Interview with Francisco Songane: Evidence of Impact of Human Rights-Based Approaches to Health

Dr. Francisco Songane was Mozambique's minister of health from 2000 to 2004. During his tenure, he oversaw the introduction of innovative strategies to tackle malaria and hepatitis B. In addition to ensuring the inclusion of HIV treatment in the public health system, he helped galvanize community partnerships and addressed rural and urban inequalities, resulting in reductions in maternal and neonatal mortality.

Since 2004, Dr. Songane has held prominent roles in the field of women's and children's health. As director of the Partnership for Maternal, Newborn and Child Health (PMNCH), Dr. Songane spearheaded the adoption of a resolution by the United Nations (UN) Human Rights Council on preventable maternal mortality, as well as the subsequent development of technical guidance, putting this issue high on the agenda of both health and human rights bodies. He has also been a board and executive committee member of Gavi, the Vaccine Alliance and is presently UNICEF's representative to Angola.

The *Health and Human Rights Journal* interviewed Dr. Songane—widely commended for his leadership, capacity to stimulate broad partnerships, and focus on practical, innovative, and effective human rights-based strategies—about the challenges of collecting evidence of the impact of human rights-based approaches (HRBAs) to health.

Q. *The focus in this special issue on "evidence of impact" is that human rights not only are good and necessary in and of themselves but have the potential to contribute practically and concretely to specific health outcomes. What difference would it have made if you, during your time as a health policy maker, had been able to draw on "evidence" testifying to the value of human rights approaches?*

A. In the context of countries like Mozambique, there are many equally important competing priorities, and the implementation of activities to address them requires human capacity, institutional capacity, and sufficient financial resources. So, the careful adoption of efficient approaches is paramount, and good evidence is critical. In Mozambique, we drew on a list of proven interventions to address the health problems affecting most of the people, particularly in rural areas. These were mainly vaccine-preventable diseases, acute respiratory infections, diarrhea, and malnutrition in the case of children. For women, the leading programs focused on ensuring safe delivery (including access to emergency obstetric care), good antenatal care, the prevention of anemia, adequate nutrition, and access to modern methods of family planning. Our system was based on a comprehensive primary health care approach in which health centers played a key role in the delivery of services, prioritizing women and children. The World Health Organization (WHO),

UNICEF, and UNFPA recommended and promoted packages of basic interventions to be delivered at the health center and district hospital levels, and provided guidance on the rollout of programs. The evidence backing these interventions with the assistance of WHO, UNICEF and UNFPA, combined with positive experiences from other countries, especially Uganda, not only provided confidence and reassurance among decision-makers but also contributed to consensus-building, leading to the agreement that those interventions would be the programs of choice. In addition, these programs were framed in the context of the overall strategy to fight poverty that guided all government interventions.[1] We achieved good results with the selected interventions, but we still faced challenges in terms of extending these programs throughout the country to achieve equity in health care access. We were limited by the primary health care network, which was not reaching all people, and we did not have the resourcing to scale this up quickly. Negotiations with the Ministry of Planning and Finance for additional funding and support required strong evidence, and we did not have this. So, to answer your question, the lack of evidence weakened our stand, and our arguments were seen to be based on morals, not human rights obligations.

Funding for the introduction of effective public health interventions to address women's and children's health was supported because strong evidence was available. Had evidence supporting an HRBA been available, it would have helped accelerate increased coverage of the effective interventions aimed at reducing inequities in the country.

Q. *As minister of health for Mozambique, you championed your commitment to human rights and focused on practical results. What is the most important lesson you learned about translating human rights principles into practice?*

A. For me, the main issue is that an HRBA to health is a new discipline that is still being established. There are very few people acquainted with HRBAs or how to apply them. Paradoxically, although the right to health is clearly stated in the UN Charter

and well articulated in the WHO Constitution, in practice, most countries' health services are provided, funded, and evaluated just like any other service.[2] Ensuring a good standard of health among the population is not seen as a state obligation, so accountability is purely technical, limited to assessing the accomplishment of what was planned. The fundamental issue of meeting the expectations of the people as rights-holders is not measured. A human rights approach is not systematically used; it is occasionally raised by specific groups about specific health issues. I learned that an HRBA—to be effective and truly rights based—must be explicit from the very beginning of health strategy development and project planning.

