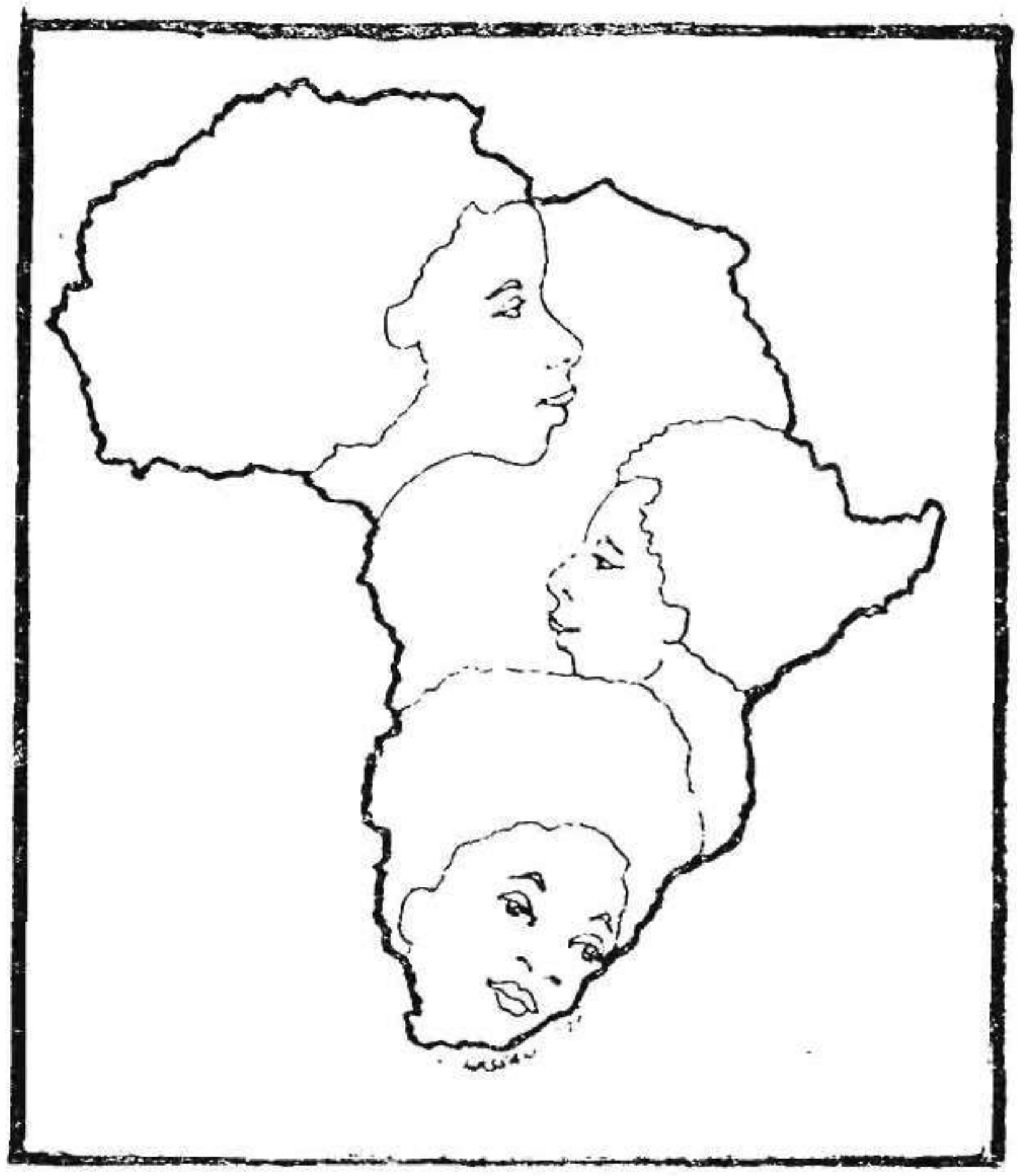


HEALTH

IN

MOZAMBIQUE:

FROM EXPLOITATION

TO REVOLUTION

TO LIBERATION

*****

INTRODUCTION.

The views expressed below are not often presented in South Africa. Much has been written and published in South Africa which seeks to denigrate Mozambique. This article, while not denying the problems Mozambique faces today, attempts to trace the historical and political roots of health and health care in that country.

A fair proportion of the article is therefore devoted to the political and historial circumstances at various junctures.

The reader is asked to bear with this for the importance of this perspective will become clear as you progress through the article.

This paper is a review of the literature available, and it must be viewed in this light by the reader.

HEALTH IN MOZAMBIQUE : FROM EXPLOITATION TO LIBERATION

PART 1.

HEALTH UNDER COLONIAL RULE : AN EXPLOITATIVE TOOL.

Mozambique was dealt out to Portugal in the scramble for Africa, late in the 19th Century. It is at this time that this European, colonial power began to wield any real control over the territory, for up until then it had confined its influence to a thin coastal strip from Sofala to Cabo Delgado sufficient for their economic interests in gold and ivory trading as well as the key position it held in the trading sea-route to the far East. From the time of gaining the "right of occupation" until about 1910 - 1920, the Portuguese slowly conquered the interior, and the main features of Portuguese colonialism were firmly established.

