Rebuilding Health in Mozambique

INTRODUCTION

Until 1975, Mozambique was a Portuguese colony. The majority of people lived in conditions of hardship and poverty and suffered from a lack of most basic needs, such as proper housing, food, sanitation and education.

"Portuguese policy produced large scale under-development of the masses and forced people off the land. Traditional systems of communal land ownership were broken down, the local social structures of the people shattered and the caring social and cultural fabric of communities destroyed. All these can be recognised as the conditions that breed ill-health." (Africa Report, 1978:11)

HEALTH CARE UNDER PORTUGUESE COLONIAL RULE

Until 1974, medical services in Mozambique were aimed largely at the settler population. They were discriminatory on a number of levels : geographically - almost two thirds of the doctors worked in the capital city where only 5% of the population lived (Segall, 1978) and racially - hospital wards were divided into black and white, the latter receiving superior health care. Almost all care was private and had to be paid for. The majority of Mozambicans could not afford the high prices charged.

Segall (1978) estimates that 70% of the people lived beyond the reach of any health care under colonialism. Also, one third of the national health budget was spent on the main hospital in Lourenco Marques which was accessible to only 8% of the population.

Health policy and planning were not designed in order to benefit all people. Preventive health care was virtually non-existent, being limited to some immunisation and sanitation control in the urban areas (Walt, 1980). Health services were fragmented, the great majority being provided by private practitioners.

In a speech in 1974, Machel described the health situation in his country just before independence.

"In the Mozambique of the colonialists and the capitalists there are hospitals only where there are settlers. There are only doctors and nurses where people who can pay live. In Lourenco Marques there are more hospital beds, more doctors, more nurses and more laboratories than in all the rest of Mozambique. Does this mean that Lourenco Marques is the only place where people get sick?

"In the mines where we work, on the company plantations which we cultivate, on the roads that we build, in the factories, in the fields, in the villages, there are millions of people who have never seen a doctor or a nurse, who have never had any medical care when they are ill" (1974:13).

In 1975 the Frelimo goverment came to power in Mozambique, committed to establishing a democratic society and improving people's lives. From the beginning, betterment of health care was one of the main priorities of the new goverment (Korn, 1976).

In an economically poor country such as Mozambique, this is not an easy task.

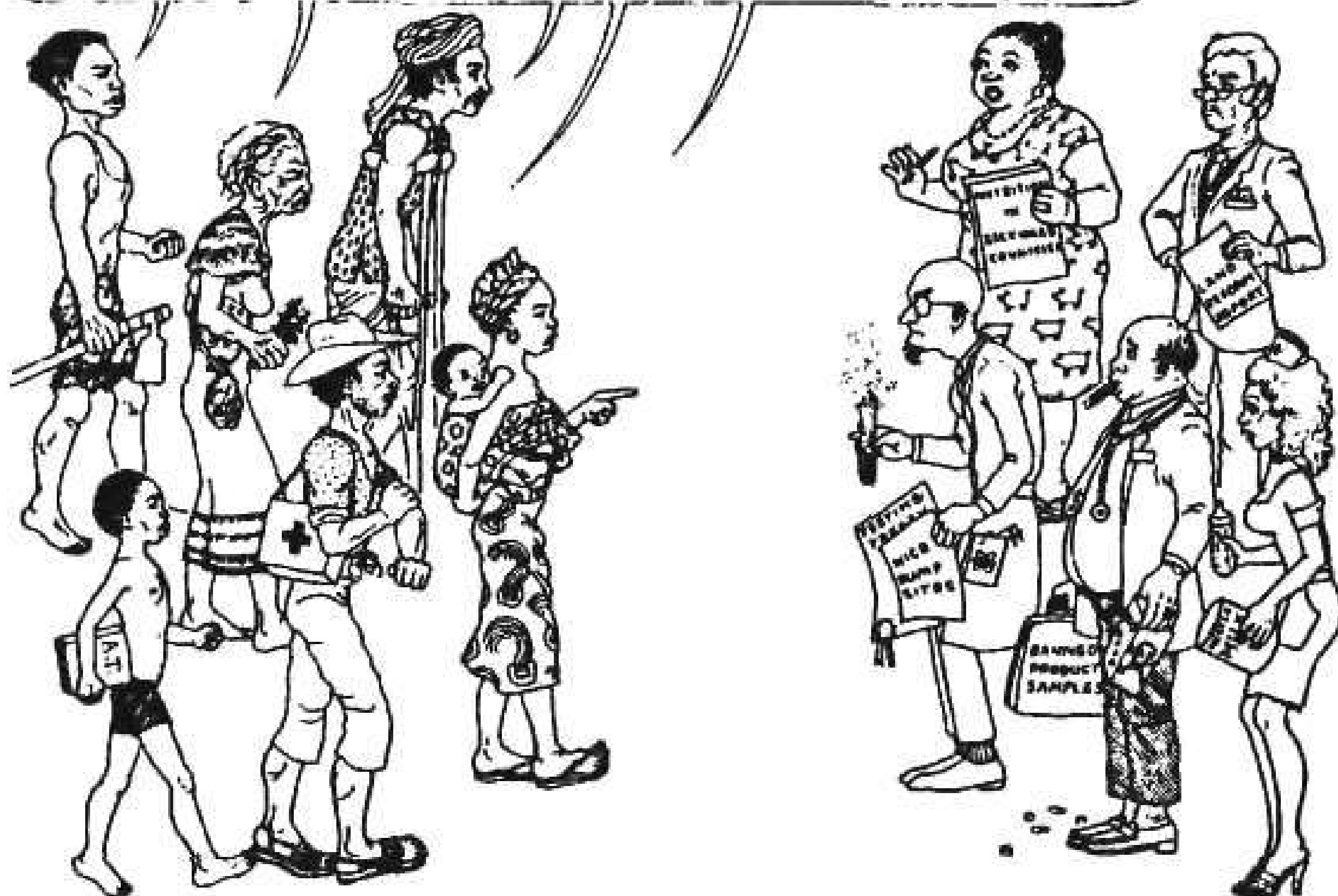
HEALTH SERVICES IN POST-COLONIAL MOZAMBIQUE