The disaggregation of data is an important entry point for translating "abstract" principles into practical meaning regarding the day-to-day work, and this should link to the selection of indicators that will be used to monitor the program.

Q. *One recurrent theme concerning the successful application of human rights is the presence of committed "agents of change." Do you have experience working with agents of change and measuring their impact?*

A. Adopting HRBAs to program design and implementation is not easy and requires time. HRBAs introduce complex concepts that can require health workers and policy makers to adopt a new vision of health care. The people involved must have commitment and enthusiasm so they can encourage co-workers to adopt the same approach; these are the "agents of change," but they require support from management. In my view, there are two types of "agents of change": upstream operators whose involvement includes education, and those who implement the programs and often work directly with clients or patients. The latter have a particularly important role in their work with beneficiaries to confirm that these individuals' unmet health needs are denials of their human rights. This is what raises awareness and helps people understand that a lack of service is not just a matter of non-availability but something more profound—a right denied or not

fulfilled. Well-informed civil society organizations can be valuable partners in this process.

To harness these "agents," political support is paramount so that there is a coherent approach that is well coordinated, consistently explained, and able to be measured.

The work led by WHO throughout the publication of *Women's and Children's Health: Evidence of Impact of Human Rights* is a good example of providing information and raising awareness.[3*]

Q. *What factors have helped galvanize acceptance of, or enthusiasm for, rights-based approaches in health policies and programs? What are some of the outstanding challenges?*

A. Two cases stand out as successful examples of persistent advocacy: the process that led to increased access to antiretroviral (ARV) therapy for HIV/AIDS, encompassing the prevention of mother-to-child transmission of HIV; and the process that made maternal, newborn, and child health a central issue for development.

Although neither example started with an explicit HRBA, it soon became clear that human rights were central because people were effectively being "sentenced" to death on account of lacking money, living in certain countries, or being otherwise marginalized and without a voice.

In the case of HIV/AIDS, committed groups of policy makers, researchers, and clinicians engaged in a process of awareness-raising about the human devastation, and its socio-economic consequences, caused by the pandemic. They highlighted the fact that the worst off were bearing most of the burden of HIV/AIDS due to the prohibitive costs of treatment and testing. Their efforts were complemented by the actions of humanitarian organizations that partnered with pharmaceutical companies to show that ARV treatment could be provided at a much lower cost. At the same time, a massive grassroots movement was emerging to demand that testing and treatment be accessible to all without discrimination. It was at this stage that this advocacy movement gained a political dimension, compelling world leaders to realize the gravity of the situation and to act on several different levels. The movement, which had begun without a specific name, eventually became known as a successful "right to treatment" movement.[4]

In the second example, PMNCH was formed in 2005 to ensure the harmonization and integration of the efforts of a range of actors—states, UN agencies, nongovernmental organizations, research institutions, professional associations, and academics—to address the unacceptably high levels of maternal, newborn, and child mortality and morbidity, particularly in sub-Saharan Africa, South Asia, and parts of the Caribbean region.[5] PMNCH's initial approach focused on highlighting the stark differences between regions, between countries, and within countries. Although inequities were a major concern, the partnership did not articulate an explicit HRBA design at the outset.

The combined efforts of policy makers, scholars, international organizations, and civil society organizations raised awareness about the magnitude of the problem. They argued that such high levels of maternal mortality were unacceptable in light of the existence of effective and affordable interventions, as well as a global abundance of financial resources. PMNCH was particularly effective in countries where civil society organizations brought the issue to the attention of senior health managers, policy makers, and political leaders, as well as communities at large. Increasingly, country leaders took up responsibility, playing a critical role in the adoption of measures to address maternal and child health. A broad consensus was built that women have the right to safe childbirth, and states have the duty to provide maternal health services. What had started as just a pivotal action by some leaders became an obligation that featured prominently on the agendas of heads of state and government meetings, resulting in commitments to activities to be implemented at the country level. The right to safe delivery and the right to survival emerged as driving mottos.

I believe there were three main factors for success in these two cases.

