

Palliative medicine in Mozambique

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Abbreviations: MOPCA, Mozambican palliative care association; AMED, Mozambican pain research association; APCA, African palliative care association; TCT, true colors trust

Mozambique

Mozambique is a southern eastern African country with 799,380 km², a tropical climate and a 2,000 km coast line over the Indic Ocean. With an estimated population over 27 million (2017), 68.4% in rural areas (2014),¹ with low literacy (56.7% did not go to school), 50% under 18 years of age,² it's the only Portuguese speaking country in this region. There are more than 20 different ethnic and Banto languages groups, several religious congregations (23.8% Catholic, 17.8% Muslim), and traditional healers have a predominant influence over rural and urban populations. Spiritual healing is very common, compensating health services low accessibility. This nation results from an old Portuguese presence (since 1500) and occupation (1900), becoming independent in 1975. A socialist one-party (Mozambican National Liberation Front, FRELIMO) system ruled the country until 1994, with severe civil war displacing 5 million and 1 million deaths. The World Bank and International Monetary Fund started supporting national public expense, since the peace agreement with the Mozambican National Resistance (RENAMO, 1992) and the implementation of a multi-party democracy. With considerable natural resources (coal, gold, precious stones, gas, oil) and a significant agricultural potential, the country has high unemployment and disease burden (infectious and emergent diseases) rates and one of the poorest populations in the world (Human Development Indicator 0.33, 2012).³ Life expectancy rose from 45 years in 2000 to 57.6 years in 2015, chronic malnutrition affects 43.1% children under five years of age and only 40% of the population have access to the national Health Service.

Palliative care target groups

Treating patients with advanced and progressive diseases to promote their wellbeing and life quality, is an essential quality of health systems to attain universal health coverage.⁴ HIV prevalence is one of the highest in the world (13%) and orphan, vulnerable and HIV positive children, adolescents and adults are the largest target group for domiciliary and palliative care. It is estimated 90 HIV positive new-born every day, 21% families have an HIV positive member and 7% are taking care of an orphan child.⁵ Cancer incidence is also rising in all age groups and gender (prostate, liver, Kaposi sarcoma, non-Hodgkin lymphoma, lung in men, breast, cervical, liver, colorectal, non-Hodgkin lymphoma in women),⁶ due to better diagnosis but mainly to HIV related Kaposi and HPV related cervical cancer. Many Mozambicans are also affected by mental health problems, but this area is not well studied. Post traumatic stress due to civil war and other violent conflicts is frequent, so as adolescent and old people suicide. Old people are mostly women living in rural areas and not a large group in Mozambique (3.2% with 65 or more years of age, 2014). Nevertheless they have a high prevalence of chronic diseases (hypertension, cardiovascular diseases), not having access to a proper

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medical diagnosis or treatment. Very few of them (1.5%) receive a monthly subsidy from Government (6 \$US) and most work to survive.

What's happening?

Scarce resources, might be the main reason why the Mozambican population seems to have high resistance and resilience capacities to pain and suffering. Infrastructure and equipment for hospice and palliative care is almost inexistent, limited to a few religious (Lhanguene, Maputo and Quelimane Aged People Support Centers) or private (Maputo) facilities, hosting less than 1,000 people. Health care facilities and professionals are scarce: only one hospital in Maputo does radiotherapy, there are four psychiatric hospital in the whole country with less than 400 beds. There are few medical doctors trained on palliative care and treatment protocols are missing in health programs. The Mozambican Medical College does not certificate this sub specialty yet and is not providing any training or monitoring and evaluation. Pain health units exist in three provinces' capital cities hospitals (Maputo, Beira, Xai-Xai) and one rural hospital (Chibuto).

The Mozambican National Health Service drug supply follows World Health Organization' essential medicines list, but it suffers from distribution problems with periodic stock outs. Pain drugs are limited, challenging palliative care (access to oral morphine is almost inexistent).⁷ Most hospice and palliative care services have been delivered by non-governmental organizations, local or international. The Catholic Church was the first to operate hospice facilities for orphan and vulnerable children, mental health patients and aged people in 1940 up today.

The French "Douleurs sans Frontières" has been working since 1996 on pain treatment and palliative care, sensitizing and training health professionals and strengthening partnerships between social and health institutions and civil society; their activities are limited to 2 of 11 provinces (Maputo and Xai-Xai). The Mozambican Palliative Care Association (MOPCA) and the Mozambican Pain Research Association (AMED) were created in the capital city (Maputo) no more than 15 years ago; with support from the African Palliative Care Association (APCA) and True Colors Trust (TCT) they trained 19 Mozambican health professional in March 2018 in children's palliative care (communication with children and families, pain assessment and management, ethics, child development and play, grief and bereavement).

A few hospice private institutions exist in Maputo and Beira cities: Rising Sun Cooperative (Cooperativa Sol Nascente) for example, provides day center care and shelter for old people, domiciliary care for the aged and their families and palliative care to terminal patients. In response to the HIV epidemics in the nineties, Community Based Organizations were created to develop domiciliary care through Local Health Agents (APE) in rural districts, working voluntarily with little institutional support or training; their impact varies widely among organizations and provinces. The Mozambican Constitution (article 124) aims to protect aged people in families and institutions and avoid marginalization, promoting health care and disability support. Since 2004, the Ministry for Women and Social Affairs, is responsible to promote and coordinate assistance to aged and vulnerable people.⁸ In 2014 the Mozambican Congress approved the “Third age’ rights promotion and protection law”. Over the last 15 years the Government implemented several programs to deal with poverty and social exclusion, but their impact remains insignificant.

Aged people living in rural communities are well cared and respected, exceptionally discriminated by disease stigma (HIV) or witchcraft accusations, lately increasing in the country. In towns and cities, without almost any hospice and care institutions and living mostly (72,5%) in sub-urban areas without water or sanitation, aged people are often miscarried by their own families: in 2016 hundreds of abandoned aged people were registered by Police officers.

What can be done?

Most population lacks information about health determinants, making health education a priority; if television can be used for urban residents, most part of the country do not have access to electricity but can be attained with radio programs. In rural populations, health volunteers (Agentes Polivalentes Elementares) might give a strong contribution to promote health and inform about palliative care. Health professionals are the main target group for training on palliative care: they include doctors, but mainly nurses and medical technicians (with three years of health and medical education), most workers in the National Health System. Medical Schools must include palliative care in their curriculum, so that students learn to deal with terminal patients and to manage death issues. Quality of care, in general, must improve: disseminate pain diagnosis scales, upgrade treatment tools to include several pain drugs and physiotherapy. The health information system must also upgrade, to collect, forward and analyses accurate data, to follow palliative care trends. Last, we must

consider the need for more health facilities, increasing the number of beds for hospice care. This area will need an increased investment on health budget from Government priorities, launching a national strategy and program for palliative care.

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Conflict of interest

The author declares no conflict of interest.

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