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经济、社会和文化权利

人人享有能达到的最高标准的身心健康的权利

特别报告员保罗·亨特提交的报告

增 编

对莫桑比克的访问 *

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内 容 提 要

人人享有能达到的最高标准的身心健康的权利(健康权)问题特别报告员于 2003 年 12 月 15 日至 19 日访问了莫桑比克。此次访问的主要目标是了解莫桑比克是如何努力落实健康权的，以便向该国政府和其他行为主体提出建设性的建议。

特别报告员与政府代表、双边和多边机构、民间组织以及保健工作者进行了多次会晤。他访问了马普托和农村地区的医疗设施。

在整个访问期间，特别报告员特别注意在贫穷和歧视状况下的健康权问题。他特别审议了以下问题：取得保健服务和保健设施的问题；使用费；捐助者和政府间组织的作用；保健工作者的处境；取得用水和卫生设施的问题；性健康和生殖健康；以及艾滋病毒/艾滋病、肺结核和疟疾的问题。

特别报告员承认莫桑比克当前的现实，这包括：殖民化遗留下来的问题、内战、以及各种人道主义灾害，其中包括 2000/01 年的洪水，这场洪水摧毁了莫桑比克的部分保健基础设施。莫桑比克的健康指数虽然近年来有所改善，但仍然及其薄弱。特别报告员鼓励莫桑比克政府增进保健部门的问责机制和社区参与。

莫桑比克政府与其双边和多边供资伙伴一起，致力于解决莫桑比克的各种保健问题，在各种国家政策和战略中把保健放在优先地位。不过，特别报告员鼓励莫桑比克政府将健康权明文纳入其所有有关的国家和国际政策。

特别报告员强调，莫桑比克许多值得称道的政策措施与其落实这些措施的能力之间存在差距。如果没有更多的保健资源，没有更多的保健工作者享有更好的工作条件，莫桑比克便不可能取得与健康有关的所有千年发展目标，也不可能在实现健康权方面取得令人满意的进展。这是莫桑比克政府和国际社会的一项重大责任。

Annex

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REPORT OF THE SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH, PAUL HUNT, ON HIS MISSION TO MOZAMBIQUE (15-19 DECEMBER 2003)

Introduction

1. In this addendum to his report, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to health") reports on his mission to Mozambique, which took place from 15 to 19 December 2003. The Special Rapporteur expresses his sincere appreciation to the Government of Mozambique for the cooperation extended to him in preparation, and throughout the course, of his mission. In particular he is grateful to the Minister for Health, Dr. Francisco Songane, and staff at the Ministry of Health (MISAU), as well as to World Health Organization (WHO) staff in Maputo. He also extends his thanks to the United Nations offices in Mozambique, especially those of the United Nations Development Programme (UNDP) and the United Nations Resident Coordinator, as well as to the Office of the High Commissioner for Human Rights (OHCHR) for assistance in facilitating a full and diverse programme of work.

2. The objective of the mission was to understand, in the spirit of cooperation and dialogue, how Mozambique endeavours to implement the human right to health, the measures taken for its successful realization and the obstacles encountered, both at the national and international levels. Throughout his mission, the Special Rapporteur paid particular attention to two cross-cutting themes, poverty and discrimination/stigma, as well as a range of more specific right-to-health issues detailed throughout this report. Within the allocated word limit, the Special Rapporteur regrets that it is impossible to address in depth all the important right-to-health issues in Mozambique.

3. During his mission, the Special Rapporteur held consultations with a wide range of actors, including representatives of various ministries of the Government of Mozambique, international organizations, donors, non-governmental organizations (NGOs), health professionals and health professional associations, and people living with HIV/AIDS. The Special Rapporteur had the honour to be received by the Minister of Health and the Minister for Women and Social Affairs Coordination. He also met with representatives of the Ministry of Health, including legal advisers to, and the director of, the National Directorate for Planning and Cooperation; representatives of the Ministry for Women and Social Affairs Coordination; the National AIDS Council; the Permanent Secretary of the Ministry of Planning and Finance; and the National Directorate of Buildings and Public Works. The Special Rapporteur held discussions with staff of several United Nations organizations including WHO, UNDP, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank.[1] In addition, he met with several donors, including the Department for International Development of the United Kingdom (DFID), the Swiss Agency for Development and Cooperation (SDC), the Canadian International Development Agency (CIDA), the Norwegian Agency for Development Cooperation (NORAD), the Japan International Cooperation Agency (JICA) and Development Cooperation Ireland (DCI).

4. The Special Rapporteur also consulted with representatives of civil society. He held a consultation on the right to health with national and international NGOs working in

Mozambique, including Médecins sans frontières, AMODEFA (a family planning association) and Save the Children. He held meetings with Kindlimuka and RENSIDA, two associations of people living with HIV/AIDS, and with the Archbishop of Maputo, who is centrally involved in the Roll Back Malaria campaign. In addition, he met with two health professional associations, the National Nurses Association of Mozambique and the Medical Association of Mozambique. The Special Rapporteur had requested a press conference to brief the media on his preliminary observations, however unfortunately this briefing did not take place.[2]

5. Over the course of his mission, the Special Rapporteur visited several hospitals, clinics and health centres. In Maputo, he visited the Alto Maé Health Centre, the Xipamanine Health Centre and the Central Hospital. In Gaza Province, he visited the Chokwe District Hospital, an HIV/AIDS testing and counselling clinic, and a hospital for people living with HIV/AIDS. He also met with the Deputy Director of the Faculty of Medicine at the Universidade Eduardo Mondlane in Maputo.

6. The Special Rapporteur expresses his sincere thanks to all those whom he met.

I. THE RIGHT TO HEALTH: PRINCIPLES, NORMS AND STANDARDS

A. International legal framework

7. In 1948, the Universal Declaration of Human Rights (UDHR) provided the foundation for the international legal framework regarding the right to health. Subsequently, the right to health was enshrined in a wide range of international and regional human rights instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples' Rights.[3]

8. The Government of Mozambique has ratified the International Covenant on Civil and Political Rights (ICCPR) and its Second Optional Protocol, as well as other major human rights treaties including the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on the Rights of the Child (CRC) and its Optional Protocol on the sale of children, child prostitution and child pornography, the African Charter on Human and Peoples' Rights and the African Charter on the Rights and Welfare of the Child. These treaties contain important provisions related to the right to health and provide a framework for legislation and policy at national level.

9. **While the Government of Mozambique has ratified many international instruments that provide for the right to health, it has not ratified the ICESCR. The Special Rapporteur urges the Government to ratify this Covenant as soon as possible.**

10. According to international human rights law, the right to health includes a right to timely and appropriate health care, including access to essential medicines. It also encompasses underlying determinants of health such as access to safe drinking water and adequate sanitation.