1. *Champions*: First and foremost was the existence

of "champions" who led advocacy efforts and who enjoyed strong support from civil society. In the first example, these champions' activities included regular updates on progress being made on HIV/AIDS, as well as updates on research results from different approaches to tackling HIV/AIDS. Within the maternal, newborn, and child health movement, the Countdown to 2015 initiative continually drew attention to the vast discrepancies between and within countries, and presented evidence-informed alternative approaches to improve maternal, newborn, and child health.

2. *Political leadership*: For HIV/AIDS, emblematic leaders joined forces with activists, which increased the visibility of the issue and forced other state leaders to address the problem. For maternal, newborn, and child health, when some leaders spoke out on the subject and committed their own countries to a course of action, this encouraged other leaders to acknowledge the magnitude of the problem and join the campaign. Currently, the maternal, newborn, and child health movement is spearheaded by the UN Secretary-General, through the Every Woman, Every Child strategy.[6]

3. *International frameworks*: The HIV/AIDS global conferences were important meetings for clarifying issues, presenting the results of the latest research, and reinforcing messages. They were "must go" conferences for world leaders, where calls for the right to treatment and the right to survival were renewed. For maternal, newborn, and child health, the side meetings at major official gatherings of heads of state and governments were a crucial platform for advocacy and consensus-building for future commitments. An important moment for the movement was in 2008, when, for the first time, the Human Rights Council discussed maternal mortality and subsequently issued a resolution classifying the prevention of maternal mortality as a human rights issue.[7]

The main challenge is limited resources to sustain progress. These health problems are greatest in countries that remain dependent on official development assistance. This is compounded by competing priorities, as well as unexpected disasters that can divert attention and funding away from previous priorities. In addition, the 2008 global economic crisis affected countries' funding capacity and provided justifications to those that wanted to pull out of funding agreements for these programs. As we transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals, it is paramount to remind ourselves that we are doing this under the umbrella of the UN. As called for in the UN Charter, countries must cooperate and harmonize efforts to solve "international problems of an economic, social, cultural, or humanitarian character."[8]

Q. *Are changes occurring in health program evaluation?*

A. Partnerships like PMNCH and Gavi have introduced results-based monitoring. This has been a key condition in cooperation agreements with several countries, and it has helped shape the way that programs are managed at the country level. One of the gains for countries has been the disaggregation of data, which has exposed deep inequities within countries and has helped redirect efforts toward those who have historically been left out. By way of illustration, PMNCH shows results by income quintiles, by district, and by subdistrict; Gavi makes the continuation of funding conditional on 80% coverage of DTP3 or pentavalent 3 (depending on the country) in all districts. Countdown to 2015, of which PMNCH is a partner, introduced a major innovation in monitoring and evaluation by presenting global results in the mother- and child-related MDGs in simple language that any political decision-maker could understand. It also helped mobilize decision-makers not only through the publication of their countries' data but by providing suggestions based on positive experiences in other countries.[9] It should be stressed that Countdown to 2015 was not limited to the indica-

tors of MDG goals 4 and 5—it also analyzed the programs and policy frameworks of each country. This broader approach boosted the enthusiasm of health managers and provided useful information for advocacy. The country profiles at the end of each report have been extremely helpful, as they summarize, in one page, the key results of each country's assessment. The Countdown to 2015 initiative was not initially labeled as an HRBA, but its content and the dynamics it engendered were rights based and explicitly addressed the right to safe delivery, the right to survival, and the right to proper care in childhood. Evidence empowered its messages.

Another important achievement by Gavi has been the gradual incorporation of all immunization-related costs into national budgets.[10] Until the late 1990s, many low-income countries did not budget or account for the supply side of immunization (for example, vaccines, cold chain equipment, and distribution chains) because this was covered by international organizations, mainly UNICEF and WHO. Now that Gavi requires financial sustainability plans for immunization as part of its contracts, countries have to include the full costs of vaccination in their health budgets. This has been critical for ensuring the sustainability of vaccination as a "pillar program" in aid-dependent countries.

Gavi's contracts address the human rights issue of overcoming inequities, as well as the technical requirements to achieve full immunization coverage.[11] Countries must review their policies and programs. Thus, Gavi adds value by extending programs to reach those most in need, as well as improving the management of programs.

*Dr. Songane was one of the steering committee members of WHO's monograph *Women's and Children's Health: Evidence of Impact of Human Rights*.

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