WHEC Update

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

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Practice & Policy

Happy New Year from all of us @ the Women's Health and Education Center (WHEC)

As we look towards the new year, let us focus on our successes, and our work together in the past, to ensure that 2023 will be a great year for everyone, everywhere! Keep your thoughts, ideas and question coming – we welcome them. We can do this!

Countries worldwide are facing complex and diverse health challenges in 21st century, and usually there is one on national health system for individual and population health outcomes. In this context, "essential public health functions" (EPHFs), have been revitalized to support an integrated approach to sustainable health systems strengthening, complementary to primary healthcare, various program-specific and health security approaches.

The Women's Health and Education Center (WHEC) believes that: public health functions as the most cost effective, comprehensive and sustainable way to enhance the health of populations and individuals and to reduce the burden of disease. Despite the gaps in public health capacities and calls from countries to strengthen EPHFs have been comprehensively applied in health systems strengthening. This edition of *WHEC Update* builds on earlier work of WHEC and synthesizes and updated knowledge base and experiences in EPHFs. The purpose is to further promote understanding of EPHFs in reference to recent complementary concepts and approaches; to ascertain its value for health systems strengthening for Universal Health Care (UHC), health security, promotion of healthier populations; and to present options for policy considerations at global and national levels in addressing the 21st century health challenges in countries of various contexts.

The EPHFs are traditionally regarded as a list of minimum requirements for countries to ensure effective public health action; they are not envisaged as a competing health systems framework. EPSF lists vary in the types, numbers, combination / selection and ways of articulating functions (e.g., the understanding of these functions as actions, services or capacities), often indicating how public health is understood in that context. The list of EPHFs is influenced by the societal and health context. EPHFs are interconnected and interdependent in a given context, and should not be viewed in isolation. It requires and building on long-term multisectoral commitment to public health efforts.

Advocacy for prioritizing public health. The development of public health is often accorded lower priority than clinical care, partially because the benefits of investing in EPHFs tend to be less visible in the short term, as well as harder to measure. However, the benefits are potentially greater than, and will reinforce the outcomes of, investment in programs like disease treatment, rehabilitation and palliative care. There is also a political need in many countries to produce measurable results within a single budgetary and political cycle. The EPHF lens highlights specific public health services of health systems alongside clinical care. Advocacy for prioritizing public health is important, as systematic investment in public health is cost-effective in improving health systems functioning leading to sustained health, social and economic gains.

The bottom line is – Workforce should be able to deliver the essential public health functions. It is critical to invest in the education, recruitment and retention of a fit-for-purpose, responsive and competent workforce. Share your projects on **WHEC Global Health Line (WGHL);** create an account.

Building Reliable Healthcare Systems

Rita Luthra, MD

Your Questions, Our Reply

Can the essential public health functions make a difference? What is an essential public health functions lens?

Concept of Essential Public Health Functions (EPHFs): Public health refers to the science and art of preventing disease, prolonging life and promoting, protecting and improving health through organized efforts of society. The EPHFs are generally regarded as a fundamental and indispensable set of collective actions under the responsibility of the State which are needed to meet public health goals, including the attainment and maintenance of the highest level of population health possible within given resources.

A list of public health functions identified as common and fundamental based on a crosswalk analysis of essential public health functions lists:

1. Monitoring and evaluating the population's health status, health services utilization and surveillance of risk factors and threats to health;
2. Public health emergency management;
3. Assuring effective public health governance, regulation and legislation;
4. Supporting efficient and effective health systems and multisectoral planning, financing and management for population health;
5. Protecting populations against health threats, including environment and occupational hazards, communicable disease threats, food safety, chemical and radiation hazards;
6. Promoting prevention and early detection of diseases, including non-communicable and communicable diseases;
7. Promoting health and well-being and actions to address the wider deteriorations of health and inequalities;
8. Ensuring community engagement, participation and social mobilization for health and wellbeing;
9. Ensuring adequate quantity and quality of public health workforce;
10. Assuring quality of and access to health services;
11. Advancing public health research;
12. Ensuing equitable access to and rational use of essential medicines and other health technologies.