The right to health includes freedoms, such as the right to be free from discrimination and non-consensual medical treatment, and entitlements, such as timely and appropriate health care, adequate sanitation and health-related education. In short, the right to health can be understood as a right to the enjoyment of a variety of facilities, goods and services necessary for the realization of the highest attainable standard of health. A State party to the relevant international treaties has an obligation to take steps towards the progressive realization of the right to health, to the maximum of its available resources.

11. States parties to international human rights treaties have an obligation to give effect to the provisions contained within these treaties. This includes an obligation to *respect* (i.e. not interfere with), to *protect* (i.e. prevent others from interfering with), and *fulfil* (i.e. take measures to facilitate realization of) human rights, including the right to health. In view of its ratification of international legal instruments such as CEDAW, CRC, the African Charter on Human and Peoples' Rights and the African Charter on the Rights and Welfare of the Child, the Government of Mozambique has an obligation to respect, protect and fulfil the right to health for those within its jurisdiction. The international community also has a responsibility to assist Mozambique in the fulfilment of its human rights obligations, including through international assistance and cooperation.[4] NGOs, health professionals, businesses and others also have important responsibilities regarding the right to health in Mozambique.[5]

12. In addition to its international legal obligations, the Government of Mozambique has committed to achieving various health-related goals through its participation in recent international and regional conferences including the Millennium Summit of the General Assembly, the Third United Nations Conference on Least Developed Countries, the International Conference on Population and Development, the Fourth World Conference on Women, the World Summit for Social Development, the United Nations General Assembly Special Session for Children, the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance, the United Nations General Assembly Special Session on HIV/AIDS, the African Summit on Roll Back Malaria, and the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.[6] The Government has endeavoured to translate these commitments into operational initiatives at the national level, including through the Action Plan for the Eradication of Absolute Poverty 2000-2004 (PARPA), the National AIDS Strategy and other health-related policy documents.

B. Domestic legal framework

13. Despite its manifold historical challenges, Mozambique has made remarkable progress from colonial status towards a democratic State that enjoys free and fair elections and that endeavours to respect the full range of fundamental freedoms and human rights. According to its Constitution, the protection and promotion of human rights is a fundamental aim of the Republic of Mozambique.[7] The Constitution guarantees that all citizens shall enjoy the same rights and duties regardless of colour, race, sex, ethnic origin, place of birth, religion, educational level, social position, the legal status of their parents, or their profession, and that men and women shall be equal before the law in all spheres of political, economic, social and cultural

affairs.[8] With regard to health care, article 94 of the Constitution provides that "all citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and preserve health". The Constitution states that "medical and health care for citizens shall be organized through a national health service which shall benefit all Mozambicans".[9]

14. The Government has recently adopted legislation, and other related regulations, on certain health-related issues. In February 2002, for example, legislation was adopted to protect people living with HIV/AIDS from discrimination in the workplace and to combat stigma and exclusion related to HIV/AIDS. Law 5/2002 includes provisions to ensure privacy and confidentiality, voluntary testing and counselling, and access to treatment and care for people living with HIV/AIDS. In April 2004, recognizing the devastating impact of HIV/AIDS on women, men and children in Mozambique, the Ministry of Industry and Commerce issued a compulsory licence in order to make HIV/AIDS-related drugs more affordable and accessible. The Special Rapporteur commends the Government for these initiatives, all of which are vital to the realization of the right of everyone to the enjoyment of the right to health in Mozambique.

15. Legislation related to mental health in Mozambique, however, is seriously outdated. Moreover, there is currently no legal recourse for the specific protection of patients' rights. **The Special Rapporteur urges the Government to review and revise its mental health legislation to ensure compliance with the right to health and other relevant human rights. He further encourages the Government to consider the adoption of a charter for the protection of patients' rights**. The task of drafting such a charter could be assigned to a national human rights institution (see next paragraph).

C. National human rights institution

16. An independent national human rights institution can help to promote and protect human rights, including the right to health, by working closely with Government, the judiciary, the private sector and civil society. **The Special Rapporteur encourages the Government of Mozambique to establish a national human rights institution, in accordance with international standards, as a means of strengthening human rights capacity within the country. The institution should also give careful attention to the preparation of a charter for the protection of patients' rights**.

II. THE ENJOYMENT OF THE RIGHT TO HEALTH IN MOZAMBIQUE: SOME KEY ISSUES

17. The prioritization of health in Mozambique's poverty reduction strategy paper, the development of health-related sectoral and intersectoral plans, and the adoption of legislation related to the right to health reflect the commitment of the Government to addressing the country's health problems. Nevertheless, although they have improved significantly in recent years, health indicators in Mozambique remain extremely weak, and the barriers to realizing the right to health for those living in poverty are formidable. The following paragraphs highlight some of these barriers, and the challenges inherent in overcoming them. The Special Rapporteur

recognizes the negative legacy on the health system of the civil war (1976-1992), as well as the colonial neglect of health care prior to independence. He also recognizes the impact of recent humanitarian disasters, including famines and the floods which destroyed part of the country's health infrastructure in 2000/01. Any assessment of health in Mozambique must be understood in this context.

A. Poverty

18. Health problems in Mozambique must also be understood in the context of widespread poverty. In the UNDP Human Development Index (2003), Mozambique was ranked 170 out of 173 countries. Mozambique's gross domestic product is US$ 230 per capita, well below even the average for least developed countries (LDCs). Approximately 70 per cent of the population live below the poverty line.[10]

B. Prevention, treatment and control of diseases

19. In Mozambique, HIV/AIDS, malaria, diarrhoea and tuberculosis are major causes of morbidity and mortality. An estimated 13-16 per cent of Mozambique's population is living with HIV/AIDS.[11] Malaria accounts for 30-40 per cent of under-five deaths, and is a particular problem in some rural areas.[12] Water- and sanitation-related diseases, such as diarrhoea, cholera, dysentery, malaria, scabies and schistosomiasis, are widespread and account for a large part of ill-health reported by communities. Mozambique is also vulnerable to outbreaks of meningococcal meningitis and bubonic plague, in particular in urban areas. Leprosy continues to affect people in certain parts of the country, although in recent years significant progress has been made towards its eradication.

20. The prevention, treatment and control of epidemic, endemic, occupational and other diseases is a central obligation of the right to health.[13] States must take steps to ensure access to goods, facilities and services for the prevention and treatment of diseases, including ensuring access to medication related to HIV/AIDS, malaria and tuberculosis; establish prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases; and ensure access to adequate sanitation and potable drinking water.

