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MOZAMBIQUE

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Introduction

1. ADF International is a global alliance-building legal organization that advocates for religious freedom, life, and marriage and family before national and international institutions. As well as having ECOSOC consultative status with the United Nations (registered name "Alliance Defending Freedom"), ADF International has accreditation with the European Commission and Parliament, the Fundamental Rights Agency of the European Union, the Organization for Security and Co-operation in Europe, and the Organization of American States.

2. This report evaluates Mozambique's efforts to improve maternal health through legalizing abortion. It discusses how legalization of abortion in Mozambique will lead to greater maternal mortality, because abortion cannot be safe in a country with such poor health infrastructure. The report details the interventions Mozambique instead must implement in order to improve maternal health.

(a) Abortion

Background

3. 76 percent of people in Mozambique consider having an abortion to be morally wrong.[1]

4. However, on 11 July 2014, the Parliament of Mozambique approved a bill on abortion as part of a new penal code. On 18 December 2014, President Armando Guebuza signed it into law. The new provisions legalize abortion in the first 12 weeks of pregnancy on the grounds of physical, psychological, or mental health, up to 16 weeks in the cases of rape or incest, and up to 24 weeks in the case of severe fetal abnormality.

5. The law has been justified by its proponents and by the government on the basis of maternal health. Mozambique has one of the highest maternal mortality ratios (MMR) in the world at 480 deaths per 100,000 live births.[2] The lifetime risk of maternal death, or the probability that a 15-year-old woman will die from a maternal cause at some point in her life, is 1 in 41.[3] An estimated 4,800 women in Mozambique died of pregnancy-related causes in 2013.[4]

6. It has been claimed that 11 percent of maternal deaths in Mozambique are due to "unsafe abortions".[5]

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[1] PEW FORUM ON RELIGION AND PUBLIC LIFE, TOLERANCE AND TENSION: ISLAM AND CHRISTIANITY IN SUB-SAHARAN AFRICA 275 (2010), *available at* http://www.pewforum.org/files/2010/04/sub-saharan-africa-full-report.pdf.
[2] WHO ET AL., TRENDS IN MATERNAL MORTALITY 1990-2013 33 (2014), *available at* http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1 [hereinafter TRENDS].
[3] *Id.*
[4] *Id.*
[5] *See MOZAMBIQUE: Govt considers legalising abortion to stem maternal deaths*, IRIN NEWS, 29 May 2007, http://pai.org/blog/advocates-achieve-liberalization-of-mozambique-abortion-law-after-10-year-effort/ http://www.irinnews.org/report/72421/mozambique-govt-considers-legalising-abortion-to-stem-maternal-deaths.

The right to life in international law

7. The legalization of abortion in Mozambique is not required by international law. There is no international right to abortion. In fact, this so-called right is incompatible with various provisions of international human rights treaties, in particular provisions on the right to life.

8. Article 6(1) of the International Covenant on Civil and Political Rights (ICCPR) states, "Every human being has the inherent right to life." The ICCPR's prohibition of the death penalty for pregnant women implicitly recognizes the right to life of the unborn. Although the ICCPR allows for the death penalty to be imposed on both adult men and women, it explicitly prohibits applying the death penalty to pregnant women. Article 6(5) states, "Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and *shall not be carried out on pregnant women*." This clause must be understood as recognizing the unborn's distinct identity from the mother and protecting the unborn's right to life.

9. As the *travaux préparatoires*[6] of the ICCPR explicitly state, "The principal reason for providing in paragraph 4 [now Article 6(5)] of the original text that the death sentence should not be carried out on pregnant women was to *save the life of an innocent unborn child*."[7] Similarly, the Secretary General report of 1955 notes that the intention of the paragraph "was inspired by humanitarian considerations and by *consideration for the interests of the unborn child*[.]"[8]

10. The protection of unborn life is also found through an ordinary reading of the language in the preamble of the Convention on the Rights of the Child (CRC). The preamble states, "[T]he child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, *before as well as after birth*." Article 6 guarantees the right to life.

Maternal health as human right

11. However, preventable maternal mortality does implicate human rights, in particular the right to health. The right to the enjoyment of the highest attainable standard of health is guaranteed in several international and regional human rights treaties Mozambique is obligated to follow, including the CRC (art. 24), and the African Charter on Human and Peoples' Rights (the Banjul Charter, art. 16).

12. The Universal Declaration of Human Rights in Article 25(2) recognizes that "motherhood and childhood are entitled to special care and assistance." Article 12(2) of the Convention on the Elimination of All Forms of Discrimination against Women requires that states "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." CRC

[6] In accordance with the Article 32 of the Vienna Convention, the *travaux préparatoires* are considered to be a "supplementary means of interpretation."
[7] A/3764 § 18. Report of the Third Committee to the 12th Session of the General Assembly, 5 December 1957.
[8] A/2929, Chapter VI, §10. Report of the Secretary-General to the 10th Session of the General Assembly, 1 July 1955.

article 24(2)(d) requires states to "take appropriate measures [. . .] to ensure appropriate pre-natal and post-natal health care for mothers."

The relationship between abortion prohibition and maternal health

13. Mozambique is right to seek to improve its maternal health record. However, this does not require the legalization of abortion.

14. It has not been proven that a prohibition on abortion results in high maternal morality. Some of the countries where it is safest to be pregnant and give birth have strict abortion laws. For example, in Ireland, where until recently all abortion was banned, the MMR since 1990 has been under 10,[9] and in 2005 was only 1[10] and in 2008 3.[11] In Poland, where abortion is restricted, the MMR is 3, one of the lowest in the world.[12] In Malta, where abortion is illegal, the MMR is 9, which is the same as in France,[13] where abortion is available on demand up to 12 weeks after conception.

15. Chile is a model for improving maternal health without providing access to abortion. Following the total prohibition on abortion in 1989, Chile experienced a steep 69.2 percent decline in the number of maternal deaths.[14] Chile came to have the lowest maternal mortality ratio in Latin America and second-lowest in the Western Hemisphere after Canada.

16. A fifty-year analysis of maternity data from Chile reveals two essential facts. First, restricting access to abortion services does not necessarily negatively impact maternal mortality. In fact, maternal mortality decreased after abortion was prohibited in Chile, highlighting a related point that improvements in maternal health can occur when abortion is illegal. In Chile, the decline in maternal mortality occurred because compulsory and free education increased women's educational attainment, and health programs focused on improving mother and child nutrition and access to health care facilities and skilled birth attendants. Second, the data make clear that women's educational levels are strongly correlated with maternal mortality rates. Education modulates effects of other variables, such as access to health care resources. The more educated a woman is, the greater her ability to access the health care resources available to her and thus go safely through pregnancy and childbirth.

17. Further, the argument that "[t]he previous highly restrictive law led to a high number of unsafe abortions in Mozambique, which in turn led to a high maternal mortality

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[9] TRENDS, *supra* note 2, at 39.
[10] *See* WHO ET AL., MATERNAL MORTALITY IN 2005 1 (2007), *available at* http://www.who.int/whosis/mme_ 2005.pdf.
[11] *See* WHO ET AL., TRENDS IN MATERNAL MORTALITY: 1990 TO 2008 24 (2010), *available at* http://www.unfpa.org/sites/default/files/pub-pdf/trends_matmortality90-08.pdf.
[12] *See* TRENDS, *supra* note 2, at 34.
[13] *Id.* at 32-33.
[14] Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, PLOS ONE 5 (2012), *available at* http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0036613&representation=PDF.

rate,"[15] fails to recognize that almost 90 percent of the maternal deaths in Mozambique were due to other causes. Overemphasizing the role of "unsafe" abortion detracts from efforts to address these other causes.

Unsafe legal abortion

18. At the same time, legalizing abortion does not guarantee that it becomes safe. A report by the Guttmacher Institute states, "Changing the law [. . .] is no guarantee that unsafe abortion will cease to exist."[16] The medical infrastructure in Mozambique is poor, and many people still do not have access to basic health care. This does not change when abortion is legalized; women who receive abortions will still encounter a lack of trained health care providers and face poor conditions, the same ones faced by women who give birth and deal with similar complications, such as bleeding and infection. Providing more access to abortion will mean more women will suffer from abortion complications.

19. Further, abortion can never be safe because it takes the life of the unborn child, and harms the mother through the loss of her child.

Reducing recourse to abortion

20. Mozambique must focus on introducing measures to reduce recourse to abortion, in line with paragraph 8.25 of the Programme of Action of the International Conference on Population and Development. Measures to reduce abortion include improving access to education, which empowers women, leads to social and economic development, and facilitates healthy decision-making. This is especially important because regardless of the legal status of abortion, it will result in the deaths of women, especially given the poor health infrastructure.

21. To improve maternal health, Mozambique must also focus on helping women get through pregnancy and childbirth safely, rather than helping women end their pregnancies. Given the maternal health crisis in Mozambique, resources must focus on improving conditions for women from pregnancy through the postpartum period.

Necessary maternal health interventions

22. Almost all maternal deaths are preventable,[17] particularly when skilled birth attendants manage complications and the necessary drugs are available, such as oxytocin (to prevent hemorrhage) and magnesium sulfate (to treat pre-eclampsia).

23. Mozambique must focus on providing prenatal care. The WHO recommends a minimum of four prenatal visits with trained health workers, in order to prevent, detect, and treat any health problems.[18] According to the Demographic and Health

[15] Katelyn Bryant-Comstock, Population Action International, *Advocates achieve liberalization of Mozambique abortion law after 10-year effort*, 13 Jan. 2015, http://pai.org/blog/advocates-achieve-liberalization-of-mozambique-abortion-law-after-10-year-effort/.
[16] *See* Susan A. Cohen, *Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide*, GUTTMACHER POL'Y REV. (2009), *available at* http://www.guttmacher.org/pubs/gpr/12/4/gpr120402.html.
[17] WHO, Fact Sheet No. 348, Maternal mortality, http://www.who.int/mediacentre/factsheets/fs348/en/.
[18] WHO, Antenatal care, http://www.who.int/gho/maternal_health/reproductive_health/antenatal_care_

Survey, only 50.6 percent of women in Mozambique had at least four visits.[19]

24. The WHO states, "Most obstetric complications could be prevented or managed if women had access to skilled birth attendant – doctor, nurse, midwife – during childbirth."[20] SBAs are trained to recognize and manage complications, and to refer women to higher levels of care if necessary. Only 17 percent of the need for SBAs in Mozambique is met.[21] Only 54.3 percent of births are attended by an SBA.[22] The population of Mozambique is expected to increase from 25.2 million in 2012 to 38.9 million in 2030.[23] It must prepare to respond to an estimated 1.8 million pregnancies per year by 2030, 75 percent of which will be in rural settings.[24]

25. Women must also receive postnatal care, ideally within 24 hours after giving birth, to monitor the mother for complications and to provide care to the newborn.[25]

26. Mozambique must recognize the barriers to adequate health care during pregnancy, childbirth, and the postnatal period, including poverty, distance, lack of information, inadequate services, and cultural practices. 61.7 percent of women in Mozambique reported that there was at least one barrier, such as needing permission to go for treatment, not wanting to go alone, and in particular getting money for treatment and distance to a health facility, in getting care for a health concern.[26]

(b) Recommendations

27. ADF International recommends the following:

- Recognize that legalization of abortion is not necessary to improve maternal health;
- Recognize that legalization of abortion in a country with such a high maternal mortality ratio and poor health care system infrastructure does not make abortion safe; and that such legalization can put more women at risk of injury or death;
- Repeal the abortion legislation of 18 December 2014; and
- Focus on improving maternal health through improving the health care system infrastructure and women's access to health care facilities, skilled birth attendants, and education.

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[19] MOÇAMBIQUE INQUÉRITO DEMOGRÁFICO E DE SAUDADE 2011 128 (2013), *available at* http://dhsprogram.com/pubs/pdf/FR266/FR266.pdf [hereinafter MOZAMBIQUE DHS].
[20] WHO, Skilled attendants at birth, http://www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/.
[21] UNFPA, THE STATE OF THE WORLD'S MIDWIFERY 2014 142 (2014), *available at* http://www.unfpa.org/sites/default/files/pub-pdf/EN_SoWMy2014_complete.pdf.
[22] MOZAMBIQUE DHS, *supra* note 24, at 133
[23] UNFPA, *supra* note 26, at 142.
[24] *Id.*
[25] WHO, Postnatal care, http://www.who.int/maternal_child_adolescent/topics/newborn/postnatal_care/en/.
[26] MOZAMBIQUE DHS, *supra* note 24, at 135.