realize to their fullest potential, their right to health and wellbeing across their life course.

Appendix Q: It is the language from the IRC (Internal Revenue Code) which officially defines a tiny house and creates a construction code specific to the needs of tiny houses. When the appendix is adopted into a state/jurisdictional code, builders (both professional and DIY [Do It Yourself] can go to their local building department with plans that meet the code, and after the project is complete, walk out with a Certificate of Occupancy (CO). Tiny House Appendix Q has been adopted in Massachusetts (USA), effective January 1, 2020. It has already been implemented in numerous states/building jurisdictions (ID, ME, GA) with many more in in line (Oregon, Texas, Colorado, New Mexico to name few).

Tiny houses provides building safety standards for houses on foundations that are 400 sq. ft. and under. However, the appendix Q does not mean you can build a tiny house on a foundation wherever you in USA; you still have to adhere to your municipality's zoning code. Appendix Q has gone through the rigorous vetting process from the International Code Council (ICC), and approved in December 2017. It is up to each state/jurisdiction to decide whether to adopt it or not.

The Homeless Prevention and Rapid Re-Housing Program has been the most effective plan for reducing homelessness.

Join the efforts!

United Nations at a Glance

Permanent Mission of Kenya to the United Nations

Kenya became Member State of the UN on 16 December 1963

Kenya, officially the **Republic of Kenya**, is a country in Eastern Africa. At 580,367 square kilometers (224,081 sq. mi), Kenya is world's 48th largest country by total area. With a population of more than 47.6 million people, Kenya is the 29th most populous country. Kenya's capital and largest city is Nairobi, while its oldest city and first capital is the coastal city of Mombasa. The Republic of Kenya is named after Mount Kenya.

As of 2020, Kenya is the third largest economy in sub-Saharan Africa after Nigeria and South Africa. Kenya is bordered with South Sudan to the north-west, Ethiopia to the north, Somalia to the east, Uganda to the west, Tanzania to the south, and the Indian Ocean to the south-east. National language is Swahili; official languages – English and Swahili. Religion: 85.52% Christin, 10.91% Muslim and rest Irreligion, Traditional and Other. Government: Unitary presidential constitutional republic; legislature: Parliament.

Modern-day Kenya emerged from a protectorate established by the British Empire in 1895 (1888 – 1962) and the subsequent Kenya Colony, which began in 1920. Numerous disputes between the UK and the colony led to the Mau Mau revolution, which began in 1952, and the subsequent declaration of independence in 1963. After independence, Kenya remained a member of the Commonwealth of Nations. The current constitution was adopted in 2010 to replace the 1963 independence constitution.

Kenya has considerable land area devoted to wildlife habitats, including the Masi Mara, where blue wildebeest and other bovids participate in a large-scale annual migration. More than 1 million wildebeest and 200,000 zebras participate in the migration across the Mara River.

Kenya's macroeconomic outlook has steadily posted robust growth over the past few decades, mostly from road and rail infrastructure projects. However, much of this growth has come from cash flows diverted from ordinary Kenyan pockets at the microeconomic level through targeted monetary and fiscal measures coupled with poor management, corruption, massive theft of public funds, over-legislation, and ineffective judiciary, resulting in diminished incomes in ordinary households and small businesses, unemployment, underemployment, and general discontent across multiple sectors.

Kenya is usually classified as a frontier market or occasionally an emerging market, but it is not one of the least developed countries. The economy has seen much expansion, seen by strong performance in tourism, higher education, and telecommunications, and decent post-drought results in agriculture, especially the vital tea sector. In 2019, Kenya's economic growth averaged 5.7%, placing Kenya as one of the fastest growing economies in sub-Saharan Africa.