During this period, while a considerable measure of decentralization was accepted by a weak government in Lisbon, the very rigid economic ties between Portugal and her African colonies were formed; economic ties which ensured complete commercial monopoly by the colonial power.

The decentralization of the colonies was soon stopped and in fact reversed when a more authoritarian government under Dr. Salazar took power in Lisbon in the late 1920's. The interests of the colonies were made more directly subordinate to Portugal's interests and any liberalizing or alternate policies were avoided.

Despite independence occuring elsewhere in Africa, with the realization by British and French governments that economic domination and exploitation could be maintained under an acceptable but independent ruling class (the so called "flag independence" or neo-colonialism) the imperial doctrine of Portuguese-African "unity" remained largely unchanged until 1974. This was because of Portugal's weaker financial and industrial position in relation to other colonial powers and the fear of economic replacement if they were to withdraw politically.

In response to the swelling tide for self-government of African colonies, and in the hope of admission to the U.N. Assembly, the Portuguese dictatorship executed a "face-lift" on its constitutional policy by changing the term "colony" for "overseas province" and the creation of a mythical concept of a Lusitanian Confederation of people. In all these "provinces" they claimed that all could become citizens of Portugal, all races were considered equal before the law and all could participate in parliament. The truth was very different.

While it was true that some could achieve the status of "assimilated" native and Portuguese citizens, less than 0,75% of Mozambicans ever did. The rest were defined as indigenas (natives).

"Assimilated" natives were required to speak fluent Portuguese and adapt the "habits and customs presupposed for the application of Portuguese common law". This status entitled you to the full Portuguese settlers' education system and freed you from the system of labour and other controls.

"AND WHAT DID THEY TEACH YOU TODAY SON?"
"AMO, AMAS, AMAT"
"... EDUCATION'S A WONDERFUL THING"

On the other hand "indigenas", more than 99% of the population, were provided with only a "rudimentary" education which did not even equip them with literacy.

"Native" labour was strictly controlled in order to extract the maximum from this highly profitable resource. The government and local administers structured a labour system in which less then 5% of the mature, able-bodied males in Southern Mozambique were legally entitled to remain within the confines of their homestead (1950 census). Of the remaining 95%, some worked in urban centres, others as farm labourers for European farmers (+ 16%) and still others as mine workers or foreign recruits in South Africa and Rhodesia. To be "idle" made a person subject to 6 months' forced labour for the government (Shibalo system). Thus the system of labour control ensured that the overwhelming majority of Mozambique males participated in the European economy which was highly detrimental to African peoples' development, but very lucrative for the Europeans.

Her Majecty's Consul General in Lourenco Marques, said in 1951:

> "The uncivilized population comprises over 5½ million natives. It is on their productive capacity that the economy of Mozambique must be based and in consequence, the Portuguese try to inculcate in them, in the mass, the habit of regular hard work and a growing appreciation of the possibility of obtaining a fuller life by being industrious. It is not the Portuguese policy to create a native "intelligensia" - such natives as receive higher education are expected to pass into the class of the "assimilated" natives and to identify themselves with the Portuguese - but it is their policy, slowly and steadily, and as far as their limited financial resources permit, to raise the mental and physical standards of the natives as a whole, in order to render them some receptive to technical and other instruction and to civilized ways."

Harsh measures were used by the colonial rulers to deal with "undesirables" and to suppress nationalist opposition.

It can thus be seen that Portuguese claims of "justice" for all was nothing more than a policy of plunder and exploitation of the great mass of Mozambican workers and peasants, in the interests of the European, colonial power's economy. This policy produced large scale underdevelopment of the masses and forced people off their land. Traditional systems of communal land ownership were broken down, the local social structures of the Mozambican people shattered and the caring social and cultural fabric of communities destroyed. All these can be recognized as the conditions that breed ill-health.

The Colonial Crisis

'The traditional subsistence economies of Africa had provided on the whole a sufficient diet for their populations, as may be seen from the historical fact that no major part of Africa ever appears to have suffered chronic famine in the past. By 1945, however, they were far gone in ruin. Devaluation of the rural economy, coupled with the migrant labour system, and the enclosure of land by Europeans, had reached a point of continental crisis from which no colonial policy-maker could see a clear escape. Official records of the last colonial years are loud with lamentations of despair.'
(Basil Davidson, *Which Way Africa?*, Penguin.)

Health and health care under Portuguese rule reflected the geographical, racial and economic discrimination. The health of white settlers in developed urban areas was built upon the ill-health of the black Africans in the underdeveloped rural areas.

Let us examine the distribution of health care under Portuguese Colonial rule a little more closely.

All modern hospital facilities and doctors were concentrated in the big cities: Beira, Lourenco Marques and Nampula. The settler community in the towns received privileged and segregated health care.