21. The Special Rapporteur commends the commitment and leadership demonstrated by the Government of Mozambique, at the highest levels, in its efforts to combat HIV/AIDS through a comprehensive and multisectoral approach. A National AIDS Council was established in 2000 in order to coordinate activities by Government, civil society, donors, and international and national NGOs. The Council has focused on prevention efforts, education and outreach, and care and support activities. Education on HIV/AIDS has been introduced in school curricula. Approximately 25 voluntary counselling and testing (VCT) centres have been created with support from NGOs, while national guidelines on VCT and the prevention of mother-to-child transmission have been developed and promoted. Major initiatives are under way to enhance prevention, treatment, care and support activities throughout the country, including through funding from the Global Fund and the World Bank Multi-Country AIDS Project.

22. Significant challenges remain, however, including the urgent and overarching need to strengthen health-care infrastructure and human resource capacity throughout the country, in particular in light of recent initiatives to scale up access to treatment and prevention. Stigma and discrimination against people affected by HIV/AIDS are still widespread, in spite of awareness-raising efforts by the Government, NGOs and civil society. Health services and facilities remain inaccessible to many Mozambicans, particularly the most marginalized populations such as women in rural areas. Very few Mozambicans - less than 1 per cent of those in need - are receiving treatment for HIV/AIDS, although progress is now possible owing to a major drop in the cost of antiretroviral (ARV) drugs and the political will to deliver treatment through the public sector.[14] At the time of writing, the National AIDS Council was in the process of revising Mozambique's national strategic plan to address these developments and challenges, focusing in particular on strategies for scaling up prevention, care and treatment. **The Special Rapporteur has been assured that implementation of the National Strategic Plan will significantly increase the number of people receiving treatment. He recommends that this anticipated development be monitored closely.**

C. Women's health

23. According to the *National Human Development Report* (HDR), policies intended to promote the advancement of women, including with regard to access to health services, are not yet producing the desired effects. Mozambique's maternal mortality rate is among the highest in the world - a recent estimate put it at 1,083 deaths per 100,000 live births.[15] Sexually transmitted infections disproportionately affect women. An estimated 57 per cent of those living with HIV/AIDS are women. Women also suffer disproportionately from the epidemic since they bear the burden of caring for people living with HIV/AIDS. Early pregnancy and unsafe abortions are both reportedly widespread.[16] Violence within the family, communities and schools, including sexual violence, is another particular health problem facing women and girls in Mozambique, although the scale of the problem is unclear.[17] The Government of Mozambique has an obligation to ensure the right to health of women, through, inter alia, taking measures to eliminate discrimination against women in the field of health and ensuring that women have access to appropriate services in connection with pregnancy.[18] This includes empowering women to make decisions in relation to their sexual and reproductive health, free of coercion, violence and discrimination. **The Special Rapporteur urges the Government to continue its efforts to promote gender equality and tackle discrimination against women in the field of health, including through combating gender-based violence.**

D. Child and adolescent health

24. The health of children is a particularly critical issue - 44.5 per cent of Mozambique's population is under 15 years of age.[19] According to a recent study, around 30-40 per cent of children suffer from chronic malnutrition.[20] The mortality rate for children under 5 is estimated at 219 per 1,000 live births.[21] While this is a significant improvement from 277 per 1,000 live births in 1994, the HIV pandemic will likely halt or reverse this decline.[22] Adolescents face health problems, including those relating to the high incidence of pregnancy, abortion, high rates of HIV infection and early marriage of girls.

25. As a State party to the Convention on the Rights of the Child, the Government of Mozambique has an obligation to give effect to the right of the child to health, including by taking steps to diminish infant and child mortality, ensure medical assistance to children, and combat disease and malnutrition.[23] **The Special Rapporteur reiterates the recommendations made by the Committee on the Rights of the Child in 2002.**[24]

III. HEALTH-RELATED POLICY FRAMEWORKS

26. The Government's overarching policies in relation to poverty reduction, including health-related elements, are elaborated in its poverty reduction strategy paper, the Action Plan for the Eradication of Absolute Poverty 2000-2004 (PARPA). Within the broader framework of PARPA sit sectoral and intersectoral plans of central relevance to health, including the Health Sector Strategic Plan (PESS), the National Water Plan (NWP) and the National Strategic Plan on HIV/AIDS. The Millennium Development Goals, as well as other commitments made at international conferences, provide a framework of internationally agreed goals and targets to be met at the national level in Mozambique. The United Nations Development Assistance Framework (UNDAF) sets out the common framework for United Nations agencies' development cooperation in Mozambique.

27. Overall, there is much congruence between the Government's health vision and the right to health. This is reflected in the mission statement of the Ministry of Health[25] which, as PESS observes: "encapsulates the citizens' rights to medical and health assistance and [the Ministry's] obligation to promote and defend health, consecrated in article 94 of the Republic's Constitution".[26]

28. Major components of PESS also correspond with the right to health. For example, the priority given to maternal and child health, and to providing health care to people living in poverty, are consistent with the principles of non-discrimination and equality, which lie at the heart of the right to health. The emphasis on prevention, education, and improving nutrition reflects the obligation on States to address the underlying determinants of health, such as health education and nutrition.

29. However, with the exception of UNDAF, policy documents do not articulate relevant policies, strategies and objectives within the framework of the right to health and other related human rights, although reference is made to human rights in places.

30. **The Special Rapporteur recommends that right to health and related human rights be mainstreamed into all national and international policy documents, and that technical assistance be provided where required. Policies based on human rights norms, including the right to health, are more likely to be effective, robust, sustainable, inclusive, equitable and meaningful - especially for the most vulnerable and disadvantaged members of society.**

31. **In particular, the Special Rapporteur urges the Ministry of Health to integrate the right to health throughout its activities as a means of reinforcing important elements of existing strategies such as community participation, poverty reduction, gender equality and accountability. For example, domestic and international human rights frameworks should**

be explicitly recognized and integrated in the revision of PESS. The international community, in particular donors and intergovernmental organizations, should be encouraged to assist Mozambique in fulfilling its human rights obligations by supporting the development and implementation of health-related policies. The Special Rapporteur recommends that the human rights components of UNDAF be strengthened and extended further in the process of review. He encourages all agencies, including WHO, increasingly to integrate human rights, and the right to health in particular, into their work.

