Health Care in Mozambique

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Independent Mozambique, despite constant threats to its very existence and three severe droughts in ten years has succeeded in evolving a framework for providing rational health care. This article examines developments in health care within the revolutionary context of the government's avowed programme for constructing a socialist society.

MOZAMBIQUE is a country of five million on the south eastern coast of Africa. It became independent in 1975 after a prolonged ten-year armed struggle against the five centuries old colonial rule of Portugal. Spearheading the liberation movement was the Frente de Libertacao de Mocambique (FRELIMO), the vanguard party of the alliance between the workers and peasants. The armed struggle can be said to have begun in September 1964 with 48 guerilla fighters in four provinces of northern Mozambique. Portuguese troops numbered 70,000, half of them European. In the 10-year war, over 2,000 FRELIMO guerillas were killed.

The constitution of the Republic of Mozambique and the government programme envisage the construction of a socialist society. Within this revolutionary context and as a part of the programme of reconstruction, Mozambique has made radical changes in its health care structure which has meant a reprioritisation of health care, the introduction of new types of health personnel; more appropriate methods of education; and a fundamental restructuring of the pharmaceuticals sector. It is the last, Mozambique's drug policy which was elicited much interest and attention by its success in bringing down the prices of drugs and making them available to the largest numbers. However, none of these have been isolated programmes—they have been proposed and implemented as an integral part of a comprehensive programme of nation-building derived from a larger political perspective of a socialist society. Also, it seems obvious that these programmes, especially relating to health care, have evolved out of the years of struggles and that experience of FRELIMO in the liberated zones has informed social policy after independence.

Before examining the health care programme in independent Mozambique, it is useful to take brief note of the political and economic developments in the country and the external pressures and internal constraints which have influenced the course of development.

In September 1975, the first FRELIMO-controlled parliament, albeit appointed by the Portuguese, was installed as the transitional government. However, even as it began to find its feet, in December it had to focus its energies on putting down an attempt by a section of the army to bring down the government. In the aftermath, President Samora Machel warned against the tendency of confusing "popular victory with permission to satisfy egotistical desires and considering luxury and depravity as a right by dint of . . . participation in the struggle."

In July 1976, the Mozambique Council of Ministers met for the first time and outlined the country's development policy and its main priorities. These were directed not at "reforming the country's old structures but at replacing them with a "new society for the benefit of the masses". The statement said: ". . . radical change (was envisaged) to place the state at the service of the masses of workers and peasants." Priority was to be given to rural areas—and national defence was to be closely linked to nation-building and resources were to be mobilised for setting up "communal villages". As regards religion, the masses would be protected against any pressure to practise religion. "The Catholic church is a reactionary organisation giving rise to counter revolutionary activities in people's democracies." Efforts were instituted to transform the FRELIMO forces into a regular army and to reorganise the police force.

One of the major features of the development policy was a series of nationalisation measures—the takeover of private schools and colleges, hospitals, clinics and all private doctors' and lawyers' practices. The export of cashew nuts—45 per cent of world output—was placed under government control. All buildings and land were taken over. "Certain individuals" were to work for three years without payment. Everyone had to pay one day's salary each month into a "solidarity bank" to be used to help "oppressed people of the world", particularly Namibia, Rhodesia and South Africa. With the announcement of nationalisation measures however, relations with Portugal deteriorated and agreements of co-operation between the two countries remained suspended.

While 60,000 Mozambique refugees who had fled to Tanzania were invited to return, new citizenship legislation denied residence to any foreigner who had satyed outside the country for more than 90 days. Thousands of Portugese who had fled the country after racial clashes in 1974 lost the right to return.

The liberation of Mozambique "radically altered the balance of forces in favour of African nationalists." There was an intensification of guerilla warfare against the White minority regime in Rhodesia by African nationals based in Mozambique. The border between the two countries was closed and Mozambique, following UN imposed sanctions including the confiscation of Rhodesian property in Mozambique. This resulted in a closure of Rhodesia's rail links with the ports Beira and Maputo. It also cut Rhodesia's food supplies to Mozambique. Mozambique appealed to the UN Security Council for an aid of $ 1,000,000 a year to meet the financial consequences of the decision to apply sanctions against Rhodesia. Sweden increased its aid to Mozambique by 40 per cent. UK supported the decision; Uganda and Zambia saw Mozambique's decision as an "act of courage and commitment to the cause of peace and justice for all mankind" and urged support for Mozambique until victory was won by Zimbabwe. Mozambique's losses in customs and port dues were estimated at £ 17,000,000 a year and about 86,000 Mozambians, it was feared, might be prevented from repatriating their earnings from Rhodesia.