Health care delivery in the developed, urban sector was based around large hospital services and private practice. The emphasis of the service was curative, but some preventive care e.g. vaccination, sanitation, etc. was practiced.

Little interest or effort was shown in providing health care for the rural population, and what there was was usually run by voluntary societies e.g. mission societies, whose ideology usually coincided with the colonial administration. This was particularly true of the Catholic missionary workers and close links with much mutual co-operation, developed between the Catholic Mission and Colonial rulets. Missionaries could at best provide curative medicine, and some midwifery, for a tiny minority of the people. Malcolm Segall estimates that 70% of people lived beyond the reach of any health care.

Two-thirds of the country's 550 doctors were to be found in the capital city (then Lourenco Marques), most of whom were in private practice, which was extremely lucrative. Health to them was a commodity for buying and selling.

One-third of the health budget was spent on the main hospital in Lourenco Marques which was accessible to only 8% of the population- 50% of this budget was spent on a wide range (± 13,000 different types) of drugs.

Segregation in hospital facilities also showed the division in society e.g. the Miguel Bombarda hospital (Lourenco Marques) for urben "indigenas" being bare, overcrowded, and inadequate, while the University hospital (on the same site) was adequately equipped for a modern hospital and served mainly the white elite. Care was graded according to social and racial categories.

Most important of all was the attitude of health workers under colonial rule. Medicine was seen as a professional and technical matter completely divorced from politics. Initiative was inhibited and corruption encouraged. Doctors and nurses did not serve the people, but themselves and their

status. Machel described the hospitals as "rigid" and individualistic and medicine monopolistic.

In rural areas virtually nothing existed in the way of preventive health schemes, health education programmes, mother and child health and vaccination schemes (the army carried out an inadequate vaccination program, without records) despite the fact that a cursory glance at health problems found in the major underdeveloped areas showed that they could only really respond on any general level to this type of care. The curriculum of the medical school also *reflected this western, curative bias.*

Health mirrored the social and economic situation in the country. Despite the fact that there was no interest by the Portuguese to collect statistics on the poor health in rural areas, some rough estimates are available.

About 90% of the people (11½ million in total) live in rural areas with a population density of 12/sq.km. 20% of population is under 5 and approximately 45% less than 15 years. These figures are comparable with an underdeveloped country and double those of developed countries.

At independence about 30% - 50% of the children suffered from malnutrition. Epidemics of measles, whooping cough, intestinal parasites, e.g. bilharzia and other communicable and infectious diseases are rife. T.B. is estimated at 250/100 000, while the comparable figure for Europe is 24/100 000. Malaria is widespread. Neonatal tetanus occurred frequently since the umbilical cord was often sealed with earth and no vaccinations were given. Occasionally cholera and typhoid outbreaks occurred.

Many similar problems existed in urban slums.

On the other hand, it would be an understatement to say *that the white elite enjoyed good health in relation to* the Mozambican people.

PART 2.

HEALTH DURING THE WAR AGAINST COLONIALISM : A REVOLUTIONARY WEAPON.

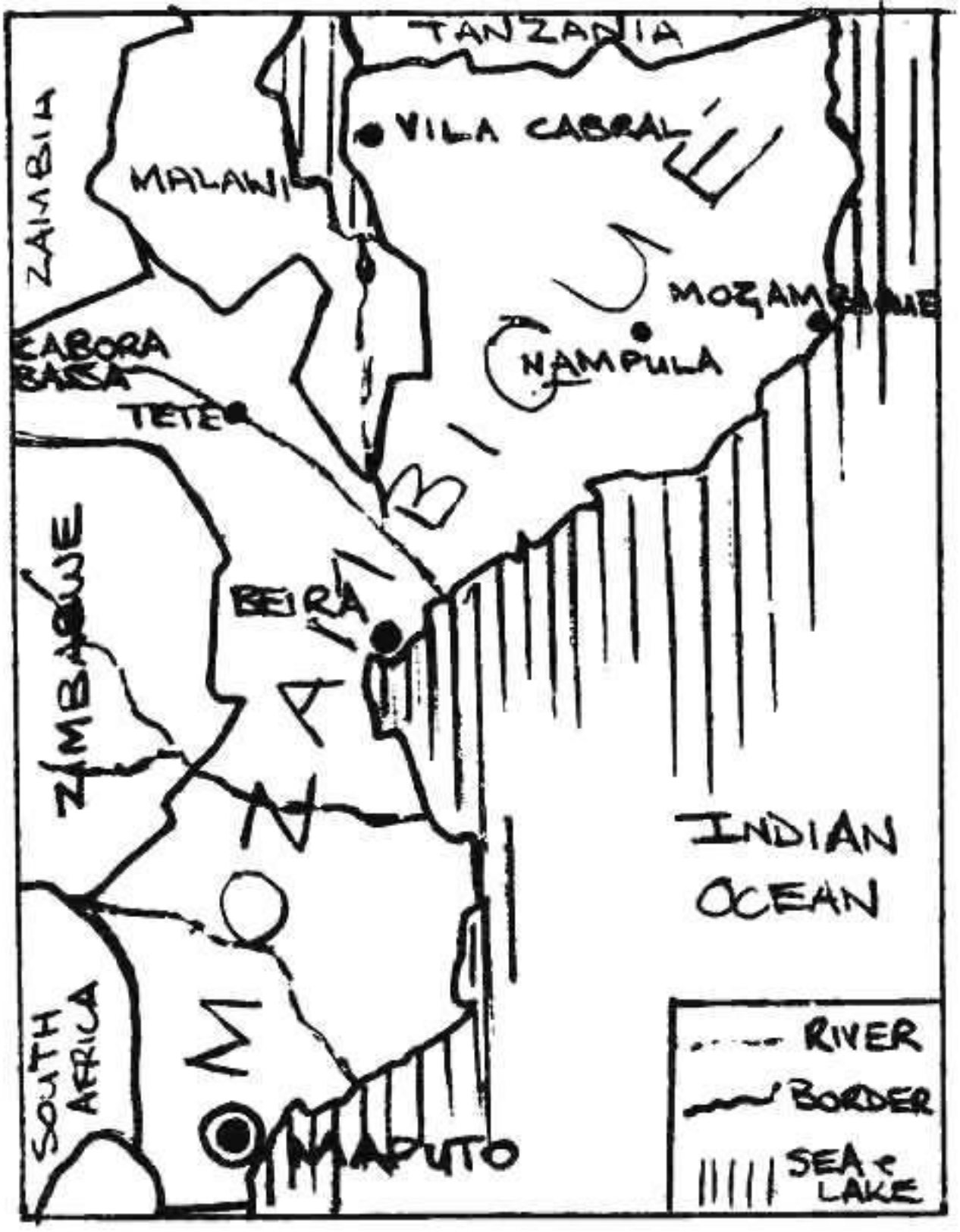
Under this colonial system of repression it was natural that anti-colonial sentiment should swell, that some educated Mozambiquans should develop a political conciousness of their condition in relation to others, and should ultimately organise themselves into Nationalist movements in order to spread this conciousness.