National policy

The health policy adopted by the Frelimo goverment reflects its political ideology: health services are to serve the mass of the people and the emphasis is to be put on preventive care (Walt, 1980).

At Frelimo's Third Congress held in 1977, guidelines for the next three years of development were established, which outlined the ideas underlying health policy: "A fundamental task of the Party is to organise a health system that benefits all Mozambican people" (Walt, 1980).

Frelimo sees health as an integral part of the development process: better health contributes to social and economic development and this in turn generates additional resources and social energy which will facilitate further improvements in health. Goals formulated at the Congress included extending the structure and benefits of health services to all parts of the country and giving priority to the practice of preventive medicine (Programa da Frelimo, 1977).



Examples of specific steps which have been taken so far to implement policy are the nationalisation of all health institutions (in July 1975) and the banning of the private practice of medicine. These measures are seen by Gabriel and Stuart (1978) as an essential first step in the implementation of later health programmes and policies. For example, it is a necessary step in breaking down conventional beliefs that health care is a commodity and building up the idea that it is the social responsibility of the society (Gabriel and Stuart, 1978).

Legislation has also been introduced to ensure that health care is accessible to all people. For example the law on Socialisation of Medicine, passed in November 1979, provides for free emergency and preventive care and the right to free in-patient treatment. In fact, most medical care is now free, with the exception of a nominal fee (less than 25 US cents) for out-patient consultations (Gabriel and Stuart, 1978).

While Frelimo's health policy appears to be sound, there is not enough evidence at hand to judge how succesfully this policy has been put into practice to date.

Health planning in Mozambique has been criticised by Hastings (1981), a director of one of the health centres there. Hastings says : "The greatest single obstacle to advancement is the extremely low awareness amongst health care planners and administrators at Ministry and Provincial level, of the real state of affairs within the health centres and health posts. As a consequence ... if a plan is not fulfilled, the people supposed to fulfill it are blamed, but that the plan itself might be wrong is never considered" (1981).

However, since his article was published, this obstacle has, through greater contact between central and peripheral health structures, become

much less dominant. In addition, the planning process, especially at the provincial and district health levels, has undergone critical evaluation and changes, and is far more systematic than in the past.

For example, planning is based on a clearer idea of the needs in a particular area, taking into account the limitations present in the health system of the area. There is a far more systematic approach to the training of provincial and district health directors in the skills of planning and management. The annual health plans, upon which national, provincial, and district health work are based, have been simplified and priorities clearly stated (Sider, 1984).

One of the serious limitations of a health plan which devotes attention to quantity of work done, such as the number of immunisations performed, is that health workers can tend to become fixated on numbers and not on the quality of services being offered. For example, vaccinating the necessary number of people but not taking care that the vaccine is kept in conditions which ensure that it is still active when administered, gives a false sense of security against basic infectious diseases.

