Mozambique: policy project

**Project objectives**

- **To increase** the technical capacity of Mozambique in mental health policy-making and planning.
- **To assist** the Ministry of Health of Mozambique to draft a mental health policy and update and improve its mental health programme.
- **To build** the capacity of mental health professionals to provide community-based care.

**Project strategies**

- Ensuring the harmonization of the mental health plan with the overall health plan.
- Strengthening the technical expertise and skills of local mental health professionals especially in the area of community care.
- Paying particular attention to the development of community-based services in the planning process.
- Ensuring the involvement of non-governmental organizations, especially traditional healers, in the area of training.
- Actively encouraging the involvement of a range of ministries, other than the Ministry of Health, in the policy-making process.

**Implementing institutions**

- Ministry of Health, Maputo
- Provincial Health Authorities
Provisional results of the national census conducted in 1997 put the population of Mozambique at nearly 15.7 million inhabitants. This is approximately 15% lower than earlier estimates of 18 million. Primary care remains the basis for the public health system in this country. The National Health Service is the major provider of all health services.

There are four levels of care in Mozambique’s 10 provinces. At the primary level, there are health posts, mobile services, and rural health centres that carry out preventive and basic curative activities. Health posts are staffed by semi-skilled or unskilled personnel. The large health centres have basic inpatient facilities and are staffed by nurses.

At the secondary level, there are rural and general hospitals. The general hospitals provide services in paediatrics, obstetrics and gynaecology, general surgery and medicine. Few rural hospitals provide surgical services.

At the tertiary level, there are provincial hospitals that offer diagnostic facilities and some specialist services.

The quaternary level includes the three central hospitals in Maputo, Beira and Nampula.

The mental health care system in Mozambique can be broadly divided into three sectors:

1) Services found in primary care facilities

Primary health care facilities are an important source of mental health care delivery. There are currently 34 psychiatric technicians located in health centres throughout Mozambique’s 10 provinces. Their main roles are to prescribe and administer psychiatric medication to patients attending the health centres and to provide psychosocial rehabilitation. The health centres also engage in mental health awareness and educational programmes in an attempt to reduce the stigma associated with mental illness and to highlight the risks associated with alcohol consumption. Medication can also be administered by staff in health posts. These are generally smaller than health centres.

2) Mental hospital services and psychiatric beds provided by general hospitals where outpatient services are also available

Psychiatric facilities within general hospitals are very limited. They are available in Maputo from the Central Hospital and in the province of Sofala where there is a small unit in the local rural hospital. There are currently two psychiatric hospitals in Mozambique. They cater primarily to inpatients with severe mental health problems who have been referred by primary care psychiatric technicians. One is based in the city of Maputo and the other in the northern province of Nampula.

3) Traditional healing

The Ministry of Health has looked positively upon traditional medicine because it recognizes its importance to...
the people of Mozambique. Given that only 60% of the population has access to formal health care services, particularly in rural areas, healers are most often the preferred port-of-call for individuals who suffer from health and mental health problems.

Since many patients who suffer from chronic mental illness are prone to relapses, one of the most important priorities for the Ministry of Health has been to monitor patients’ access to health and social care services once they have been discharged from the hospital. There is evidence to suggest that the psychiatric hospital in Maputo has been a victim of the same “revolving door” phenomenon that bedevils hospital services in many developed mental health care systems. Nevertheless, it is evident that some arrangements have been made with local health centres to monitor patients on discharge and provide general assistance to them and their families in the process of re-integration into the community.

Within the ministerial hierarchy, mental health is one of six sections that together make up the Division of Family Health. The Division of Family Health comes under the Department of Community Health, which has its own National Deputy Director. A National Programme Coordinator for Mental Health is responsible for planning and policy decisions. In each province, there is a coordinator for the local mental health programme. The coordinator is usually a psychiatric technician, except in two provinces where the work is carried out by psychiatrists. A two-year strategic plan for mental health was drawn up but has only been partially implemented. It is related to the National Integrated Plan/Community Health 2001.