This occurred to a large extent by the early 1950's, when a number of smaller groups existed, but it was not until 25th June 1962 that a single national liberation front under the name of FRELIMO was constituted and the first Congress held in Dar es Salam.

It was only in 1964, after careful consideration of the situation, that armed struggle was adopted to free the people of Mozambique from Portugal's fascist colonialism.

The main area of action after 1964 lay in the two northern provinces of Cabo Delgado and Niassi, where guerilla forces were so successful that by 1968 they controlled the territory.

At this stage they were able to re-open the attack on the Tete front. By July 1968, the second Congress was held inside Mozambique.



The first president of FRELIMO was Eduardo Mandlane, a man of significant leadership, organizational and intellectual ability. His political thought was channelled in four directions:

a.) Formation of a national movement capable of military conflict.

b.) Independence from Portugal.

c.) Fostering of a national consciousness among Mozambicans.

d.) Restructuring of society to ensure true equality with an end to exploitation.

In terms of the fourth goal, Mondlane said: Thus far independence constitutes only one phase of our revolution. Liberation consists of more than merely driving out the Portuguese authority. True liberation requires the constructing of a new society".

He envisaged a society

> "directed towards economic progress .... where the power will belong to the people".

Frelimo had to act as "a guide to the people to end the exploitation of man by man".

Within the liberation zones which FRELIMO controlled, FRELIMO began to implement its plans by providing for the inhabitants in line with its overall political analysis; diversification of agriculture, co-operative and communal village structures and modes of production, cottage industries, education, social and cultural changes, etc.

There was a counter-revolutionary, political and ideological backlash which emerged at the second congress which retarded progress of the movement, including its efforts in health. In 1969 Eduardo Mondlane was assassinated, which was a further setback, but with the eventual appointment of Mondlane's successor, Samora Machel, the rough period was weathered and the party attempted, successfully, to recover lost ground.

From the second congress a clear definition of people's power emerged.

> "In order to consolidate and extend the liberated regions, to promote the social and economic progress of the masses and transform the social basis of society, to create favourable conditions for the victorious development of the revolutionary struggle for liberation, a new type of power was needed. A power that, through its method, nature and aims, would respond to the deep longing for change, and would be a justification for sacrifices taken. A power that would enable the people to live their conquests in their daily lives."

In May, 1970, the Portuguese launched a major offensive in an attempt to regain liberated areas, but they were soundly defeated. The reason for FRELIMO's ever-advancing military successes can be found in the communal action and support to resist the colonialist onslaught; an attitude engendered by FRELIMO's policies and practices and spread through the raising of a new social and political order.