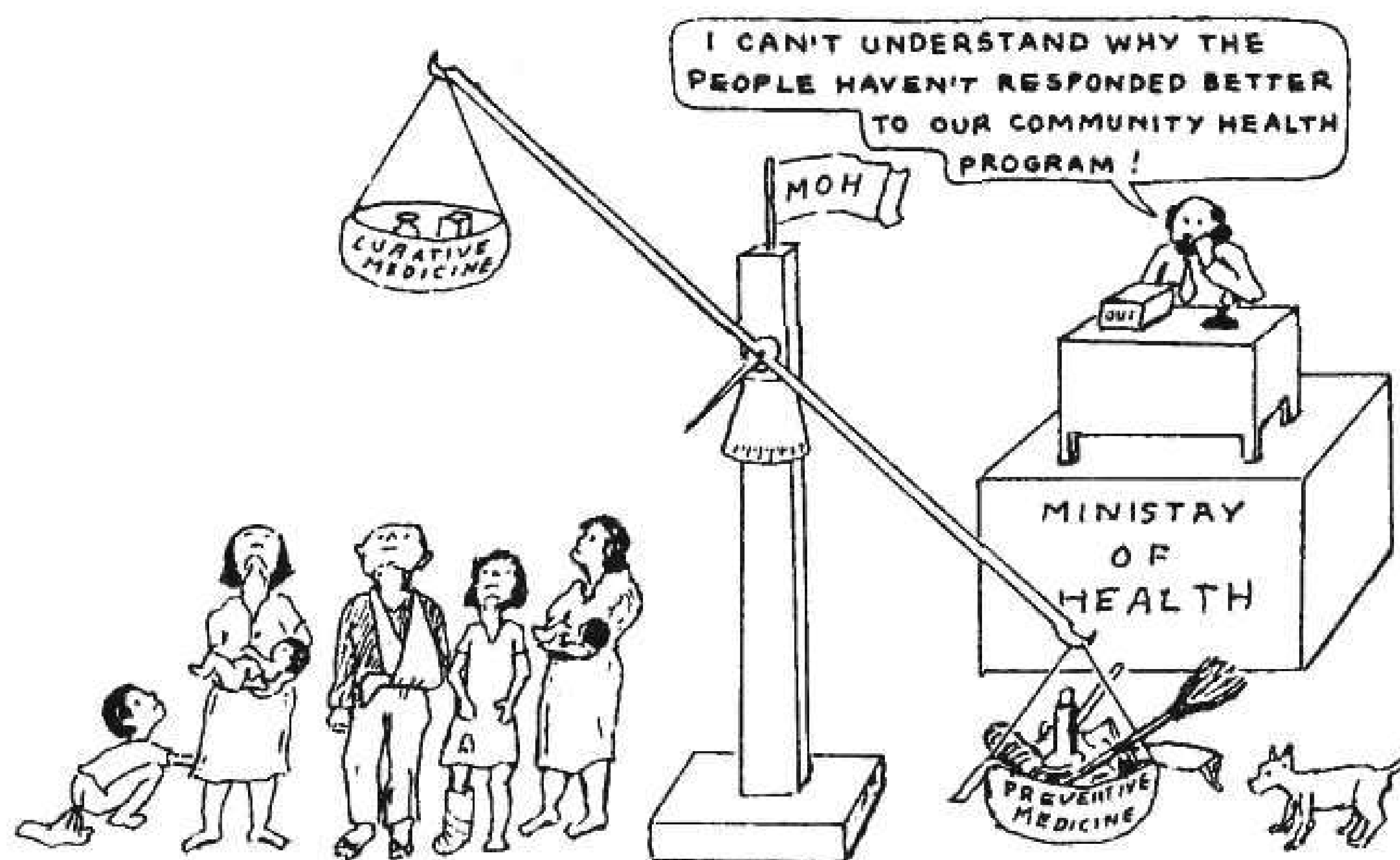
One problem identified by Hastings is the "hierarchical structure and introspectiveness" of the Health Ministry. The complexities of the enormous obstacles to changing the orientation of health care from a disease-based service, centred on large well-equipped hospitals, to preventive primary care are "ignored or glossed over".

Hastings states that he sees little evidence of a serious attempt to analyse in depth the problems of primary health care and work out a long-term strategy for their solution. However, he does

also say that the basic structure and orientation of primary care is correct and it is not over-optimistic to expect that Mozambique will one day have one of the best systems of primary care in Africa.

Sider (1984) believes that these criticisms are not accurate at this point in time.

In a community-based program, curative care cannot be separated from prevention. The first leads to the second.



A HEALTHY BALANCE BETWEEN PREVENTIVE AND CURATIVE MEDICINE MUST TAKE INTO CONSIDERATION WHAT THE PEOPLE WANT.

Priorities in health care

In Mozambique, the need to establish a correct balance between curative and preventive health care has been a major focus of attention of the health authorities (Walt, 1980). The Mozambican Health Minister, in his statement to the World Health Organization regional conference for Africa in 1975, declared that maximum priority had been given to preventive medicine through the planning of a nation-wide health programme.

