MOZAMBIQUE BRIEFING

HEALTH UNDER ATTACK

2/1987

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Mozambique's health delivery was expanded after independence in June 1975, and the primary health care network showed rapid growth in the early years. But this sector like others has been affected by external aggression against Mozambique.

For the past decade Mozambique's development efforts have been hampered in varying degrees by a form of terrorism promoted from outside its borders by the racist regimes of southern Africa. In the second half of the 1970s this armed banditry, as it became known, was commanded and created by the security services of the illegal regime in Rhodesia under Ian Smith. In this early phase the attacks were directed mainly against the central provinces and aimed partly at undermining Mozambique's support to the national liberation struggle being waged by the Zimbabwean people.

When in late 1979 it became clear that Zimbabwe was due to accede to independence within a few weeks, the terrorist force which had recruited former agents of the Portuguese colonial secret police (PIDE), criminals and anti-social elements from the fringes of Mozambican society was placed under the direct tutelage of the apartheid regime in South Africa. Arms, equipment, financial backing and training were provided on a much greater scale than before and the aggression by South African sabotage teams or the bandit groups was directed over a wider area of the country. Since 1982 this undeclared war waged by South Africa has had an increasingly visible effect on the health services for the Mozambican people.

In areas less affected by the war health delivery has continued to improve and in some instances the preventive health programmes compare favourably with the standard maintained in the wealthy western countries. But Mozambique's Health Ministry estimates that as a result of

direct destruction and looting by the enemy, the forced closure of health units and displacement of population, more than 2 million people had lost access to health care by the end of 1986, out of a population of more than 13 million. The devastation is most marked in the primary health care network that serves the rural population; by the end of 1985 a quarter of that network had been destroyed, looted or closed down.

1. THE COLONIAL SITUATION

The provision of health care in Mozambique under Portuguese colonial occupation was entirely determined by the needs of the colonial society. The few curative services were set up for the settlers and almost exclusively available to them. The settlers were afraid of such endemic diseases as malaria, and the minimal preventive services aimed largely at protecting settlers from common infectious diseases. The threat of infection was associated with the African population, and the stress was on isolation rather than prevention.

Only in the final decades of colonialism was lip service even given to preventive medicine, with a scant dozen doctors and other health professionals engaged in the programme at the end of the 1950s. Some places of work provided their own services, but the state services were too costly to be accessible to all but the most privileged patients.

Doctors employed by the state performed token official duties and gave much of their time to private practice. In the last year of colonial rule, a third of the health budget was spent on the central hospital in Maputo (then Lourenço Marques), in a city where two thirds of the doctors were working. Nearly all the colony's doctors were in private practice in the three main cities (Maputo, Beira and Nampula), where one in 14 of the population lived. The system was characterized by economic, racial and geographical discrimination. Mission health centres provided some low-cost curative services, linked to their

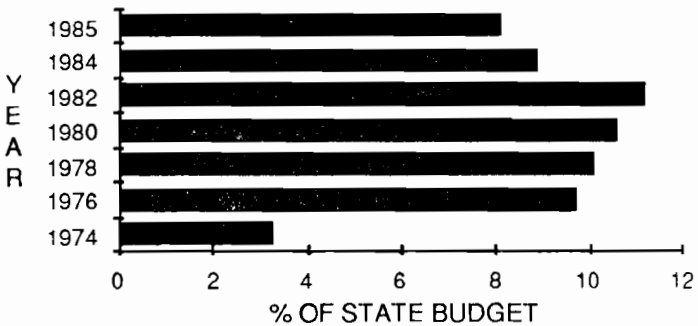
religious proselytizing.

Mortality and morbidity figures under the colonial regime covered only the settlers and those Africans who appeared at the health facilities for treatment or died there. These colonial statistics provide no information about the appalling health conditions for the majority of the population. In the late 1960s, life expectancy at birth for a Mozambican was estimated between 25 and 33 years; about a third of children died at birth or in infancy. By 1970 the colonial authorities reported that for out-patient mother and child care they had 8 child care centres, 7 pre-natal centres and 230 general assistance centres. Under Portuguese rule, most of the population were abandoned to traditional healers who fulfilled a social role but through methods based on obscurantism and superstition.