Public health is not understood in the same way throughout the world. Advancing the agenda of operationalizing the EPHFs within primary-health-care-oriented health systems strengthening must be responsive to population needs and overall health and social contexts in whatever setting they are being applied. It is critical to restate that the ai of this *WHEC Update Edition* is to promote a common understanding of and facilitate discussion on what the EPHFs are, what applying the EPHFs in health systems strengthening could look like, and what changes the EPHFs can bring to health systems strengthening, rather than pursuing a common global agenda in operationalizing the same set of public health functions in every country. There is no one-size-fits-all solution to addressing health systems challenges and meeting population health needs. As the initial step zero, there should be a continuing participatory dialogue on the conceptual and operational clarity of the EPHFs, built on exploratory practices, with the collective efforts of all key actors.

Political commitment to public health agendas. Public health is inherently political. It is critical for countries to make long-term political commitments to strengthening EPHFs as a national health sector priority to promote, protect and maintain population health. this could involve developing or updating health legislation and policies to specify EPHFs in the national context and supporting focused investment so that each EPHF is recognized and strengthened to a sufficient degree. Political commitment for prioritizing public health by strengthening EPHFs is essential for all other enablers.

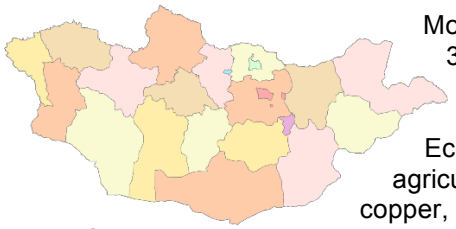
Facing the future – join our advocacy efforts!

United Nations at a Glance

Mongolia became UN Member State on 27 October 1961

Mongolia, is a landlocked country in East Asia, bordered by Russia to the north and China to the south. It covers an area of 1,564,116 square kilometers (603,909 sq. mi.), with a population of just 3.3 million, making it the world's most sparsely populated sovereign nation. Mongolia is the world's largest landlocked country that does not border a closed sea, and much of its area is covered by grassy steppe, with mountains to the north and west and the Gobi Desert to the south. Ulaanbaatar, the capital and largest city, is home to roughly half of the country's population. Official Language: Mongolian; Ethnic groups: 95% Mongols, 4% Kazakhs, 1% others. Religion: 51.7% Buddhism, 40.6% no religion, 3.2% Islam, 1.3% Christianity. Government: Unitary Semi-Presidential republic. The symbol in the left bar of the national flag is a Buddhist icon called Soyombo. It represents the sun, moon, stars, and heaven per standard cosmological symbology abstracted that seen in traditional thangka paintings.

Mongolia joined the World Trade Organization in 1997 and seeks to expand its participation in regional economic and trade groups. Mongolia's foreign relations traditionally focus on its two large neighbors, Russia and the People's Republic of China. Mongolia is economically depended on these countries: China receives 90% of Mongolia's exports by value and accounts for 60% of its foreign trade, while Russia supplies 90% of Mongolia's energy requirements. It has begun seeking positive relations with a wider range of other nations especially in cultural and economic matters, focusing on encouraging foreign investments and trade. Mongolia has been pursuing a third-neighbor foreign policy since early 1990s to build deeper relations and partnerships with countries beyond its two neighbors.



Mongolia is divided into 21 provinces (aimags) and subdivided into 331 districts (sums). The capital Ulaanbaatar is administered separately as a capital city (municipality) with provincial status.

Economic activity in Mongolia has long been based on herding and agriculture, although development of extensive mineral deposits of copper, coal, molybdenum, tin, tungsten and gold have emerged as a driver of industrial production. Mongolia is ranked as lower-middle-income country by the World Bank. Some 22.4% of population lives on less than US $ 1.25/day. In 2011, GDP per capita was $3,100. Despite growth, the proportion of the population below the poverty line was estimated to be 35.6% in 1998, 36.1% in 2002-2003, and 32.2% in 2006.