However, although prevention has been made the foundation of the nationalised health service, the goverment has not ignored the curative services (Walt, 1980).

Machel, in a speech to health workers in 1974, said "... overcoming under-development does not signify only preparing for the future; it means also guaranteeing the present. In terms of health this means that, on a par with preventive action, it is necessary to develop our curative capacity according to the needs of our people..." (Machel, 1974).

Hastings (1981) identified a problem in the country's preventive health services. While there have been a number of highly succesful immunisation campaigns (in one national campaign over 95% of the population were immunised), there is still little understanding by most people that immunisation has to be given at regular intervals.

People have learnt the idea that immunisation is something a child should have only when the newspaper, radio, and other media are warning of an imminent danger. The amount of publicity to explain immunisation as a measure to be taken at definite ages has been minimal.

New emphasis is being placed on the development of integrated under-fives' clinics, where one of the principal concerns is to be the immunisation of all well and ill children brought to the clinics. This may help to overcome some of the problems mentioned by Hastings (Sider, 1984).

Resources

In 1975 the Mozambican Minister of Health described existing facilities to WHO delegates at the United Nations : "In the three main cities there was a great imbalance between one goverment *department and another ... the city of Lourenco* Marques where we have a neuro-surgery centre with equipment that would be the envy of many an international centre, but where in a maternity ward women give birth on a cold and bare floor, where rain leaks through, where three beds must make do for five..." (Korn, 1976).

From the beginning Frelimo attempted to rectify this imbalance in the distribution of resources. Korn (1976) sums up the objectives of the Mozambican health system as follows : "the largest possible amount of health care for the greatest possible amount of the population which can be obtained for the resources actually available".

In the first year after independence, the health budget was increased by 40-50% (Gabriel and Stuart, 1978). Even during the liberation struggle, Frelimo did more to improve the people's health in seven years than the colonial power had done in all its time of occupation.

A major priority after 1975 was the establishment of an organised rural health service (Walt, 1980).

The rising cost of health services

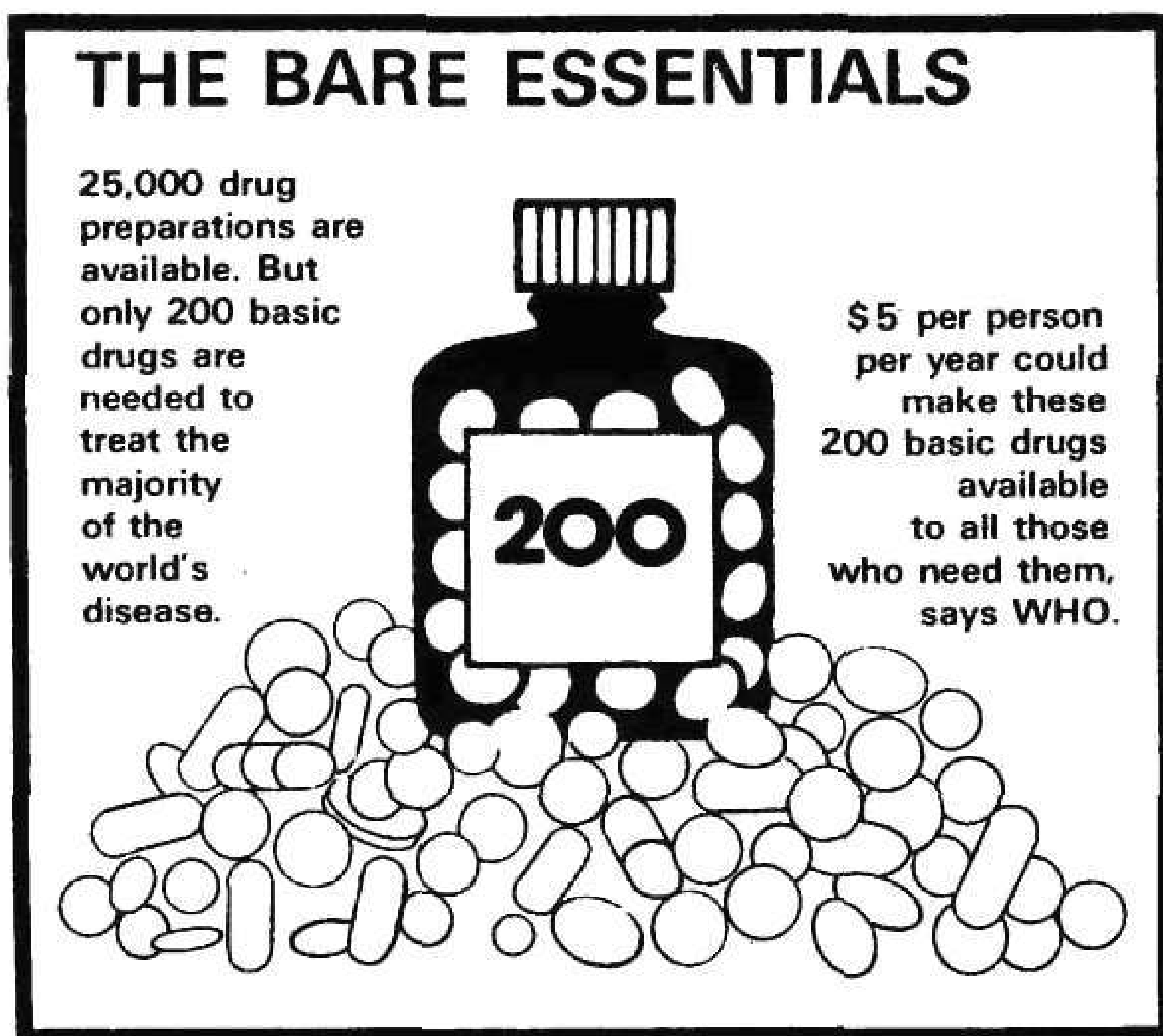
An economically poor country like Mozambique faces tremendous problems because of the shortage of resources. Areas such as the health sector are obviously affected by this.