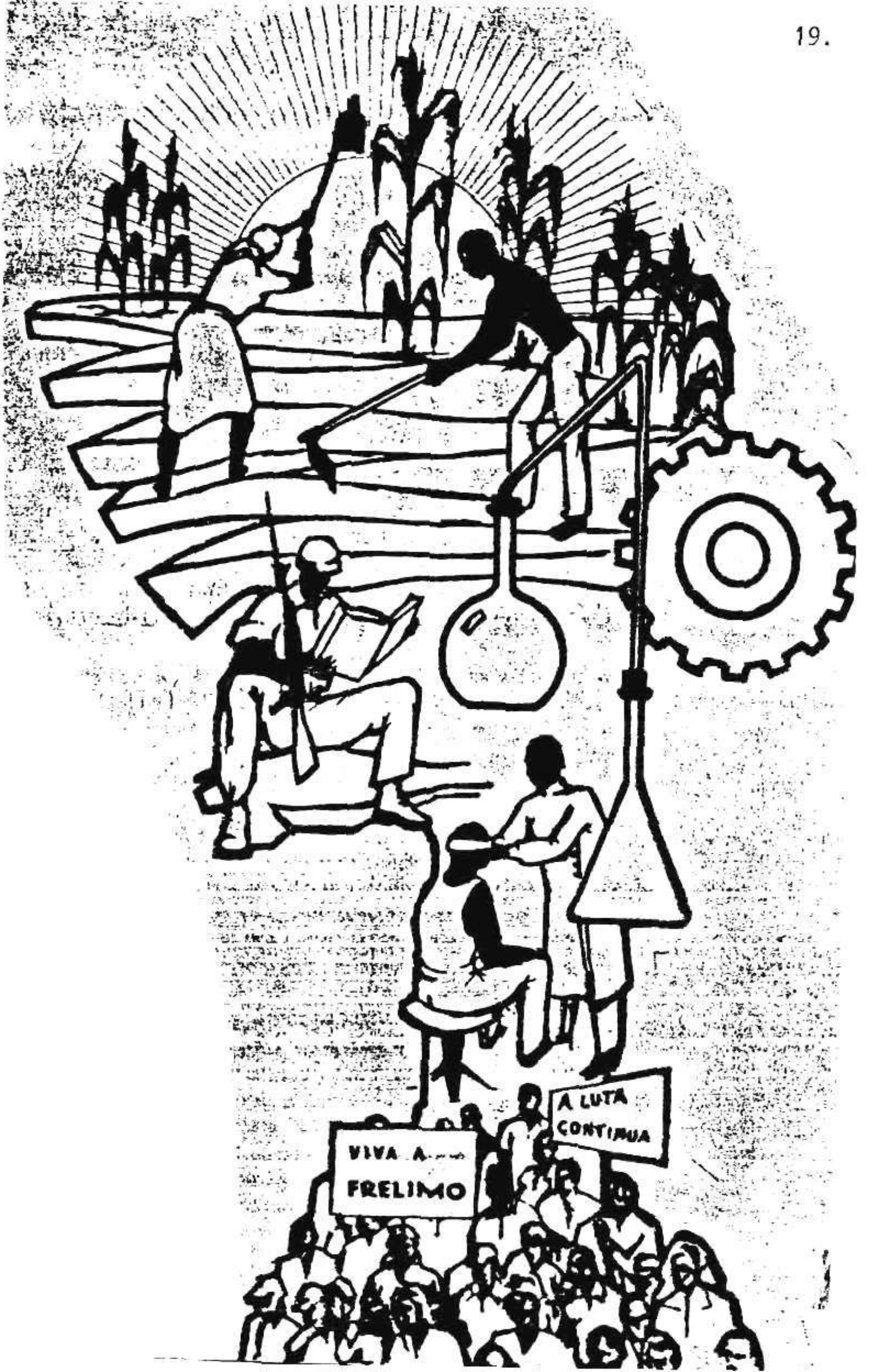
What is that new order in health? The content of the health system is determined by the kind of political power that exists in the society.

In the liberated zones, because the power is in the hands of the masses, the hospitals and health care in that society must necessarily also serve the interests of the people. The hospitals were not only for curing the body, but also for "freeing and forming the mind". Since the health care was inextricably linked with the people, hospitals were viewed as a front line in the creation of national unity and the fight against colonialism. Thus the health care is made up not so much by the medical and technical resources, but by the attitudes of those serving and served in the system. FRELIMO believed that doctors, nurses and health personnel must have a heightened political and class awareness, must have the moral armament of unity and must spread a new mentality to the people they treat.

The health care system should help to dispell tribalism, help to eradicate belief in the supernatural by promoting scientific methods, and replace individualism with team-work.

Thus there was a conscious political decision to emphasize primary or preventive health care. Health was to be seen as a combined effort on the part of the community. The principle task in health is to provide the masses with the indispensible scientific knowledge so that they can understand and fight against the causes of illness. It was necessary to win the enthusiasm and active support of the people for the better health of their own community.

In order to achieve these objectives in health, a hospital school in Southern Tanzania trained health cadres .These cadres were both politically and medically trained and this training emphasized community health but gave some skills in


A LUTA CONTINUA
VIVA A FRELIMO

in curative medicine e.g. treatment of war-injuries.