Vision 2030

In 2007, the Kenyan government unveiled Vision 2030, an economic development program. The Big Four being within the framework are:

1. Universal Healthcare; 2. Manufacturing; 3. Affordable Housing and 4. Food Security.

Details: https://www.worldbank.org/en/country/kenya/overview

Collaboration with World Health Organization (WHO)

WHO | Kenya

Country Cooperation Strategy

The WHO Country Cooperation Strategy III (CCS III) is a medium-term strategic framework for WHO's work with the Government of Kenya for the period 2014-2019. It articulates a clear vision of how to improve the quality of WHO's work in Kenya with the aim of making the greatest possible contribution to the health development. It specifically aims to:

1. Provide the strategic direction for WHO/Kenya in advancing the national health agenda for the six-year period;
2. Provide a framework for WHO biennial work plans and budgets; and
3. Provide an institutional structure that reflects how the WHO office in Kenya will function and collaborate with the other levels of the Organization and country partners.

Health Status of the Population

The expectation of life at birth (Life Expectancy [LE}) in Kenya has improved from a low of 45.2 years in the 1990s to an estimated 60 Years by 2009. This improvement was particularly noted for persons under five years of age and adults due to improvements in health for these age groups.

- HIV/AIDS is still estimated to cause the highest proportion of deaths and lost disability-adjusted life years. The overall HIV/AIDS prevalence is on a downward trend and is currently estimated to be 5.6%, attributable to implementation of an aggressive HIV control strategy. At the end of 2013, 81% of eligible adults were assessing antiretroviral therapy (ART), thus improving their overall and disability-adjusted life expectancies. However, there are gaps, including the low ART coverage of 43% among children.
- Perinatal conditions remain quite high and are the major contributor to the high neonatal mortality rate, and therefore infant mortality rates. Efforts to improve these rates are ongoing, ranging from improving awareness in communities on the need for safe pregnancies to scaling up interventions associated with antenatal and safe birth and improving neonatal care facilities across the country.
- Lower respiratory infections are still a major cause of mortality and morbidity, particularly among under-five children in Kenya.
- Diarrheal diseases remain one of the major causes of childhood morbidity and mortality in Kenya, particularly in areas where there is poor access to safe drinking water.
- Tuberculosis (TB) incidence is 298 per 100,000 population but is unlikely to achieve the targets for reductions in prevalence and mortality.
- Malaria counts for 30% of total outpatient morbidity and is the leading causes of mortality among under-fives.
- Noncommunicable diseases (NCDs) are perceived to be on the increase in Kenya, though data is scanty.
- Kenya has high fatality rates due to traffic crashes in excess of 3,000 deaths annually. Notably, injuries to motorcyclists have increased by 29% annually; and fatalities among motorcyclists have increased by 51% annually.

A mid-term review of the CCS III implementation was carried out at the strategic level, to review progress, and re-align the CCS III priorities with the country's priorities as this was the end of the devolution transition period. In addition, the post-MDG agenda has just been defined, and WHO/Kenya need to ensure that it is aligned with the agreed agenda.

Details: https://www.afro.who.int/countries/kenya

Bulletin Board

Diagnostic Ultrasound Section

The application of diagnostic ultrasound in obstetrics are numerous and provide reliable information whereby the health and well-being of the mother and unborn baby can be readily assessed. Included withing these applications are the evaluation of early pregnancy; estimation and confirmation of gestational age; monitoring fetal growth, development and viability; in addition to its use as an adjunct to various interventional procedures such as amniocentesis, chorionic villus sampling, fetal blood sampling, and fetal surgeries. More recently, it has become possible to evaluate functional changes in blood flow in the uteroplacental and fetoplacental circulations in addition to the fetal heart and peripheral vasculature.

It has been almost five decades since the first ultrasonic devices for imaging the conceptus were developed. There continues to be a general belief in the medical community that ultrasound is “safe” and poses no risk to mother or fetus. The concept of two-tier ultrasound examination system was established on the principle one is more detailed than the other. Level I study is directed toward assessment of the following areas: pregnancy dates, fetal growth, number of fetuses, placental location, amniotic fluid, and major anomalies including anencephalous and obvious masses in fetal trunk, chest and abdomen. Level II examination is directed toward detailed imaging of fetal anatomic structures; specifically includes more detailed views of the heart and central nervous system.

