

ministry itself, as often it does not have a strong presence within the cabinet and doesn't always have a good robust dialogue with the minister of finance. Finance ministers must realize that the health budget can save them money if it's applied well. We hope that these five countries will be able to show that when you strengthen the health ministry, both politically and in a management sense, to cope better with the strains and stresses of health interventions and planning for health equity, then the results can be really dramatic.

*Q: Can you give examples of countries that have successfully integrated ethics into public policy-making?*

A: Post-genocide Rwanda has managed to implement a good universal health insurance scheme that covers a large proportion of the population. This came about because of the severity of the country's problems and the resulting high proportion of women in the parliament and among professional caregivers, which had a positive effect on policy.

Another good example of a country that is thinking very ethically is Norway. It knows that it cannot meet its needs for health workers from Norwegian sources over the next

25 years. So it has made a commitment to finance the cost of training the health workers needed, and is entering into bilateral agreements with countries such as Poland to that effect.

*Q: Where do you see the greatest need for greater equity in health?*

A: One of the most acute problems is maternal mortality. It is the saddest thing that mothers are given such a low priority. We know that to achieve progress in this it is vital that countries have a functioning health system and this includes trained health workers at different levels. We are partners in a project called Health Systems Strengthening for Equity, which aims to highlight the crucial role of mid-level providers in maternal and newborn health and to influence policy-makers on making good use of their services. While mid-level health providers may not be well-recognized and don't have high status, growing evidence shows that such providers who are trained in obstetric care can make a dramatic impact on maternal mortality.

Malawi, Mozambique and the United Republic of Tanzania have been selected as models for in-depth research in this project because mid-level providers already provide the bulk

of obstetric care in these countries and there are good training programmes in place in each. We have to be careful because we don't want to give the idea that a "second-class" system will do. We still need all categories of health worker: doctors, researchers, nurses, as well as primary care community workers. So it's a matter of sensitively integrating this very scalable solution of trained providers into the broader health profession.

*Q: Are there any good examples?*

A: I'm impressed with steps taken in Ethiopia, which has been training 30 000 girls out of high school in primary community health care and then placing them in villages, where they will work alongside middle-aged women health workers. It is very likely that these girls will adapt to new technology such as mobile phone technology for health surveillance, for health education, to provide health information, for transfer of money. This is all relevant for strengthening health systems. Realizing Rights tries to find the good practices and make them better known to encourage other countries to follow suit. This is another practical way to implement the right to the highest attainable standard of health. ■

### Recent news from WHO

- In response to the **worsening food crisis in Ethiopia**, WHO was working closely with government partners, UNICEF and nongovernmental organizations to provide urgent emergency food relief to 4.6 million people nationwide in July. WHO's response includes immunization activities, sanitation interventions and the provision of urgent medical supplies to combat the increased risk of outbreaks of diarrhoeal disease, measles and meningitis.
- International Emergency Conventions (1986) and the International Health Regulations (IHR, 2005) were put to the test in a **simulated nuclear emergency** in Mexico on 9–10 July. Coordinated by the International Atomic Energy Agency, together with 74 of its Member States and 10 international organizations (including WHO), the exercise was a crucial part of the international efforts to respond to any radiological or nuclear incident or emergency worldwide.
- At the annual G8 summit in Hokkaido, Japan on 7–9 July, G8 leaders committed to annual progress measurements in meeting their **pledges to improve global health**. The leaders also noted the need for a voluntary code of practice regarding ethical recruitment of health workers as well as greater progress on maternal, newborn and child health.
- Two new initiatives aimed at **reducing the impact of multidrug-resistant tuberculosis** (MDR-TB) were unveiled by WHO, the Stop TB Partnership, UNITAID and the Foundation for Innovative New Diagnostics on 30 June. The first initiative will provide 16 countries with molecular tests known as line probe assays, which can diagnose MDR-TB in less than two days, as opposed to the standard two to three months. The second project will boost the supply of drugs in 54 countries and is expected to achieve price reductions of up to 20% by 2010.

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