In a speech at the start of a cadre course in 1971, Samora Machel pointed out that the struggle is one. Even in the field of health two battle lines are drawn up. The "two lines in the field of health" are quite clear when one looks at the two radically opposing health systems that exist in Mozambique at this time - on the one side, the colonalist side, a health care system which promotes the well-being of the elite at the expense of the health of the underdeveloped, peasant sector; where health ensures the domination and exploitation of the masses in the interest of capitalist's higher profits. On the other, FRELIMO's side, a socially and community based health, in the hands of the masses, where preventive rather than curative medicine is emphasized.

Machel believed that by 1971 after only 7 years, Frelimo had done more to improve the health of the Mozambican people than the colonialist power had done in all its occupation. By 1970, 100 000 people had been vaccinated. Many doctors and nurses had been trained and an extensive health education campaign was well underway.

The expansion of health care in liberated areas continued until the fall of the Portuguese dictatorship in April 1974. This event heralded a mass exodus of doctors and other health workers which made the task even more demanding for the new government. Only 85 of the 550 doctors remained at independence in 1975.

PART 3.

HEALTH IN INDEPENDENT MOZAMBIQUE : A LIBERATING FORCE.

Between September 1974 and June 1975 the transition Government administrators consisted of FRELIMO cadres together with Portuguese bureaucrats. Many of the latter were covertly, if not overtly, hostile towards Frelimo and to changes envisaged in the health care system.

The immediate priority was to maintain existing services in the cities and to extend them to urban workers and unemployed. This was no easy task considering the mass exodus of health workers and the poor morale and commitment of those who remained, having led privileged lives unexposed to the political

and military struggle. Old patterns of behaviour continued - arrogance, racism, ill-treatment, authoritarianism - ills which permeated the hospitals under colonial rule. There was serious deficiencies in the medical standards, partly due to lack of staff, but also due to inflexibility of thought, and even a desire to sabotage FRELIMO's efforts. Corruption was rampant.

Independence day came in mid-1975. While the struggle for physical political power was over, the struggle against the colonial inheritance of undemocratic structures, human and economic under development and colonialist mentality had only just begun.

In establishing FRELIMO's development strategy, they attached special value to their chief strength, the mobilization and organisation of the people. There they drew heavily on their experience in the liberated areas.

In July 1975, all health institutions were nationalized and private practice banned,"an essential first step in making the country's health resources available to all the people."

The principle behind the Party's health activities was to make each and every citizen a health agent. Thus there was a fundamental commitment to preventive medicine and to the participation of all in health care, wherein lies the basis of the revolutionary practice of health in Mozambique. In October 1975, a National Environmental health campaign with the slogan "Promotion of Community Health by the Community itself" was launched, in which the rural population were mobilized to dig latrines. Sanitation, one of the corner-stones of prevention of disease, was being spread.

The following year a highly successful second mass campaign was launched - this time to immunize the entire population. The population was so well mobilized that 2½ years later 90% of the 11 million people were immunized.

Legislation was introduced in relation to health care. The law on Socialization of Medicine (Nov. 1977) provided for free emergency and preventive care and the right to free in-patient treatment. Fixed rates were set for non-emergency

TABLE 1.

Extract from a diagram of the new career structure in Mozambique.

Level:	Educational requirements:	Nursing:	Medicine:	Preventive Medicine and Community Health:	Obstetrics:	Child Care and Education
1.	Nine years basic schooling and 2 years university foundation course.	--	Doctor	Senior technician or health officer	Obstetrician	--
2.	9 years basic schooling.	Specialist nurse (eg teaching)	Medical Assistant.	Technician or health officer.	Specialist midwife.	Technician.
3.	6 years basic schooling.	Group A nurse.	Medical agent.	Auxiliary health officer.	Group A midwife.	Agent.
4.	4 years basic schooling.	Group B nurse.	--	Assistant health officer.	Group B midwife.	Auxiliary.

Note: Translation of the terminology has been slightly modified.

out-patient care, the charge for which covered treatment.

The law also dealt with the level at which a patient should seek health care, stating that except in an emergency the person must first go to their local health post and thence can be referred within the health system (see below).

In line with a policy of "good therapeutics at the lowest cost" the Ministry of Health severely limited drug imports and published an annual National Formulary. The 1977 edition had limited drugs from 13 000 to 640 products which could only be prescribed by their generic (chemical) names. This has made a beginning to curbing the intensely profit-orientated and monopolistic Western drug industry.

To examine the present health care system being introduced by the independent Mozambique government, we should look briefly at two areas: the structure of the system and the personnel working in it.

The system combines preventive and curative services based in the village, workplace or residential areas. It is a system of health with the people.

(a) Personnel.

Table 1 outlines the large number of categories of health personnel which have been defined. Their roles become more clear when one sees which level of the health care structure they slot into. (discussed below)

Table 2, below, gives some examples of the length of training of different health cadres.

Perhaps one criticism of the categories is that many are remnants of the old colonial system and while the training of these health workers through the Institute of Health Science and the University has radically changed there is some division of curative and preventive personnel. A more multipurpose health worker may be more appropriate to Mozambique's needs.

