1 Assessing Mozambique's performance on the reduction of the maternal mortality ratio by **Teddy Namatovu**

Teddy Namatovu completed her LLM/MPhil degree in Human Rights and Democratisation in Africa at the Centre for Human Rights, University of Pretoria in 2016.

Introduction

Despite its having committed to the reduction of the MMR by three-quarters between 1990 and 2015 under the Millennium Development Goals (MDG), which have since been reinforced into the Sustainable Development Goals (SDGs) (United Nations 2015), Mozambique is still grappling with one of the world's highest MMRs, at 408 deaths per 100 000 live births (WHO, 2013).

A myriad factors account for this, notwithstanding the ratification of several treaties that necessitate the reduction of maternal mortality and efforts by the Mozambican government to this end. This article seeks to identify the reasons for the persistence of Mozambique's high MMR and to make recommendations for reducing it. The assessments made in this article are based on a field study conducted in Maputo, Mozambique between 11–15 April 2016.

Scope and content of the right to maternal health care

According to the Committee on Economic Social and Cultural Rights (CESCR), the right to maternal health care is an integral part of the right to health (CESCR general comment No. 22). This right is protected under various international and regional human rights instruments to which Mozambique is a state party, such as:

* article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW);
* article 16 of the African Charter on Human and Peoples' Rights (Banjul Charter), and
* article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol).

However, in spite of the fact that the International Covenant on Social and Economic rights (ICESCR) is the key instrument spelling out the right to maternal health care, Mozambique has not ratified it (Nabeneh 2015).

Maternal health rights have been interpreted to include women's right to safe motherhood and emergency obstetric services, access to family planning, pre- and post-natal care as well as access to information and resources to act on that information (CESCR general comment No.14 para. 14).

The UN Committee on Economic Social and Cultural Rights also highlights the core contents of sexual and reproductive health care, which encompasses the following essential elements:

* an adequate number of functioning health-care facilities, services and goods to provide the fullest possible range of sexual and reproductive health care (CESCR general comment No. 22 para12);
* availability of medical personnel trained to perform the full range of sexual and reproductive health-care services (CESCR general comment No. 22 para. 13); and
* accessibility of all health facilities goods, services and information related to sexual and reproductive health care to individuals without barriers (CESCR general comment No. 22 para15).

Accessibility includes physical access and economic access in terms of affordability (CESCR general comment No. 22 paras. 16, 17 and 18). The various contents mentioned can therefore be used as indicators for assessing state performance in the realisation of maternal health rights.

Maternal health rights have been interpreted to include women's right to safe motherhood and emergency obstetric services, access to family planning, pre- and post-natal care as well as access to information and resources to act on that information.

Suffice it to say, the reduction of maternal mortality is subject to progressive realisation based on the allocation of resources to the maximum extent of what is available (Committee on Elimination of All Forms of Discrimination Against Women (CEDAW), general recommendation No. 24 para. 27). Notwithstanding the requirement for progressive realisation, states are required to move as expeditiously and effectively as possible while taking deliberate, concrete and targeted steps to use all appropriate means to reduce maternal mortality (CESCR general comment No.14 para. 33).

The UN Committee on CEDAW has highlighted the prevalence of a high mortality rate as an indication of a breach by the state of its duty to ensure that women have access to health care (CEDAW general recommendation No. 24 para. 17).

Factors that contribute to the high maternal mortality ratio in Mozambique

Even though Mozambique registered significant progress in attainment of MDG 5A by reducing its MMR from 1 390 to 408 per 100 000 live births between 1990 and 2015, the country still has one of the highest MMRs in the world (World Bank IBRD-IDA 2015). Currently, with MDGs having

Teddy Namatovu completed her LLM/MPhil degree in Human Rights and Democratisation in Africa at the Centre for Human Rights, University of Pretoria in 2016.

been overtaken by SDGs, the country needs to reduce its MMR to less than 70 per l00 000 live births by 2030 (United Nations 2015).

A number of pertinent respondents interviewed for this article raised concerns about the factors accounting for the country's high MMR. In particular, the low ratio of skilled personnel compared to the number of women in need of maternal health services was highlighted as a major contributor to maternal mortality in Mozambique.

The methodology employed in identifying the factors discussed below included a site visit of Central Hospital in Maputo and interviews with officials in the Ministry of Health and discussion interviews with members of civil society, journalists, and officials of the national human rights institution. The transcripts of the interviews are available on file with the author.