Ethical dimensions of diagnostic ultrasound applied to obstetrics are a rigorous intellectual undertaking. Ethics is the discipled study of morality, and morality concerns both right and wrong behavior, that is, what one ought and ought not to do, and good and bad character, that is, virtues and vices. Ethics in obstetrics ultrasound deals with these same questions, focusing on what morality ought to be for physicians who employ this diagnostic technology in their practice. The bedrock for centuries for what morality ought to be in clinical practice has been the obligation to protect and promote the interests of the patient. This general ethical obligation must be made more specific if it is to be clinically useful. This can be accomplished by attending to different perspectives in terms of which the patient’s interests can be understood. The interests of the patient can be understood from two perspectives: that of physician and that of the patient.

Women’s Health and Education Center (WHEC)
http://www.womenshealthsection.com/content/obsdu/

*The mission of the Journal, **WomensHealthSection.com** is to publish and disseminate scientifically rigorous public health information, with special focus on women’s health, of national and international significance that enables healthcare providers, policy makers, and researchers to be more effective.*

It aims to improve health, particularly among disadvantaged populations in both developed and developing countries. Women’s Health and Education Center (WHEC) welcomes unsolicited manuscripts, which are initially screened in-house for originality and relevance.

Submit a Manuscript:
http://www.womenshealthsection.com/content/submit_manuscript.php

Collaboration with UN University (UNU)

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

The Politics of Scaling Up Social Protection in Kenya

Literature on social protection in Kenya shows progress in implementation of cash transfers but not the social health insurance scheme. With a dearth of explanation for this contrasting promotion of social protection, this paper examines the role of Keya's political settlement and the interests of donors. It argues that whereas the competitive clientelist political settlement is conducive to the supply-oriented cash transfer programmes, it is averse to the demand-oriented social health insurance scheme that requires clients to contribute and also threatens the market interests of donors. The paper therefore concludes that the scaling up of social protection is dependent on the convergence between the clientelist interest of politicians and the motivation of donors.

The Kenyan government has implemented a series of cash transfer programmes since the end of the Moi regime in 2002, with over 450,000 direct beneficiaries reached by 2013/14. Social protection has been identified as a key response to poverty in the two national development plans directing in the manifestos of all the main political groupings by 2012. These developments have been complemented by a range of international donor interventions relating to technical assistance in policy development and programme design and implementation, as well as financing. There have also been attempts to introduce social health insurance during this period, but this has met with less success, such that despite parliamentary and donor support, health insurance provision has not yet been extended to the poor.

The examination of the process of social protection policy and programme development in Kenya since 2003 indicates that the nature of the political settlement is influential in shaping outcomes. While UNICEF lobbying for cash transfer provision began prior to the 2003 election, detailed discussions regarding cash transfer programme development started only after regime change. What occurred in 2003 was an opening of policy space at a time when donors had ideas to test, alongside funding and technical expertise resources to back them.

The extent to which the political settlement shapes social protection outcomes has been mediated by preferences and incentives emanating from the donor community. It is the convergence of the requirements of the political settlement with donor interests, policy framing, and ideation that seems to have driven the successful provision of social assistance, whereas a lack of convergence has hindered the development of social health insurance (SHI). External funding remains a key factor in this extended provision, and plans are not yet in place for domestic resources to absorb the full cost of social protection once current donor support comes to an end, which may raise a question over long-term sustainability. However, the nature of the political settlement at this point may serve to render future financing for social protection politically irreversible, as social assistance has become incorporated as a component of the patronage structures on which the state is dependent.