32. **The Special Rapporteur underscores the crucial importance of monitoring and accountability in relation to the right to health in Mozambique, both at the national level and with regard to international assistance and cooperation. National and international policies require effective mechanisms for ensuring transparency and accountability. For example, when discharging their responsibilities of international assistance and cooperation, donor Governments and institutions must be as transparent as possible. If a Mozambican stakeholder wishes to know how a developed State is contributing to the realization of the health-related Millennium Development Goals in Mozambique, this information should be readily available. Moreover, the reasons for partners' policies should be clear and accessible. Any major shifts in policy should be foreshadowed, explained and discussed. The Government, civil society and the people of Mozambique are entitled to this information and process; such transparency is one of the qualities that distinguishes the discharge of an international responsibility from an act of charity.**

A. Poverty reduction

33. Poverty reduction can be a positive force for the realization of the right to health and other human rights, and vice versa. Appropriately, health is one of six priorities of PARPA "aimed at promoting human development and creating a favourable environment for rapid, inclusive and broad-based growth".[27] PARPA outlines several key health objectives in the context of poverty reduction, including an expansion of, and improvement in, primary care focusing on programmes targeting women and children; a campaign to reverse the growth of the HIV/AIDS epidemic; greater efforts in the fight against endemic diseases such as malaria, TB, diarrhoea and leprosy; development of human resources; and other important health-related objectives such as increased food security and supply of clean drinking water and sanitation.

34. These objectives are consistent with right-to-health norms such as ensuring universal access to primary health care; the prevention, treatment and control of HIV/AIDS, malaria and tuberculosis; reducing child and maternal mortality; enhancing access to safe and effective methods of contraception; ensuring access to potable water; and eliminating gender inequity in access to health care. Nevertheless, PARPA does not, at present, seem to adequately address some human rights concerns relating to poverty in Mozambique, including the situation of some particularly marginalized groups, such as children affected by HIV/AIDS. **The Special Rapporteur recommends that greater attention be given to integrating human rights, in particular the human rights of vulnerable groups, into PARPA during the review process. Particular attention should be paid to addressing inequalities between men and women, as well as the impact of poverty on vulnerable groups, such as children affected by HIV/AIDS.**

35. The health objectives of PARPA reflect the health-related Millennium Development Goals, such as reducing infant and maternal mortality, combating malaria and improving access to safe water. Some targets set within the PARPA framework, however, appear to differ from the Millennium Development Goal targets. **Given international commitment to the Millennium Development Goals, including by the World Bank, the Special Rapporteur recommends that the Government integrates Millennium Development Goal targets into PARPA when it is updated, and that the Government and the international community devote maximum resources to ensuring that the Millennium Development Goals become a reality.**

B. Non-discrimination and equality

36. Discrimination on grounds of gender, race, ethnicity and other factors is a social determinant of health. Social inequalities, fuelled by discrimination and marginalization of particular groups, shape both the distribution of diseases and the course of health outcomes amongst those afflicted. As a result, the burden of ill-health is borne disproportionately by vulnerable and marginalized groups in society. At the same time, discrimination and stigma associated with particular health conditions, such as mental disabilities, and diseases - like HIV/AIDS - tend to reinforce existing social divisions and inequalities.[28]

37. The Government has identified a "continual need to prioritize disadvantaged population groups"[29] and has adopted policies that implicitly or explicitly address the health problems of some disadvantaged groups, in particular women living in poverty and rural populations. This resonates with the important human rights principles of non-discrimination and equality.

38. An important element of addressing discrimination is identifying affected groups. The collection of sufficient and reliable health data, disaggregated according to the prohibited grounds of discrimination, can be particularly helpful for identifying discrimination or disparities in the enjoyment of the right to health.[30] Much of Mozambique's data on health are disaggregated by region and by rural/urban location. The Special Rapporteur also welcomes a suggestion in PESS to incorporate into the monitoring system data on access to health care disaggregated on the basis of gender.[31] However, effectively combating discrimination requires the identification of individuals and groups at risk, followed by the development and implementation of appropriate policies and legislation. The disaggregation of health data by prohibited grounds of discrimination is an important step in this process. The international community should help to develop the capacity of Mozambique to gather such disaggregated data.

39. Gender. The Special Rapporteur commends the Government of Mozambique for establishing gender mainstreaming as a national priority. One positive development in this regard is the recent establishment of a Ministry for Women and Social Affairs Coordination. Particular attention is given to gender issues in PESS which states that gender should be "analysed from the point of view of social justice and human rights", and strengthened "in every health programme". PARPA contains a focus on improving access to, and the quality of, health care for women, in particular reducing the maternal mortality rate and expanding the coverage of institutional births.[32] PESS proposes various gendered health strategies, including researching

the relationship between gender and health, training health professionals on gender issues, promoting gender equality, promoting reproductive health rights, and the adoption of legal protection measures against sexual abuse and physical or domestic violence.[33] A study on violence is currently being carried out by WHO, UNDP, UNICEF and the Ministries of Health and Justice, with a view to the development of a plan to combat violence against women.

C. Availability, accessibility and acceptability of health care

40. The right to health includes an entitlement to health-care services, goods and facilities which are *available, accessible, acceptable* and of adequate *quality*.[34] Over the course of his mission, several concerns related to these vital dimensions of the right to health in Mozambique were brought to the attention of the Special Rapporteur.

41. Health facilities, goods and services have to be available and accessible - both physically and economically - to everyone, without discrimination. Access to health care in Mozambique is hindered by a number of factors including an insufficient number of health-care facilities, a severe shortage of health professionals, weak civil society participation in decision-making processes and reported corruption in the health sector. These factors all have a bearing on the enjoyment of the right to health.

42. Overall, about 40 per cent of the population who report illness in Mozambique do not seek care, according to a 1999 survey. The two main reported reasons for this are the distance to facilities and lack of money.[35]

43. Physical accessibility. The Government of Mozambique has made significant efforts to expand the rural health network around the country. In the period between independence and 1985, the number of health posts in the country increased from 326 to 1,195.[36] During the civil war, however, many of these facilities were targeted and destroyed or looted. Since 1994, the Government has focused on rehabilitating health infrastructure and improving health facilities, including in rural areas. More than 400 health facilities have been rehabilitated or newly built, although there has reportedly been slow progress in expanding health-care services to new locations. To its credit, the Government plans to build new, and rehabilitate existing, health centres and rural hospitals, and the Ministry of Health is also investigating innovative approaches such as mobile clinics, as well as health posts with pharmacies and community agents.[37]

44. In spite of these efforts, however, it is estimated that only 50 per cent of the population has access to basic preventive and curative services.[38] In rural areas distance is particularly prohibitive: on average the mean distance for rural households is 46 kilometres to a doctor, 21 kilometres to a midwife, and 19 kilometres to a health post.[39] There are also reportedly inequities in access to health-care facilities between regions. The Special Rapporteur commends the Government for its commitment to increasing the availability and accessibility of health-care services, goods and facilities. **He urges the Government to enhance its efforts towards ensuring access to health services for rural populations, including through training and recruitment of more health professionals.**

45. Economic accessibility. The distance to health-care facilities can be a problem where patients have to pay a significant sum for transportation to reach them. The charging of user fees was also an issue raised by many organizations and individuals over the course of the Special Rapporteur's mission.