In November 1996, a national mental health programme was outlined for the first time. This programme identified several areas of importance for Mozambique that needed to be addressed to improve mental health facilities. These included:

- The failure to prioritize mental health services.
- The dominance of a custodial system of psychiatric care, which perpetuates stigma against persons with mental health problems.
- The lack of epidemiological information on mental illness.
- The lack of human and financial resources and facilities.
- The lack of awareness among health staff and the community as a whole about mental health problems.
- The lack of systematic knowledge about the influence of social and cultural factors on Mozambique’s mental health problems.
- The absence of an agency to organize, promote, coordinate and supervise action in the mental health sphere.
- The lack of continuity in action undertaken. This can be attributed to lack of resources and heavy reliance on international cooperation.
- A highly centralized structure and a lack of intersectoral collaboration.
Each issue is discussed in turn, below.

*The low priority given to mental health services*

This continues to be the case in Mozambique largely because of limited financial resources and the pressing needs created by communicable diseases.

*The dominance of a custodial system of psychiatric care, which perpetuates stigma against persons with mental health problems*

There has been a noticeable improvement in the conditions of patients in the psychiatric hospital and in their management. Therapeutic work, in the form of agricultural projects, has been developed on land surrounding the hospital in conjunction with members of the local community.

Owing to the work of Italian Cooperation, the management of the hospital has been improved and work in the community has been encouraged and promoted. Italian Cooperation has also had an input into the training of psychologists, nurses and psychiatric technicians through the Central Hospital in Maputo. A new project to further develop community activities will shortly begin. Community projects have also been developed and implemented by the Italians in Manica and Sofala and by WHO in Niassa.

*WHO is encouraging joint-working between mental health workers and traditional healers*

The lack of epidemiological information on mental illness

For the first time as part of this project, WHO has funded the undertaking of a pilot epidemiological study to provide an evidence base for the mental health policy.

The Ministry of Health has outlined the benefits of the pilot epidemiological study as follows:

- Increase the availability of reliable epidemiological information on mental health in Mozambique.
- Begin the integration of mental health epidemiological information into the general health information system (statistics).
- Improve, monitor and supervise the effectiveness of mental health interventions on the basis of the initial evidence.
- Monitor the changes and trends in mental and neurological disorders. These are a major cause of disability in Mozambique, a country undergoing rapid and severe social, political and economic changes with serious impacts on the population.
- Work towards reducing the incidence and prevalence of mental and neurological disturbances with better information systems.

*The lack of human and financial resources and facilities*

These continue to be a big challenge to the provision of mental health service particularly in the community. Until 2002 there were only five psychiatrists in Mozambique, (none of whom are Mozambican). Three Mozambican doctors have been trained as psychiatrists, but their location and the duration of their stay in Mozambique in the future cannot be predicted with any degree of certainty. In addition, because of the shrinking pool from which to draw nurses for training as psychiatric technicians, no new
psychiatric technicians were being trained. Most of the psychiatric technicians who provide the bulk of psychosocial rehabilitation and are trained to administer medication, are due to retire shortly (two-thirds) or are planning to change careers. Training of new technicians was not envisaged because of the lack of financial resources in the Ministry of Health to absorb staff at this level. The issue of training is therefore a crucial one and is addressed in the mental health policy.

The lack of awareness about mental health problems among health staff and the community as a whole
The first training sessions given to mental health personnel in June 2000, have been continued in a limited way with general health staff at some health centres, in particular in Cuamba where there was another WHO community-based mental health project.

The lack of systematic knowledge about the influence of social and cultural factors on Mozambique’s mental health problems
While anecdotal knowledge exists, no systematic research has been carried out on a national scale. However, a study was carried out as part of the preparation of another WHO-funded project in the province of Niassa in the north of the country. Beliefs about the causes, the types of treatment and where treatment is sought, were recorded. The study also gathered information about local names given to mental health problems. As part of an epidemiological study, a comparison was made between these and ICD-9 classifications.