Publisher: UNU WIDER; Authors: Fredrick O. Wanyama and Anna McCord; 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)

Kenya: Background

Kenya has more than 40 tribal groups, encompassing numerous cultures, religions, traditions, customs and languages. Unifying these groups remains a challenge, but the country has been able to build on its current strengths and past achievements to tackle the obstacles that hinder education today.

The Kenya Education Sector Support Programme (KESSP) includes a five-year gender and education investment programme and states that the coordination of initiatives from other agencies, such as civil societies, will be through the United Nations Girls' Education Initiative (UNGEI).

The introduction of free primary education has greatly increased girls' enrolment. Although Kenya has achieved gender parity nationally, there are still significant gender and geographic disparities, with nomadic districts recording very low girls' participation in primary education.

Barriers to girls' education

Emergencies caused by drought have curbed school attendance by both girls and boys. Child labor due to high levels of poverty, particularly in rural areas, keeps girls out of school. Religious and cultural traditions generally favor boys. Nomadic tribes have very low enrolment rates, especially for girls.

Key Initiatives

A five-year investment programme for girls' education within the Kenya Education Sector Support Programme launched in 2005 is coordinated through UNGEI.
UNGEI partners have developed 'Terms of Reference' that guide the initiative's activities.
Advocacy and community mobilization are ongoing.
UNGEI is a key player in the development and review of a girls' education policy in Kenya.
Research and documentation of best practices is one of UNGEI's priorities.

Partnerships

The Forum for African Women Educationalists (FAWE), Kenya Chapter, is the lead non-governmental organization (NGO) and works in collaboration with the Government and UNICEF. Other partners at the national level include local NGOs, the Canadian International Development Agency (CIDA), Oxfam GB, UK Department For International Development (DFID) and the United States Agency for International Development (USAID). UNGEI partners have conducted a variety of girls' education activities at the provincial and community levels, but these projects are not necessarily labelled as UNGEI activities.

UNGEI within other National and International Frameworks

UNGEI has participated in the sector wide approach to planning (SWAP) process that resulted in the Kenya Education Sector Support Programme, for which UNGEI is the key framework for girl's education in Kenya.

School Meals Help Girl Rise To Top Of Class

Nyipher remembers having to fight to keep her eyes open in school. Even when she could stay awake, she says it was a daily struggle to keep her mind on the lesson and off her empty stomach. Then her school started serving meals at lunch and Nyipher rose to the top of her class. Now, she is thinking about

college and beyond. This 14-year old girl growing up in the slums of Nairobi, her problem is not laziness – It is hunger.

Details: http://www.ungei.org/infobycountry/kenya_2765.html

Supporting your child's mental health as they return to school during COVID-19

How parents can help their children navigate their feelings during school re-openings.

My child is not part of the same group as his close friends returning to school and is feeling even more isolated. How can my child feel more connected to the classroom and his friends?

If your child's school starts to return gradually, your child may be anxious about being separated from his friends. When the official reopening of school is announced, help your child get ready to return to school by sharing information on when and how this will happen.

Letting your kids know ahead of time that the schools may need to close again will help them to be prepared for the period of adjustment ahead. It is also important to continue to remind them that learning can happen anywhere – at school and at home.

For those with access to Internet, safe and monitored use of online games, social media and video chat programs can provide great opportunities for children to connect with, learn and play with friends, parents and relatives while at home. You could also encourage your children to use their voices online to share their views and support those in need during the crisis. You can encourage your children to take advantage of digital tolls that get them up and moving, like online exercise videos for kids and video games that require physical movement. Remember to balance online recreation with off-line activities, including time outside, if possible.

How can I gently check in to see how my child is coping?

It is important to be calm and proactive in your conversations with children – check in with them to see how they are doing. Their emotions will change regularly, and you need to show them that is okay. Whether at school or at home, caregivers can engage children in creative activities, such as playing and drawing, to help them express and communicate any negative feelings they may be experiencing in a safe and supportive environment. This helps children find positive ways to express difficult feelings such as anger, fear or sadness.