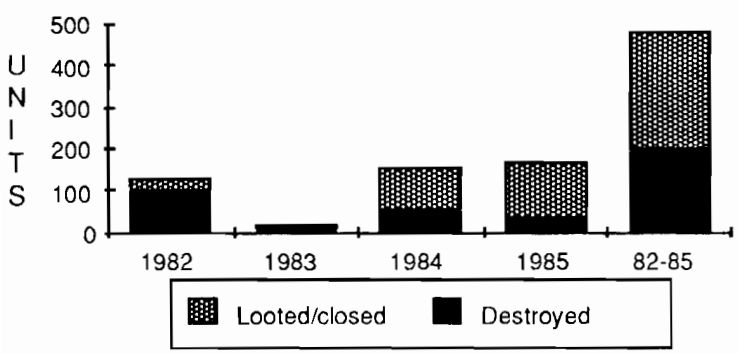
By contrast FRELIMO's health programme began at the start of the armed struggle for national liberation in 1964. In 1965 the programme included a vaccination campaign against a smallpox epidemic. In July 1966 a first group of thirteen Mozambican male nurses graduated in Dar es Salaam after a year's training to go and provide medical assistance to the liberation fighters and to the people in the liberated areas FRELIMO was establishing. Gradually a network of first aid posts, health centres, mobile units and even rural hospitals was established. The FRELIMO health service in the liberated areas provided curative and preventive medicine: vaccinations, and instruction on hygiene and nutrition.

While the anti-colonial war was still raging, FRELIMO held a health services conference in February and March 1973 and decided to increase the training programme for first aid assistants, midwives, nutritionists, laboratory assistants and dental workers. In the next year came the fall of fascism in Portugal and the surrender of the Portuguese colonial forces in Mozambique, paving the way to a transitional government followed by national independence on 25 June 1975.

HEALTH SPENDING IN MOZAMBIQUE 1974-85



DESTRUCTION OF HEALTH UNITS BY BANDITRY, 1982-85



2. THE POST-INDEPENDENCE SITUATION

Independence gave FRELIMO the opportunity to extend the policies it had shaped in the liberated areas and to make health the basic right of every citizen. The first step was taken a month after independence with the nationalization of health services, and abolition of private practice. This step was taken against a background of a massive outflow of the colonial medical staff: of more than 500 doctors in Mozambique in 1974 (almost all of whom were Portuguese), only 86 remained in 1975; the rural mission hospitals and the few health posts of the colonial era were abandoned.

Undeterred the Mozambican government launched a national environmental health campaign within weeks, and in the following year a national immunization campaign to counter tuberculosis, smallpox, measles and tetanus. Sympathetic foreign doctors were recruited, training programmes designed and initiated for health professionals, particularly those able to work with the village and the community. In the first seven years of independence (before South Africa's undeclared war took its drastic effect), Mozambique trained more than 3,000 new health workers and built or renovated more than 1,000 health posts and centres.

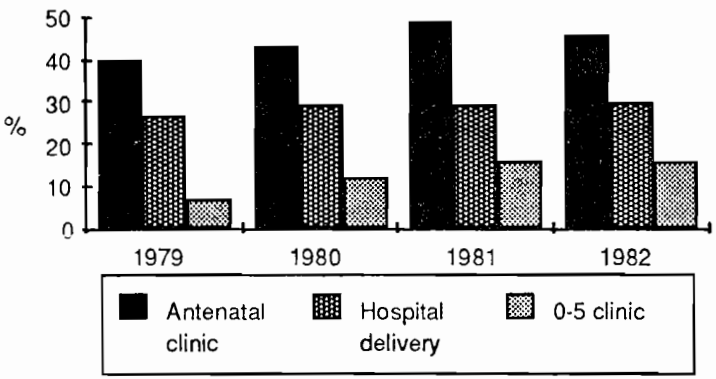
Independent Mozambique also moved rapidly to make the most cost effective use of pharmaceutical products, which in many third world countries account for 30 per cent to 40 per cent of health budgets. Import licences were withdrawn for products lacking proven therapeutic value or entailing unreasonable profit margins to the supplier. This reduced 13,000 branded products on the market to 2,600.

A state company was established in 1977 to import and export medicines, and a second state company was given responsibility for abandoned retail pharmacies and ensuring effective distribution of drugs. A new National Formulary of regulated medicaments was published in 1977, with 640 items, and was improved and updated in

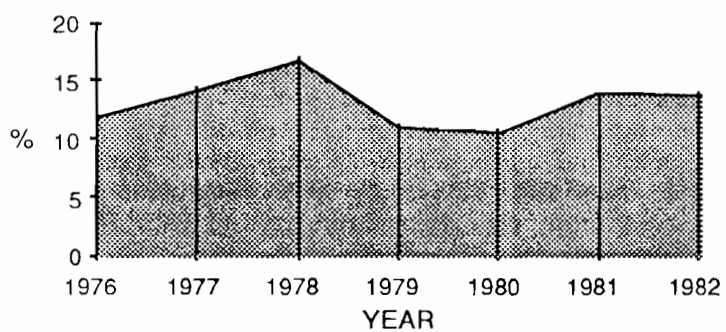
1980 with a list of 355 different therapeutic substances, to be kept constantly under review (special permission is required for a doctor to prescribe a non-Formulary drug). The National Formulary uses only generic names, and Mozambican law requires prescription to be by generic name. Mozambique's initiative was taken before the World Health Organization published its lists of 200 essential drugs, but reflects a similar approach.