Mongolia was never listed among the emerging market countries until February 2011 when Citigroup analysis determined that Mongolia to be one of the "global growth generating" countries, which are countries with the most promising growth prospects for 2010 – 2050. The Mongolian Stock Exchange, established in 1991 in Ulaanbaatar, is among the world's smallest stock exchangers by market capitalization.

As of 2006, English is taught in all secondary schools across Mongolia, beginning in fourth grade. Mongolian national universities are all spin-off from the National University of Mongolia and the Mongolian University of Science and Technology. Almost three in five Mongolian youths now enroll in university. There was six-fold increase in students between 1993 and 2010. Mongolia was ranked 58th in the Global Innovation Index in 2021, down from 53rd in 2019.

Details: https://sdgs.un.org/statements/mongolia-16000

Collaboration with World Health Organization (WHO)

WHO | Mongolia

Mongolia inherited a relatively good healthcare system from its socialist period, a World Bank report from 2007 notes “despite its low per capital income, Mongolia has relatively strong health indicators; a reflection of the important health gains achieved during the socialist period.” On average Mongolia’s infant mortality rate is less than half of that of similarly economically developed countries, its under-five mortality rate and life expectancy are all better on average than other nations with similar GDP per capita.

Mongolia faces a range of stubborn health challenges, including illnesses and liver cancer caused by chronic hepatitis, and a rising burden of non-communicable diseases. Growing urbanization brings new challenges, such as air pollution and access to safe drinking water and sanitation for communities on the outskirts of Ulaanbaatar. To address these issues and support Mongolia’s progress towards universal health coverage and the Sustainable Development Goals (SDGs). It is important to strengthen the health system and to improve the efficiency of major health programs. To this end,, cross-sectoral collaboration is vital.

National Strategic Goals of Mongolia

Mongolia is a democratic country with significant natural and agricultural resources. Guided by the Mongolia Sustainable Development Vision 2030 (MSDV), the country is striving by 2030 to be among the leading middle-income countries based on per capita income, with a diverse economy, ecological balance and democratic governance. The Government is committed to ending poverty, improving the living environment and increasing life expectancy at birth to 78 years by 2030. These national goals are in line with and contribute to Mongolia’s progress towards the UN SDGs.

Strategic Priorities of WHO in Mongolia

1. Building resilient health systems to advance universal health coverage;
2. Strengthening the integrated, people-centered delivery of priority public health programs;
3. Promoting heath and healthy environments for all Mongolians through multisectoral engagement and health in all policies.

Leaving No One Behind – Concept

The Government of Mongolia fully supports the Leaving No One Behind principle, promoted by WHO as a means to introduce universal health coverage (UHC) and enable countries to work towards achievement of SDGs. In February 2016, Mongolia endorsed its own Sustainable Development Vision 2030 to accelerate progress towards the achievement of the SDGs. Without introducing the Leaving No One Behind concept into the national and local policies, reaching SDGs and Mongolia’s Sustainable development Vision 2030 will be impossible.

Health programs are increasingly recognizing that a one-size-fits-all approach does not work and are aiming to meet the different needs of and preferences of women and men and girls and boys from diverse population. A key dimension of this effort is the extent to which gender impacts and interacts with other social stratifies, such as income, education and urban or rural residence.

Details: https://www.who.int/countries/mng/

Mongolia Joined UNESCO on 01 November 1962

Great Burkhan Khaldun Mountain and its surrounding sacred landscape.

The site is stated in the north-east of the country in the centra part of the Khentii mountain chain where the vast Central Asian Steppe meets the coniferous forests of the Siberian taiga. Burkhan Khaldun is associated with the worship of sacred mountains, rivers, and ovoo-s (shamanic rock cairns), in which ceremonies have been shaped by a fusion of ancient shamanic and Buddhist practices. The site is also believed to be the place of Genghis Khan's birth and burial. It testifies to his efforts to establish mountain worship as an important part of unification of the Mongol people. A draft Management Plan was submitted as part of the nomination dossier. This will run from 2015 – 2025 and covers both cultural and natural heritage. It includes both long-term (2015-2025), and medium-term (2015-2020) plans. Archeological sites on the mountain that may contribute to a wider understanding of mountain worship and have not been formally identified nor are they actively conserved. Both of these aspects should be addressed in the Plan.