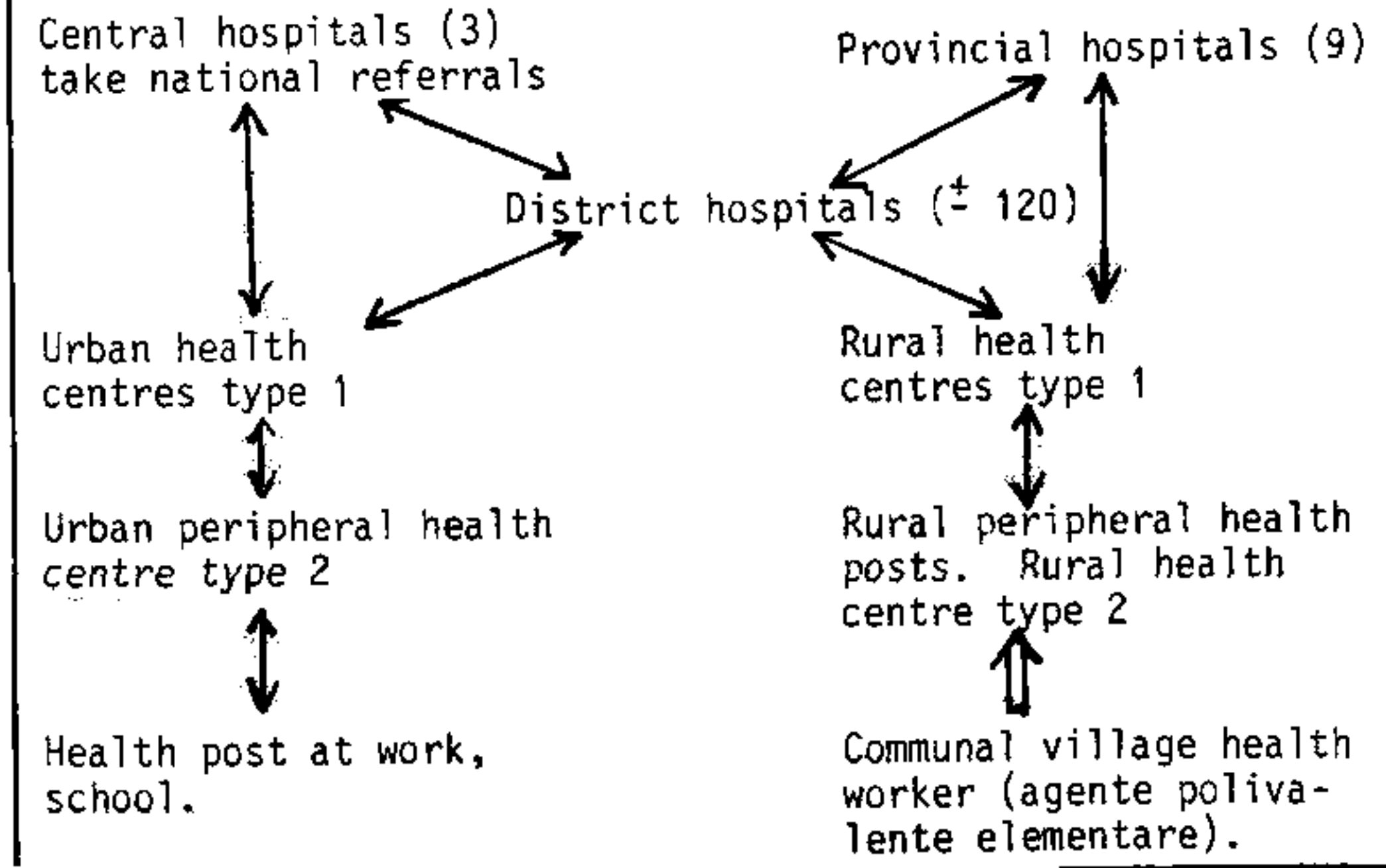
There is still a great lack of staff, but already by September/October 1979, 1 200 primary health care workers had been trained and 450 doctors were working in Mozambique (80% foreign "co-operantes" on 2 year contracts)

Table 2 Length of training of some Mozambican Health Cadres

Cadre	Years of training
Community health promoter	Few months
Medical agent Public health agent Auxiliary nurse	2
Medical technician Public health technician Nurse	3
Doctor	6(+1 internship)

(b) Structure of the Health System.

Diagram 1 shows the two-way referral for urban and rural areas



Note:

This is a two-way referral system. Personnel will also travel out from the health centres, when possible, to the peripheral health posts for purposes of supervision and support of junior health workers and to see referrals. Not all districts and provinces yet possess all these intermediate health units.

In the rural area the chief difference between the rural health centre type 2 and type 1 is that the former has no living-in facilities and is staffed by a nursing auxillary or a medical aide and they deal with minor illness or accidents, while the latter have beds (+ 40) and carry out maternity care and simple surgery. They are staffed by medical technicians and/or a nurse (Group A) and preferably a midwife. They are also visited by the doctor from the nearest district hospital.