The result of intensive democratic debate within the health sector, imaginative planning, new approaches to training and a careful allocation of scarce resources was a simplified and rationalized health service reflecting an integrated approach to health and environmental factors. The strategy won international respect and backing from the United Nations specialized agencies and Mozambique's allies and friends. The proportion of national expenditure that Mozambique allocated to health was higher than in most countries in Africa. It is worth noting that Mozambique's determined emphasis on primary health care (at urban and rural level) was adopted as national policy a year before such an approach was formally advocated by the WHO and UNICEF at a conference in Alma Ata in 1978.

MOTHER AND CHILD CARE, 1979-82



PERCENTAGE OF HEALTH BUDGET SPENT ON DRUGS



3. THE IMPACT OF DESTABILIZATION

Increasingly in the 1980s, the apartheid regime in South Africa has made Mozambique a target of attacks intended to negate political and economic independence. Mozambique's health service by virtue of its success was one of the prime targets of aggression. We indicate just some of the ways advances made in health, especially in the primary sector, are being undermined by the South African aggression.

3.1 Primary health care

The post-independence policy is based on providing health posts and health centres for the rural population, the majority group in the country, whose needs were almost totally neglected in the colonial era.

Under normal circumstances the country would by now have at least 1,900 of these peripheral health units. By the end of 1985, 196 of the posts and centres had been destroyed by bandits and a further 288 looted and/or been forced to close. Despite the persistent attempts to destroy the system, provincial health authorities stood by the policy and in 1985 succeeded in reopening 88 of the peripheral units which had been closed by the terrorism and building 53 new posts. Mozambique is seeking aid to restore another 200 health posts.

Community participation is essential to primary health care. Communal villages with village health workers were seen as the cornerstone of the primary health care system. In 1980 training was given for 303 village health workers; in 1985 that number was down to 33. Some health responsibilities have shifted from the community, and a new category of basic health worker paid by the health services is being trained to staff some health posts.

These changes reflect the fact that rural communities have been disrupted by a combination of drought and enemy action, and communal villages have also been the

target of the enemy. Village health workers have abandoned their posts, in fear or through lack of the support that makes their work possible. Even where health posts remain open, travel to the post has become dangerous for the would-be patient.

A successful primary health care system depends on support with regular supplies of drugs and contact with the higher levels of the health delivery system. In the early years, despite logistical problems, the units received supplies of drugs and benefited from supervision. A WHO/UNICEF review mission visited 23 randomly selected health units throughout the country in 1982 and reported that three-quarters had a regular supply of drugs. As a result of the war, road travel has become hazardous, fuel and transport shortages have worsened, and there are drug shortages at all levels.

The armed bandits have attacked health workers and health vehicles. Zambezia province in 1983 had ambulances for 16 out of its 17 districts; by mid-1986 all but five ambulances had been destroyed by bandits. In a typical early instance a health vehicle clearly marked with a red cross was hit by a bazooka on the road from Quelimane, the provincial capital, to Maganja de Costa. The vehicle was carrying medicines; the accompanying pharmacist was killed by the bazooka shell and the driver was bayonetted to death. In this undeclared war South Africa's instruments pay no heed to such universally respected norms of conduct as that embodied in the Geneva Convention (Article 11, Section 1):

Medical units and transports shall be respected and protected at all times and shall not be the object of attack.

3.2 Mother and child care

The care of mothers and children has a high priority within the primary health care system, but this care has suffered as a result of the undeclared war. Up to 1982 the percentages of pregnant women attending the antenatal clinics, of births in hospital, and of children attending

under-five clinics were steadily rising. Since then there has been a levelling off or decline, and the overall trends disguise the severe impact of terrorism on such provinces as Tete and Zambezia. In Zambezia in 1982, for example, 37 per cent of pregnant women were attending antenatal clinics but in 1985 the rate was down to 24 per cent.

