HEALTH EDUCATION IN THE CONTEXT OF NATIONAL LIBERATION : A CASE FROM OCCUPIED PALESTINE

By
MOUSTAFA BARGHOUTHI AND RITA GIACAMAN

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Introduction

It is now well established that a key element in the development of adequate health care is community involvement and participation in the solution of their own health problems ([1]). Likewise, there is an increasing awareness among educators everywhere that, for health education to have an impact on the general health conditions of the community, special attention should be given to health education at the level of the community, and not only the school ([2]).Health educators view health education practice in two major ways : one view emphasizes changing individual behaviour while the other focuses on changing the structures/institutions that damage health ([3]). Some combine both perspectives, advocating both individual and public health education, viewing health as the concern of both individual and communities ([4]).

A Case From Occupied Palestine

The Union of Palestinian Medical Relief Committees - UPMRC - ([5]) first began its health activities in the Israeli Occupied West Bank and Gaza Strip in 1979, as an integral part of the Palestinian national liberation struggle. It is a movement of health professionals that developed an 800 strong constituency by 1988, including about 350 physicians or one third of the physician population of the entire country, nurses, village health workers, technicians, pharmacists and others. UPMRC bases its activities primarily on the voluntary participation of its members - after work hours and during days off and holidays - in attempting to

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[1] World Health Organization, **Alma-Ata Declaration,** 1978.

[2] Young, Beverly and Durston, S., **Primary Health Education**, Longman, london, 1987, pp.x-ix.

[3] Freundenberg, N., Training Health Educators for Social Change, International Quarterly of Community Health Education, Vol 5(1), 1984-85, p.37 and Brown, RT. and Margo, GE, Health Education : Can the Reformers be Reformed ? **International Journal of Health Services** , 18(1), 1978

[4] Wallack, L and Wallerstein ,Nin, Health Education and Prevention: Designing Community Initiatives, **International Quarterly of Community Health Education,** Vol 7(4), 1986-87 pp.319-342.

[5] See Union of Palestinian Medical Relief Committees, **Statement of Purpose and Activities**,Jerusalem 1984 and **Report of Activities During 1984** , Jerusalem, 1985 .

create an 'alternative model' to health development in Occupied Palestine. Alternative here denotes an approach calling for reaching people with basic health services, an emphasis on preventive and health education activities and people's participation in the solution of health problems, in contrast to purely curative, urban based medicine focusing on the mechanical solution to health problems - otherwise known as the engineering/biomedical approach to medical care. .

At the time of UPMRC's inception, Palestinians had undergone at least two major shattering experiences . The first was the dismemberment of their society and the dispossession and dispersion of hundreds of thousands of refugee all over the world as a result of the Arab Israeli conflict and the creation of the State of Israel in 1948. The second was the fall of the West Bank and Gaza Strip and its population under Israeli military rule in 1967. The events marked the beginning of a period where the survival of the Palestinian community under occupation became linked to the people's ability to organize at the community level and fulfil basic needs despite harsh Israeli policies and measures aimed at possessing the land without its people ([6]).

Founded primarily by young urban based health professionals with broadly progressive inclinations and links to the mass based organizations, whether women's committees, trade unions or other, increasingly active in the towns, villages and refugee camps of the West Bank and Gaza Strip, UPMRC shared with the Palestinian health establishment that existed at the time a perception situating medical care within the context of the national struggle. To Palestinian health professionals then as now, the delivery of medical care and the obsessive drive to build independent Palestinian health institutions form an integral part of the struggle against Israeli policies . Given that these policies are seen to aim at the destruction of the infrastructure that is crucial for reconstructing Palestinian society in the future, and the reduction of Palestinians into a situation of dependence on Israeli for livelihood, health care delivery quickly became an important arena for political struggle.

Nonetheless UPMRC - exemplifying a new health movement emerging in the late 1970's - possessed two decisive characteristics that distinguished it from the health establishment . The first was a strong decentralized, curative and preventive community orientation. When centralized , urban based and highly technical and curative services were the principles guiding the activities of the medical establishment of the time ([7]), UPMRC as a health

[6] For further information on the history and plight of Palestinians see for instance, Said, E. **The Question of Palestine**, Routledge and Kegan Paul, London, 1980 , Aruri, N.,editor, **Occupation, Israel Over Palestine**, Zed Press, London, 1984 and Rothschild,J., Editor,**Forbidden Agendas : Intolerance and Defiance in the Middle East**, al-Saqi, London, 1984.