46. In accordance with Law 4/87 of 19 January 1987, official user fees for admission and consultation are set at a relatively low rate.[40] Exemptions exist for certain services, such as the prevention and care of sexually transmitted diseases, and for certain groups such as the elderly, children under 5 years of age, the poor and so on. In theory, such exemptions can help to ensure equitable access. However, some of those whom the Special Rapporteur met expressed the opinion that the user fees system still acts as a barrier for people living in poverty.[41] One report, published by the World Bank, captures some of these criticisms:

> "In the reality the system is complex and rarely functions. There are no clear guidelines defining exemption categories or giving instructions on how to collect fees and how to use the funds collected. The categories that are difficult to define, such as the poor, do not get exempted, and even if the people get exempted from official fees, in order to actually get services, they have to pay unofficial charges … [T]he system is clearly hurting the poor and increasing inequality."[42]

47. In addition to charges established by law, the illicit charging of user fees is reportedly a significant problem in Mozambique.

48. While official user fees are set at a relatively low rate, a recent study investigated the effect of eliminating user fees at rural health posts from the current rate of 1,000 meticais (Mt), and found that this would increase the mean predicted probability of seeking care by more than 10 per cent. The study also projected increasing user fees to Mt 5,000 and found that this would result in a large reduction in health-care demand and the likelihood that people would not consult a medical practitioner in the event of illness.[43] In other words, according to this study, user fees do inhibit access to health care at least in the setting of primary care, and any increase may act as a further deterrent to seeking essential care.

49. The issue of user fees has been addressed in recent years in the policy documents of the Government and the international financial institutions. Currently, user fees yield about 3 per cent of total government health revenue. PARPA envisages a possible role for cost recovery through user fees in the public health sector.[44] The Special Rapporteur understands that the Government is against charging user fees for the purpose of cost recovery. In his meetings with the World Bank, he was informed that the Bank does not currently have a formal position on user fees in Mozambique. In the past the international financial institutions had encouraged the Government to pursue cost recovery through user fees.[45]

50. In many countries, user fees tend to exclude the poor and other marginalized groups from essential services,[46] and this may be considered to be inconsistent with the right to health. Thus, the Special Rapporteur is strongly inclined to recommend the abolition of user fees in Mozambique on the grounds that they constitute an obstacle to access, especially for those living in poverty.

51. However, the evidence is less clear on some details. For example, what would be the impact of abolishing user fees at the lowest level of delivery and for any subsequent referral to the higher levels, while retaining a small fee for a patient who elects to go directly to the secondary level without a referral? Such an approach would encourage patients to attend initially the lowest level of delivery, which may relieve unnecessary congestion in the upper levels. On the other hand, such an arrangement would only be fair if the entire population has equally convenient access to primary care facilities.

52. **Thus, the Special Rapporteur recommends that the Ministry of Health establish an independent review of user fees, with technical support from WHO. The review should determine whether user fees impede access, especially for those living in poverty, women and other disadvantaged groups and, if so, whether user fees should be abolished across the board or retained in some limited circumstances, such as the one indicated in the preceding paragraph. The review should include user fees for medical services and medicines. The review process should include the participation of disadvantaged groups. The Special Rapporteur also recommends that the donor community in Mozambique takes a clear position on user fees in the health sector, taking into account (i) evidence of the impact of user fees on those living in poverty and (ii) the human rights obligations of the Government to deliver medical services without discrimination in law or fact. If evidence confirms that user fees inhibit access to care, especially for those living in poverty and other disadvantaged groups, then prima facie their introduction or retention is inconsistent with the right to health.**

53. Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned. Several issues relating to acceptability were raised over the course of the Special Rapporteur's meetings. One reported problem was a lack of respect of some health professionals for their patients. The Special Rapporteur also received information about cases of disclosure of information by health professionals concerning the HIV/AIDS status of patients. **He urges health professionals to respect, at all times, the human rights of patients and recommends that human rights form a compulsory part of their training.**

D. Health professionals

54. The right to health requires that functioning public health and health-care facilities, goods and services be available in sufficient quantity. This includes trained health professional personnel receiving domestically competitive salaries.[47]

55. There is a serious shortage of health professionals in Mozambique. A recent estimate suggests that there are only 3 doctors per 100,000 population.[48]

56. A major objective of the Government of Mozambique is to increase the coverage of the health service by making facilities more accessible. Both PARPA and PESS signal that human resources in the health sector need to be enhanced.[49] However, without a significant increase in

the number of health professionals at all levels, the Special Rapporteur is concerned that the Government of Mozambique will not be able to establish a health system consistent with its right-to-health obligations. **The Special Rapporteur strongly recommends that the human resources component of the Government's existing health strategy receive much more attention, and attracts much more investment, than hitherto.**

57. The issue is multifaceted. There is a need to train more health professionals. Given the short duration of his mission, the Special Rapporteur was not able to gather adequate information on the number of health professionals that would be required to meet the health needs in Mozambique, or which type of health professional should be prioritized. However, he notes that such priority-setting must be undertaken consultatively with all relevant stakeholders.

58. The training of more health professionals will not be possible without improving and extending Mozambique's medical training capacity. Since 1975, the Faculty of Medicine at the Universidade Eduardo Mondlane, which is the only university training doctors, has only graduated on average 21 doctors a year.[50] This number is particularly low in view of the current shortage of doctors. A considerable increase in investment will be needed in Maputo Central Hospital and selected provincial facilities with a teaching function, to train more doctors and other health professionals.

59. A further dimension is the need to improve the terms and conditions of health professionals. Health professionals working in the public sector, in particular higher- and middle-ranking health professionals, are paid below the market rate. According to information received by the Special Rapporteur, this contributes to further problems such as the illicit charging of user fees. Problems are not confined to the levels of remuneration, but also affect the availability of basic materials and equipment needed by health workers to carry out their functions in a professional manner and with safety. Improving terms and conditions of employment will increase the retention rate in the profession, improve morale and reduce corruption in the health sector.

60. The training, recruitment and employment of health professionals demand significant resources. During his mission, the Special Rapporteur was advised that the Common Fund established under the memorandum of understanding of November 2003, a commendable initiative by which many bilateral donors have pooled their international development assistance under the control of the Ministry of Health, could be used to enhance human resources in the health sector. Moreover, he was informed that any budgetary ceilings would not extend to the Common Fund. **The Special Rapporteur urges the Government of Mozambique and its funding partners to consider increasing the resources available under the Common Fund in order to address the urgent need for more health professionals, as well as for better terms and conditions of employment.**

61. Mozambique would benefit from a statutory medical council responsible for regulating, registering, supporting and disciplining health professionals.[51] **The Special Rapporteur encourages the Government to consult extensively with health professionals and other interested parties in relation to the proposed structure, mandate and powers of a medical council, including whether one council should be responsible for all health professionals,**

or whether different councils should be established for different types of health professionals. The Special Rapporteur suggests that the Government might approach the Commonwealth Secretariat to enquire whether they could provide technical assistance to establish a medical council.