However, there are ways in which costs can be quite substantially reduced and Mozambique is making a big effort in this direction by promoting a health service consisting primarily of paramedical and village health personnel.

Another way in which the health authorities have managed to cut down on unneccessary costs is in the supply of drugs. Between October 1975 and 1980, the number of different pharmaceutical products available in the country was reduced from about 13 000 to 340 (Contact, 1983).

Drug imports today cost the same as they did 10 years ago. Mozambique is consequently buying a lot more drugs for its money by not wasting money on useless and dangerous drugs, fancy packaging and well known trade-names.

This means that basic medicines are now available for the first time in even the most remote parts of the country. There has also been a strong attempt to educate health workers to use drugs more sensibly, training them to prescribe the least expensive and most effective drugs (Walt, 1980).



One example of this is the treatment of diarrhoea, which at one time was responsible for large amounts of drugs being wasted. Diarrhoea treatment by means of oral rehydration instead of antibiotics has been a special focus for training to form good prescribing habits. Results have been dramatic. Fewer children die of diarrhoea and less money is spent on unnecessary drugs (Contact, 1983).

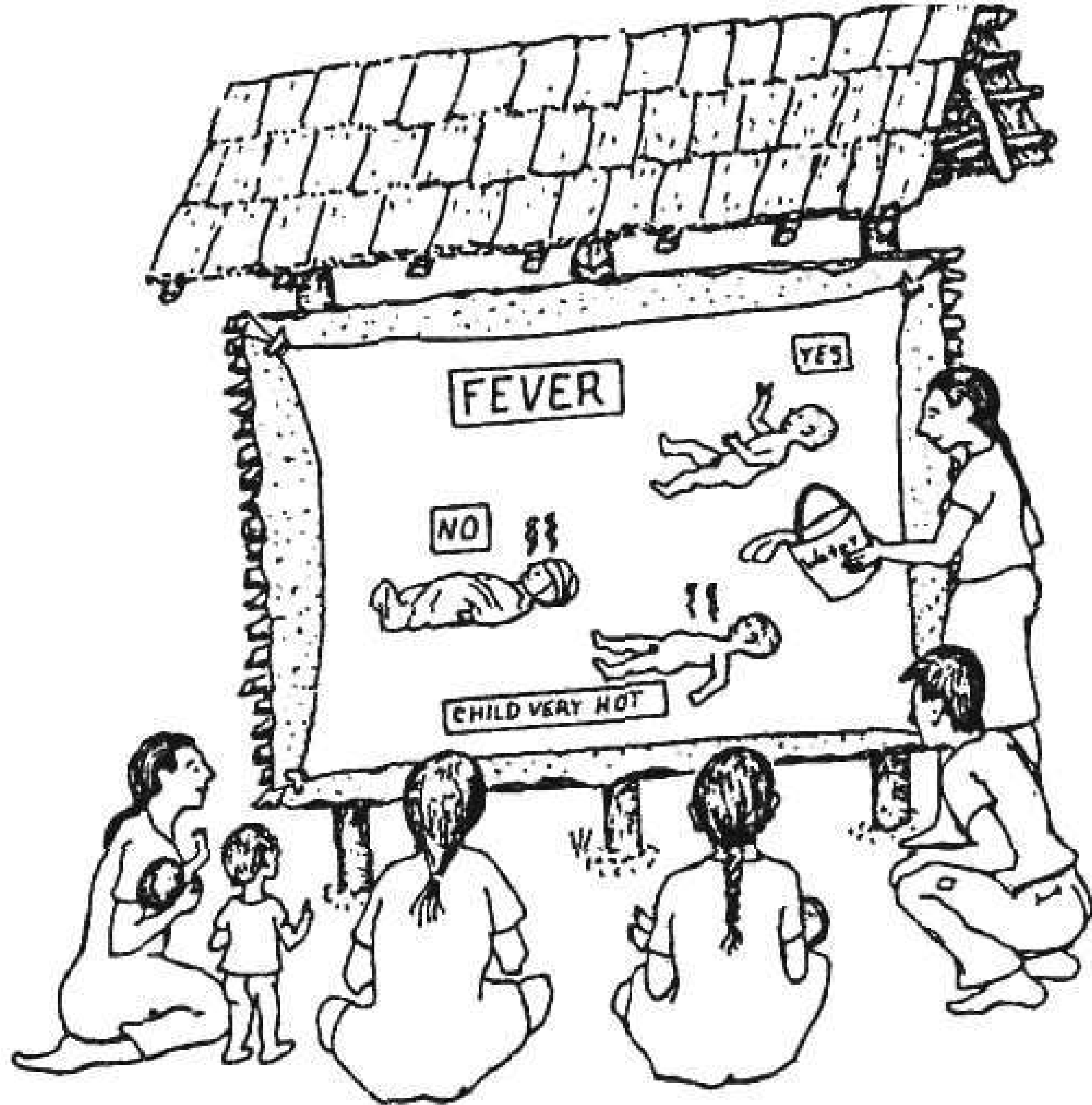
Training health personnel

During the colonial period, the kind of training that health workers received was reflected in their attitudes towards their work. Medicine was seen as a professional and technical matter completely divorced from politics. Initiative on the part of the community was inhibited and corruption flourished (Africa Report, 1978). Machel described hospitals at that time as "rigid", "individualist" and "medicine monopolistic" (Africa Report, 1978).

Since independence, however, a genuine effort has been made in Mozambique to provide health personnel with the kind of training which will equip them to be effective health workers.

During the liberation struggle, Frelimo established a hospital in southern Tanzania to train health cadres. The training of these health workers reflected Frelimo's understanding of the "politics of health" (Gabriel and Stuart, 1978). Cadres were both politically and medically trained and this training emphasised community and preventive health as well as providing skills in curative medicine.

Other issues raised during training were those related to social class, the social and economic effects of capitalism and the many traditional and economic restrictions placed on women.



