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Weak capacities and resource constraints

The Right to Health Approach in Mozambique: Facts, Figures and Dilemmas

Von Franziska Freiburghaus

Mozambican health officials frequently use the wording "lack of resources" as an explanation for the fact that health as a human right is not properly reflected in the countries service delivery. This article aims at providing a brief overview of facts, figures, as well as existing dilemmas in the country in order to make the current situation regarding health and human rights better understood. Multiple factors need to be taken into consideration when trying to understand the right to health approach in Mozambique.

These multiple factors are related to (i) the socio-economic context, (ii) the legal framework which includes the political readiness to subscribe to human rights, and (iii) an effective and efficient quality health system. By definition, the right to health comprises of determinants of health and an accessible and available health care system for all, required to be put in place by duty bearers (governments and public authorities). Evaluation of the right to health means examining availability, accessibility, acceptability and quality of service delivery. Public authorities can be held accountable for failing to ensure the right to health, if the respective Covenants and treaties are signed and ratified.

Mozambique has ratified several major international and regional human rights treaties that address the right to health and a number of rights related to conditions necessary for health. However, Mozambique is not yet party to the International Covenant on Economic Social and Cultural Rights (ICESCR), the most important Covenant on the right to health. The Mozambican government declares not to be capable of enforcing the Covenant by delivering health and other services covered by the ICESCR (education, water, social security, etc), due to lack of resources. Is this a sufficient explanation? And which consequences does the non-ratification have for the health status of the Mozambican population?

Context

Almost forty years after independence, the socio-economic context in Mozambique gives reason for concern. Ranking at position 184 out of 187 countries in the 2011 UNDP Human Development Index, Mozambique remains one of the least developed countries in the world. Existing strategies for poverty reduction are not producing the expected results. 46 percent of children under 5 years suffer from chronic malnutrition and the mortality rate of this age group remains alarmingly high, at 138/1,000 live births. In terms of inequalities, significant regional differences in poverty reduction and absolute poverty can be identified, and are also gender-related with women facing severe discrimination in terms of ownership rights, lack of information and economic opportunities. Violence against women is common. Literacy rates show substantial disparities between men (67 percent) and women (38 percent). The HIV prevalence for women aged 15-49 is 13.1 percent compared to 9.2 percent for men, but for the age group 15-24 the likelihood for women to be infected is almost three times higher than for men. About 70 percent of the urban and 35 percent of the rural population have access to safe water, whilst 40 percent of the urban and only 5 percent of rural population have access to improved sanitation facilities. In terms of discrimination, it is known that e.g. homosexuality is culturally not accepted and handicapped children are preferably hidden from the public in their home. Transparency International's 2010 Corruption Perceptions Index ranked Mozambique 116 out of 178 countries surveyed, with a Corruption Perception Index of 2.7 (10=highly clean, 0=highly corrupt).

Human Rights situation

In February 2011, Mozambique underwent a high level review by the UN Human Rights Council, the so-called Universal Periodic Review. In preparation of a position for this review, the EU Commission elaborated a document identifying the major constraints in the implementation and protection of all human rights in Mozambique. They include a high level of poverty, institutional weaknesses, a certain degree of impunity and low levels of citizens' awareness. In terms of effective implementation of the principle of non-discrimination, the EU Commission concluded that this is limited by a number of factors including (i) lack of ratification of UN instruments, (ii) scarce resources, (iii) structural factors, (iv) insufficient rights awareness and (v) limited access to state-provided legal services. These factors are obviously hindering a successful human rights implementation. Most relevant for the negligence with regard to implementing the right to health is the insufficient rights awareness of the citizens, the high level of poverty, the institutional weaknesses which negatively impact efficiency and effectiveness of service delivery but also the scarce human and financial resources and the limited access to justice.

Insufficient rights awareness can (also) be explained with the tremendous lack of capacities within the Mozambican civil society. In fact, understanding, knowledge and skills are still to be developed to ensure a meaningful participation of citizens. In general, the role of Civil Society Organizations (CSOs) – when considered as rights holders – is to give critical inputs for the promotion of human rights. CSOs should translate rights-based approaches from theory into practice, be lobbyists and watchdogs for good governance, promote citizen participation,

represent citizens' views and needs and be counterparts and counter-power to the government. In Mozambique, many key civil society actors are very new. Thus, organizations and networks are still weak in terms of institutional development and coordination. A review of CSOs in 2010 also pointed out the high risk of political co-option, expressed in (too) close collaboration with the party. However, their activities and voices are improving. For example, health related NGOs (MONASO, NAIMA+, MSF etc.) recently defended access to essential health care services including access to vital drugs like antiretrovirals and artemisinin-based combination therapies to treat malaria – in an open letter to the health, finance and prime minister. Also gender inequalities, for example the feminization of AIDS or domestic violence against women, have moved up on the political agenda since NGOs and CSOs are stepping up their pressure.