When interviewed on 13 April 2016, an obstetrician from the Central Hospital in Maputo noted that there is an alarmingly low number of skilled or qualified obstetricians in the country who can offer emergency obstetric and essential care to women in need. The situation is exacerbated by their being stationed in provincial and general hospitals in the cities, leaving the rural areas in limbo. These sentiments were shared by two doctors interviewed on 12 April 2016 at Hospital Geral Jose Macamo, who revealed that the scarcity of skilled health workers puts insurmountable pressure on existing personnel. They also revealed that the shortage is more pronounced in rural hospitals and health centres. This has prompted training of maternal and child health nurses from these facilities in essential obstetric care as well as antenatal and postpartum care.

. . . expressed concern about the absence in these facilities of midwives to attend to waiting pregnant women in case of emergencies, which cripples the effectiveness of these maternity waiting homes.

When interviewed on 14 April 2016, officials from the Ministry of Health averred that the government was aware of the limited number of skilled personnel and thus hired foreign personnel to reinforce the country's human resources. They further stated that, despite the foreign reinforcements of trained medical and professional staff, the number of health professionals remains low and therefore stains to adequately respond to the maternal health needs of women in Mozambique.

The officials emphasised that underfunding of the health system was also a contributing factor to the country's high mortality rate. They stated that insufficient funding has resulted in limited numbers of personnel, inadequate medical equipment and a shortage of drugs in the hospitals, which has weakened the health system and impeded the full realisation of maternal health rights for many women Likewise, a report by the United States Global Fund Initiative highlighted inadequate funding as a major underlying factor impeding the performance of Mozambique's health sector. The report indicates that a meagre eight per cent of the national budget is allocated to the health sector despite the country's commitment to dedicate 15 per cent of its total budget to health (United States Global Health Initiative Mozambique Strategy 2011–2015). The minimal number of ambulances, restricted for general and provincial hospital use, was never highlighted as a major contributing factor to the country's high MMR. All the medical workers interviewed raised concerns regarding the fact that health centres have to call for ambulances from general hospitals, which is problematic in cases of emergency when the ambulances are unavailable. The effect of this is more devastating for women in hard-to-reach or rural areas.

All of the interviewees highlighted the inaccessibility of health facilities, especially in rural areas even more affected by the poor transport system in the country, as a contributing factor to the country's high MMR. In this vein, a 2014 study by BioMed Central found that 21.3 per cent of maternal deaths in Mozambique are a result of inaccessibility of health centres due to long distances (David, Fmchungo, Zanconato, Cavaliere, Fiosse, Sululu, Chiluvane & Bergstrom 2014).

An obstetrician interviewed at the Central Hospital in Maputo stated that indirect costs such as transport to health facilities, especially in the rural areas where a considerable portion of the population lives in poverty, compound challenges of inaccessibility. She also stated that indirect costs prevent most women from seeking institutionalised births, forcing them to risk their lives with traditional birth attendants. This is despite the absence of the requirement for user fees in public health facilities.

Measures taken by Mozambican government towards the reduction of the maternal mortality ratio

Respondents at the Ministry of Health revealed that the government of Mozambique is aware of the country's high MMR as well as its contributing factors and is therefore adopting various measures to address the issue. The effectiveness of these measures has to be assessed against the country's commitments under international and regional human rights law.

All the respondents underscored the critical role played by Casa de Espera (meaning maternity waiting homes) in increasing accessibility to obstetric care for pregnant women, especially in the rural areas, and thus reducing the risk of maternal mortality. The WHO defines maternity waiting homes as 'residential facilities located near a qualified medical facility, where women defined as high risk can await their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier should complications arise' (WHO, 1996). However, the interviewees also expressed concern about the absence in these facilities of midwives to attend to waiting pregnant women in case of emergencies, which cripples the effectiveness of these maternity waiting homes. This indicates a shortfall in the state's efforts, given that the availability of an adequate number of trained medical and professional personnel is crucial in the reduction of MMR (CESCR general comment 14 para 12a). To address the high maternal mortality rates perpetuated by traditional birth attendants assisting women who deliver in rural areas, the Ministry of Health collaborates with attendants who are now trained to sensitise communities about the advantages of institutionalised delivery (WHO, 2015). The collaboration is based on the unique network and cultural connection that the attendants have with rural communities. This has helped the project to achieve considerable success in increasing the number of institutionalised deliveries in the rural areas (WHO, 2015). The measure is a sensible one, intended to increase the number of institutionalised births and protect women from

the risks associated with deliveries by unskilled attendants (WHO, 2015).

The medical personnel interviewed lauded the government's decriminalisation of abortion in 2014. The decriminalisation was aimed at addressing the high maternal deaths arising from clandestine abortions. The law permits institutionalised abortion by qualified practitioners within the first 12 weeks of pregnancy and 16 weeks in case of rape. This is in line with the state's obligations under the Maputo Protocol, which prohibits states' adoption of restrictive abortion laws and which recognises women's right to safe abortion in instances of rape, incest, sexual assault, and when a pregnancy endangers the physical and mental health of the mother or the life of the mother or foetus (Maputo Protocol a.14.2.c).