[7] For a representative elaboration of this trend see

- and not only medical - movement, advocated the need to reach people in remote rural and refugee camp areas and poor urban communities with basic curative services in addition to promotive and preventive health activities, including community health education . Secondly, whereas both the medical establishment and the new health movement were constituted within the context of generalized resistance to Israeli military rule and the struggle for national liberation, UPMRC carried with it the elements of a new social and class consciousness. Indeed, the very membership of UPMRC reflected to some extent the interests of oppressed and exploited groups. Most of those volunteering their services as doctors, nurses and other health professionals, came from poor peasant and/or refugee backgrounds, having been catapulted to middle class and professional status through educational opportunity while remaining at the bottom of the medical establishment's ladder. This background reflected itself in a specific community and class based consciousness that was strongly sharpened by the failure of the medical establishment to coopt this newly emerging class of physicians and health professionals. Consequently, the foundation for the new movement was created.

UPMRC's realization of the significance of health education at a generalized level did not evolve out of extensive theoretical knowledge or through the process of systematic education. Rather, it was through intensive contacts with poor and remote communities in the context of the mobile clinic - the embryonic form of UPMRC's primary health care activities - that an understanding of the need for a health education project for UPMRC became evident ([8]) . However, UPMRC met serious difficulties in attempting to institute health education as an essential component of its preventive activities.

To begin with, hardly any written health education material existed in Arabic language for use by either the health care provider or the literate population . The design and production of health education materials proved to be difficult at first because of the absence of trained manpower capable , for example, of producing leaflets, posters and booklets in simple Arabic and geared towards local health needs. The technical problem was solved through learning by practice, through cooperation with other local institutions interested in the project of community health

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Thirty-Fourth World Health Assembly, summary Records of Committees, World Health Organization Document WHA34/181/rec/3, Geneva 4-22 May, 1981 pp.344-346.

[8] Mobile clinics are a form of health care provision extension to the countryside where health professionals visit communities periodically, along with their equipment and medications, and provide simple treatment and health education instruction to people . When UPMRC first began its activities, volunteers used their private equipment and vehicles to transport medical teams to the target community. As activities developed over the years, UPMRC acquired special minibuses that continue to reach people in remote areas with basic services until today.

education - most notably the staff of Birzeit University's Community Health Unit nearby - and through the later formal training of UPMRC volunteers in health education material production abroad. As for knowledge of local needs, that required the gradual build up of an understanding of the major health problems in the country and their determinants. It was a piecemeal process, involving not only primary health care service provision in the villages and refugee camps of the West Bank and Gaza Strip , but also the development of an extensive home visiting programme over the years. Initially, the home visiting programme was founded on the cooperation of selected individuals from communities were health services were being provided. Later on the support and involvement of the community health workers that UPMRC succeeded in training (see below) ensured the continued success of this endeavour. Finally, knowledge of local health needs and demands from health care was grasped through volunteer involvement in baseline data collection and health research, involving raising the question of needs and aspirations with the communities themselves and specifically women of child bearing age who have the ultimate responsibility for family health in the Palestinian context.

But the community health education project faced even more critical difficulties. On the one hand people's consciousness of what constitutes health, disease and health services had been distorted by the influence of years of medical care provision utilizing the biomedical/engineering approach ([9]), it having been firmly established as the only mode of medical care worth taking seriously. On the other hand, the consciousness of the large majority of physicians and health care professionals was also limited, having in the main been trained in and profoundly influenced by the biomedical model for health care provision.

Moreover, experience in attempting to institute preventive health services in the country , to the exclusion of curative services, had all failed . We especially note the pilot project launched by Bethlehem University on the West Bank in the early 1980's. It was decided to train community health workers at the post high school level. When those recruiting trainees failed to locate women with high school diplomas willing to train - women with high school training willing and capable of leaving home to train in the town for a period of two years was a rather unrealistic expectation - the catastrophic move of training male health workers was made . It was a catastrophe because local culture precluded the possibility of make health workers delivering basic services to women and children, leaving the male health workers with very little to do. The other problem that this programme fell into was that training took place in the absence of a comprehensive health care provision plan for disadvantaged communities. Thus some of these health workers were sent back to their communities and were expected to carry out preventive activities without being linked

[9] For an interesting critique of the Western/biomedical system of medicine See Navarro, V., **Medicine Under Capitalism**, Prodist, New York, 1976

to supportive, advisory or supervisory structures that delivered the other services that people needed and demanded. Because of the failure of the first group of trained health workers to successfully establish practices in their communities , the training programme was eventually terminated.