The war has also disrupted the programme of vaccination against the common preventable diseases of childhood. As a result, children in some areas are unprotected against tetanus, tuberculosis, measles, diphtheria, whooping cough and polio. Vaccination also requires a high level of community participation. In Maputo city where this participation is at a high level, a survey in 1986 using WHO methodology showed that 86 per cent of children between 12 and 23 months of age had been vaccinated against measles. In general vaccination, UNICEF cites Maputo as the first city in Africa to show a 90 per cent rate of full immunization of children to the age of one year.

In the war-affected provinces of Tete and Niassa the estimated vaccine coverage fell sharply between 1983 and 1985. Sofala province's capital, Beira, had a measles vaccine coverage of 68 per cent when surveyed in July 1985; in 1986 the vaccine coverage was much lower.

3.3 Chronic diseases

The primary health care system aims to diagnose and treat the common severe chronic diseases of tuberculosis and leprosy by providing diagnostic facilities and drugs near to the patient's home. Supply of diagnostic reagents and drugs to primary health care units has become increasingly erratic. Patients have had increasing difficulty in following through their courses of treatment as access to the health services became more uncertain. For the first time since independence there was a national shortage of antituberculous drugs in 1984. The shortage was overcome with an aid agreement, but the difficulties of distribution to the periphery remain.

An estimated 23,715 new cases of tuberculosis occur

annually in Mozambique, half of which would be fatal without treatment. The war has played havoc with the programme of diagnosis and treatment. In 1980, the number of cases notified was 15,718; in 1985 notification fell to 9,603, and only 4,734 were in treatment. Under normal conditions, treatment could be expected in at least 8,300 cases. So, as a result of the war, some 3,500 adults are not in treatment, and half may die - an estimated excess mortality of 1,750 annually.

The leprosy control programme has suffered similarly. The total number of cases under control fell from 14,681 in 1981 to 12,796 in 1985. In provinces less affected by the war the control programme was maintained or expanded; in the war- affected provinces, control slumped: in Zambezia from 4,871 patients in 1981 to 829 in 1985 and in Tete from 410 to 47.

3.4 Infectious diseases

The war (coupled with the drought) has favoured the spread of infectious diseases. Malnutrition has made large numbers of children more susceptible to severe disease; crowded living conditions with limited access to clean water has brought an increase in all the common infections: pneumonia, diarrhoea, measles and skin diseases. Severe epidemics have also occurred in war-affected areas: cholera in southern Mozambique in 1983 with 447 notified deaths; scabies in Maputo city in 1984 as a result of crowded conditions after an influx of people to the city; poliomyelitis in Inhambane in 1984 after a drop in the vaccination coverage.

The preventive and control measures have been severely hampered by enemy action. Children have been dying from preventable diseases or conditions that can be cured by simple treatment. The major childhood killers are diarrhoea, malaria, measles, pneumonia and malnutrition. Death from diarrhoea can be prevented with oral

rehydration salts. Malaria can be treated with antimalarial drugs, and pneumonia with penicillin. Measles is preventable by vaccination, and much of the malnutrition is a direct result of the war.

In 1985, 16,507 measles cases were notified, the highest number since the immunization programme began in 1980. Under poor conditions of diet and environment, measles can be lethal. Childhood malnutrition has increased through the combined effects of low food production and displacement. In Niassa province, traditionally rich in agriculture, malnutrition was in the period between 1981 and 1984 the least commonest cause of hospitalization of children (5 per cent to 8 per cent of the total). By September 1986 as the province faced famine due to a combination of war and natural disasters, malnutrition had become the commonest cause of children's hospital admission (40 per cent of the total).

3.5 Health workers

Communities and all kinds of health facilities have come under attacks by the armed bandits, who have destroyed buildings, transport, supplies and equipment. Health workers too have been attacked, plundered, kidnapped, or murdered. At least 21 have been murder victims, and 243 have lost all their belongings through looting by bandits, without counting the village health workers.

These factors cut right across the policy of improving staffing in rural areas. Shortly after independence Mozambique had 86 doctors and initiated international recruitment. It took a decade to build a full-scale medical training programme, as the secondary schools were expanded to provide better educated entrants. In 1986 there were 130 Mozambican doctors, and 230 expatriate (cooperant) doctors. These cooperants were a prime target, and for security reasons it has been necessary to reduce the number working in rural areas, with district hospitals severely under- staffed. Documentary evidence came to light that the targeting of doctors and nurses was a

conscious part of the terrorist strategy when the bandits' central base at Gorongosa in Sofala province was taken in August 1985 in a joint operation by Mozambican and Zimbabwean armed forces. Documents captured at Gorongosa included diaries of the bandit ring-leaders recording South African military instructions to prevent the work of foreign cooperants. Zambezia province, for example, in 1983 had doctors working in 13 out of the 17 districts; by mid-1986 doctors were present in only two. Overall the rural areas had a ratio of one doctor to 161,000 people in 1982; one doctor to 234,000 in 1984; one doctor to 443,000 at the end of 1985.