The absence of an agency to organize, promote, coordinate and supervise action in the mental health sphere
This has been overcome to some extent by the appointment of a National Programme Coordinator for mental health based in the Ministry of Health. However, this programme is only managed by two people and the Coordinator also has clinical responsibilities. Some progress has been made to coordinate action in the mental health sphere by giving people in the province (mainly psychiatric technicians) responsibilities for mental health. However, whether or not a mental health programme is implemented remains the responsibility of the provincial director of health.

The lack of continuity in action undertaken, attributable to the lack of resources and heavy reliance on international cooperation
This continues to be the case except in a few provinces where community services have been established.

A highly centralized structure and lack of intersectoral collaboration
At the regional and provincial levels, there has been some decentralization of services, and regional and provincial officials responsible for mental health have been appointed.

Mozambique faces many problems and challenges due to the lack of human and financial resources in the field of mental health. There is a need to address all of these issues in a systematic and practical manner. Because of the scale of communicable diseases in Mozambique, that are exacerbated by periods of flooding and drought, the health sector in general is under considerable pressure. The project therefore set out to address the objectives spelt out at the beginning of this document.
WHO has assisted the government of Mozambique to develop and write a mental health policy. The policy has addressed *inter alia*, a number of key areas. Among them areas such as: the organization of mental health services; human resource development; the provision of psychopharmacological drugs at all levels of the health system; intersectoral collaboration; the role of the traditional practitioners; and, the need for adequate epidemiological information to support the planning process.

The policy-making process was achieved through joint collaboration and planning between officers responsible for mental health in the Ministry and consultants hired by WHO to collaborate with the Ministry and guide it through the process.

As previously mentioned, a pilot epidemiological study has been undertaken and has provided a base for policy-making and planning. It was conducted in one rural and one urban province and included a sample of people in the community, as well as people in primary care and general hospitals.

The training given by WHO as part of the pilot epidemiological study has been part of a capacity-building exercise to enable the Department of Epidemiology within the Ministry of Health to begin to integrate some information into its routine statistics and for record-keeping purposes.

In June 2000, approximately 90 mental health professionals and representatives of non-governmental organizations from all 10 provinces of Mozambique were trained in best practices in community mental health. The training also included persons from the statutory and non-statutory sectors.

An international meeting of experts and local mental health policy-makers and practitioners was also convened in June 2000.
It has already been recognized that this is a fundamental part of the process of strengthening the role of mental health in primary health care. Discussions with Ministry and clinical staff indicated a high rate of re-admission. It was recognized that there is a need for greater follow-up in the community. This is a problem because of the insufficient numbers of trained staff. Given the size of the country and logistical problems in servicing communities with poor infrastructure, the provision of mental health services is greatly limited. There are however successes in a few provinces where international aid is being injected into the community by Italian Cooperation. Overall however, the issue of staff training, support and retention is one that runs across the whole of the health sector and affects the provision of community services.

Existing community services were visited and discussions held with workers and international NGOs, where they existed, in order to evaluate the impact on community service provision.

Actively encouraging the involvement of a range of ministries other than the Ministry of Health in the policy-making process

This process of building intersectoral collaboration where none has previously existed was initiated with the Ministry of Social Action and the Ministry of Labour. It was then extended to cover a range of other ministries who were consulted to contribute recommendations on the way forward.

Other areas that need to be addressed as part of the policy-making process affecting community care include:

- Integrating mental health into existing community health programmes within the Ministry of Health (such as the Infant and Maternal Health Programme (UNFPA), and the Integrated Management of Childhood Illnesses Programme (WHO/UNICEF)).
- Introducing/strengthening the training and use of primary health care staff such as health agents and social agents. This is aimed at improving care in the community as part of a national programme of training by the Ministry of Health.
- Ensuring the adequate provision of psychopharmaceutical drugs at each of the four levels of distribution and ensuring the introduction of the necessary psychopharmaceutical drugs into the “kit system” at the PHC level.
- Rationalizing the work of psychiatric technicians with the roles of health agents, recently trained psychiatrists and social action agents from the Ministry of Social Action, with particular reference to roles and responsibilities, and career structures.