By 1983 Mozambique was reeling under the worst ever drought in 50 years. Moreover, the tactics of the Mozambique National Resistance supported and funded by South Africa, of attacking crucial economic targets, of kidnapping foreign technicians and attacking health centres were aimed at under-

mining Mozambique's effort at creating badly-needed development facilities. Harvests were disrupted and in one district all the seven communal villages, three agricultural co-operatives and state farms were destroyed. Black marketing in food and other consumer essential were rampant and there was a rise in crime rates. Death penalty which had been abolished in 1979 was reinstated as was public flogging for robbers, rapists and black marketers, whereas the previous emphasis was on clemency. In early 1983, chloera killed 250 people and afflicted 7,000 in drought affected regions.

In April 1983 the Fourth Congress of the FRELIMO party set out some immediate goals which necessitated a change in priorities in certain areas. The Congress recognised that combating hunger was the immediate priority. It outlined agrarian reforms—small family farms, which had thus far received little help were to be supported. The development of large farms, and of agriculture co-operatives was seen as a medium-term objective. State farms were to be reorganised and consolidated instead of expanded in the following five years. Existing machinery was to be put to better use. Resources were to be diverted from large projects in industry and agriculture to small projects which would yield immediate returns. In the party politburo the emphasis shifted from military personnel to peasants and those who had been active in the liberation struggle. President Machel acknowledged that Mozambique had "erraneously developed a hostile attitude to private enterprise". A new investment code was drawn up in 1984 permitting transfer of profits and tax exemptions, etc, in certain sectors, but not in sectors such as petroleum. No private unit has been allowed to be set up in the pharmaceutical sector either.

By 1984 over 5,000,000 people had been affected by drought. Agricultural production was cut by 80 per cent in the country's 10 provinces. Lakhs of tonnes of cereals and cassava, a staple food, were lost. According to an FAO report, 100,000 died of starvation. Mozambique signed an agreement with South Africa—in return for South Africa withdrawing support to the guerilla forces of the Mozambique National Resistance, Mozambique would expel ANC activists. However, MNR continues to receive aid and clandestine support from wealthy Portugese in South Africa who number over 600,000. The MNR is now said to be operating in all the country's provinces. Only the northern most province, the cradle and stronghold of FRELIMO is free from such activity. The RNM is said to have 8,000 to 17,000 men.

Food aid has come in from East European countries as well as from USSR, Zimbabwe etc. However, Mozambique has never been self-sufficient in food. The country's annual cereal requirement is around 515,000 tonnes; local production is only 180,000 tonnes. It is against a background of these developments of the last ten years that we must view changes in health status and health care.

State of Health Care in Mozambique before Independence

Health service before independence had the characteristic features of health care under colonialism. There was economic, racial and geographic diserimination. Health facilities were predominantly urban and in White settler areas—over ⅔rds of the doctors in 1974 were in Maputo. Auxiliary diagnostic facilities were available only in three cities. Private health care was available only to a privileged urban bourgeoisie. Even within the public health care system fees were charged for services as the basis of race. Social discrimination was practised in all hospitals and services were separate to Blacks and Whites. With the emphasis on lucrative private practice, curative medicine developed to the detriment of promotive and preventive health care. Major public health programmes were taken up only sporadically or under pressure from the international community.

Typically, as elsewhere, the country was purposely kept underdeveloped—people had little access to educational or other facilities. Mozambicans were a source of cheap labour, especially in mines in other countries. Police and military authorities were used to repress progressive ideas and movements.

Medical Training

The first medical school was set up in 1963 and the first doctors graduated in 1969—the students being drawn mostly from the elite. Of 122 graduates before independence only two ever joined public service. The training which was for seven years was archaic and outmoded even by existing European standards with "excessive theorisation" and lack of practical training. What little there was of "practical" training comprised thoeretical demonstrations in the presence of patients. Basic laboratory methods were not taught, but diagnosis according to the trainers, depended upon sophisticated laboratory methods.

Pharmaceutical Industry

Mozambique had no pharmaceutical industry of its own—all drugs were imported. The six supplying countries were Portugal, Switzerland, West Germany, South Africa, France and UK. Over-invoicing, monopolies for supply of certain drugs, etc, were typically rampant. Most TNC subsidiaries showed large deficits. The government drug budget was $ US 1 milion in 1974 for a population of 9 million—average of US $ 0.11 per capita. Any drug regulation was virtually non-existent. Almost the only drug ever banned from being imported was thalidomide. Most drugs were available over the counter irrespective of their potential hazard.

Health Care in the 'Liberated Zones'

Even at the outset when the armed struggle for liberation began in 1964, the health of the fighting people was a major concern. First aid assistants and rural medical aides were trained and supported by one doctor and a few nurses. As the struggle developed into a 'popular democratic revolutionary' movement the colonial administration collapsed in many places. Invariably, the destruction of health services accompanied the withdrawing of colonial authority.

In these 'liberated zones' FRELIMO took over the responsibility of administration and building new structures to govern the areas. One of the first such services the FRELIMO was compelled to set up were health care facilities. In the beginning the liberated zones were divided into smaller administrative units. In each geographical administrative unit were built health centres and hospitals using locally available materials. A hierarchical network of health units was created. These health facilities became particular targets of attack. These units had to be built in the forests and even there they

were constantly under threat of air attacks which included napalm bombing. Education and health facilities became priority areas of concern. Ambulatory services were also provided in remote villages and also so as to protect the health structures from being detected by the colonial army—which would have been likely if obviously ill people had had to move over distances to come to hospitals.

However, the lack of adequate personnel for providing health care led to innovations and the training of local people. Political and military training of course preceded health training. Neither the militants nor any other category of worker received salaries at this stage.

Attached to these larger health units was a farm where land was worked and food produced collectively by everyone. These hospital farms played a very important role in defining a more realistic concept of health—health was associated not just with the curative process but with production and proper distribution of the right kinds of food.

Once the liberation movement gained strength and the colonial structures began to break down rapidly, constraints regarding resources and personnel became more acute. It was at this point that it was acknowledged that the preventive measures would considerably ease the pressure on curative facilities which was becoming acute due to lack of resources. Military personnel began to be trained as 'sanitary agents' and health educators. Over a million people—almost the entire population of the liberated zones—are claimed to have been immunised against small pox and cholera in this period.

Post Independence Development

The experience gained during these years was attempted to be generalised even during the phase of the transitional government. In the health sphere this was a period of confrontation in many ways between the health workers trained in the liberated zones and the university trained medical personnel. The concentration of sophisticated equipment and the razzled dazzle of medical technology often undermined the confidence of the 'new' health personnel. The attitude of the university trained doctors was both openly challenging and subversive. This group, both nationals and foreigners with its technical expertise and its class background played a significantly detrimental role.

The decision to nationalise health services was therefore an urgent necessity, especially if access to health services were to be open to all without class and race distinction. Secondly, these measures were necessary to stop "misfortune and diseases" from being "motives for exploitation". And thirdly, it was only with this decision that it became possible to "ensure the reprioritisation within health care" and ensure that the curative component of health did not mask the relevance of the socio-economic roots of ill-health of disease. Most importantly, the role played by doctors and the medical establishment was becoming a threat to the liberation movement. In nationalising the services, president Machel aptly described doctors as "social parasites" and "traitors" who dispensed medicines "like beer from a bar".

An immediate consequence of this nationalisation was an exodus of doctors from Mozambique. Only 60 doctors remained in the country by October 1975 together with about a 100 medical students and teams from North Korea, China and Bulgaria. Two years before there had been 300 doctors, almost all White. Of the teaching staff of 96 in 1973 only 14 remained—of these only five opted for Mozambican citizenship.

In 1977 a new National Health Service (NHS) was set up and a new health policy defined and evolved certain priorities:

Preventive medicine and environmental sanitation and primary health care:

Extending health coverage, the top priority being given to "communal villages" which were being constructed incorporating agricultural co-operatives, medical care, family planning, occupational health and school health programmes.

Strategies for controlling major epidemics—TB, leprosy, schistosomiasis, sleeping sickness, blindness, intestinal parasitosis with the diagnostic and prophylactic measures defined.

Evolving a health team approach with new categories of personnel.

And most importantly, ensuring and encouraging community participation.

In 1977, to provide a basis for changes in the health structure and the redefining of personnel a pedagogical seminar was held with doctors who had been exposed to health problems in the liberated zones. It was decided that the doctors of the future were to be able to organise, lead and train a health team and act as a 'health agents' to transmit health concepts to people. A new curricula was designed to suit the purpose. A community orientation in even those subjects which had hitherto had a clinical approach was attempted. However, the leader of the health team, it was proposed, would be a 'graduate in health services' and not a 'doctor'. Specialisation would be after 2-5 years in primary health care work at the community level under supervision. He/she would then be called 'doctor in health sciences'. This concept of the 'doctor' as the leader of the health team has undergone some change. By 1981 attempts were being made to 'democratise' the decision as to who should lead the team. Also, there was provision now for horizontal mobility. But these changes aimed at diluting the rigidity of the hierarchies in the health system were being opposed vigorously by doctors.

There were other problems in bringing about such radical changes in the concepts of medical education. There was only one training school for doctors and this could not be closed. Secondly, any change in the medical education curriculum had to be such that the final qualifications would be recognised by the world medical community, as well as sceptical elements within the country.

Drugs for All

By 1978 a new pharmaceutical policy had also been adopted which has been resoundingly successful. It was directed at reinforcing national economic independence; a new pharmaceutical regulatory system was established to check the flow of drugs into the country; the NHS was to develop adequate structures for the management of drugs.

