

From rhetoric to reality



Courtesy of Mary Robinson

Mary Robinson

Mary Robinson was elected the first female President of Ireland in 1990, a position she held until she resigned in 1997 to take up the post of United Nations High Commissioner for Human Rights, which she held until 2002. The daughter of two physicians, she holds a Master of Arts from Trinity College Dublin, a law degree from King's Inns, Dublin, and a Master of Law from Harvard Law School. In 1969, at the age of 25, she became Ireland's youngest professor of law when she was appointed Reid Professor of Constitutional and Criminal Law at Trinity College. That same year she became a senator in the Irish Upper House of Parliament, a position she held for 20 years during which she campaigned on many issues including the right of Irish women to sit on juries and have access to contraception.

Human rights should be the fundamental basis of all government policy, according to Mary Robinson. As founder and leader of Realizing Rights: the Ethical Globalization Initiative, she works with civil society, government, business and nongovernmental organizations to advocate for the development of ethical policies in areas such as work rights, legal empowerment of the poor and gender equity.

Q: Why did you decide to establish Realizing Rights: the Ethical Globalization Initiative?

A: When I finished my five years in Geneva (as United Nations High Commissioner for Human Rights), I wanted to do something practical that would tackle the divides that exist in our world. With committed colleagues and partners including the Aspen Institute, Columbia University and the International Council on Human Rights Policy, we founded Realizing Rights: the Ethical Globalization Initiative in 2002. The title is provocative: people asked how we could put the words "ethical" and "globalization" together? Isn't that a contradiction? It was our intention to provoke! We believe that ethical globalization is possible if only we can hold governments and business accountable for respecting human rights, not just in the traditional political and legal realms, but in everything – health, education and the other social determinants of health – rights to food, safe water, sanitation and so on. Many people think that we have no shared value system in the world today but we actually do. Every government has signed up to a voluntary legal commitment under at least one of the international covenants

and conventions based on the Universal Declaration of Human Rights. But who is holding them to account? Our mission is to make it known that these conventions are good tools for civil society to hold their local authority, their government and businesses accountable.

Q: This all sounds very noble but how do you turn the rhetoric into reality?

A: We see our role as a catalyst, convener and communicator. When I say "we" here, I am talking about Realizing Rights working in conjunction with very knowledgeable partners. Our goal is to achieve changes in approach in such a way that they can be scaled up into government policies. I've learned a little truth recently: If you are small and don't particularly want credit for what you are doing, you can achieve a lot. We are quite happy for others to take credit for what's being done. By the end of 2010, we hope that this approach will have gained such traction and credibility that our programmes will have come to fruition or will have been passed on for continuing work to existing partners. We are planning an exit strategy. It might seem a bit strange when we are achieving our objectives but, philosophically, we don't think we

should go on forever. We feel that we shouldn't be the only ones doing this. It should be everyone's responsibility.

Q: Why should ethics be applied to public health?

A: The underlying ethical issue is that the burden of health care shouldn't be borne by the poorest families. We should have equity within health systems so that families are able to cope with serious illness and not be driven into poverty and relationship breakdown because they don't have access to health care. We need a more holistic approach in which we take account of society's most vulnerable sectors. We shouldn't just do broad averaging of country statistics but rather we need to disaggregate the data to determine where the resources are most needed. In most cases, it's usually the reverse: those who are most marginalized – minorities and rural and remote communities – get the least attention and money. We are not only looking at the poorest countries but we are challenging every country to take a human rights perspective. One of the richest countries in the world – the United States of America – is facing a real ethical dilemma in terms of providing equitable access to health care.

Q: What is being done within ministries of health to strengthen health systems?

A: I can give an example of one project, funded by the Gates Foundation, which focuses on health ministries. Together with the Health Financing Task Force (which is supported by the World Health Organization) and the Council of Women World Leaders, we are working on a project called the Ministerial Leadership Initiative for Global Health. The ministries of health from five countries – Ethiopia, Mali, Nepal, Senegal and Sierra Leone – were competitively selected to take part in the project, which aims to help strengthen their management capacity by providing technical assistance, peer support and expertise in three areas: financing for health equity, managing aid effectiveness and reproductive health.

We see these countries as the pioneers of a new approach. The focus is on helping to strengthen the health

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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