Communities and CSOs are not only rights holders but also "duty bearers", although more in a moral than legal sense. Duties include the use of the governmental health system as the primary entry point for health care, positive contributions to improve the determinants of health like women's empowerment, access to information and protection of environment and last but not least non-discrimination of specific groups (e.g. homosexuals, people living with AIDS). For certain of these aspects, there is definitely room for improvements.

Health Service Delivery

The Mozambican Ministry of Health (MoH) is the main provider of public health care in the country. Outsourcing of particular services, e.g. supply chain management, to the private sector hardly exists. The private for-profit sector is gradually growing, especially in cities, but regulation by the government is weak. The form of the system (national or non-governmental service provision) is not important anyway, as long as it delivers health outcomes to all and is respectful of human rights and democratic principles. In relation to the public health approach, the health policy framework in Mozambique is excellent with a clear focus on primary health care which prioritizes on women and children. In addition, the health sector – in collaboration with other ministries – adopted various strategies like anti-corruption, multi-sector nutrition, gender health, MDG 4 and 5 acceleration, traditional medicine, community participation, health promotion etc. and elaborates annual implementation plans at national, provincial and district level. However, the implementation and prioritization of all these strategies and plans remains a huge challenge.

In fact, if the MoH as duty bearer of the right to health would be evaluated according to the evaluation criteria of the World Health Organization (WHO) mentioned above, what would be the probable outcome in terms of violation of the right to health? Health system strengthening and implementation support of the strategies mentioned above resulted in slow, but steady improvements in health outcomes of the Mozambican population. For example, health care costs less than 0.03 USD per consultation and is free for vulnerable population groups like pregnant women and children under five. Health and service information is provided and disseminated whenever possible and a lot of effort goes into community involvement. Big investments in outreach services to improve accessibility are done and health service deliveries

try to respect life-cycle requirements. Since its inception end 2010, the new health minister shows clear leadership in the fight against all forms of corruption. On the other hand, with 0.6 trained workforces per 1,000 populations, professional workforce is clearly insufficient. Similar ranges of the problem can be found in relation to sufficient quantity of hospitals, clinics, essential drugs etc. the majority of the population has to walk more than half an hour to reach a health facility. Although no clear evidence on discrimination exists, a certain degree of this phenomenon can be anticipated. Information on the extent of under-the-table payment or amount of household spending for traditional health services is hardly available. Confidentiality can seldom be guaranteed because of lack of adequate infrastructure. Not much information exists in relation to medically and scientifically appropriate quality of service delivery. However, given the fact that on average only USD 20/per capita/per year is the amount invested in health, it can be anticipated that the quality criteria is not fulfilled. Consequently, the picture in relation to the criteria availability, accessibility, acceptability and quality of service delivery is mixed, with a tendency to the conclusion that the right to health is violated.

However, the causes of the problem are definitely broader. In fact, not only the inadequate health service delivery, but also the gender related inequalities (see above) strongly influence negative health outcomes. Women's social, sexual and reproductive health rights are not respected which is reflected in the feminisation of HIV/AIDS and the high maternal mortality rate, with 1 in 16 women dying of complications connected to pregnancy and childbirth. Also delivery of social services other than health, like clean water and sanitation to prevent diarrhoea or adequate quantities of food to prevent under-nutrition and stunting, is not guaranteed by government.

Discussion and way forward

The EU Commission found that shortcomings of the Government of Mozambique (GoM) as duty bearer are mainly lack of provision of legal services, non-ratification of human rights instruments and scarce resources. Similar to CSOs, the GoM is suffering from weak capacities and resource constraints. Fact is that the GoM has a finite budget and has to choose between e.g. building more rural clinics (right to health), hiring more teachers (right to education) and improving places of detention (prohibition ill-treatment). Addressing priority setting, both in the health sector and across sectors, in a way that is consistent with the right to health and all other human rights is a sensitive and difficult issue. More research by the human rights community and ethics specialists is needed to support countries in better integrating the human right to health approach in priority setting and in policy-making. However, in Mozambique, resources are finite for all sectors. Thus, lack of resources is not explanation enough for not signing up formally to the right to health. Ratifying the ICESCR might contribute for the right to health not lagging behind legally on other human rights obligations that the GoM already ratified. With the current situation, there are no legal means to hold the government accountable for non-fulfillment of the right to health and all other rights included in the ICESCR. Thus, the big advantage of the right to health, namely that the state has an obligation to secure that every citizen can enjoy the highest attainable standard of physical and

mental health, does not exist. Instead there is solely the public health approach. It is complementary to the right to health approach and very valid, but it is not a legally binding approach.

**Franziska Freiburghaus, pharmacist, PhD, MPH, works for the Swiss Development Cooperation (SDC) in global and bilateral health programs since 2004. She is currently based in Mozambique and leads the health domain. The priority areas of SDC in Mozambique are health system strengthening, community health participation and health promotion.*

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Medicus Mundi Suisse
Rue de Varembé 1
CH-1202 Genève
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Bankverbindung
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX