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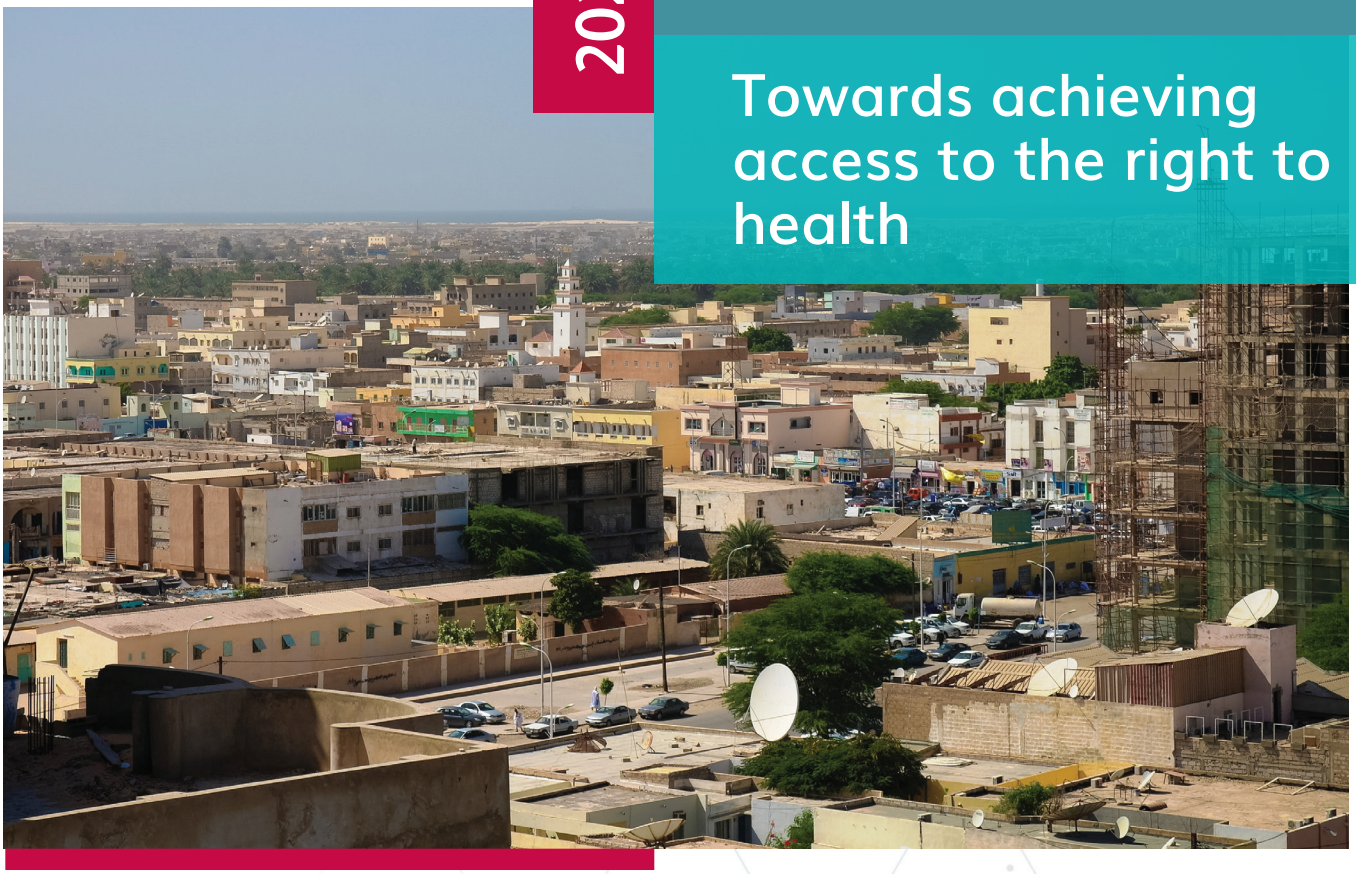
NATIONAL REPORT ON THE RIGHT TO HEALTH IN MAURITANIA

2023

Towards achieving access to the right to health



Mohamed Ahmed el Mahboubi

Development expert, consultant and independent social expert

Sidina Ould Khatri Elatigh

Consultant in economics

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

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NATIONAL REPORT ON THE RIGHT TO HEALTH IN MAURITANIA

Towards achieving access to the right to health

Mohamed Ahmed el Mahboubi

Development expert, consultant and independent social expert

Independent consultant. Holder of the Scientific Grade Master I and II in Development, in Sociology-Philosophy. Mahboubi has an extensive experience in studies, development research, consulting, and policy evaluation. He is involved in civil society activities and has participated in seminars and research with a number of national and international partners.

Sidina Ould Khatri Elatigh

Consultant in economics

Elatigh is a trainer at the Institute for Vocational Education and Training, Nouakchott, Mauritania. Civil society activist, head of the Mauritanian Network for Social Action. He conducted various researches in the social field and on the civil society organizations' role in development. He participated in several national and regional economic and social forums.

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INTRODUCTION

This paper presents an overview on Mauritanian citizens' access to the right to health, health insurance, and healthcare, especially the vulnerable groups, in a country suffering from poverty, marginalization, poor health infrastructure, and inequatible access to hospitalization between citizens living in the city center and the outskirts, and citizens in rural and urban areas. This context pushed us to draw the attention of stakeholders including public authorities, civil society, the media and partners, and to promote advocacy that leads to improving the level of services, especially with regard to social and economic rights (health, education, welfare and social protection).

The report is primarily based on the methodological axes included in the background paper of the sixth Arab Watch Report, with a focus on the Islamic Republic of Mauritania in terms of information availability, the right to health and its enforcement.

Objective: Presenting a comprehensive and critical analysis of the situation of the right to health in Mauritania, with some insights on the post-COVID-19 period.

Methodology: The reporting methodology is based on two axes: the first focuses on desk research, meetings, and interviews with relevant specialists, human rights activists, actors in the health sector, and civil society activists working for the developmental health field, this is an active participatory approach. The second focuses on objective research, questioning history, and analysing reality, based on answers to the report's key questions on the reality of access to the right to health in Mauritania, the level of human rights awareness concerning this specific right, and inequality in health services availability.

GENERAL CHARACTERISTICS OF THE MAURITANIAN CONTEXT

This section addresses the most important characteristics of the Mauritanian context, with a focus on some aspects related to the right to health. It provides an overview of the institutional, historical, economic, social, political, and legal aspects of the context, and highlights the positive and negative distinguishing points.

POLITICAL, GEOGRAPHICAL AND HISTORICAL DATA AND CHARACTERISTICS

Since Mauritania's independence in 1960, various government policies included the right to health, but it wasn't until the 1980s that a new approach in health policies was adopted to respond to the needs of the largest possible number of citizens with regards to health and basic treatments program. From the Fourth Health Plan 1981-1985 to the Basic Plan 1998-2002, priority was given to primary health treatments and the improvement of health coverage. In 1998, new concepts and terminology were introduced on the type and quality of performance and effectiveness of the health system.

ECONOMIC AND SOCIAL DATA

The general demographic situation in Mauritania is changing, as 52.8% of the population were living in urban areas in 2013, while 48.3% were living in rural areas. 28.2% of the population[1] are below the poverty line, and 50.7% of the total population are women. The population is mostly young, as 44.2% of people are under 15 while the elderly constitute 5.3% of the population. Social services are still poorly distributed among regions, and access to these services varies between regions and districts, and even at the economic and social levels.[2] Furthermore, displacement from the countryside to the cities has contributed to demographic fluctuations and increased pressure on the already poor services' infrastructure, greatly limiting access to health, education, water, electricity, food and employment services, as the capital alone attracted a third of the country's population.

[1] المسح الدائم حول الظروف المعيشية للسكّان 2082

[2] المرسوم رقم 361 المُحدِّد لصلاحيات وزير الصحة المادّة 2

Access to the Right to Health and How it is Linked to the Mauritanian Political System

The process to accessing the right to health in a country like Mauritania was not easy. Despite its intentions and the expressed and implied will for reform, the Maurtanian state has faced and is still facing many challenges that, to say the least, are multifaceted challenges, where the territory is large, the resources are lacking, and the outdated manners hinder development in every sense.

A major factor also limiting access to the right to health is related to the political orientation and nature of the respective regimes and their varying national and international approaches and agendas. In fact, the right to health was an official approach in various government policies and plans, and the achievements, even if few, were effective and marked with a kind of responsibility at the birth of the state. However, with the link to the global health approach and health internationalization, we are facing an "imported" health starting from medicines, to devices, and to the laws regulating health. Local health has become a cross-border health, whereas it should be based on climatic and geostrategic findings. Health economy has become one of the most important economies in the world; opening health to the private sector and depriving it of any humanitarian and rights-based essence.

The political orientation remains the first determinant of access to the right to health. Only the political will allows the citizens to access their right or deprives them of it; it determines, prioritizes and prohibits the financial resources. The political will is the factor that classifies citizens as first or second class and grants them insurance and access to health for free or in exchange for an amount of money. This political dimension in Mauritania revealed the ability to adapt and try to take care of the sick. It also revealed the significant dysfunction and failure behind various government achievements, which are mainly intended for media consumption.

We would like to point out a very important issue, which is that access to the right to health is granted to some with favors. For example, the state provides healthcare for persons who are national symbols, such as heads of parties, former presidents, opposition figures, or poets, which are granted as extra benefits, or what has been called presidential, royal, and princely gratuities, but these are limited in time and space, and the beneficiaries are very few. As for all others who have the right to health, they are often not granted this access, not even to its financial and human infrastructure, and this is mainly due to a political choice.

DETERMINANTS OF THE RIGHT TO HEALTH IN MAURITANIA[3]

INSTITUTIONAL AND LEGAL FRAMEWORKS FOR THE RIGHT TO HEALTH IN MAURITANIA

The right to health is considered a national priority and one of the state's strategic objectives. It is a subject of attention for legislators, policymakers and strategists. It is a right that has been addressed in various national health and non-health instruments and strategies. The Constitution of 1961 and the Constitution of 1991 address the right to health several times. The Mauritanian Constitution guarantees equality between men and women and all citizens or residents without discrimination based on color, race, religion, sex or social status, which is equality in rights and before the law, and health is one of the pillars and components of these rights.[4]

The current Mauritanian Constitution does not differ from previous constitutions, as it adresses citizens' social and economic rights, indicating in many of its articles that all citizens are entitled to enjoy all rights within the conditions established by the law. The Constitution stipulates in Article 16 that "the State and the society protect the family," in Article 31 that the State protects the family, motherhood and childhood, and in Article 33, that the State protects public health and works to encourage free medical assistance to the needy. Article 35 provides that the State guarantees freedom of education, and that it is free in government schools in its early stages. Article 37 of the Constitution stipulates that the state shall ensure social security and aid and shall guarantee the right to a pension for its employees, as well as the right to assistance in cases of accidents, illness, or inability to work, according to the law.[5]

We list in this paper some of the Mauritanian legal instruments related to access to the right to health, as we have come across more than 36 decrees, laws, and decisions, that all deal with health, insurance, security, access to the right to health and treatment in a purely legal way. The instruments cover the various health aspects and concerns and the structuring of insurance and social security systems during the past fifty years, revealing that the topic was analyzed from the

[3] السياسة الوطنية للصحة في أُفق 2030 المصدر 2017 ص 8
[4] المخطّط الوطني لترقية قطاع الصحة 2020 - 2030 ص 34
[5] التقرير الوطني للجمهورية الإسلامية الموريتانية في موضوع)منظومة الحماية الاجتماعية للمرأة في مجال الصحة في المنطقة العربية(إعداد الخبيرة الزينة محمد الأمين. يمكن الوصول إلى التقرير على هذا الرابط

institutional and legislative point of view and was not targeting a specific group but rather included the entire population, including citizens, expatriates, refugees, vulnerable groups, disabled people and the elderly. Withouth marginalizing any group, the instruments focus in some of texts on specific groups and prioritizes them in treatment, service, and health insurance.

Mauritania is also party to most or all the international charters, covenants and agreements related to economic, social and cultural rights, especially those related to the right to health and social care, issued by the United Nations General Assembly since its establishment, and by other regional, continental and inter-regional assemblies.

THE DETERMINANT RELATED TO RIGHT TO HEALTH AND GENDER

Improvements in health at the national level hide some of the existing social and economic disparities between groups. In fact, health indicators have been and are still alarming, especially in rural areas, among the poorest groups, and for those that do not have a high educational level. Analysing health indicators according to social and economic groups reveals several differences at various levels, especially in terms of access to the right to health. Health indicators related to malnutrition, fertility, and death rate explain these disparities and may even provide economic explanations for them due to low income, poverty, illiteracy, and the severe lack of access to services, especially care for children, monitoring their growth, giving birth without receiving proper medical care, and others.

Practically, we note the permanent inequality, discrimination, and perhaps even disparity based on gender in the health field. These relate mainly to social, economic and cultural barriers and obstacles that limit women's access to their right to health and treatment like family planning, gender-based violence in all its forms, traditional societal practices harmful to women such as female circumcision,[6] early marriage or force-feeding (leblouh), etc. Moreover, it should be noted that there is what we call "health violence" and that the quality of the provided health services is affected by the gender. This is clearly evident when dealing with maternal mortality, gender discrimination, stigmatization and contempt, or refusal to provide services, for example, to people with sexual diseases, sex workers, or those who are not in a legitimate relationship. According to the Ministry of Health's 2018 statistics, 58% of the ministry's workers are women, but they are still marginalized at the level of decision-making.

[6] excision or female circumcision

THE ECONOMIC DETERMINANT OF ACCESS TO THE RIGHT TO HEALTH

Mauritania is among the poorest countries around the world, thus, investment in health requires significant financial resources that are crucial to provide health infrastructure, or even to acquire equipment, medicines, or build clinics that guarantee citizens' insurance and care for patients. Despite efforts to increase budget allocations for the sector, these are still at a modest level compared to neighboring countries in the south and north: i.e., about 5.3% of the state budget compared to 10% in Senegal and more than 18% in the Kingdom of Morocco. Furthermore, resources distribution is not optimal in terms of geographical justice, fair and equal access, and respect for the National Health Policy's priorities.

DETERMINANTS RELATED TO WATER, SANITATION AND ENERGY

68.1% of the population have access to potable water, 34.2% have access to proper nutrition, while 40.4% have access to adequate sanitation. All of the latter factors have a significant impact on health [7] and can contribute to the spread of infectious, parasitic and nutritional diseases.

The availability of energy services of all kinds at affordable prices and the increase in investments in energy infrastructure also facilitate access to the right to health. In Mauritania, energy is only available to 48% of the total population. As for the energy infrastructure, Mauritania has a national network that is among the weakest in the Arab region, in terms of production, distribution, or transportation. Access to the right to health requires the existence of a strong and comprehensive energy network with multiple options that guarantee fair access to electricity at the national level. Health and electricity are interlinked, as without electricity and energy, diagnostic equipment breaks down, food spoils, access to water becomes challenging, and other social services may be affected. [8]

NATIONAL HEALTH INFRASTRUCTURES

Access to the right to health depends on providing the service within the closest possible distance to the citizen and without excluding any part of the country. Most of the policies related to health infrastructure have focused on providing comprehensive health coverage including for adjacent areas, and ensuring accessibility within a distance not exceeding 5 to 10 kilometers

[7] ملخّص الاستراتيجية النموّ المتسارع والرفاه المشترك

[8] استراتيجية النموّ المتسارع والرفاه المشترك 2022 - 2026 ص 40

for all. However, despite all the achievements, there is still a considerable shortage, and there is a need to build more health posts, as the currently existing 808 posts do not meet most of the population's needs and do not meet the recommended international standards. Many health posts and centers were built due to the interventions of the Ministry of Health and the Taazour Delegation. Civil society activists and businessmen involved in the health field tried to contribute to posts according to their capabilities.

TRANSPORTATION

In recent years, Mauritania has tried to pay attention to road infrastructure and means of transportation due to its importance and its role in economic growth and health and the enjoyment of rights. The national road network guarantees access to 70% of the population withing a distance of less than two kilometers in 2020, compared to only 40% in 2016. Access to the right to health requires the provision of modern road infrastructure, airports and ports that guarantee the transport of goods and medicines, the provision of equipment and the supply of food to the market. However, transportation infrastructure in Mauritania suffers from several obstacles related to the lack of proximity to medical and health services to citizens, especially for those who live in remote areas.

EPIDEMIOLOGICAL TRANSITION

The spread of communicable and non-communicable diseases with high costs places an increasing burden on the health system, that is already insufficiently prepared to provide the protection, prevention, diagnosis and treatment of these diseases. Mauritania has quickly adopted the One Health approach that takes into consideration the health of humans, animals, and the environment at all levels. The country is witnessing waves of epidemics that are not familiar to the national health system, represented by the difficulty of managing the emergency cases of malaria, dengue fever, COVID-19 and viral foot-and-mouth disease, in addition to issues related to climate change, rainfall, drought, and malnutrition. As for the pharmaceutical sector and the provision of medicines and medical supplies, the general situation in Mauritania is characterized by weak capacities at all levels, raising questions about availability, quality and access.

ANALYSIS OF THE CURRENT SITUATION OF THE RIGHT TO HEALTH IN MAURITANIA

Public authorities have made great efforts and taken many measures to guarantee citizens' access to health as a human, religious and legal right. These measures and efforts have been portrayed in the adoption of many plans and strategies since independence to date, but access to quality health services remains a challenge. We present here a general idea of the level of access and related obstacles.

THE NATIONAL PLAN FOR UPGRADING THE HEALTH SECTOR 2020-2030

Mauritania has established a plan to upgrade its health work. This plan was previously consistent with the strategic framework for combating poverty and is now in line with the current strategy of accelerated growth and common prosperity, which represents the reference framework for government policies that are aligned in some of their provisions with the Sustainable Development Goals and various national and international commitments.

SECTOR GOVERNANCE AND MANAGEMENT

A multisectoral approach was adopted aiming at coordinating the implementation of health strategies, which facilitated the work of those involved in the health and social sectors. A formal mechanism for cooperation was created between the Ministry and the various actors involved in the sector. In fact, this cooperation improved the performance of the Ministry of Health and the Ministry of Social Work. However, several issues persist, especially when it comes to the governance of human resources and the management of the scattered health infrastructures, which are often built based on political desire and not on a needs assessment.

HEALTH COVERAGE

Comprehensive health coverage remains an out-of-reach goal. Access to the minimum level of health services at the national level requires huge investments and more human resources,[9] as more than half of the population (55.3%) live more than 30 minutes away from the nearest health center, and only a

[9] اليونيسف 2009 : مذكرة تشخيصية حول السياسات الاجتماعية وصحة الأمّ والطفل – فوائد الحماية الاجتماعية في غرب ووسط إفريقيا.

third of them (32.7%) live within 5 km of the nearest health institution. This coverage varies in the different regions, going from 52% in the semi-urban countryside to 98% in the capital. As for the countryside, health services are not available in the first place, and if they are available, most people do not trust them. Inequality is portrayed in the fragility of a large proportion of the population, such as women, the elderly, immigrants, prisoners and the poor, who are affected more than others. For example, 13% of women do not benefit from prenatal health coverage, and 33% of them give birth without any medical assistance. Child immunization, a basic indicator of health protection, witnessed an alarming decline, from 80% in 2014 to less than 70% in 2018.

The Mauritanian health system consists of several levels through which health services are provided:

- Level of districts, municipalities and villages where the health posts and centers are located.
- Regional level, where there are a number of medical bodies such as regional hospitals, and their number exceeds twenty hospitals in all regions' capitals, including those that have been converted into administrative public institutions.
- The national level, which includes the national reference institutions in the hospital field, the four regional health schools, the Faculty of Medicine and the National Institute of Medical Specialties.

As for private health centers, they are spread mainly in large cities such as Nouakchott and Nouadhibou, and they play a pivotal role in improving the performance of the public sector, complementing it, facilitating citizen access to services, and assisting in expanding and simplifying health coverage and facilitating access to health. However, benefiting from the private health sector services often requires significant and even high costs that are not available to everyone. Therefore, the most important beneficiaries of these services are the rich, those who have a sponsor, and people who have health insurance.

FINANCIAL ACCESS TO THE RIGHT TO HEALTH

Various national reports analyzing the situation of the sector show the urgent need for financial reconsideration of the health sector, especially at the regional level. Public funding does not cover the expenses necessary for the citizens to access their right to health, and the annual allocations from the state's general budget do not meet the needs of the

sector and are not in line with the Abuja recommendations, which acclaim providing 15% of the state's general budget for the health sector. Health expenditures show that hospitals benefited from 46% of the Ministry's budget, at the expense of facilities that provide direct services to the most marginalized population, and primary care that only benefited from 20% of the expenditures.

In this context, the distribution of the Ministry's expenditures shows that the urban community benefited from an increase of 43% compared to 12% for the rural community,[10] while funds were unevenly distributed among the regions. However, the Ministry adopted multiple approaches and systems to bridge these gaps and respond to the problem of financial access to treatments and services, and to ensure their access and preservation. One such approach, the reimbursement of costs system that supports the provision of essential medicines, responds to obstacles related to inefficiency, poor representation in the steering committees, lack of supervision, and the problem of frequent interruption of the medicines' supply and interruption of warehouses' supply. Nevertheless, paying the costs for medicines remains very difficult for the poor, marginalized and other disadvantaged groups such as women, women immigrants, immigrants, persons with chronic diseases, and others.

COMPREHENSIVE HEALTH COVERAGE

Theoretically, Mauritania, like other countries, has committed at the highest levels to achieving comprehensive health coverage that leads to almost total access for citizens and residents to quality health services, and social protection and care, if available. Usually, health coverage is funded through the government's general budget, the international funding and contributions from private and charitable persons of goodwill and civil society. Recently, the government has adopted important policies that have so far resulted in the establishment of a health map and a health investment plan, opening a number of insurance funds, such as the Health Insurance Fund and the Health Solidarity Fund. The Taazour Agency has introduced an initiative to access health treatments and expand access to treatment services, the expanded Health Department's "Taahoudati" (تعهداتي) program, the "Muyassar" (مُيسَّر) program and the regional Health Solidarity Fund. An approach was also adopted, and was approved by the Ministry of Finance, the Ministry of Health and partners related to budget management, based on programs and results.

[10] خطّة ترقية قطاع الصحة

However, the population benefiting from health coverage in the form of support, assistance, or health insurance remains modest, and the largest family expenses are health expenses. This confirms what was previously mentioned, that the individual benefits annually from only $57, compared to the necessary amount set by the United Nations at $112 needed to achieve SDG 3.[11] Concerning the government budget, we find that the government allocated approximately 7% of the budget for health in 2020, which is less than half of what is stipulated in the recommendations of the Abuja Declaration, which recommends spending and allocating no less than 15% of the state budget for health.

The government's various efforts remain limited and collapse before the fragility and quick expansion of the country and before unhelpful citizens' mentalities and behaviors, the decline in funds and the deterioration and even the lack of service infrastructure that facilitates access to the right to health, such as electricity, water, roads, and transportation infrastructure, etc. "The values of equality and justice and the fairness, cooperation and social cohesion principles constitute a guide that indicates the strategic choices of health and social policy; they also represent the guarantee for the sustainable improvement of the population's health."[12]

In Horizon 2015, the Mauritanian National Health Policy sought to develop, establish and provide a contemporary, well-functioning, interactive health system that was suitable and available to all the country's residents, regardless of their place of residence, educational level, age, gender, origin, economic status, etc. The report affirms that "this health system will contribute significantly and clearly to raising life quality, life expectancy, and other health rights in coordination and integration with other sectors involved in combating poverty and destitution and eliminating disease associated with poverty and ignorance."[13]

KEY PLAYERS IN THE HEALTH AND SOCIAL CARE SECTOR

- Ministry of Health: (National Fund for Disease Insurance, National Fund for Health Insurance, National Solidarity Insurance Fund (إنصاف), National Executive Secretariat for AIDS Control, Ministry of Social Affairs, Children and Family)
- Ministry of Public Service (National Office of Occupational Medicine)

[11] تمويل النظم الصحية التحويلية نحو تحقيق أهداف التنمية المستدامة للصحة: نموذج للاحتياجات المتوقعة من الموارد في 67 من البلدان المنخفضة الدخل والمتوسطة الدخل. الرابط.
[12] السياسة الوطنية للصحة 2015 - 2025 الصحة 22
[13] السياسة الوطنية للصحة 2015 - 2025 ص 9

- Ministry of Islamic Affairs and Original Education: newly established Zakat Fund
- The comprehensive organization of the health sector includes other ministerial sectors: Ministry of Water and Sanitation, Ministry of Environment and Sustainable Development, Ministry of Trade, Ministry of Equipment, Ministry of Education, Ministry of Communication, etc.
- Development partners, the private sector, and civil society organizations.

THERAPEUTIC HEALTH SERVICES ACCORDING TO THEMATIC PRIORITY

MATERNAL AND CHILD HEALTH OR REPRODUCTIVE HEALTH

Mauritanian laws relating to reproductive health and its regulation are based on principles established by the international community in this field. The public authorities have enacted a currently applicable reproductive health law (the Reproductive Health Act No. 2017-025), facilitating access to health services and raising awareness in the areas of sex, health, as well as obstetric and reproductive services.

Data from 2019 indicate that the maternal mortality ratio (MMR) reached 454/100,000. This is a relatively high number, despite attempts by the competent authorities to provide the necessary reproductive health related services. According to the 2019 data of the National Health Information System, the percentage of married women who use contraceptive methods amounted to 13.3%, while 2018 data indicates that only 25% of health authorities provided family planning services. Meanwhile, only 33% of trained health agents in the field of family planning were available in 2018 compared to 54% in 2016, due to socio-cultural obstacles and constraints, access to health facilities providing health services related to family planning and reproductive health, and the lack of supply mechanisms and access to nearby health services. This fundamentally hinders full access to these health services and prevents attaining the approved related indicators.

There was a sharp decrease in coverage between 2018 and 2016, where 32% of health facilities did not have the necessary treatments in 2018, compared to 49% in 2016. Additionally, these health facilities and structures lacked 58% of needed personnel trained to provide care and primary

prenatal treatments in 2016. Meanwhile, coverage of prenatal consultations totaled 69%, as a result of weak capacities and lack of capacities outside the capital and large cities. Health facilities have only 28% trained staff to manage antenatal care, compared to 58% in 2016. The coverage of prenatal consultations at the national level is 69.1 out of 100 births according to 2019 data. On average, the rate is 70.37%, still far from the 80% target (PNDS).[14] With regard to cesarean delivery (C-section), the target has not yet been met, as it reached 8.1% in 2019. According to the national health information system (SNIS),[15] the lack of blood units in health facilities is a contributing factor to maternal and neonatal mortality.

Health and Gender

Regarding women and their access to the right to health in a qualitative and equal manner as men, the Ministry of Health has adopted several positive programs in favor of women (including reproductive health, combating obstetric and cervical fistulas, specialized health programs, women's health insurance, taking care of divorced women, social support programs for vulnerable groups, the feminist movement, etc.). However, the various programs have yet to succeed in bridging the gender-based gap and disparities. Indeed, health services are still patriarchal despite all the investments and incentives that were made. Furthermore, inequality still persists, especially in access to health services at the regional and rural levels, where women suffer from several problems related to customs, traditions, and access to health, most of which are stereotyped, such as early marriage, violence against women, and health violence.

NUTRITION

Mauritania is one of the most food-fragile countries and is located in a geographical area subject to successive droughts. As such, it requires food assistance and is dependent on imports for nearly two-thirds of its food needs. Mauritania also faces challenges related to food security due to low food sufficiency rate, as its grain production covers only 20% to 50% of its population needs, as well as widespread poverty, especially in rural areas, and due to the dependence of

[14] PNDS : Perioperative Nursing Data Set
[15] SNIS : Système National d'Information Sanitaire

agricultural production on rainfall and climate changes and their impacts on living conditions. As a result, food insecurity affects 30% of families during droughts and 20% during the harvest period, while the rate of malnutrition among children is 10%, and the number of food insecure people has reached record levels of 800,000 people.

The results of the Permanent Living Conditions Survey for 2019-2020 indicate an increase in food insecurity rates estimated based on the World Food Programme's Food Insecurity Experience Scale (FIES) indicator related to food insecurity, as 9.43% of households suffer from severe malnutrition. The nutritional reality of infants and children is also alarming due to harmful practices with regards to nutrition (as per a demographic and health survey). Less than half of infants aged less than six months are breastfed (41%), while only one-fifth of children aged between 6 to 23 months benefit from appropriate complementary feeding. Underweight newborns represent a significant percentage, and 3% of the population consumes iodized salt. As for anemia, it affects 77% of children under 5 years of age and 56% of women of childbearing age (as per the summary report of the second action plan of the Strategy for Accelerated Growth and Shared Prosperity (SCAPP 2022, p. 55-56).

■ TAKING CARE OF THE TREATMENT OF THE ELDERLY AND PEOPLE WITH DISABILITIES

Taking care of the elderly and people with disabilities is considered a fundamental problem, as there is no consensus regarding the term old age and its definition. Taking care of the elderly and people with disabilities is the mandate of the Ministry of Social Work, Childhood and Family through the Department of Social Work and National Solidarity, in addition to the Taazour delegation, several projects, the National Human Rights Committee and the concerned NGOs, including the Mauritanian Network for Social Work[16] and some approaches developed by the Ministry of Health and the Ministry of Islamic Affairs through the Department of Endowments and Zakat, as well as others. However, the implementation of said approaches lacks seriousness and speed. It was noted that the system of community health associations[17] is almost nonexistent in Mauritania, as there are fragmented, discouraged, and scattered experiences. A relevant example would be the initiative of the International Labor Organization, which funded a pilot health insurance project for

[16] الشبكة الموريتانية للعمل الاجتماعي، مقابلة بتاريخ أيلول/سبتمبر 2022
[17] وهي جمعيات/Associations orAmicales/

the informal sector through the establishment of mutual fund under the STEP initiative.[18]

Status of Access to Mental Health

Psychological or mental health and its relevant issues (drugs, addiction, and alcohol) are one of the main public health concerns in terms of their different effects on the schooling of children (or young adults), the high crime rates in quantity and quality, and with regards to taking care of addicts and prisoners. Undoubtedly, drug abuse is closely connected to the public health system, as a result of the fragile health system and the limited resources, even at the level of human resources, whether in terms of care, rehabilitation, or treatment. The issue is still considered a taboo, and all those suffering from psychological problems hide it by using other names related to colon diseases, or by blaming the evil eye or envy. However, the bitter truth is that we are witnessing an unprecedented spread of mental illness, addiction and drug abuse at different educational levels, at the level of upper social classes, and it is spreading among people from poor social classes. Data related to this subject is unavailable, as it is classified as confidential at the level of the health and security sector. As for the treatment, it is rarely possible to make an appointment with a specialized psychiatrist due to fully-booked schedules, since psychiatrists are few while the number of patients is large. The Ministry of Health adopted a mental health strategy that is yet to be implemented. In fact, the department charged with handling the strategic and planning aspects was abolished in the Ministry's last restructuring process. With regard to drugs and stimulants, Mauritania adopted in 2018 a multisectoral strategy to combat drugs, accompanied by a practical action plan. However, it did not receive sufficient funding for implementation.

COMBATING NON-COMMUNICABLE DISEASES

Mauritania was marked by an alarming spread of urinary tract diseases, cancers, strokes, arterial diseases, obesity, diabetes, heart and chest diseases, mental disorders, as well as oral and dental diseases. Changing food culture and

[18] The International Labor Organization's (ILO) global Strategies and Tools against Social Exclusion and Poverty Program (STEP) supports the design and deployment of innovative systems aimed at extending social protection to excluded populations, contributes to strengthening linkages between these systems and other social protection mechanisms, and supports the establishment of social protection systems.

habits have contributed to this spread. Early detection of non-communicable diseases is so far absent as an approach in Mauritania. There is no national communication strategy or even a vision for combating non-communicable diseases. Furthermore, there is severe shortage of well-trained staff and lack of equipment and infrastructure to deal with these types of diseases. Non-communicable diseases are also associated with high costs of care and there is a complete lack of involvement of other health sectors. A national strategic action plan was introduced in 2016 aiming to prevent non-communicable diseases, as well as a national plan to combat addiction, however, neither plan has been implemented due to a shortage of financial resources. Available resources are mainly directed to support national centers for combating these diseases, such as the National Center for Heart and Arteries, the National Center for Cancer Treatment, and others.

Nevertheless, heart and arteries related diseases are no longer neglected, rather they are almost completely covered through the center for heart diseases, whether in terms of human or financial resources or medical staff and equipment. This has enabled many citizens, especially the vulnerable, to access therapeutic services at this level. Finally, we highlight a reduction in the cost of health services related to the heart and arteries diseases such as catheters and surgeries by half during the first week of March 2023 which has enabled access to these services for various vulnerable groups.

The transition from a traditional diet to a modern, multi-calorie diet, rich in carbohydrates and sugars, without fruits and vegetables, is one of the main causes of these types of non-communicable diseases, in addition to the lack of health education, protection and prevention, the spread of smoking, obesity, refraining from exercising, and the lack of health education, especially among women and the elderly. Cancer diseases, heart diseases, diabetes and AIDS are the main health challenges facing our country. Both the health community and the civil society have made significant efforts in the mobilization and sensitization to combat diseases in general, with a special focus on prevalent diseases.

HIV/AIDS

The spread of HIV in Mauritania is considered confined, as it spreads at a rate of less than 1% among the population and more than 5% among some high-risk groups such as prisoners. National estimates indicate that 3,944[19] persons

[19] تقرير فريق الأمم المتحدة في موريتانيا حول فيروس نقص المناعة، تشرين الأوّل/ أكتوبر 2009

(1,904 women, 1,614 men and 120 children) live with the virus and require treatment, although the total number of infected people exceeds 9,968. Nevertheless, the country's coverage of HIV treatment does not exceed 39%. This results in incomplete health coverage for the population, especially the most vulnerable, through interventions affecting the spread of the epidemic.[20] Patients still lack healthcare, access to health insurance, and treatments for opportunistic diseases, as the national program only provides medication. Indeed, examination, diagnosis, nutrition, and others, are unavailable since 2018. There is also a pressing need for collective assistance and socioeconomic support for children, orphans, widows, and families living with the virus. This has become challenging as the activities are limited and centralized in the capital, Nouakchott, while the actors in the field require greater efforts, especially with regard to training and supervision. The authorities adopted Law No. 42-2007 related to preventing HIV/AIDS and taking care of affected people, which improved public health. Among the involved partners, we mention the United Nations Fund to Fight AIDS in Mauritania, as it followed up with the patients and provided them with support during the COVID-19 pandemic and continues to do so today.[21]

RIGHTS OF PERSONS WITH DISABILITIES

Legal Order No. 2006-043 on the Protection and Promotion of the Rights of Persons with Disabilities includes provisions on their access to vocational training and work. To enhance their protection, Decree No. 2015-062 was adopted, stipulating the implementation of Article 46 of aforementioned Legal Order No. 2006-043. Moreover, the state guarantees for persons with disabilities the different medical treatments necessary for their mental and physical safety and health, according to Article 204. Persons with disabilities can access these services for free, provided they hold a disability card from one of the government medical institutions or municipalities. These services are also available for children with physical disabilities preventing them from engaging in an income-generating activity. This insurance provides its beneficiaries with coverage from the risks of disease and the costs of health treatments related to maternity accidents, illness, physical or functional rehabilitation and compulsory insurance against disease. It also grants the right to compensation and direct responsibility for the costs of preventive treatment, medication and appropriate medical rehabilitation, specifically: primary treatments, hospital treatments, medication, and taking care in cases of treatments abroad, pursuant to the adopted regulations.

[20] الشيخ ولد سيدي رئيس الشبكة الموريتانية لمنظّمات الأشخاص المصابين بالسيدا، مقابلة بتاريخ 11 تشرين الأوّل/ أكتوبر 2022
[21] الدكتور المصطفى خطري، مكلّف بمهمّة لدى صندوق الأمم المتّحدة لمحاربة السيدا نواكشوط. مقابلة بتاريخ 10 تشرين الأوّل/أكتوبر 2022

As for the procedures for taking caring of and protecting children: preserving the child, raising the child, developing the child's capabilities, and protecting the child's family has been a concern for the Mauritanian authorities and partners. CSOs played an active role in the field of mobilization and sensitization aimed at raising awareness about this issue.

HUMAN RESOURCES FOR HEALTH

Mauritania records a significant deficit in health activities, if population density is taken into consideration. In fact, for every 1,000 citizens there are 0.39 specialized doctors, and for every 1,000 citizens there are 0.41 general practitioners. Thus, we are far from international standards in the health field, which allocate a general practitioner for every thousand citizens. Also, 60% of doctors mix general and specialized practice. Further, financial resources allocated to human resources are neglegted, as is training.

Sufficient human resources require significant investments; a matter that authorities were late to realize. Once the structural reform process that precluded the state from investing in sectors such as health and education ended, the health sector was liberalized and a policy for capacity building and up-scaling was adopted. Many institutes, schools, medical colleges, and several nursing schools and a higher school of health sciences were opened in Nouakchott.

We conclude that the sector suffers from a severe shortage of human resources, medical staff, workers, and health personnel who are qualified, trained, and motivated. This shortage was exacerbated by the opening of a large number of clinics, hospitals, and health centers across the country due to the lack of human resources, in addition to widespread clientelism, lack of respect for legal and administrative procedures, and the refusal by several employees to work in remote areas or outside the capital, Nouakchott.

TRADITIONAL MEDICINE AND THE RIGHT TO HEALTH

Traditional medicine is part of Mauritania's cultural heritage and is rooted in the Mauritanian mentality and subconscious. Even those who practice modern medicine sometimes integrate ancient and traditional medical treatment in addition to ruqyah in their practice, which is a widespread practice that is tolerated and allowed as long as it does not lead to a

major health problem (death or total or partial disability of the patient). To date, Mauritania does not have a legislation regulating this practice, nor a licensing process to perform the latter or even methods of adopting traditional therapeutic prescriptions. Rather, those who provide these treatments are not included in primary treatment programs.

THE RIGHT TO HEALTH AND HEALTHCARE FOR IMMIGRANTS AND NON-CITIZENS

Given that guaranteeing freedom, equality, and human dignity is only possible in light of a society that enshrines the rule of law, and out of their keenness to create favorable conditions that aid in harmonious social growth that respects the provisions of Islam—the sole source of law—and which aligns with the requirements of the modern world, the Mauritanian people, in particular, stress the following rights and principles: "the right to equality, basic human rights and freedoms, etc."[22] In this sense, Mauritania provides all primary health, educational and treatment services to immigrants, political and economic asylum seekers, displaced persons and others, where possible, with the support of a range of UN agencies, organizations and bodies, and parties involved in the humanitarian field. These services are extended to residents of the Mbera camp in the far eastern basin on the Mauritanian-Malian border, which hosts more than 119,000[23] displaced Malian migrants, in addition to migrants from sub-Saharan countries, Syria, Libya, Sudan, Liberia, Sierra Leone, Guinea and Guinea-Bissau, estimated at 142,975, as per the last immigrant census in 2023.[24]

[22] ديباجة الدستور الموريتاني
[23] حسب مصادر وزارة الداخلية الموريتانية
[24] تقرير الوزير الأول أمام البرلمان 2023 ، إلخ

THE RIGHT TO HEALTH AND SOCIAL SECURITY FROM SOCIAL PROTECTION PERSPECTIVE

Article 9 of the Mauritanian Covenant recognizes "every person's right to social security, including social insurance." This requires the introduction of some form of social insurance system protecting people from the risks of illness, disability, maternity accidents, work injuries, unemployment and old age, in order to provide it to survivors, orphans and those who cannot afford healthcare costs, and to ensure that families are adequately supported and that the benefits from this scheme are sufficient and available to all without any discrimination. Social protection is a pivotal pillar for all the different national strategies. It is not available under a unified institutional framework, it is rather unevenly distributed among several government sectors, including: The Ministry of Social Work, Children and Family, the Ministry of Health, and the General Delegation for Combating Exclusion.

However, social protection remains part of a whole and varies depending on the geographical location and service access of citizens to health, treatment, preventive and awareness facilities. In order to contribute to overcoming these obstacles, facilitating equal access to different services, and ensuring social protection, the state is currently working on developing a multi-partner national strategy aimed at protecting the elderly, in addition to ensuring and providing social protection to vulnerable and disadvantaged groups. Therefore, the following objectives were set:

- Preparing an integrated national plan to ensure social health coverage at the level of the most vulnerable population;
- Expanding and integrating the different programs and social protection mechanisms to include and cover all potential beneficiaries (Taazour) and insure 100,000 people, and to provide symbolic salaries to several families (about 215,000 beneficiaries). Additionally, reviewing the microfinance policy and facilitating access to financing services;
- Encouraging access to basic services by bringing these closer to citizens and focusing on isolated, vulnerable areas.

On the other hand, determining social protection targets is done in multiple ways and on several levels, through:

- The Ministry of Health, by setting and developing plans to facilitate and ensure universal access geographically, financially and technically through: expanding health coverage, reforming and revitalizing the system of costs covering, mainstreaming the lump sum for childbirth, and expanding the trial to include the elderly, the disabled, and children in dire circumstances.
- Financial and monetary access targeting disadvantaged groups, the unemployed and the elderly with no support and those who are most affected by social and financial disparities.
- The Ministry of Social Work, Childhood and Family, the Ministry of Islamic Affairs, the Taazour Delegation, loan institutions and the private sector, by improving taking care of the elderly and developing mechanisms for risk sharing (loans and savings to finance income-generating activities, health cooperatives, collective funds, solidarity funds, etc...).
- Expanding social protection coverage and introducing new mechanisms suitable and compatible with the Mauritanian milieu and culture.

FINANCING SOCIAL PROTECTION

In 2012, investment in social protection amounted to 5.8% of total public spending and 0.3% of GDP. Meanwhile in 2021, the rates reached 8% and 0.43% of GDP.[25] Government spending amounted to more than 1.1 billion Mauritanian ouguiyas on social protection alone and 1.52 billion on health (health: 1,362,301,510 new ouguiyas, about 3,884,170.76 USD and social protection: 908,501,023 new ouguiyas, about 2,582,243 USD), according to a review of public spending prior to the pandemic. As for the 2023 draft budget, it included significant expenditures for social protection. Expenditures on anti-poverty activities amount to 668,304,453 new ouguiyas, and the allocations for loans and microfinance total 17,000,000, while an amount of 15,000,000,000 new ouguiyas has been allocated for social services, and an amount of 1,500,000,000 new ouguiyas for old age services.[26]

[25] ارتفع الناتج الداخلي الخام الى 355.032 مليار أوقية جديدة خلال النصف الأوّل من سنة 2021 MRU 25

[26] قانون المالية 2023 مشروع

There are several positive points resulting from increasing social protection:

- The existence of a political will committed to social protection.
- The establishment of Taazour agency in 2019 in charge of Social Solidarity and Combating Exclusion.
- The Program for Improving Purchasing Power, Job Creation and Access to Basic Services.
- Extending and increasing the value of cash transfers to vulnerable groups.
- The provision of free health services to the poor.
- The establishment of a new health insurance system consisting of a set of institutions.
- The establishment of the School Feeding Program.
- The ratification of the Zakat Fund.
- The economic integration of persons with disabilities.

HEALTH INSURANCE

In Mauritania, there are many mechanisms for social protection, insurance, and healthcare, varying between modern and traditional. The ILO Convention No. 102 of 1952 serves as the reference in terms of social protection issues. Health insurance in the country is relatively new. Various researches and studies confirm that social care in Mauritania is still fragile, especially for the poor and the unemployed, although it is a union demand and a constitutional right dictated by need but hindered by resource availability. The lack of free health services, the lack of patient care and linking it to employment, and the weak health system in its different structures and formations indicate the shortcomings of various policies, despite the attempts of successive governments to formulate decrees, laws, and health strategies related to care, social protection, insurance, and establishing many institutions for patient care and social care.

Among the main actors with regard to social protection and health insurance systems in Mauritania, we can mention some institutions and governmental bodies legally in charge of the issue, for instance:

THE NATIONAL SOCIAL SECURITY FUND

The law establishing the latter and the Social Security System in 1967, amended on July 18, 1972/1987, stipulates that a Social Security System shall be established throughout the territories of the Islamic Republic of Mauritania, in charge of the following services: Family benefits (family benefits branch), compensation services in the event of accidents at work and professional diseases (professional risks branch), old-age, disability and death pensions (pensions branch), and any other social security benefits that may be established at a later stage for wage workers.[27]

The Fund's law stipulates that the employer shall provide social security and insurance for workers and their families, especially health treatments, and shall commit to paying daily allowances in case of illness. However, one of the shortcomings of this scheme is that it does not cover unemployment risks. Also, maternity benefits are compensated in a delayed manner and within the framework of family services, and the compensatory percentages are very low, ranging between 2% for old age,

[27] The National Social Security Fund is a public institution of an industrial and commercial nature that was established by virtue of Decree No. 87-099 issued on July 1, 1987. It is mandated to run the social security system established by Law No. 67-039 of February 3, 1967 and the accompanying texts: Decision No. 464 of 4 September 1967 Regulating Social Security Services. For laws and decisions related to the National Social Security Fund in Mauritania, see link.

disability and death, 2.5% for accidents at work and 8% for maternity. The typical wage (minimum wage) is 39,000 ouguiyas, equivalent to 92 USD per month). On the National Independence Day in 2022, the President of the Republic issued a decree increasing the minimum wage to 59,000 thousand ouguiyas, equivalent to 140 USD.

THE NATIONAL HEALTH INSURANCE FUND (CNAM)

The state was late to introduce health insurance. The first serious attempt was in 2005 when it approved the establishment of the CNAM, which was established as a fund dedicated to employees and state agents. The CNAM continued to expand and its mandatory statute states that it shall be applied to several groups of insured persons: parliamentarians, civil servants, state agents, members of the armed forces in service, civilian or military pensioners from the two previous groups, and workers in public institutions and state companies. Its duties were extended to cover the largest number possible of citizens.

Overall, the Fund currently insures 30% of the country's total population, and it has brought different services closer to citizens, expanding co-payment systems to cover different public and private health agencies, while reducing the review period, especially for compensation cases related to chronic diseases, dialysis, and procedures for transferring patients abroad.

The proceeds of the CNAM for 2018 amounted to approximately 1.05 billion new ouguiyas, or five million USD covering 462,279 numbered and registered insurers in March 2019, i.e., about 11.6% of total population, without taking into consideration the hundred thousand people consisting of poor and vulnerable families, who were added in 2021. However, the total number of insured persons reached 1,200,000 people by the end of 2022, according to the Mauritanian Minister of Health. As for health cooperatives and private insurances, they are special mechanisms designed to assist in social health protection. These initiatives are still primitive.

ESTABLISHMENT OF THE NATIONAL SOLIDARITY INSURANCE FUND IN 2022

This fund targets self-employed persons and the informal sector. It shall carry out the tasks of social protection for the most vulnerable groups, in addition to a set of traditional actors, each in their respective fields, such as the Ministry of Social Work, Children and Family, the Ministry of Health, the

General Delegation for Combating Exclusion, Taazour (social protection net system), the Ministry of Islamic Affairs and Indigenous Education, and the Zakat Agency, which will be introduced in 2022, Small and Medium Enterprises Support Program, the multi-sectoral national plan to address the COVID-19 pandemic, the women's empowerment project and the demographic dividend, the private sector, and CSOs working in the health field or active in the human rights field in general and health in particular. These CSOs are one of the major components of the Mauritanian civil society and, among many functions, they take care of patients, provide medication, build health centers, provide aid and charitable equipment in the health field, prepare and organize health and medical staff, health advocacy, mobilization, awareness-raising and sensitization, as well as financing and operating some health centers.

Examples of the role of civil society in providing patient care in some neighborhoods: Al-Nour Hospital in Toujnine, Al-Radwan Eye Hospital in Riyadh, Dar Al-Naim and Bouamatou Ophthalmological Hospital, Ard Al-Rijal Hospital and the health center of the Mauritanian Society for Health Education in Dar Al-Naim, Casablanca Hospital, etc., in addition to the health centers in a number of villages and rural municipalities, which are funded and built by civil society, in addition to other organizations active in the field of family, mother and child rights. We recall that Mauritania has a large legal arsenal, all related to social protection.

TRADITIONAL SOCIAL INSURANCE

This is related to community cohesion in Mauritania, as traditional ties and clan and tribal kinships still take care of a large part of social insurance in all its aspects, whether relating to illness, security, education, financing for digging a well, owning a car, or other general matters. Indeed, tribes provide security for their members and assist them to overcome difficulties. Community insurance against disease is provided through materially and financially taking care of the expenses and costs of surgeries and medication, which is mutually shared between the members of the group in the form of a division among the different members of the clan. We notice a kind of socioeconomic cohesion based on religious and social dimensions. Since the state is unable to provide insurance and health protection for all citizens, tribes continue to play a pivotal role, even if the latter diminished along with the resources. The traditional and rural society still socially takes care of its members through a range of mechanisms.

PRACTICAL STEPS TOWARDS THE REALIZATION OF THE RIGHT TO HEALTH TAKEN BY AUTHORITIES

Following are a few of the most important steps taken by the Mauritanian authorities to contribute to the realization of the right to health:

- Formulating an appropriate legal and legislative framework that is adapted to the global foundations of access to health.
- Building an infrastructure that contributes, as much as possible, to bringing treatment and health services closer to citizens (see **Table 1**).

Table 1. Distribution of health services

	Public Sector (Hospitals)	Private Sector (Private Clinics)	Total
Grade A Health Facility	21	37	58
Grade B Health Facility	115	49	164
Grade C Health Facility	794	62	856
Total	930	148	1078

- Establishing a solidarity insurance system to ensure that 100,000 low-income families are secured.
- Semi-functional and comprehensive care of critical cases.
- Designing programs for vulnerable groups.
- Building specialized hospitals such as the Cardiology Center, the National Oncology Center, Dialysis Centers, the National Center for Infectious Diseases and the National Liver Institute.
- Trying to expand health coverage and mainstreaming social protection.

- Funding for reproductive health to focus on maternal and child health.
- Creating a legal framework that regulates the issue of patient care, especially for poor patients, and taking care of them.
- As for human resources: 402 medical specialists, 532 general practitioners, 117 dentists, 76 pharmacists, 526 high-level technicians, 1,027 midwives, 1,556 state nurses and 2,208 social nurses were subscribed. Furthermore, there are between 473 and 702 general practitioners, 142 dentists, 4,500 medical staff members with 204 ambulances, in addition to 955 health institutions that have kidney filtering devices and 905 that have tomography devices.
- Medication prices were unified across the country and the salary of all health sector employees was doubled.
- As for free health services, some are now 100% free of charge, including those related to medication, intensive care, medical transport between hospitals and the transport of traffic accident victims while covering 60% of the treatment of pregnant women through a lump-sum cost approach.
- The development of a national solidarity insurance fund "Insaf", which is mainly directed towards the informal sector and will insure about 500,000 people by 2024. The services provided include hospital services and primary treatments across the entire country. According to the Mauritanian Minister of Health, this fund will, for the first time, include parental insurance.
- An easy system that ensures the provision of quality medication at reduced prices of 50% of the general pharmaceutical price at all health establishments across the country, and it will also contribute to the provision of free treatments for the poor. Central medication purchasing is available from a safe pharmaceutical inventory that enables the provision of medicines for a period of 6 months for an amount exceeding 8 billion ouguiyas, in addition to the availability of 15 cars equipped to ensure the transport of the medication.

CONTRIBUTION AND ROLE OF CIVIL SOCIETY

A healthy or active civil society in the field of human rights in general and health in particular constitutes the most important component of Mauritanian civil society. Numerically, it is the most important component in the national associative fabric, where 37% of non-governmental organizations working to ensure the right to health carry out various tasks such as patient care, provision of medication, construction of health points, provision of health-related charitable aid, organization of health and medical convoys, health advocacy, mobilization, awareness and sensitization, as well as funding and operating some health points.

There are several model NGOs working on health, the right to live in a healthy, balanced environment and fighting for patient care in line with their field of expertise. However, prioritization is difficult because of the complexity of the context, varying interests, urgency and vast needs. In general, Mauritanian civil society organizations working on health, social protection and protecting rights played and still play pivotal roles that have and will yield benefits. They are also credited with health transitions, changing health behaviors, the adoption of several legislative texts, laws, and decrees related to strengthening the healthcare system, maternal and girl health, taking care of the disabled and people with chronic diseases, and constantly maintaining attention to human rights issues, including related to the right to health, environmental rights, women, girls and migrants' rights and economic and social rights, particularly in vulnerable and marginalized rural settings and poor neighborhoods in large cities such as Nouakchott and Nouadhibou. Finally, it should be noted that in February 2023, civil society organizations working in the field of non-communicable diseases formed a network of organizations interested in partnerships, especially ones with the World Health Organization.

MAURITANIAN HEALTH SYSTEM AND COVID-19 PANDEMIC

When the first case of COVID-19 appeared on March 13, 2020, the government took several precautionary measures and prepared an action plan for the health response to the pandemic in addition to several social measures on top of the restrictive measures that were already in place. The COVID-19 pandemic revealed that the right to social protection is a fundamental human right that enables people to live in dignity and to face shocks and pandemics with strength, determination and preparedness. The repercussions and consequences of the pandemic have exceeded the already weak capacities of the state, with all its resources (human, financial, material, media and societal) that remain insignificant and vulnerable. The effects of the pandemic specifically on women were noted based on the comprehensive epidemiological trajectory survey[28] as well as the human, economic and health losses sustained, the severe suffering of the sick and healthy due to the difficult economic effects on an already weak economy such as ours, the high cost of health systems, the economic downturn, and the loss of employment. The impact on women and the elderly was more serious, as they represent the vulnerable groups most affected by the pandemic, where women were exposed to hunger and domestic, family and marital violence during lockdowns. Women lost access to the right to health, especially reproductive health, where pregnant women were subjected to a lot of arbitrariness due to the closure of hospitals and clinics and due to health and home confinement. Many women lost their jobs and were not able to attend school. They were exposed to sexual harassment,[29] rape and lost access to their civil status rights due to poor health, lack of insurance and social security.

In response to the pandemic, the government adopted a comprehensive plan that focused on the health and preventive aspect. It did not neglect resilience and the ability to adapt to pandemic conditions, and relied on the health aspect while planning using a coordination approach that followed the progression of the pandemic and development of the national economy. The government also adopted a number of measures to mitigate the pandemic's socio-economic side effects, all of which was accompanied by the launch of a presidential program that contributed to facing the pandemic. Examples of government interventions during 2020 include:

[28] Comprehensive epidemiological trajectory survey
[29] A personal analysis of the situation during and after the pandemic

- The development of an epidemiological surveillance system that enabled the permanent reprocessing of information.
- The provision of necessary supplies to national laboratories in addition to supplies, equipment and human resources that enable the availability and access to a highly capable technical platform for the National Institute of Research on Public Health allowing us to perform 1,000 tests per day instead of 100.
- Increasing Nouakchott's patient care capacity to 219 beds, including 59 recovery beds.
- The provision of supplies, tools and testing tools to as many health agencies as possible based on number of patients.
- Carrying out mobilization and awareness-raising campaigns on cleaning, sterilization, etc. at various public places designated for confinement.
- Equipping all regional and central administrations and hospitals with remote telecommunication techniques and equipment.

In order to achieve faster success and better effectiveness, the operational branch of the health sector and other sectors concerned had to coordinate their activities. The COVID-19 pandemic displayed the need for coordination and activation of the role of all sectors in order to move towards the concept and activation of the "One Health" approach and the need for coordination of various interventions and policies. The pandemic demonstrated the importance of the multilateral and solidarity dimensions of the interveners for a more effective performance, and that health work and the healthcare system must be strong, coordinated and prepared for all possibilities and to face shocks of all kinds. It also showed that urgent preventive measures should be taken to confront the crisis and to prepare to take immediate practical steps related to the establishment of a better social protection system than the existing one with the aim of providing assistance that ensures the continuity of life and helps to recover quickly in the short and medium term. In this context, the authorities waived water and electricity fees for a period of two months, exempted fishermen and workers in the informal sector from some taxes, and offered compensated leave for some of the working classes, provided free testing, screening and medication, provided cash subsidies to the poor and families in need, and partially covered the costs and expenses of vulnerable groups such as women, the disabled and others for a period exceeding one year.

Pre-pandemic data indicate that approximately 6.6% of the Mauritanian population had social coverage of any kind and 41% had access to universal health services, which is equivalent to 3.6% of GDP in 2015. As for the data from the pandemic period, there were 61,870 confirmed cases and 987 deaths related to the pandemic during October 2022. Several approaches were adopted to face the pandemic, including social distancing, vaccination, diagnosis, quarantine, closing schools and mosques, closing roads, confinement, closing land, air and sea borders, banning movement between cities, suspending various activities based on the development of the virus, its propagation and containment, and spreading awareness. Among these measures were interventions by the military, civil society, and the private sector.

The virus cycled between spreading and being contained during 2021, as a result, public authorities lifted and imposed the ban based on health variables. The government worked continuously to cope and develop strategies and plans for immunization, vaccination and protection from the virus. In addition to other proactive measures to address the various socio-economic impacts of the crisis the following was done:

- The launch of the national prevention and response campaign for the food and nutrition crises.
- Sustainable investments in social protection.
- The establishment of a special fund for social solidarity and the fight against COVID-19 with a government contribution of 2.5 billion ouguiyas, reaching 4.3 billion ouguiyas at the end of June 2020.
- The development of a multisectoral response plan in May 2020.
- The establishment of a special fund for solidarity and the fight against COVID-19 (FSS), with its revenues reaching 6.2 billion ouguiya (164 million USD) in January 2021.

Despite the authorities' efforts to monitor the situation regularly and raising pensions to protect everyone, unemployment among vulnerable groups increased during the pandemic. Accordingly, it was necessary to strike a balance between contributory and non-contributory pension systems. Women, modest workers, informal sector workers, other unemployed people and disabled persons face multiple types of discrimination. Their situation does not allow them to contribute to the social protection system in any way, despite the fact that the law guarantees their access to economic and social rights.

HEALTH ECONOMICS: THE IMPACT OF NEOLIBERAL POLICIES ON HEALTH INVESTMENT AND ACCESS TO THE RIGHT TO HEALTH

After gaining its independence on 28 November 1960, the Mauritanian republic undertook all economic activities in order to meet the urgent needs of a newly established country. In addition to the traditional state functions (security, defense), Mauritania has worked to carry out most of the other functions of establishing economic and social infrastructure and managing economic activity in general. However, over time, the country faced unfavorable internal and external conditions and experienced a period of political instability from 1979 to 1991, when the debt ratio (the World Bank, the African Development Bank, the Islamic Development Bank, the International Monetary Fund, Arab and European funds, etc.) with respect to GDP worsened, and debt service exceeded all expectations.[30]

The political and economic conditions of the country increased its burdens along with the public budget deficit which required the search for ready-made solutions to reduce this deficit or generate savings. However, the country found it necessary to implement International Monetary Fund reforms which are usually known for not taking into consideration the social impact. Consequently, the country cooperated with the World Bank and the International Monetary Fund in a series of structural reform programs[31] whereby the state abandons a large part of its social obligations, and opened the door wide for the private sector to participate in economic, production and service activities thus resulting in privatization or restructuring.

The health sector was not spared from the direct effects of the restructuring as the state allowed the private sector to provide many basic health services at double the prices. In addition, a charge was introduced for health services and consultations. Despite the charge being nominal in some health centers and at reduced prices in government hospitals, this still does not match the capabilities of most citizens as there is no health insurance that covers the variety of health services. It also became clear that government hospitals were ill equipped as there was a lack of specialized staff, stress level, time allocated for examinations, and availability of equipment and medication.

[30] عبدوتي ولد عالي استاذ بجامعة نواكشوط، مدخل إلى الاقتصاد الموريتاني: المسيرة، الملامح، المؤشّرات، ص 23 ، إصدارات المركز الموريتاني للدراسات والبحوث الاستراتيجية.