" The supreme treasure is knowledge, the middle treasure is children, and lowest treasure is material things" – **Mongolian Proverb.**

As Matters Stand in Today's Mongolia:
Mongolia is a landlocked country located in northern Asia, sharing borders with China and Russia. With a small population size of 2.8 million, in a vast geographical territory of 1.5 million square kilometers, Mongolia is one of the most sparsely populated countries in the world. The following priorities are relevant to the mandate of UNESCO:

1. Promoting human development, including sustainable educational, healthcare, scientific, technological, cultural and environmental development.
2. Creating a knowledge-based economy whose growth is ensured through high technology based, environment-friendly production and services.
3. Fostering a democratic system of governance, which serves its citizens, protects human rights and freedoms, is free from corruption and excessive bureaucracy and promotes national culture.
4. Good quality comprehensive HIV and sexuality education delivered by Member States, promoting healthy lifestyles, gender equality and human rights.
5. Promoting STI policies and access to knowledge. Awareness raised and capacities improved among political leaders, planners and policy makers on technology transfer.
6. Master trainers able to deliver training on application of modern tools of groundwater management in arid and semi-arid regions.
7. Promoting a culture of peace and non-violence through action pertaining to human rights democracy, reconciliation, dialogue and philosophy and including all political and social partners, in particular youth.
8. Supporting Member States in responding to social transformations by building and strengthening national research systems and promoting social science knowledge networks and research

Details: https://en.unesco.org/countries/mongolia

Education-for-All and Health-for-all

Bulletin Board

Goal 5
Achieve Gender Equality and Empower All Women and Girls

FACTS & FIGURES

- It would take another 40 years, for women and men to be represented equally in National Political Leadership; at the current pace.
- Women accounted for 39% of total employment, in 2019; but 45% of global employment losses in 2020.
- More than 1 in 4 women (15+ years); have been subjected to intimate partner violence (641 million); at least once in their lifetime.
- Only 57% of women (15-49 years), are making their own informed decisions on sex and reproductive health care (64 countries, 2007 – 2011).

Discriminatory laws and legal gaps continue to prevent women from enjoying their human rights. Based on 2020 data from 95 countries and territories, more than half lacked quotas for women in the national parliament; while 83% included budgetary commitments to implement legislation addressing violence against women, 63% continued to lack laws defining rape based on the principle of consent. Although over 90% mandate non-discrimination based on gender in employment, almost half continued to restrict women from working in certain jobs or industries and almost one quarter of countries did not grant women equal rights with men to enter marriage and initiate divorce.

One in five young women worldwide (19%) were married in childhood in 2021. Child marriage is most common in sub-Saharan Africa, a region where progress has been modest, followed by South Asia, which has achieved greater declines. Globally, the prevalence of child marriage has declined by about 10% in the past five years. however, the profound effects of the COVID-19 pandemic are threatening this progress, with up to 10 million additional girls at risk of child marriage in the next decade because of pandemic.

On an average day, women spend about 2.5 times as many hours on unpaid domestic work and care work as men, according to the latest data from 90 countries and areas collected between 2001 and 2019.

As of 1 January 2022, the global share of women in lower and single houses of national parliaments reached merely 26.2%, up from 25.6%in 2021. Well-designed legislated gender quotas, zero tolerance for violence against women in politics and gender-sensitive and safer political environments are key to fast-tracking and sustaining women's equal representation in decision-making.

Ownership of mobile phones has been shown to be an important tool for empowering women. 1 in 30 of 70 countries with data for 2017 – 2021, gender parity in mobile phone ownership has been achieved and in 13 additional countries, the number of women who own a mobile phone is greater than the number of men.

The Women's Health and Education Center (WHEC) with its partners, promotes progress needed to align public financing with gender equality objectives. Building back better from COVID-19 means doing so in a way that advances gender equality and women's empowerment.