The government has also developed a National Strategy for Reduction of Maternal Mortality, which forms the basis for formulation of interventions to reduce the MMR in Mozambique (Jamisse, 2015). The strategic plan aims to improve services at provincial level and the provision of emergency obstetric and essential care, which are reinforced by a strengthening of referral systems, community involvement and data collection systems (Jamisse, 2015). The plan is complemented by establishing a department in the Ministry of Health dedicated to the reduction of maternal mortality (Jamisse, 2015). However, interviewees stated that, despite the adoption of legislative and administrative measures to ensure reduction of MMR as required under CEDAW and the Maputo Protocol, the lack of proper implementation, especially in rural areas, makes the efforts taken almost futile.

Conclusion and recommendations

Research for this article shows that although the government has the political will to address maternal mortality, political will should be actuated by practical measures to engage with the root causes of maternal deaths. However, despite the strides taken by the government to curb maternal deaths, a myriad challenges still persist in the health sector and account for the overwhelmingly high MMR in the country. To this end, the study makes the following recommendations to address the persisting challenges:

* Addressing most of the highlighted factors contributing to the high MMR in the country requires availability of resources. The government should therefore heed its commitment under the Abuja Declaration and increase the budgetary allocation for health from eight per cent to 15 per cent of the national budget as this will go a long away in the fight against maternal mortality (United States Global Health Initiative Mozambique Strategy 2011–2015). The government can also mobilise more resources through international assistance and cooperation so as to increase the amount of funding available to improve maternal health services and curb maternal mortality (CESCR general comment No. 2 para 13).

* More medical personnel skilled in emergency and essential obstetric care at all levels , especially in the rural areas, are needed. The government should also mobilise international technical assistance through the recruitment of skilled medical personnel to complement the existing labour force (CESCR general comment No. 2 para 13). Additionally, the government should facilitate the provision of maternity waiting homes staffed by midwives to assist pregnant mothers in case of emergency during the waiting period.

* More health facilities are needed, especially in the rural areas. There should also be coordination between the Ministry of Transport and Communications and the Ministry of Health to revamp the transport network, especially in the rural areas, so as to improve accessibility to health facilities.

* Implementation of the National Strategy for Reduction of Maternal Mortality, especially in rural areas, is required.

References

* David E, Mchungo F, Zanconato G, Cavaliere E, Fiosse S, Sululu C, Chiluvane B and Bergstrom S Maternal near miss and maternal deaths in Mozambique: a cross-sectional, region-wide study of 635 consecutive cases assisted in health facilities of Maputo Province BMC Pregnancy and Childbirth 2014, 14:401 Available at http://www.biomedcentral.com/147-2393/14/401

*Jamisse L Maternal neonatal and child health one plan: Mozambique's experience. Ministry of Health-Mozambique 2015 (PowerPoint presentation)

*Mail & Guardian Mozambique decriminalises abortion to curb maternal deaths Posted 19 December 2014 Available at http://www.mg.co.za/article/2014-12-19-mozambique-legalises-abortion-to-curb-maternal-deaths

* Nabaneh S Challenges in litigating the right to health in Mozambique: a critical analysis in Durojaye E (eds) Litigating the Right to Health in Africa: Challenges and Prospects (2015) New York: Routledge.

*Sustainable Development Solutions Network Indicators and a monitoring framework: launching a data revolution for the sustainable development goals Available at http://www.indicators.report/targets/3-1

*The United States Global Health Initiative Mozambique Strategy 2011 – 2015. Available at: http://www/ghi.gov/wherework/docs/mozambiquestrategy.pdf

*UN General Comment No. 3 of the Committee on Economic Social and Cultural Rights

*UN General Comment No. 22 of the Committee on Economic Social and Cultural Rights

*World Health Organisation, Department of Reproductive Health and Research Maternity Waiting Homes: a review of experiences (1996) 2. Available at www.who.int/reproductivehealth/publications/maternal_perinatal_health/MSM.../en/

*World Health Organisation, Mozambique. Available at http://www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/moz.pdf

2

Arbitrary home demolitions in Zimbabwe and the right to adequate shelter: Case study of Arlington Estate, Harare by **Rodger Owiso**

Introduction

Zimbabwe's human rights obligations under international and domestic law secure the rights to property, adequate shelter, freedom from arbitrary evictions, protection and benefit of the law, fair administrative action and due process. Despite these protections, the government has repeatedly and arbitrarily demolished homes it considers illegal

Teddy Namatovu completed her LLM/MPhil degree in Human Rights and Democratisation in Africa at the Centre for Human Rights, University of Pretoria in 2016.