E. Water and sanitation

62. The right to health extends beyond the right to health-care services and includes the right to underlying determinants of the right to health such as water and sanitation. In Mozambique, water and sanitation are characterized by low levels of coverage, poor services delivery and weak sustainability;[52] 75 per cent of the rural population and 60 per cent of the urban population lack access to adequate sanitation facilities, and 71 per cent of rural and 64 per cent of the urban population do not have access to safe water supplies. Water- and sanitation-related diseases such as malaria, cholera, diarrhoea, scabies and schistosomiasis are common.[53]

63. The Government has made some progress towards improving access to safe drinking water and adequate sanitation. A National Water Policy was developed in 1995, followed by a Rural Water Transition Plan in 1997. Efforts have been made to establish an institutional framework for implementation of these policies. However, major gaps will need to be addressed in order to meet the Millennium Development Goals, including the need to ensure adequate programmes to promote sanitation and hygiene behaviour; the involvement of users in the implementation of projects; and the empowerment of women as "agents of change" in hygiene practices.[54] **Particular attention must be paid to addressing the needs of rural populations. The Special Rapporteur also urges the Government of Mozambique and its funding partners to establish a Common Fund for water and sanitation services, along the lines of the Common Fund for the health sector.**

F. Availability of resources

64. International human rights law recognizes that realizing many aspects of the right to health demand resources. It creates obligations on States to progressively realize the right to health, in accordance with maximum available resources, including resources available from the international community. The four major sources of funds for health financing in Mozambique are the Treasury, bilateral and multilateral funders, employers and households. **Under international human rights law, States have primary responsibility to make resources available for the realization of the right to health. Thus, it is incumbent on the Treasury to make maximum resources available for improving health outcomes in the country. The Special Rapporteur also stresses the responsibility of the international community to provide assistance and cooperation in a manner supportive of Mozambique's efforts to implement its international human rights obligations.**

65. National level. The national budget, and other relevant budgetary frameworks relating to Mozambique, should reflect the Government's obligations towards the right to health by allocating maximum available resources to the right to health. Under the Heavily Indebted Poor Country (HIPC) and Enhanced HIPC (eHIPC) initiatives, expenditure on health has risen in

recent years, both in real terms and as a proportion of total government expenditure (1998 - 7.1 per cent; 1999 - 9.0 per cent; 2000 - 10.1 per cent).[55] As a proportion of total government expenditure, this is one of the highest levels in Africa.

66. Despite this, the Special Rapporteur notes that expenditure on health is still extremely low at under US$ 10 per capita. This figure still falls far short of the international recommendation on health expenditure for a minimum basket of interventions of US$ 34 per capita.[56] The Special Rapporteur also regrets that the Government devoted less to expenditure on health in 2003 than in previous years. The Special Rapporteur questions whether health budget allocations are adequate for ensuring the minimum essential levels of the right to health, and reminds the Government that it must ensure that it devotes *maximum available resources* to health, including drawing on resources available from the international community. The Special Rapporteur also notes that in 2002, the Committee on the Rights of the Child expressed concern about the lack of human and material resources of State institutions connected with health, and recommended that the Government increase the proportion of resources spent on health as well as other priority areas, where needed within the framework of international cooperation.[57]

67. Integral to the notion of making more resources available is the timely disbursement of resources. The Special Rapporteur was concerned at reports of delays in funding from donors and delays in disbursement from the central to provincial levels. In the health sector, these delays can be extremely serious, and may amount to a breach of the right to health or life. Another issue is the capacity of the health system to absorb resources: some people remarked that even when resources were made available, they were not used. In addition to increasing resources to the health sector, the Special Rapporteur urges the Government, and donors, to work to redress these problems of delays and absorptive capacity.

68. Over the course of his mission, the Special Rapporteur was alerted, in general terms, to a problem of corruption in Mozambique, including in the health sector. Although the Special Rapporteur was advised that corruption is widespread in the health sector, he was not informed of any specific allegations of corruption. Some NGOs also complained about the reported embezzlement of funds by some civil society organizations.

69. Corruption can act as a severe constraint to the enjoyment of the right to health, for example when resources intended for the health-care system are diverted into private pockets, or when bribery comes to define priorities. Those living in poverty inevitably suffer the worst in the face of corruption. Integral features of the right to health include participation, access to information, transparency, monitoring and accountability. Each of these features helps to establish an environment in which corruption cannot survive. **In other words, a right-to-health policy is also an anti-corruption policy.**

70. The Special Rapporteur has received information that since his visit, the Government has adopted a law against corruption.[58] PARPA also contains a commitment to prevent the spread of corruption, reduce its occurrence amongst public sector workers and adopt regulatory mechanisms aimed at prevention, investigation and prosecution of corrupt practices.[59] **In line with the obligation of the Government, including its civil servants, to respect the right to**

health, and the obligation of the Government to protect the right to health from interference by third parties, the Special Rapporteur urges it to take all appropriate action to combat corruption in the health sector. He recommends that the Ministry of Health integrate the right to health - including the features of transparency and accountability - into all its policies and programmes, and publicly renew its commitment to remove all corruption from the health sector.

71. International partners. The realization of the right to health in Mozambique is linked closely to donor assistance. Donors make significant contributions to the health sector as a percentage of overall expenditure, estimated at around 50-60 per cent. PARPA includes an objective of reducing dependence on external financing as a percentage of GDP.[60] While dependence on aid is a serious issue, any aid reduction must not jeopardize health objectives associated with the Millennium Development Goals and minimum essential levels of the right to health. The Special Rapporteur stresses that the provision of financial and technical assistance by developed States to the Government of Mozambique is not an act of charity. It is an international responsibility arising from obligations of international assistance and cooperation enshrined in binding international human rights treaties, such as CRC and ICESCR. As CESCR has stated, "Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required."[61] The United Nations Millennium Declaration and other international conference documents confirm the shared responsibility of all actors for the eradication of extreme poverty, while Millennium Development Goal 8 places particular responsibilities on developed States, including to increase development assistance to countries committed to poverty reduction. Thus, it is incumbent on developed States to provide international assistance and cooperation to the Government of Mozambique. **While the bilateral and multilateral partners already make an indispensable contribution to the health sector, it is strongly recommended that they increase their financial and technical assistance to the health sector in Mozambique.**

72. In recent years, bilateral and multilateral cooperation partners have developed a more integrated and coordinated approach in relation to their financial and technical assistance in the health sector. For example, the Kaya Kwanga Commitment (Code of Conduct) and the memorandum of understanding in respect of the Common Fund for Support to the Health Sector (November 2003) represent significant progress. The Common Fund should help ensure that the Ministry of Health has greater control over allocation of donor resources in accordance with national priorities. However, some major partners, notably USAID and Japan, have declined to become signatories to the memorandum of understanding. Thus, the Government of Mozambique has to manage bilateral arrangements in the health sector, as well as the Common Fund, which tends to aggravate its systemic lack of capacity.