A new Pharmaceutical Service was created in 1975 under the ministry of health. A Theraputics Expert Committee (CTTE) was established as well as a central agency for medicines and medical supplies. A new law was passed compelling drug agencies to re-register their products, and firms were told that the government wished to see as few products as possible in the market. However, their compliance was entirely voluntary. In the months that followed the 'request', the number of products in the market fell from 13,000 to

2,600. It also earned the government US $ 70,000 through registration fees.

By December 1976 the CTTE had produced a new national formulary 10 months after the WHO's first report on Essential Drugs. It listed 640 items comprising 430 therapeutic substances, 20 diagnostic agents and 14 dressings. A second revision of the formulary was published in 1980 which contains only 502 items.

Prescription rules were also established, one of these being that all prescriptions were to use generic names. In 1981 a study of 4,000 prescriptions showed that 33 per cent were in accordance with the National Formulary rules. Compliance was lowest in the casualty department of the reputed Central Hospital in Maputo where there are health personnel from various countries who are not familiar with generic names.

A state corporation MEDIMOC has also been established for drug procurement by the merging of five private import companies which had been abandoned by their foreign owners. By 1981 60 per cent of the drug procurement for NHS was being handled by MEDIMOC. The new drug tender system had also accounted for a 41 per cent savings on drug purchases. In 1977 a state corporation for the retail sales of drug was also formed to ensure availability of quality drugs.

The creation of a national pharmaceutical industry is one of the objectives decided upon at the Third congress of FRELIMO in 1977. Preparatory studies are under way and a small ORS plant has been set up. The government pharmaceutical budget has gone up from US $ one million in 1974 to $ 12.5 million in 1982 accounting for 20.1 per cent of health budget from 8.1 per cent in 1974.

Conclusion

Given the fundamental conviction that everyone has a right to health, the actual realisation of the political nature of the skewed distribution of health facilities came about through FRELIMO's experience in liberated zones. Not only were health facilities the targets of the colonial army, the medical establishment's support to the government acted to strengthen anti-people measures. The denial of health care to people on the basis of class, race or sex was not a matter of chance but a deliberate measure by the colonial rulers to suppress and undermine the development of the revolutionary potential of the masses. Nationalisation of health services was an important act not only because it would ensure that health care would be more accessible to people but because the measure effectively nullified the subversive nature of a discriminatory health system and deflated the potential influence the medical establishment could wield over the masses.

However, implementing changes that strike at the social status of doctors has not been easy. Although there does not appear to be any reporting on this aspect, there is reason to believe that dissatisfaction among doctors regarding their remuneration and social status has been rising. The idea that a doctor may be just one of a health team and not its leader will take a long time to be accepted. Another feature of the health system which is not much discussed appears to be the notion of community participation. While the 'health agent' is selected by the 'community', it is not clear as to what is the extent of their participation. Mozambique's 12 million people speak 12 languages and 21 dialects and also belong to numerous different tribal groups. In such a situation only a determined effort at decentralisation can ensure that community participation will be a fact rather than a notion. Moreover, the persistent activities of the MNR have made this even more difficult to achieve.

There is also some indication that the emphasis on primary health care and the balancing of resources between it and more sophisticated hospital oriented services may be under some strain. For instance, the incidence of heart diseases which often necessitates hospital care and even surgical measures, may be rather high. In a health census of six villages the incidence of hypertension was 33 per cent in the coastal villages and 25 per cent inland. The 1,800-bed hospital in Maputo has highly sophisticated cardiac service with one of the three theatres being reserved exclusively for it. Whether this is a genuine response to health needs or a matter of 'prestige', especially considering the close association of some of these surgeons with the famous South African heart surgeons is not clear.

Another area about which little is said is the status and use of local/tribal health practices. Although some of the local doctors have been retrained as health agents, this does not mean that local practices, if they have survived at all, have been integrated. In fact, this is very unlikely. The emphasis has been on using modern preventive and promotive measures—immunisation, nutritional inputs (which has hardly got off the ground) popularising the use of latrines, use of 'clean' water, etc.

It is Mozambique's drug policy which is an unqualified success. Prices of drugs have fallen since 1977; they are being made available to an increasing proportion of the population and there has been a drastic curtailment of unnecessary and toxic drugs. The policy is under periodic review and revision. But the development of an indigenous pharmaceutical industry will bring other problems—of imports of machinery, raw materials, of wages and ultimately, of cost of drugs. These are, however, not insurmountable problems.

Even ten years after independence Mozambique has to cope with constant threats to its very existence as a state necessitating heavy military expenditure it can ill afford. It is dependent on imports of grain to feed its drought-struck population. Despite all this, it has so far succeeded in establishing a framework for the provision of rational health care to its population.

[*Acknowledgement*: Some of the information (and insights) is from interviews with Dr Carlos Marzgao in 1983.]

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