Urban centres are similarly staffed but have no beds and deal mainly with preventive health care.

Communal village health worker:

It was recognized very early in medical and paramedical training courses that these existing personnel were not enough to extend the health network to the rural areas, necessary to eliminate the profound imbalance between urban and rural care.
In order to harness the power of the people's collective endeavours and to provide social services, FRELIMO, even during the war, emphasized "Communal villages" as the basic structure for the rural people's economic, social and political development. The communal village Health Workers (or Agentes Polivalentes Elementares) were created as a vital link between the health centre workers and the organised community - their main role being to involve the people in promoting their own health and providing a simple curative service. They are chosen by the village, sent for 6 months training and then supported by their community. About 450 have so far graduated, but there are many problems with their functioning.

Central Hospital - Maputo : A case study.

A brief look at the developments at the country's main hospi-

PEOPLE'S HEALTHCARE
ANTI-COLONIAL REVOLUTION
MEDICINE FOR PROFIT
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tal provides a very interesting case study of the struggle for change and the methods used to overcome the problems. The structures set up at this hospital are now being used as a model for other hospitals.

The Central Hospital was formed in 1974 by fusing the Miguel Bombarda Hospital and the university hospital (previously catering for black and white respectively).

However, for all the government's early efforts, they were unable to rid the hospital staff of their predominantly colonial mentality. It seemed that this hospital that had formerly used 1/3 of the country's health budget and had held a privileged position in the society, was particularly resistant to change. Complaints ranged from arrogance and apa on the part of hospital staff to poor food, unhygienic conditions and disorganisation. Bureaucracy was extreme.

In a hard-hitting speech by Samora Machel, on the state of the hospital, he described hospitals as "far more than centres for dispensing medicines and cures. A patient's stay in hospital should serve to heighten awareness of nationa unity".

The party appointed a "commission of restructuring" and democratically elected "conselhos" (committees) in each ward or service, thus creating a popular democracy. They also introduced peer evaluation, a code of discipline and developec direct and active links with the community (e.g. clean-the-hospital day).

By involving all the workers, the patients, their families and the city's population in the hospital's problems, very tangible improvements in hygiene and treatment took place within a year. For example, the death rate in paediatrics dropped from 21% (May, 1977) to 14% (May, 1978).

Dr. Fernando Vaz, leader of the "Commission of Restructuring" speaking in May, 1978, said "It is important that our hospitals have medications and surgical equipment, but the decisive factor is the health worker, whose consciousness and attitudes can make the hospital a centre in which we can concretize our political line to 'serve the masses' and

Few newly independent nations have faced as many far-reaching problems as Mozambique. Although 400 years of Portuguese rule ended on June 25, 1975, the legacy of colonialism remained. The Mozambican Liberation Movement (FRELIMO) inherited a country whose population suffered from the brutal afflictions of underdevelopment.

Despite these setbacks the new government, guided by practices developed during 10 years of armed struggle, embarked upon a carefully designed program to unify the country, improve the quality of life for all its citizens, and reorganize the paralyzed economy.

An even more impressive transformation has taken place in the delivery of health care. When the government nationalized the medical profession, it declared that proper health care would be a right rather than a privilege of wealth or race. Today, virtually all medical treatment is free, and the number of people treated in hospitals has dramatically increased despite the departure of most Portuguese doctors. Simultaneously, Mozambican health officials initiated a preventative medicine campaign, involving health brigades who have travelled the countryside where 90 percent of the Mozambican population resides. These mobile units emphasized the need for proper nutrition and sanitation and inoculated the rural population. To date, almost four million Mozambicans have received smallpox vaccinations, and by 1979 it is estimated that 90-95 percent of the population will have been immunized against basic infectious diseases — a figure which will place Mozambique far ahead of most of Africa

Africa Report

July - August, 1978

"Mozambique after Independence"

achieve our political principle that "the revolution liberates the people".

There are many other aspects to the health care system such as preventive dental care, orphanages, creches, the role of the Women's Movement (OMM) in health, occupational health, school health programmes etc. which are unfortunately beyond the scope of this paper.

Conclusion.

While the new Mozambique government has elaborated and planned a health care system and while there have been many successes to date, we must not believe that it is without problems.

It is beset with very serious problems, some of which will take years, or generations, to overcome.

Mozambique is not a rich country; to the underdevelopment inherited in centuries of colonial misrule was added the effects of a war against Portuguese colonization and more recently attacks from the troops fighting for the pre-independence, racist Rhodesian regime. Mozambique's fragile economy was severely weakened and is still recovering from these onslaughts.

Thus history manifests today in the ongoing struggle that must be waged against the colonial mentality, which often has a retrogressive influence, as well as shortages of personnel and supplies, a cumbersome, inherited bureaucracy and an illiterate population.

But there is little doubt that through its emphasis on health education, decentralization of health services, democratization of health care decisions and delivery and the emphasis on primary health care, Mozambique's health system is on the correct road to social justice.

Hence the now often repeated phrase: A LUTA CONTINUA - The struggle continues !

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