73. **Accordingly, the Special Rapporteur recommends that all bilateral and multilateral cooperation partners develop an integrated and coordinated approach in the health sector that is as comprehensive, simple and efficient as possible. In particular, he recommends that USAID and Japan join the Common Fund. The need for greater integration and coordination is not confined to the health sector as represented by the Ministry of Health**

and reflected in the memorandum of understanding of November 2003. For example, a comprehensive memorandum of understanding in relation to the Ministry of Public Works and Housing (whose responsibilities bear closely upon the health of the people of Mozambique) should be negotiated as soon as possible. Bilateral and multilateral partners should ensure that all contributions made under the Common Fund, or other arrangements, are paid promptly according to the agreed schedule.

74. **In addition to the contribution made by financial donors, the vital role played by the United Nations system in Mozambique, including through the provision of technical cooperation and assistance, must be recognized, supported and enhanced.**

75. International financial institutions. The international financial institutions (IFIs) have played a major role in Mozambique since the mid-1980s, through adjustment programmes, investment support and technical assistance. **The Special Rapporteur emphasizes that it is incumbent on the IFIs to respect the domestic and international human rights obligations of the Government of Mozambique. They must not pursue policies, or encourage the Government to pursue policies, that are inconsistent with the Government's human rights obligations.** The Special Rapporteur encourages the use of impact assessments by IFIs (and other actors) to determine the effect of policies or projects on people living in poverty or other marginalized groups, such as women, children, and people living with HIV/AIDS.

76. The Special Rapporteur acknowledges the importance of the HIPC and eHIPC initiatives from the point of view of the right to health. Resources freed up under HIPC and eHIPC are allocated to key anti-poverty programmes and, from 1997 to 2002, debt relief had reportedly contributed Mt 110 billion to the health sector.[62]

77. As well as setting out national policy priorities for the Government, PARPA provides a basis for programme support by the IFIs and has become a significant platform for donor and United Nations assistance. While PARPA is a nationally owned document, it must be endorsed by the IMF and the World Bank if it is to attract programme support from these institutions. **The Special Rapporteur recommends that when the IFIs assess and make recommendations on Mozambique's country-owned strategies, including Joint Staff Assessments, they take into consideration Mozambique's national and international human rights obligations.**

78. Despite the significant focus on health in the Millennium Development Goals, the health sector does not appear to be a priority for the World Bank in its assistance to Mozambique. The World Bank's support of the health sector is very modest, approximately 13 per cent of total World Bank support, compared to 14 per cent in water and sanitation, 16 per cent in education, and 38 per cent in transport.[63] The first poverty reduction support credit (PRSC) disbursed by the World Bank does not include funds for the health sector. **The Special Rapporteur is concerned at this limited support and suggests that the World Bank include a greater focus on assistance to the health sector. He encourages the World Bank to ensure that its second PRSC gives due attention to the health sector, in addition to other sectors vital to poverty reduction, human rights and health, such as water and sanitation.**

IV. PARTICIPATION: THE ROLE OF CIVIL SOCIETY

79. While States have obligations to give effect to human rights, engagement of civil society is essential for the enjoyment of rights. PARPA and PESS both stress the importance of civil society participation. Some consultation was carried out with civil society in the development of the PARPA and health sector plans,[64] although some civil society organizations reported that the participatory processes had not adequately engaged civil society. The Government is also in the process of developing a policy of community participation in health. The Special Rapporteur endorses efforts to enhance participation of civil society in relation to health policies, programmes, and other health-related initiatives.

80. The policy of enhancing participation resonates closely with the human right to participate and other related human rights, such as the right to take part in the conduct of public affairs. An important element of the right to health is the participation of the population in all health-related decision-making at the community, national and international levels. This principle is reflected in the Constitution of Mozambique which provides that "the State shall promote the participation of citizens and institutions in the raising of the level of public health".[65]

81. **The Special Rapporteur encourages the Government to actively seek the engagement of civil society, including NGOs and marginalized groups such as women, children, the elderly, and people living with HIV/AIDS, in the health sector. For example, the meaningful participation of civil society should be a key feature of the review of PARPA.**

82. **The Special Rapporteur also recommends that the media be kept closely informed of government initiatives in the health sector. An independent media can help to enhance grass-roots participation and community responsibility, and will have a crucial role to play in any comprehensive and effective public information campaign on HIV/AIDS. The Government should regard the media as an ally in the struggle for a pro-poor health system and against corruption in the health sector and beyond. For its part, the media should provide accurate reporting of health issues.**

83. Civil society groups have been very actively working to improve the health situation for Mozambicans living in poverty. Many of these impressive initiatives have not been explicitly grounded in human rights, even though there was much congruence between them and human rights norms and principles. The value added of human rights is that they give rise to entitlements, obligations, accountability and participation, and can help empower communities - but to do this, human rights have to be known. **The Special Rapporteur suggests that civil society organizations could make more use of the explicit language of human rights, including the right to health, in their activities and campaigns.**

84. PESS recognizes that, in general, community participation is still weak and sporadic. It notes: "up till now, community participation has implied collaboration in the execution of health programmes rather than in planning, monitoring, assessment and management of some health activities".[66] Current health structures reportedly do not work with local communities to develop the most appropriate forms of service delivery, and this lack of engagement can lead to lower utilization of services.[67] A human rights approach to health requires active and informed

community participation including in the formulation, implementation and monitoring of health strategies, policies and programmes. Community support can also generate an environment conducive to effective voluntary HIV/AIDS testing and counselling; campaigns for the prevention of HIV transmission in young people; and treatment compliance, as well as more generally for reducing stigma.