Collaboration with UN University (UNU)

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

Drivers of Poverty Reduction in Lagging Regions
Evidence from Rural Western China

Using 2000 – 2004 panel data this study analyses the pathways rural households followed out of poverty in two lagging provinces of China, Inner Mongolia and Gansu. Rising labor productivity in agriculture has been key, and still holds much promise. Labor mobility has also been important tin Gansu. So far, rural diversification has not been important in Gansu. So far, rural diversification has not proven to contribute much to poverty reduction. Income transfers and agricultural tax abolishment have helped at the margin, overall, the findings highlight that the scope for reducing poverty in lagging rural regions is often substantial in agriculture, also in countries where non-agriculture drives overall growth.

For rural diversification to be a promising pathway out of poverty, the poor must be assisted in overcoming barriers to remunerative rural non-farm jobs such as lack of skills and access to capital. Income transfers (either through the abolishment of taxes or an increase in transfers) can help in reducing poverty, but are unlikely to be sufficient, even though substantial increases are possible as they start from low base.

While the lagging regions studied here have their own peculiarities, they also share many of the characteristics of other lagging regions in western China and beyond, in that they are remote, populated with ethnic minorities and characterized by unfavorable environments such as degraded highlands and arid plains. As such, the results are seen as useful case study inputs into a broader debate, albeit case study results which stand out for two reasons.

First, the continuing promise of agricultural pathway in poverty reduction in these lagging areas is observed in an environment where agriculture has long ceased to be the trigger or major contributor to national growth. Second, in Inner Mongolia the critical contribution of agriculture to poverty reduction in its lagging areas was observed while its mining industry was booming. This resonates well with the finding from cross-country analysis that the presence of a mining sector substantially reduces the poverty-reducing powers of growth outside agriculture.

Overall, the experience in Inner Mongolia and Gansu suggests that during the early phases of development, the scope to reduce poverty in rural lagging regions by increasing incomes locally, including in agriculture, should not be discarded, also not when non-agriculture clearly drives national growth, and especially not in mineral resource rich settings.

Publisher: UNU-WIDER; Authors: Luc Christiaensen, Lei Pan, Sangui Wang; Sponsor: UNU-WIDER acknowledges the financial contributions to the research programme by the governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Ministry for Foreign Affairs), Sweden (Swedish International Development Cooperation Agency—Sida) and the United Kingdom (Department for International Development)

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

Point of View Segment

Ban on Abortions after 15 Weeks Will Kill Pregnant Women

If you are pregnant, how close to death do you have to be to justify terminating your pregnancy? Now that the constitutional right to an abortion in the United States previously guaranteed by *Roe v. Wade* has fallen, forced-birth advocates in this country fear that allowing doctors to use their clinical judgement to determine pregnancy risks will permit devious women will wriggle through this so-called loophole to obtain "unjustified" elective abortions. The same kind of repressive thinking is found in many countries around the world. Such people believe that there are no legitimate medical indications for terminating a pregnancy before viability.

Outlawing second trimester abortions will kill or injure large numbers of women every year because many pregnancy complications occur in the second trimester that can lead to death or serious injury for a pregnant woman. One such complication is rupture of the membranes before fetal viability. The fetus develops in a liquid environment contained within the amniotic sac that is critical for the development of its lungs and limbs. This fluid regulates intrauterine temperature, allows for fetal movement, and provides a secure, sterile environment for fetal growth. If the sterile sac of membranes ruptures and the fluid leaks away before viability, the fetus is doomed. This also puts the life of the pregnant woman at risk from infection. Rupture of the membranes before fetal viability is uncommon, but not rare. It occurs in roughly 1 in 250 pregnancies. A hospital with a busy obstetrical service will likely see dozens of such cases every year. Once the membranes have ruptured (often because a developing sub-clinical infection is not yet fully manifest), the risk to the pregnant woman's life from serious infection increases dramatically. This risk increases exponentially the longer the membranes have been ruptured but the pregnancy is undelivered.

If a fetal heartbeat is still present, forced-birth advocates would deny the woman a life-saving termination of her pregnancy because they see the life of the fetus as a higher priority than the life of the woman herself. Cases of this kind can deteriorate rapidly as the infection explodes systemically beyond the uterus. The Royal College of Obstetricians and Gynaecologists in Britain estimates the risk of death for a pregnant woman with severe sepsis at 20% to 40%, increasing to 60% or more if she develops septic shock.