As children often take their emotional cues from the key adults in their lives – including parents and teachers – it is important that adults manage their own emotions well and remain calm, listen to children's concerns, speak kindly and reassure them.

To be continued in December Edition…

UN World Food Programme wins 2020 Nobel Peace Prize

The UN World Food Programme (WFP), which provides lifesaving assistance to millions across the world – often in extremely dangerous and hard-to-access conditions – has been awarded the 2020 Nobel Peace Prize.

The agency was recognized “for its efforts to combat hunger, for tis contribution to bettering conditions for peace in conflict-affected areas and for acting as a driving force to prevent the use of hunger as a weapon of war and conflict.”

WFP (https://www.wfp.org/) is the largest humanitarian organization in the world. Last year, it assisted 97 million people in 88 countries. Its efforts focus on emergency assistance, relief and rehabilitation, development aid and special operations. Two-thirds of the network is in conflict-affected countries where people are three times more likely to be undernourished than those living in countries without conflict.

Global Food Insecurity Aggravated by COVID-19

Praising the work of the UN agency, the Nobel Committee chair highlighted its role in boosting resilience and sustainability among communities by helping them to feed themselves. The COVID-19 crisis has also added to global food insecurity. there will likely be 265 million “starving people within a year.”

Only the international community can tackle such a challenge. WFP had helped millions of people in extremely dangerous and hard-to-reach countries affected by conflict and natural disaster, including Yemen, Syria and the Democratic People’s Republic of Korea.

There is also a hunger in our world for international cooperation – feeds that need, too operating above the realm of politics, with humanitarian need driving its operations.

Everyone has the right to live peacefully and without hunger. And now, a global pandemic with its brutal impact on economies and communities, is pushing millions more to the brink of starvation.

UN and the Nobel Peace Prize

With this recognition, WFP joins the Office of the UN High Commissioner for Refugees (UNHCR), the International Labor Organization (ILO), the UN Children’s Fund (UNICEF), UN Peacekeeping, the International Atomic Energy Agency (IAEA), the Intergovernmental Panel on Climate Change (IPCC), former Secretaries-General Dag Hammarskjöld and Kofi Annan, and former Under-Secretary-General Ralph Bunche; and the UN itself as Nobel Peace Prize Laureates.

Two Articles of Highest Impact, October 2020

Editors' Choice – Journal Club Discussions
Fully open-access with no article-processing charges
Our friendship has no boundaries. We welcome your contributions.

1. Benign Vulvar Skin Disorders: Part 2;
   http://www.womenshealthsection.com/content/gyn/gyn038.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. Newborn Hearing Loss Detection and Intervention;
   http://www.womenshealthsection.com/content/obsnc/obsnc011.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.

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

WHEC Projects under Development

Women's Health and Education Center (WHEC) Calls To Action and Our Pledge

Never before has the world been so clearly forewarned of the dangers of a devastating pandemic, nor previously had the knowledge, resources and technologies to deal with such a threat. Yet, never before has the world witnessed a pandemic of such widespread and destructive social and economic impact.

The COVID-19 pandemic has revealed a collective failure to take pandemic prevention, preparedness and response seriously and prioritize it accordingly. It has demonstrated the fragility of highly interconnected economies and social systems, and the fragility of trust. COVID-19 has taken advantage of a world in disorder. It has exploited and exacerbated inequalities, reminding us in no uncertain terms that there is no health security without social security.

The WHEC calls for urgent actions to strengthen the current response to COVID-19 and better prepare the world for future pandemics and health emergencies; to bring order out of catastrophe and chaos.

Our Recommendations:

1. Responsible leadership. National leaders of international organizations and other stakeholders take early decisive action based on science, evidence and best practice when confronted with health emergencies. They discourage the politicization of measures to protect public health, ensure social protection and promote national unity and global solidarity.