After independence, the medical curriculum was changed. It was orientated towards Mozambican epidemiology instead of disease patterns in Portugal as it had been previously. More emphasis was placed on paediatrics, obstetrics and gynaecology to cover the groups most at risk in the community. Medical students also have to spend two years in rural areas after graduating.

There are various levels of primary health care workers being trained at present, and the diversity and numbers of different training centres demonstrates clearly Frelimo's commitment to improving primary health care services.

Seven or eight provincial training centres have been established for the training of Agentes Polyvalentes Elementares (APEs). The APEs are trained in primary health care and one of their main tasks is to promote mother and child health. In particular, they are expected to perform ante-natal and basic child health programmes.

Most of the APEs are men. As acceptance of males within the process of child-birth is limited, there has been increasing interest in upgrading the knowledge, skills and attitudes of the traditional birth attendants.

The APEs have mostly preventive health skills, and their lack of curative health skills shows a failure to respond to the felt needs of the communal village members. The APEs have had to overcome the problem of poor credibility in the eyes of villagers, and this has necessitated some changes in their training.

The insufficiency of collective production in many communal villages has meant that the community is often unable to support the APEs, who therefore have to spend more time in the fields and less time in health-related activities. In some cases APEs have been forced to give up their health work altogether.

Over the last one to two years provincial training courses for nurses and midwives have also been set up. These courses upgrade the skills and knowledge of many health workers in the rural health posts and centres, returning these new health cadres to the areas where they worked previously.

There are also four Institutes of Health Sciences, in Maputo, Beira, Quelimane, and Nampula, plus a new course for medical technicians based in the provincial hospital of Lichinga, the capital of Niassa Province.

Here people receive a basic preventive medicine course. The growing emphasis has been that there is no such thing as a purely "preventive" or purely "curative" health worker, but that each worker should have sufficient skills in both areas. This has led to changes in the training of primary health workers.

Several older post-independence health worker categories are being phased out and substituted by the basic nursing course. These basic nurses will have an integrated training in curative and preventive skills, nursing and rehabilitation. After a period of several years service in the rural areas, new career structures give them the right to go on to more specialized training in curative, preventive, or nursing fields.