Savita Halappanavar is largely unknown to Americans, but she is a household name in Ireland. In 2012, Savita, a 31-year-old Hindu dentist from India working in Ireland, was pregnant with her much-wanted first child, when her membranes ruptured at 17 weeks' gestation, long before fetal viability. She and her husband requested termination of the pregnancy due to the inevitable poor fetal outcome and the increasing risks to her health; but she was denied delivery because a fetal heartbeat was still present even as she became severely infected and desperately ill. Savita was told that nothing could be done because "Ireland is a Catholic country" and the proper medical care that she needed was regarded as an unjustified abortion.[1] A week after admission to the hospital, Savita died of cardiac arrest and septic shock. One Savita is more than enough.

Reference

1. Wall LL, "The ghost of Savita Halappanavar comes to America," Obstetrics & Gynecology 2022;140(5):724-728. doi: 10.1097/AOG.0000000000004979

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Two Articles of Highest Impact, December 2022

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

1. Human Trafficking and Exploitation;
   http://www.womenshealthsection.com/content/vaw/vaw014.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. Vitamin K Deficiency Bleeding;
   http://www.womenshealthsection.com/content/obsnc/obsnc014.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.

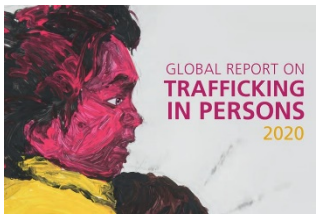
Partnership for Maternal, Newborn & Child Health (World Health Organization)
PMNCH Member

Worldwide service is provided by the WHEC Global Health Line

From Editor's Desk

WHEC Projects under Development

Preventing and Responding to Sexual Exploitation, Abuse and Harassment: Our Work; Our Campaigns in 2023.



The Women's Health and Education Center (WHEC) has *zero tolerance* for any form of sexual misconduct by any one of our workforce. We are taking concrete measures to prevent sexual exploitation, sexual abuse and sexual harassment, and prompt action whenever an allegation of sexual misconduct is raised.

Sexual exploitation, abuse and harassment (SEAH) within the workforce and the communities we serve is a grave violation of our commitment to do no harm and protect the vulnerable. In the past we have not taken adequate or consistent measures to safeguard from sexual misconduct but are now taking systematic and intensive approaches to reach zero tolerance.

Our current plan of work is outlined in the Unified Framework in response to the report of Independent Commission. In 2023, to lay the foundation for our work, we will focus on three areas:

1. Shift to a victim- and survivor-centered approach;
2. Ensure accountability across the organization, especially of our leaders, accompanied by capacity building;
3. Reform our culture, structures and systems.

Together with the UN System and Agencies, the UN Special Coordinator for SEA, the UN Victim's Advocate, the Interagency Standing Committee (IASC), NGOs, and civil society, we are working to transform our joint commitment to zero tolerance into action in countries and communities.

Whenever possible we listen to the needs and wants of victims and survivors to shape our work.

Our Task Team

Bringing together leaders from across WHEC accountability functions (Compliance, Risk Management and Ethics, Office for Internal Oversight and Human Resources and Talent Management), Health Emergencies Program and field operations, the task team:

1. Coordinates efforts to ensure a comprehensive end-to-end response spanning sexual exploitation, abuse and harassment in the field among communities we serve, and withing the WHEC workforce.
2. Scales-up, develops and reviews strategies to accelerate progress and implement existing policy and procedures.
3. Strengthens the capacity of staff to prevent, detect and respond to sexual exploitation, abuse and harassment in all its forms and settings.
4. Re-focuses our work to ensure a survivor-centered approach.
5. Reaches out to external experts, UN, and other partners to ensure collaborative and unified action.
6. Supports and guides WHEC's Programs, and field operations to meaningful implementation of Prevention & Response to Sexual Exploitation, Abuse and Harassment.
7. Communications and engages with our personnel, Member States, and internal and external stakeholders to ensure transparency and accountability.