2. Engaged citizenship. Citizens demand accountability from their governments for health emergency preparedness, which requires that governments empower their citizens and strengthen civil society.
3. Strong and agile national and global systems for global health security. Heads of government strengthen national systems for preparedness: identifying, predicting and detecting the emergence of pathogens with pandemic potential based on a 'One Health' approach that integrates animal and human health; and sharing of information on outbreaks and similar events; strengthening health systems based on universal health coverage with surge capacity for clinical and supportive services; and putting in place systems of social protection to safeguard the vulnerable, leaving no one behind.
4. Sustained investment in prevention and preparedness, commensurate with the scale of a pandemic threat. G20 leaders ensure that adequate finance is made available now to mitigate the current and future economic and socio-economic consequences of the pandemic. The UN, The WHO, and the International Financing Institutions develop a mechanism for sustainable financing of global health security, which mobilizes resources on the scale and within the timeframe required, is not reliant on development assistance, recognizes preparedness as a global common good, and is not at the mercy of political and economic cycles.
5. Robust global governance of preparedness for health emergencies. State Parties to the International Health Regulation (IHR), or the WHO Director-General, propose amendments of the IHR to the World Health Assembly, to include: strengthening early notification and comprehensive information sharing; intermediate grading of health emergencies; development of evidence-based recommendations on the role of domestic and international travel and trade recommendations; and mechanisms of assessing IHR compliance and core capacity implementation, including a universal, periodic, objective and external review mechanism.

A World in Disorder

The COVID-19 pandemic is providing a harsh test of the world's preparedness. Little progress has been made on any of the actions called for in last year's lack of leadership. Failure to learn the lessons of COVID-19 or to act on them with the necessary resources and commitment will mean that the next pandemic, which is sure to come, will be even more damaging.

As an *NGO in Special Consultative of the Economic and Social Council of the United Nations*, we pledge to support good governance of global health security by fulfilling our mandate to independently monitor preparedness across all sectors and stakeholders, report regularly on progress, and continuously advocate for effective action.

Join the efforts!

Treatment of COVID-19 by Remdesivir: A Report from Clinical Trials

Adaptive COVID-19 Treatment Trial (ACTT)
Sponsor: National Institute of Allergy and Infectious Diseases (NIAID)
Clinical Trial number: NCT04280705

Remdesivir (GS-5734), an inhibitor of viral RNA-dependent, RNA polymerase with in-vitro inhibitory activity against SARS-CoV-1 and Middle East respiratory syndrome (MERS-CoV), was identified early as a promising therapeutic candidate for COVID-19 because of its ability to inhibit SARS-CoV-2 in-vitro.

Although several therapeutic agents have been evaluated for the treatment of COVID-19, no antiviral agents have yet been shown to be efficacious.

In this trial a total of 1,062 patients underwent randomization (with 541 assigned to remdesivir and 521 to placebo). Those who received remdesivir had a median recovery time of 10 days, as compared with 15 days among those who received placebo. In an analysis that used a proportional-odds model with an eight-category ordinal scale, the patients who received remdesivir were found to be more likely than those who received placebo to have clinical improvement at day 15.

The Kaplan – Meier estimates of mortality were 6.7% with remdesivir, and 11.9% with placebo by day 15 and 11.4% with remdesivir and 15.2% with placebo by day 29. Serious adverse events were reported in 131 of the 532 patients who received remdesivir (24.6%) and in 163 of the 516 patients who received placebo (31.6%).

Conclusion: the data shows that remdesivir was superior to placebo in shortening the time to recovery in adults who were hospitalized with COVID-19 and had evidence of lower respiratory tract infection.