It should be noted here that the failing experiments had been primarily conceived under the influence of theoretical perspectives and experiences developed exclusively outside the country . It was therefore essential to develop a new perspective, taking into consideration experiences generated elsewhere in the world so as to not need to reinvent the wheel, yet grounding such perspectives in the indigenous reality, and ,ultimately leading to the development of native prototypes suitable for local needs and sensibilities.

The absence of a theoretical perspective to guide the health education activities of UPMRC proved to be a double edged sword. It had a negative effect in that it took almost 10 years for the experiment to develop coherence and for an alternative health consciousness to emerge among both health professional and population groups. This negative influence was however tempered by the strong sense of social justice and the need for popular medicine that UPMRC espouses . Yet the very absence of a set framework - a prototype or model for project development - had important positive influences in that it allowed for sufficient flexibility to enable the digestion and assimilation of local influences and the evolution of an/interactive responsive approach to project design and implementation. In other words, the attempt to launch a community health education project turned into a health education reeducation project for the volunteers themselves.

This reeducation of health professionals through practice - in rural areas and refugee camps - led to two further realizations . First, it became obvious that the first step in implementing community/mass health education projects was to train individuals from specific communities where there is a pressing need for health education. These health workers, being culturally in tune with their communities, could be expected to take the 'front line staff' position not only in the health education of the public ([10]), but also in the process of helping the communities to organize for the solution of their health problems . Note that community organization in the UPMRC context includes helping the community in forming health committees to oversee the establishment and operation of a UPMRC directed primary health care centre. These community based committees are composed of representatives of all trends, groups and sectors on local, with the exception of women. Until today, traditional culture precludes the possibility of women

[10] For an absorbing perspective on training teachers learners, see Brieger, W., et al, Selecting Alternative Strategies from Community Health Education in Gineworm Control, **International Quarterly of Community Health Education** , Vol. 5(4), 1984-85, pp.313-230.

joining men in these decision making structures, as well as other decision making structures at the community level. Seventeen such primary health care centres are currently in operation in the various regions of the West Bank and Gaza Strip.

The second realization related to the fact that, given that 70% of the Palestinian population is composed of women of childbearing age and children under 15 years old and that the responsibility for child and family health is mostly that of women/mothers, it was evident that prospective community health workers had to be women in order to have access to women and children - a priority in health care provision and health education - given the context of traditional Palestinian culture.

It is in this 'learning by practice ' method that the major strands of UPMRC's community health education project were initially formulated . Those include reeducation of young newly-graduated health professionals through mobile clinic exposure to remote and rural areas and the health problems there and their determinants, as well as the training of community health workers, health education of young women and mothers , both individually and collectively , production of health education materials in simple Arabic - including leaflets, booklets, posters and slide series - generalized health education campaigns for the eradication and control of infectious and communicable diseases, such as brucellosis and hepatitis, and campaigns to promote blood donation, especially relevant within the context of the violence of the past 16 months.

This type of learning did not take place in isolation from experiments conducted elsewhere in the world, but those were examined with caution. For the basic lesson that was learned from studying experiences generated in the country and abroad pointed to the need for absorbing elements of successful experiences elsewhere without ' swallowing them whole' or duplicating them 'by the book'. It also pointed to the need for substantial flexibility when implementing health and development projects - a necessary precondition for the adaptation of programmes to community needs.

While not without its problems, UPMRC's experience in training community health workers can be singled out as one of the most successful experiments in community health education taking place in Occupied Palestine. What follows is a detailed characterization of the project and the elements leading to its success.

TRAINING OF COMMUNITY HEALTH WORKERS

The prototype of community based training members of the community who do not possess extensive qualifications was already known to UPMRC volunteers through reading about experiences taking place in developing societies. Such a prototype appears to have evolved to solve three problems coming in the way of adequately reaching people with basic health services : the large size of the population to be served, such as in India and Brazil, extensive

territories to cross before reaching people in remote areas who need health services, such as the case of China, and the unavailability of funds to establish developed health services covering the needs of all the population.

Although Occupied Palestine shared with developing countries some of these characteristics - most notably the lack of resources - the context had its own specificity. Palestinians have no authority or control over their lives : they are ruled by a military occupier, have no control over public sector health and educational institutions which are under the direct administration of the Israeli military. Thus Palestinians are incapable of affecting changes at the formal structural level that would assist in improving health conditions in the area.