Human Trafficking and Exploitation

Today, some label human trafficking as a form of "modern day slavery," and frequently human trafficking has been linked to sex-work and prostitution, although there are other form of trafficking such as forced labor and domestic work. UN report estimates that there are about 28 million people worldwide victims or survivors of human trafficking today. Moreover, trafficking of persons is believed to be fastest growing criminal industry in the world and is estimated to be a $ 33 billion business annually, second only to illicit drugs.

Suggested Steps for Organizing a Multidisciplinary Medical Clinic for Human Trafficking Survivors:
http://www.womenshealthsection.com/content/vaw/vaw014.php3

Sexual Violence

Rape of women and of children often used as weapon of war, as a form of attack on the enemy, typifying the conquest and degradation of its women or captures male fighters. It may also be used to punish women for transgressing social and moral codes, or instance, those prohibiting adultery or drunkenness in public.

Role and Responsibility of Health care Providers in managing Sexual Violence:
http://www.womenshealthsection.com/content/vaw/vaw013.php3

Child abuse is a serious global health problem. We hope our efforts encourage countries and governments to implement injury control policies and programs that will actually lower the currently unacceptable toll on child injury. .

We welcome reports on new approaches to old problems and accounts of experiences, where successes or failures, from which others may profit.

Join the efforts!

In The News

Global Issues: Disarmament

Since the birth of the United Nations, the goals of multilateral disarmament and arms limitation have been central to the Organization's efforts to maintain international peace and security. The UN has given highest priority to reducing and eventually eliminating nuclear weapons, destroying chemical weapons, and strengthening the prohibition of biological weapons – all of which pose the direst threats to humankind.

While these objectives have remained constant over the years, the scope of deliberations and negotiations has changed as political realities and the international situation has evolved.

Nuclear Disarmament and Non-proliferation

Nuclear weapons are the most dangerous weapons on earth. One can destroy a whole city, potentially killing millions, and jeopardizing the natural environment and lives of future generations through its long-term catastrophic effects. The dangers from such weapons arise from their very existence.

Although nuclear weapons have only been used twice in warfare, about 13,080 reportedly remain in our world today. And there have been over 2,000 nuclear tests conducted to date. Disarmament is the best protection against such dangers but achieving this goal has been tremendously difficult challenge. Weapons of Mass Destruction (WMD) such as biological and chemical weapons are profoundly destructive to humanity.

Implementation Plan for the Secretary-General's Disarmament Agenda

The implementation plan is a living document. As work progresses, new steps and initiatives will be added. The status of activities will be updated on a regular basis, and links to specific outputs on a regular basis, and links to specific outputs will be uploaded on a regular basis. The Agenda aims to achieve:

1. Disarmament to save humanity – Towards the elimination of nuclear weapons, ensuring respect for norms against chemical and biological weapons, preventing the emergence of new domains of strategic competition and conflict.
2. Disarmament that saves lives – Mitigating the humanitarian impact of conventional arms, addressing the excessive accumulation and illicit trade in conventional arms.
3. Disarmament for future generation – Emerging means and methods of warfare.
4. Strengthening partnerships for disarmament – Strengthening partnerships for disarmament.

It is an essential tool to secure the world and our future.

Join our efforts!

https://www.un.org/disarmament/sg-agenda/

Art & Science

Art that touches our soul

The Belgian version of the Yellow badge, compulsory from 1942

Photograph credit**:** Ronald Torfs

Yellow badges are badges, that Jews were ordered to wear in public during periods of the Middle Ages, by the ruling Christians and Muslims, and in Nazi Germany in the 1940s. The badges served to mark the wearer as a religious or ethnic outsider, and often served as a badge of shame.

The badge pictured is in the collection of the Kazerne Dossin Memorial, Museum and Documentation Centre in Mechelen, Belgium.

Yellow badges (or yellow patches), also referred to as Jewish badges (German: *Judenstern*, lit. “Jew’s star).

https://www.jewishvirtuallibrary.org/stars-triangles-and-markings

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

http://www.WomensHealthSection.com