### The following received training as part of the project:

- Clinical psychologists
- Psychiatric technicians
- General practitioners
- Psychiatrists
- Traditional healers
- Technicians in preventive medicine
- Nurses
- Nursing tutors
- Heads/representatives of nine NGOs
- Chiefs of provincial community mental health services
- Senior primary health care staff
- National Programme Coordinator for Mental Health
- Psychiatric technician based in the Ministry of Health

### Paying attention to the development of community-based services within the policy and planning process
As far as future collaboration is concerned, the involvement of the Department of Mental Health in the training of “social agents” who work in the community has been discussed with the Ministry of Social Action as part of this project. This is seen as a fruitful area for cooperation. Future collaboration also includes further work with the Directorate for Women within the Ministry of Social Action. This is because domestic violence is an area of concern.

For the Ministry of Labour, recent labour legislation has been drawn up but still needs to be implemented through various regulations. Input from the Department of Mental Health in drawing up regulations for workers who have mental health problems has been welcomed.

A series of consultations were held with other Ministries during the course of the project. These are outlined below. Consultations and visits covered all of the 10 provinces.

Some of the chief aims of the activities that have taken place included:

- understanding the problems and issues of mental health;
- understanding how health/mental health services were organized at all levels;
- discussing recommendations on the key areas that need to be addressed in the policy document and suggestions on how to address the current problems in mental health;
- getting a better idea of the role and contribution of the traditional sector;
- agreeing on the nature and scope of collaboration with other ministries in order to optimize limited human and financial resources.

The following consultations and visits have been made:

**Ministry of Health**
- Deputy Minister of Health
- National Director of Community Health
- Head of School and Adolescent Health
- National Director of Human Resources and Training
- Deputy National Director of Medical Assistance
- Head of Pharmaceutical Department
- Meeting with Restricted Consultative Group (a Maputo-based group with representatives from the Ministry of Health, the Military Hospital, the psychiatric hospital, the central (General) hospital and NGOs).

**Psychiatric Hospital - Infulene**
- Meeting with the Psychiatric Hospital Director followed by a tour of the hospital.

**Ministry of Social Action**
- National Director of Women and Social Action
- National Director of the Institute of Social Action (INAS)
- Chief of Programmes – INAS

**Ministry of Labour**
- Permanent Secretary
- Head of “Gabinete de Estudos” (Study Cabinet)

**NGOs**
- Italian Cooperation
- Executive Director of Reconstruindo Esperanha (Reconstructing Hope) – children and adolescents
- Mahotas (adults)

**Focal points for mental health in all of the provinces**
- Relevant local health personnel
- Provincial authorities
- International NGOs
- Local NGOs
- Traditional healers
- Ministry of Education
- Ministry of Youth and Sports
- Ministry of Justice
- Ministry of Internal Affairs
- Ministry of Finance
- The City Health Board
Key results

The formulation of a national mental health policy.

This was achieved through a process of:

- Political commitment and collaboration with senior personnel in the Ministry of Health.
- Training of mental health professionals in the area of community mental health.
- Undertaking an initial situational analysis of mental health issues and problems.
- Drawing up a clear and costed plan-of-action.
- Engaging in widespread consultations and discussions at the central and provincial levels (75 meetings involving over 250 persons).
- Ensuring consensus on areas to be included in the policy through a national meeting.
- Underpinning the policy with an evidence base by undertaking a pilot epidemiological study.
- Building in-country capacity for undertaking epidemiological research.
- Disseminating the final policy document for comments.
- Holding a final meeting before submission for formal adoption by the Council of Ministers.