In addition, the country does not share with other developing countries the problem of extensive territories or population : the West Bank and Gaza put together total approximately square kilometers and are inhabited by about 1.5 million people. In the Palestinian context, the problem is, at best, a highly inadequate transportation system, and at worst, a total lack of public transportation to and from rural and refugee camp communities and towns and urban centres, where people seek medical services.

At the time, UPMRC had the benefit of hindsight : the failing experiment in community health worker training of Bethlehem University underlined the fact that adoption of the Latin American 'where there is no doctor ' model was inappropriate for the Palestinian setting. The country did not lack doctors : there were between 150-250 unemployed physicians at any one time during the early and middle period of the 1980's. What was lacking and needed was a special sort of manpower , women from the communities themselves assisting in health promotion and prevention activities through intensive individual and community health education measures and community mobilization to participation in the solution of health problems.

Yet no nursing or health educational institution, public or private, was capable or willing to train such manpower. These institutions were too rigid to adapt their form of systematic education to newly developing community roles or to accept students who have traditionally been excluded from this type of education by the requirement of a high school diploma. They were also conceptually and technically incapable of instituting a new education programme which would be geared towards community health preventive needs, in contrast to the hospital-oriented training that prevailed in the nursing colleges and institutions. These programmes of course neglected the needs of about 70% of the population that lives in rural areas and refugee camps without ready access to medical care.

Consequently, it was need which prompted the UPMRC volunteers to develop their educational project, in cooperation with communities where primary health care centres and community

health worker programmes were to be established and in dialogue with them. The task was to train these community health workers - women from the communities themselves - to eventually take charge of health care in their own communities. Through discussion and consciousness raising aimed at helping people in identifying their health problems and through individual and communal mobilization, these health workers were to constitute a bridge of access between proper curative and preventive health care and community members, especially women and children.

By 1989, 42 community health workers had been trained through this informal system. All were rural and refugee camp women who did not possess high school diplomas and whose type had been excluded from higher education in the past. UPMRC volunteers maintain regular contact with the trained women who are now working as trainers/facilitators/ health workers in their communities, either within the framework of a UPMRC primary health care centre or in conjunction with the volunteers that periodically visit communities via a mobile clinic system.
Interestingly, the initial reactions of the health establishment to this initiative was one of a firm rejection of the model and its principles. However, the experiment proved to be such a success, emerging as an effective and low cost model for health care development despite military rule, that the Palestinian medical establishment nonetheless feels obliged to begin seriously considering utilizing this novel and community based type of education as a foundation for its medical and health care development plans for the country.

There were further unforseen ramifications to the success of this health education project. Until the training and the firm establishment of these women health workers in their communities,all matters pertaining to community health, education and development was considered the exclusive domain of men. In the Palestinian traditional setting, women do not form part of the decision making structures, neither at the community or national levels. Training provided the new women health workers, perhaps for the first time, with the justification for a public role in society, and established them as social actors instead of dependents of men. The impact of such a newly emerging social role for women is potentially transformative. Already, some have succeeded in shattering the gender divide and are attending community health committee meetings. Whether such an interesting change would continue to develop and become generalized, lasting through the period after liberation or not remains to be seen. Clearly, the prevailing political conditions in the country are exceptional and do call for a deviation from accepted norms and standards of behaviour.

Conclusions

This experiment in alternative health education for liberation is important in more than one respect. It demonstrates

how conditions of military rule/national liberation, while removing power from the hand of the oppressed - in this case all sectors of Palestinian society - nevertheless create the very conditions for people's empowerment . These conditions have produced the fertile ground for the development of strong capabilities of community and mass mobilization for survival among Palestinians . Indeed, UPMRC itself is but one of the symbols of the Palestinian self-reliant response to military rule through mobilization of the sector of health professionals to participate in the solution of local health problems. Secondly, it illustrates the need not only for the health education of the deprived, but also the reeducation of those who serve the deprived . While considered technically well-trained by local and international standards, it was crucial for UPMRC volunteers to be educated and sensitized to the actual health conditions of the deprived - in contrast to what they have learned in medical school or through practice in urban areas - in order to then be able to assist in the mobilization of the poor to solve their own health problems. Finally , it serves to show how alternative education for liberation must take into consideration more than one form of oppression to be effective. In our case, it was both Israeli military rule of the area and the oppressive forces within Palestinian society itself - exemplified in the traditional medical establishment - that were together disempowering the population and excluding entire sectors from the decision making apparatus and from participation in the solution of their own health problems . In the end, this experiment serves to reinforce the view that true liberation involves the emancipation of all sectors of society from all forms of exploitation.