There are separate and defined career structures for midwives, basic pharmacy, x-ray, laboratory and dental personnel.

Thus, in comparison with the 12-20 doctors trained annually, literally hundreds of primary health workers and APEs are trained, all destined for the expanding rural health network.

Community involvement in health care

Since independence, there has been an emphasis on health as "... a combined effort on the part of the community" (Africa Report, 1978). This emphasis on drawing people in to take part in their own health care develops out of a broader political objective of encouraging the participation of people at all levels.

Walt (1980) sees the period of armed struggle in Mozambique as important for Frelimo in the formulation of these later principles. Through their struggle, Frelimo learned that only with the participation of ordinary people in the different spheres could any real advances be made. This ideology was obviously extended into the health sector, in which Walt (1980) sees participation as being "extensive and on-going".

Through the Frelimo Party structure, regular meetings are held between communitiies and health services. Health teams are expected to leave health centres and go into communities --villages or suburbs - to hear criticisms and problems, and exchange views.

People from the community are involved in the life of their local hospital or health centre. There are often collective work sessions in the gardens where community groups are joined by hospital staff in cleaning, planting and other necessary maintenance chores of the health facilities.

But the reality is a little more complex and sobering according to Sider (1984). He states that there is a contradiction between central health planning processes and local popular participation.

Although those health priorities that are identified are in the best interests of the vast majority of the people, they may not be congruent with people's felt needs. The main felt need is for curative health services, while the major priority is largely the improvement of preventive services. Thus the concept of community participation is problematic in this respect.

Amongst all the demands and tasks faced by health workers, communication with the community is often far down the list of their priorities, being sporadic at best.

Many criticisms that are raised in meetings with community members have to do with dissatisfaction over the type of treatment people receive from health workers. The positive results to be gained from public criticism occur only when a solid and active Party structure permeates the health unit, because this enables that criticism to be acted upon.

When, on the other hand, its members are weak, indifferent or prone to the very behaviour criticised by the people, the net effect is minimal. Thus popular criticism produces few visible results and people's willingness to be involved with, criticise and suggest improvements during these community meetings diminishes.

This dynamic is particularly severe when difficult economic conditions lead to conditions such as understaffing and drug shortages. This results in much public dissatisfaction with the health services and greater concern about more and more visible inequalities in access to and quality of treatment.

It also results in the overworked and under-supported health workers being prone to much less self-critical attitudes, poor morale, and at times desires to switch to more remunerative and less demanding work elsewhere, especially in the private sector.

In general, although there is a constant commitment to comunity participation, and given the limitations described above, a popular and representative voice in the organisation and functioning of the health services is still under-developed (Sider, 1984).