Details: https://clinicaltrials.gov/ct2/show/NCT04280705

In The News

Pandemic Response Failure

Report by the Global Preparedness Monitoring Board (GPMB) offers a harsh assessment of the global COVID-19 response, calling it " a collective failure to take pandemic prevention, preparedness, and response seriously and prioritize in accordingly." It highlights the lack of multilateral cooperation in responding to ongoing COVID-19 pandemic, citing "geopolitical tensions" as an obstacle to leadership by the G7, G20 and multilateral organizations. The report calls on leaders to renew their commitment to the multilateral system and strengthen World Health Organization (WHO) as an impartial and independent international organization.

Viruses do NOT respect borders. The only way out of this devastating pandemic is along the path of collective action, which demands a strong and effective multilateral system.

The GPMB was created in response to recommendations of the UN Secretary-General's Global Health Crises Task Force in 2017 and is co-convened by WHO and the World Bank Group.

Lessons Learned from COVID-19

1. Political leadership makes the difference. Effective leaders act decisively, on the basis of science, evidence and best practice, and in the interests of people.
2. Preparedness is not only what governments do to protect their people; it is also what people do to protect each other. In the absence of an effective vaccine or treatment, individual behaviors have never been more important.
3. The impact of pandemics goes far beyond their immediate health effects. In addition to its immediate death toll, COVID-19 will be remembered for its rapid global spread and devastating social and economic impact, especially for the vulnerable and disadvantaged. It has demonstrated the importance of protecting lives and livelihoods and widening our understanding of preparedness to make education, social and economic sectors "pandemic proof."

4. Current measures of preparedness are not effective. Our understanding of pandemic preparedness has been inadequate. National measures of preparedness have not predicted the effectiveness of countries' response in stopping viral spread and saving lives, and the critical importance of social protection has been neglected. The ultimate test of preparedness is response.
5. The return on investment for global health security is immense. Expenditure for prevention and preparedness are measured in billions of dollars, the cost of a pandemic in trillions. It would take 500 years to spend as much as on investing in preparedness as the world is losing due to COVID-19.
6. No one is safe until all are safe. Global preparedness is not simply the sum of national preparedness. A pandemic is, by definition, a global event and as such demands collective global action. The multilateral system exists to support that action. Where it is weak, it needs strengthening, not abandoning. The world of pandemic preparedness is already complex. It needs consolidation, not further fragmentation.

UN Secretary-General Antonio Guterres urges more countries to step up and fund global COVID-19 vaccine effort. The aim is to ensure that everyone, everywhere, gets protection from the virus.

https://twitter.com/i/status/1311012052513763331

Art & Science

Art that touches our soul

The Marriage Settlement by **William Hogarth**

The Marriage Settlement is the first of a series of six oil-on-canvas paintings by English painter and pictorial satirist William Hogarth, created around 1743. The series, entitled *Marriage A-La-Mode,* depicts an arranged marriage and its disastrous consequences in a satire of 18th-century society, and is now in the collection of the National Gallery, London.

In this painting, a marriage is being arranged between the son of the bankrupt Earl Squanderfield and the daughter of a wealthy but miserly city merchant. Construction on the earl's new mansion, visible through the window, has stopped, and a usurer negotiates payment for further construction at the table in the center. The gouty earl proudly points to a picture of his family tree, originating with William the Conqueror.

The son views himself in the mirror, showing where his interests in the matter lie. The distraught merchant's daughter is consoled by the lawyer Silvertongue while polishing her wedding ring. Even the faces in the portraits on the walls appear to have misgivings. Two dogs chained to each other in the corner mirror the situation of the young people.

The plot of the painting is the unmitigated greed of the two fathers, the father of bride is wealthy to excess, and the Earl heavily in debt but still retains his ancient title. The father of bride is desirous of becoming the grandfather to a noble son, and the Earl wants to ensure his line is carried on and is willing to put up with the commoner for the sake of his money. Meanwhile, the soon to be married two are completely ignoring each other, and the bride is being courted by the lawyer. Myriad details show the true natures of the characters present, especially the Earl and his son.

Dimensions 69.9 cm X 90.8 cm (27.5 in X 35.7 in)

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