3.6 The death toll

The total of deaths due to the undeclared war is unknown and virtually incalculable, but some indicators are available. Children are the most vulnerable section of the population and their mortality rate rises under conditions of stress.

By 1980 five years after independence the new health policies had brought substantial improvement on the colonial situation, albeit under difficult circumstances. Mozambique's overall infant mortality rate was 159 per thousand, reflecting a range from the province of Zambezia with the highest rate of 243 per thousand to Maputo province with a rate of 125 per thousand (Maputo city's rate was 108 per thousand). Life expectancy over the whole country was 43.6 years (42.1 for men and 45 for women), although in the countryside it was about 38.6 years, and in the city of Maputo life expectancy was 52.4 years.

By 1985, however, the aggression was replicating the stress of the colonial era and the infant mortality rate was estimated to be 200 per thousand per year, and the under five mortality rate 325-375 per thousand. War and destabilization was estimated to have caused 84,000 child deaths in Mozambique in 1986 alone, with a total of 320,000 child deaths between 1981 and 1986.

The war has also directly killed and maimed tens of

thousands of adults in the community A community survey on the number of such deaths showed that in Inhambane and Gaza provinces alone in 1983 an estimated 6,480 people died as the result of trauma. The estimate of the number directly killed by 1986 as a result of external aggression from the illegal regime of Rhodesia in the 1970s and the continuing aggression from South Africa is a conservative 100,000. Mothers and newborn babies have suffered severely from the war. With reduced antenatal assistance and with home delivery of high risk mothers, maternal mortality is now high in Mozambique, due to haemorrhages and other conditions. Women with no access to the health services have an estimated maternal mortality of 2,000/100,000 live births. As a result of the war an additional 1000 women may be dying annually in childbirth.

Before vaccination programmes were established, neonatal tetanus, a fatal disease of newborn babies delivered under unhygienic conditions, was a common disease in Mozambique, with a death rate of at least 10 in every 1000 newborn babies. In Maputo, the number of hospital deaths fell steadily from a high of 195 in 1976 to 5 in 1985 as women were vaccinated. Although no statistics are available from the rural areas, it was expected that a similar, though less dramatic, fall would follow the national mass vaccination campaigns of 1976- 79 and the subsequent routine vaccination programme. Now in areas affected by the war the fall in immunization and the worsening of delivery conditions will have caused a new increase in neonatal tetanus deaths. An estimated additional 800 children are dying annually from this disease. As was indicated in section 3.3 above on chronic diseases, adult patients are dying from tuberculosis and leprosy that would be receiving diagnosis and treatment under normal circumstances.

3.7 The costs of the war

The costs of the war to the nation's health are, like the death toll, incalculable. How do you quantify the cost of the loss of 320,000 children, or the future burden of disease that will follow chronic malnutrition? The cost of damage to health buildings alone to the end of 1985 is estimated at 16.5 million US$, and the loss of their contents estimated at a further 2.75 million US$.

The burden of national defence in the face of South Africa's war of destabilization against Mozambique has drastically cut funds available for the health services. In 1974 on the eve of independence health expenditure accounted for 3.3 per cent of the annual state budget. In 1976 that figure had risen to 9.7 per cent, and in 1982 was 11.2 per cent. In 1985 it fell again to 8.1 per cent, allowing about 4 US$ a year per head of population.

4. THE FUTURE

Mozambique's health services show the determination of the people to continue working under the most difficult conditions and to press on with reconstruction. Most health workers are still at their appointed posts; they make the difficult and dangerous journeys to collect medicines and to take vaccination to the people. Training courses and seminars continue and health workers attend from the most remote parts of the country. Health posts are being rehabilitated and new ones are planned.

The primary health care system continues in its essence but is in urgent need of support. The Ministry of Health has drawn up an emergency programme for the health sector that includes equipping 200 health posts, four health centres and five rural hospitals, and building six new health posts in resettlement areas of Tete province. The total bill for priority needs in this emergency network is 8 million US$.

What *YOU* can do to help!

As well as your existing political and humanitarian support for Mozambique's people, you can assist us in bringing you this and other current information on our country's situation in the face of external aggression threatening *OUR* efforts to build a new society.

This is the second of a series of **briefing papers** on aspects of Mozambican policy and action that have aroused interest and inquiry in the international community. If you have not already done so, you can CONTRIBUTE towards our postage costs by sending at least 10 US$ (more if you can) OR an alternative hard currency equivalent to the

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