Opposition to change

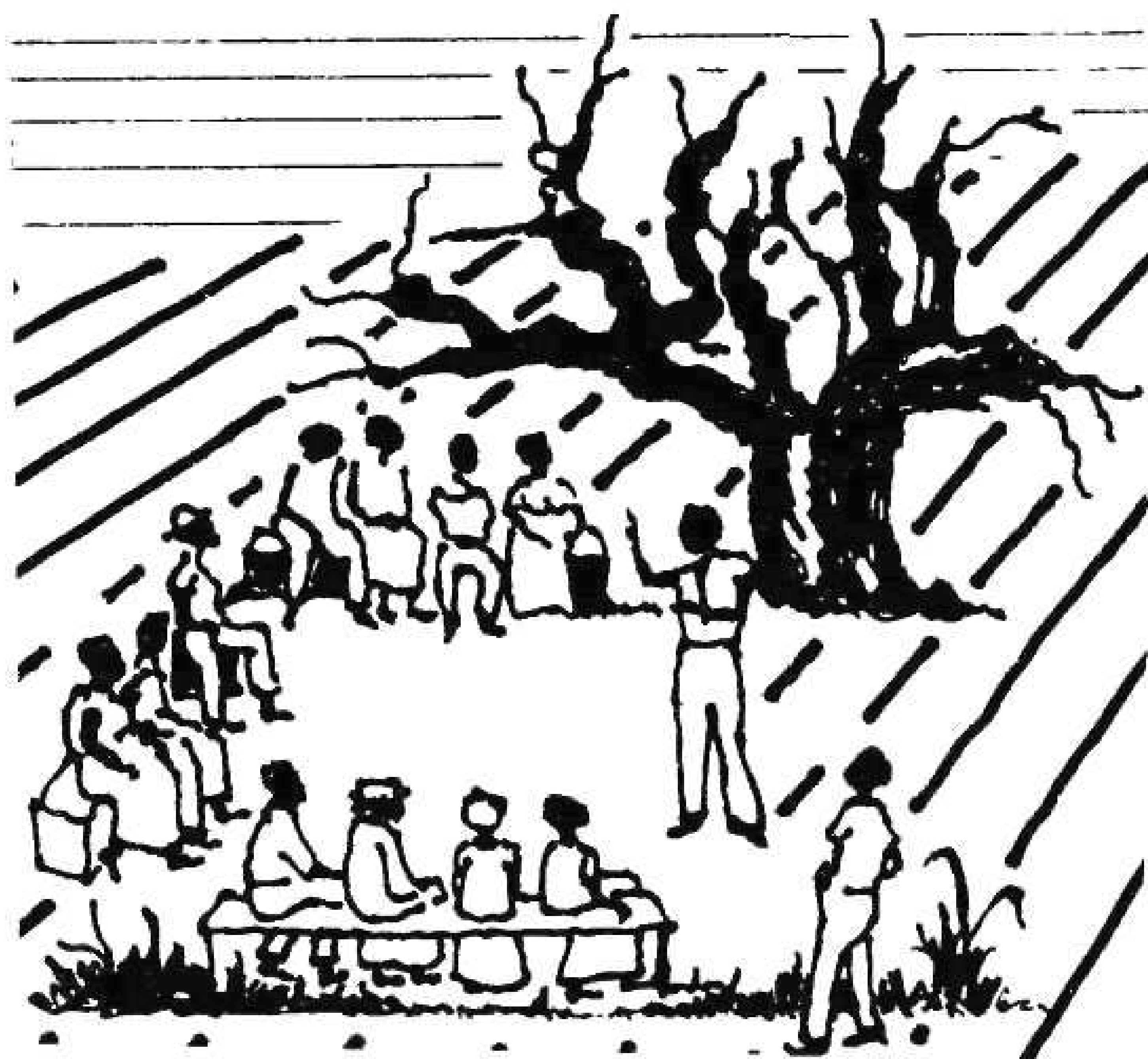
Opposition from the medical profession to progressive changes in a health care system can have serious repercussions on health plans and

programmes. In Mozambique, many doctors who were opposed to the new goverment demonstrated their opposition by leaving the country. Although this created tremendous problems in terms of staff shortages, in another sense it can be seen as a "cleansing process" (Gabriel and Stuart, 1976).

After independence, most of the 500 doctors left the country, leaving about 80 to cope with providing health care for approximately 12 million people (Walt, 1980). Many people with other technical skills also left. By May 1976, the number of doctors for the entire population had decreased to twenty (Gabriel and Stuart, 1978).

This situation was made even more difficult by the attitude of some of those who did remain : old patterns of behaviour such as racism continued.

There were serious deficiencies in the maintenance of medical standards, partly due to lack of staff, but also due to inflexibility of thought and political opposition to the new regime (Africa Report, 1978).



Mozambique has been inundated with expatriot doctors from around the world. Sider (1984) cites this as a problem :

"As a result of this 'cleansing process', Mozambique has become markedly dependent on an international polyglot of expatriate medical personnel, called cooperantes. While much useful interchange can be a positive result, the tremendous diversity in motivations, attitudes and technical and political practises of these cooperantes, makes it much more difficult to create a medical system with uniform training and practice.

"Many of the cooperantes are insensitive to the limitations, priorities, and conditions in Mozambique. Arrogance, racism, ill-treatment, incompetence are not just 'old patterns of behaviour', but are features of some of the cooperante health workers, especially doctors.

"Considering that there has been little real change in the position and power of doctors in the health system and the fact that health is such a visible and political interface between the goverment and the population, the political costs of such a dependency is worrisome."

REFERENCES

Africa Report (1978) "Health in Mozambique : from exploitation to liberation".

Contact (1983), Christian Medical Commission, no. 73.

Gabriel P.S. Stuart S.M. (1978) "The role of health care in Socialist Revolutions : Mozambique and Cuba", Ufahumu, Vol 8, no. 2.

Hastings A. (1981) "Health care in Mozambique", Medicine in Society, Vol 7, nos. 2 and 3.

Korn J. (1976) "A report from the health sector of the People's Republic of Mozambique", WUS/Davida Report, 1 April 1976.

Machel S. (1974) "Our hospitals' role in the revolution", Mozambique Revolution, Jan-Mar 1974.

Segall M. (1976) "Mozambique : priorities for health", New Perspective, Oct-Nov 1976.

Segall M. (1978) "Health and national liberation in the People's Republic of Mozambique", International Journal of Health services, vol 7, no 2.

Sider D. (1984), personal communication and interviews.

Walt G. (1980) "Commitment to primary health care in Mozambique : a preliminary review", Rural Africana, nos. 8 and 9.