V. CONCLUSIONS AND RECOMMENDATIONS

85. **The Special Rapporteur's specific conclusions and recommendations are reflected throughout the present report. Here, he emphasizes a few particularly crucial general concluding observations.**

86. **The commitment of the Government of Mozambique, together with its bilateral and multilateral funding partners, to addressing health challenges in Mozambique is clearly reflected in the prioritization of health in national poverty reduction strategies, as well as the development of sound policies, strategies and regulations in the health sector. However, in order to make these initiatives more sustainable and equitable the Special Rapporteur urges the Government to explicitly integrate human rights norms, including the right to health, into all national and international policy documents, with particular attention to key human rights principles such as participation, non-discrimination, equality, access to information, transparency, monitoring and accountability. In this context, he urges that technical assistance be provided to the Government where required.**

87. **The Special Rapporteur underscores the need to address the discrepancy between the many commendable policy initiatives in Mozambique and the country's capacity to implement them in practice. The Government and its bilateral and multilateral cooperation partners are encouraged to develop an integrated and coordinated approach in the health sector that is as comprehensive, simple and efficient as possible.**

88. **The Special Rapporteur recalls the central role played by health professionals in health service delivery. He underscores the need to increase significantly the number of health professionals and improve their working terms and conditions, including levels of remuneration. Improving terms and conditions will increase the retention rate in the profession and reduce corruption.**

89. **The Special Rapporteur emphasizes that adequate resources must be allocated to the health and health-related sectors, and these resources should address the major right-to-health problems in the country.**

90. **The Special Rapporteur encourages the Government of Mozambique to establish accountability mechanisms that bear upon health-related human rights, including the creation of a national human rights institution; a charter for the protection of patients' rights; and a statutory medical council responsible for regulating, registering, supporting and disciplining health professionals. He also encourages the Government to ratify ICESCR, which provides a form of international accountability.**

91. **The Special Rapporteur encourages the Government to actively enhance community participation in the health sector, including by way of close collaboration with NGOs.**

Notes

[1] The Special Rapporteur also requested a meeting with the International Monetary Fund country office.

[2] The Special Rapporteur issued a press release with preliminary observations on his mission on 23 December 2003 - see www.ohchr.org/news.

[3] See preliminary report of the Special Rapporteur to the Commission on Human Rights (E/CN.4/2003/58, paras. 10-21).

[4] E.g. ICESCR, art. 2.1; CRC, art. 4 and art. 24.4. See also general comment No. 14 adopted by the Committee on Economic, Social and Cultural Rights (CESR), paras. 38-42.

[5] See UDHR, preamble, and CESCR general comment No. 14, para. 42.

[6] Ministry of Foreign Affairs and Cooperation and the United Nations System, *Inventory of Conference and Convention Follow-up in Mozambique* (2000).

[7] Constitution of Mozambique, art. 6.d (November 1990).

[8] Ibid., arts. 66 and 67.

[9] Ibid., art. 54.1.

[10] S. Chao and K. Kostermans, *Improving Health for the Poor in Mozambique: The Fight Continues,* World Bank (2001), preface.

[11] Report on the Global HIV/AIDS Epidemic, UNAIDS 2002; UNAIDS/WHO Epidemiological Fact Sheet, Mozambique (2002 update).

[12] Mozambique, Millennium Development Goals Report (MDGR), p. 22.

[13] See ICESCR, art. 12; CRC, art. 24; see also general recommendation No. 24 adopted by the Committee on the Elimination of Discrimination against Women.

[14] *Strategic Plan for Scaling up HIV/AIDS Care and Treatment in Mozambique,* The Republic of Mozambique and the Clinton Foundation: Business Plan 5.7, 9 May 2003, p. 21.

[15] Health Sector Strategic Plan (PESS), p. 7.

[16] MDGR, p. 24.

[17] PESS, p. 24; UNDP, Mozambique HDR, 2001, pp. 48-51.

[18] CEDAW, art. 12.

[19] See Health Sector Strategic Plan, p. 4.

[20] Chao and Kostermans, op. cit., p. 3.

[21] PESS, p. 7.

[22] See Mozambique MDGR, p. 4.

[23] CRC, art. 24.

[24] CRC/C/15/Add.172, paras. 50-51.

[25] PESS, p. 20.

[26] Ibid.

[27] See PARPA, p. 3.

[28] See E/CN.4/2003/58, paras. 59-68.

[29] PESS, p. 1.

[30] See Committee on the Rights of the Child, general comment No. 5, para. 48; A/58/427, paras. 5-37; and CESCR, general comment No. 14, para. 11.

[31] PESS, p. 25.

[32] PARPA, para. 138.

[33] PESS, p. 25.

[34] CESCR, general comment No. 14, para. 12. While all four dimensions are very important, because of the constraints of space this report does not devote a section to each.

[35] Chao and Kostermans, op. cit., p. 15.

[36] See M. Lindelow, *Health Care Demand in Rural Mozambique: Evidence from the 1996/97 Household Survey*, International Food Policy Research Institute (2002).

[37] PARPA, para. 141.1; PESS, p. 45.

[38] PARPA, para. 131.

[39] Ministry of Finance (1998), see Chao and Kostermans, op. cit., p. 16.

[40] This is Mt 1,000 in rural outpatient clinics, Mt 5,000 in urban outpatient clinics and Mt 10,000 for inpatients.

[41] Also see Chao and Kostermans, op cit., p. 22.

[42] Ibid., p. 23.

[43] See M. Lindelow, p. 75.

[44] See PARPA, para. 135.

[45] In 1998, the Heavily Indebted Poor Countries (HIPC) Decision Point contained a cost recovery target of increasing the share of receipts in recurrent health expenditure to 10 per cent in 2000, from 2 per cent in 1995, to be verified through preparing new user fees legislation and adjusting user fees to reflect inflation. See International Development Association and the International Development Fund, *Final Document on the Initiative for HIPC*, March 1998, appendix, table 5, p. 36.

[46] *Macroeconomics and Health: Investing in Health for Economic Development*, report of the WHO Commission on Macroeconomics and Health, p. 61; M. Whitehead, G. Dahlgren, T. Evans, *Equity and Health Sector Reforms: Can Low Income Countries Escape the Medical Poverty Trap? The Lancet*, vol. 358, No. 8, September 2001.

[47] CESR, general comment No. 14, para. 11 (a).

[48] World Bank, World Development Indicators, 2001. See M. Haacker, *Providing Health Care to HIV Patients in Southern Africa*, IMF Policy Discussion Paper 2001, p. 4.

[49] PARPA, para. 14.

[50] Figures given by the Faculty.

[51] This role is currently performed by the Ministry of Health.

[52] MDGR, p. 17.

[53] Ibid., p. 16.

[54] Ibid., p. 17.

[55] IMF and IDA, Mozambique HIPC Completion Point Document, 2001, para. 22.

[56] See WHO, report of the Commission on Macroeconomics and Health, op. cit., pp. 53-57.

[57] CRC/C/15/Add.172, para.18.

[58] Law 2004/6.

[59] PARPA, p. 75.

[60] PARPA, para. 60.

[61] CESCR, general comment No. 14, para. 39.

[62] Chao and Kostermans, op. cit., p. 12.

[63] World Bank, *The World Bank in Mozambique* (2003), p. 3.

[64] PARPA, paras. 279-309.

[65] Article 54.3.

[66] PESS, p. 37.

[67] See MDGR, p. 23.