[31] Economic evaluation program covering the period from 1985 to 1988, followed by a program for financial support and payment (PREF), the two framework documents for economic policy that were adopted in 1992 to 1995, as well as the development strategy covering the period from 1998 to 2001.

In this context, the Mauritanian authorities paid close attention to the role of the private sector in development, especially in the health field, and to the role of the beneficial partnership between the public and private sectors (public-private partnership), and despite the delay in doing so, they took the initiative to legitimize and codify the role of the private sector. In accordance with the national orientation in the health sector and the need to have access to health, the position of the private health sector in the national health system should have been strengthened to enable it to integrate effectively and meaningfully into the national health system as a lever and as an essential and even pivotal element in the implementation and development of health and social policy. On that account, the institutional and legal framework for the private health sector had to be improved to ensure respect for legal procedures and the adoption of the ministry's approach.

Access to the private sector's health services is much easier than it is for the public sector despite the latter's near-free access. The private sector is very prosperous in Mauritania and covers various specialties, but it remains exclusively accessible to the well-off financially or to those who have health insurance from the state or the private sector. It is noteworthy that 83% of private sector agencies do not provide vaccination services. The average availability rate reached 60% in hospitals, 39% in health centers and 12% in health establishments. It is necessary to organize the private sector in order to improve its performance with regards to basic treatment services and to search for ways to integrate between the public and private sectors where needed, and this is an important issue given the existence of about 37 private clinics compared to 21 public clinics.

The private health sector is mainly located in major urban centers such as the capital Nouakchott and Nouadhibou, and has witnessed significant growth during the last twenty years, and has contributed to the improvement of the health sector. Based on the survey held in 2018, there are 1,078 health institutions, of which 148 belong to the private sector and 930 to the public sector.[32]

Despite that, and despite the advantages of the private sector, we must refer to some observations related to commercial health sector and its relationship to neoliberal capital and the resulting capitalist opportunism that is already familiar in various sectors. The health philosophy remains originally based on the principle of free or almost free access to the right to health, medication, diagnosis, care and insurance, especially for the poor and vulnerable groups. However, this is a missing issue

[32] الخطّة الوطنية لترقية قطاع الصحة 2021 الى 2030 الصفحة 15

in the private approach as it is based on profit. Mauritania by virtue of its poverty and geographical and developmental situation, which was imposed on it at one point in its history, followed the Bretton Woods institutions methodology (i.e., the International Monetary Fund and the World Bank, which held a conference in 1944 in the Bretton forests in the United States of America), and were coerced to submit to their harsh conditions based on profitability.

This is the philosophy of ruthless neoliberal rentier economics. However, the private sector has pros as well as cons. Though its services are based on profitability, means and quality rather than on the social and human dimension, in some cases, these services are more equipped and more easily accessible than the services provided by the state, especially in the service field. The private health services provided to citizens are built on the basis of profit and not on the basis of rights. The road to obtaining rights is long and mined, and the other path is fraught with financial challenges before anything else. The most important negative effects of the neoliberal economy on access to the right to health can be summarized as follows:

- The decline of central state services and the abandonment of some of their responsibilities.
- The right of access to health services becomes a commodity and not a right.
- Lack of access by vulnerable groups.
- Discrimination based on resource and financial capacity.
- Availability and quality of service.
- High cost of access to health.
- Trafficking in rights.
- Reliance on financial capacity and marginalization of the social and human dimension versus focus on profit.
- Temporal and spatial availability of the right to health components.
- Relative availability of the right for those who can afford to pay the price.
- Inability to access services by the poor due to lack of means.
- The increase in the number of uninsured citizens with the absence or decline of social welfare.

PRACTICAL CONCLUSIONS

We draw out of this work some conclusions related to our assessment of the access to the right to health in Mauritania. These include:

- That the Mauritanian network for social work and its partners, in cooperation with the relevant sectors, especially the Ministries of Health, the Ministry of Social Work, the National Human Rights Commission and other civil society organizations, should start advocating for human rights issues related to health, education and social protection.
- The network should follow the work that has begun and be a living example of an enlightened civil society that realistically and objectively defends the social and economic rights of all citizens while highlighting shortcomings.
- Adopting a human rights approach and advocacy that serves inclusive growth.
- The success of any initiative to implement the right to health is conditional on our ability to ensure the establishment and development of an integrated policy.
- Adopt a comprehensive human rights approach.
- Provide political stability and ensure security.
- Provide a political, economic and social ecosystem.
- The stated and clear commitment of the various actors such as the government, civil society and parliamentarians.
- Comprehensively mobilize all those involved in the realization and implementation of the right to health while mobilizing them to advocate for the relevant causes.
- Engage health professionals at all levels to provide community health as a right, not as a service.
- Mobilize the necessary funds on a permanent basis, especially for remote areas.
- Change the mindsets of beneficiaries and decision-makers about the need to understand the right to health.

- Include the right to health in various government policies and action plans as a development lever involving various actors and not related to health as a sector or ministry that is part of it.
- Full coordination with government sectors concerned with the enforcement of rights, as well as civil society, the private sector, parliament and the press to make everyone understand the need to change perceptions and adopt a rights-based approach that makes the right to health and social protection a citizen's right.

OVERVIEW OF CHALLENGES TO ACCESSING THE RIGHT TO HEALTH

- Access to health insurance for rural women.
- Rural women are in areas not covered by the primary health service.
- Women in the city suffer from the absence of alimony and the spread of diseases.
- Poor health infrastructure and associated infrastructure such as roads, electricity, water and others.
- Weak civil society resources and partnerships.
- The limited financial and human resources of the country.
- The chaotic report, which fragments state resources.
- Healthcare and social security services are focused at the urban centers' level.

GENERAL RECOMMENDATIONS TO ENSURE ACCESS TO THE RIGHT TO HEALTH

- Adopting a rights-based approach to enable citizens to access the right to health.
- Adopting an integrated approach focused on changing mindsets in the health field.
- In the area of health, prioritizing the health of mothers and girls, and care for the disabled and vulnerable groups.
- Adopting a doubled budget for the health sector to enable it to acquire and procure financial and human resources.
- Expanding health and social coverage.
- Addressing human rights issues, whether health, environmental, women's, girls', migrants', or economic and social rights, in particular in vulnerable settings of former slaves and vulnerable groups in rural areas and poor neighborhoods in large cities such as Nouakchott and Nouadhibou.
- Activating the role of the media and health education.
- Consider a 'One Health' approach that addresses the veterinary, environmental and human dimension.
- Fighting pollution and prioritizing the environmental dimension.
- Controlling food products and ensuring their validity and sources.

CONCLUSION

The health situation in Mauritania is not much different from its counterparts in most Arab countries and the poor countries of the Sahel region, although it has witnessed a remarkable and clear improvement in recent periods. However, access to and enjoyment of the right to health as a human rights goal remains elusive, as society and citizens' understanding of the access to the right and the level of adherence of actors and decision-makers to the issue at the strategic level remains unexpected and below the required level. Achieving the fulfillment of commitments in this area requires a strict policy, adequate and appropriate funding and an effective approach that involves civil society and the private sector as essential and indispensable actors, and the development and implementation of programs and policies based on human rights rather than a therapeutic approach through the mobilization of human and financial resources and infrastructure that are not yet available. This health policy changes and fluctuates with the fluctuations of international conventions and agreements, United Nations policies and programs, and based on the situation. On the ground, the diagnosis and in-depth analysis (of the current Mauritanian health situation in a given period) in its various economic, cultural, environmental, educational, climatic and commercial manifestations is necessary, while taking into consideration the cultural, societal and environmental framework of the country and global health trends, and the fight against poverty as a determinant of health.

Through all strategies, policies and plans, Mauritania is committed to the implementation and development of a health policy within the framework of universal access for its citizens to health services in an equitable manner and that is easily accessible to all. Progressive governments have tried and continute to try to create the necessary conditions for the success of such a strategy by ensuring successful leadership and mobilizing the necessary resources to achieve this goal.

The administrative and technical health services at various levels are tasked with implementing these policies, each according to its capacity, competency, and authority. The government will also work on involving all actors, especially local groups, beneficiaries, development partners and civil

society, who must play an important and critical role in health and social work and access to the right to health, services and social welfare.

This paper constitutes the Mauritanian report on the right to health, and covers the public sector, the private sector and the role of civil society. We hope that it will be activated and its outputs implemented by taking into consideration the recommendations offered to the various actors, through a human rights' approach that adopts health as an economic, social, constitutional, national and international right, not as a political service that may or may not exist based on political desires.

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P.O.Box Mazraa 5792/14 Beirut, Lebanon

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American University of Beirut
P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
Lebanon