NAMIBIA

NEED TO PLAN AHEAD

HEALTH WORKERS AND THEIR RELATIONSHIP TO THE SOCIAL AND POLITICAL DIMENSIONS OF A COUNTRY

by David Werner

This is a paper presented at a seminar dealing with health care in a post-independent Namibia, and which sought to illustrate health care services and their relationship with politics, in a number of different countries.

No one knows better than the people of Namibia that a declaration of independence - or even an armed revolution - is only the first step toward liberation of the people. Even after foreign invaders have been driven out, many forces of oppression will continue to operate.

The process of liberation is not primarily one of armed struggle or political decree. It is one of gradual social transformation, a group educational process in which persons learn to live and work together, both freely and fairly:

freely in the sense that each nation, each community and each family is free to become self-reliant and to make independent or inter-dependent decisions on matters that concern their wellbeing.

fairly in the sense that groups of people, small and large, learn to peacefully prevent any member of the group (or outsider) from seeking control or privilege at the expense of others.

In short, liberation is an ongoing collective process in the defense of basic rights.

Where do health workers fit into this process? That will depend on many factors, most of which are political.

After Namibia's independence, the intention is to restructure the health system to meet the needs of all the people. This is coupled with an overall commitment toward achieving greater equity in the socio-economic and political sectors. Thus the political climate will be in favour of selecting and training health workers at every level who will serve, rather than take advantage, of the people.

But, there are many obstacles along the way - many decisions to make. Much can be learned from other countries that have recently gained independence or undergone popular revolutions.

MEXICO

The last Mexican revolution took place from 1910-1917. This resulted in the writing of the most socially progressive constitution at that time (1917). A 1934 amendment guaranteed that all Mexicans had a basic right to health.

Since then, many rural development programmes have been launched - roads, schools, and more recently agricultural and health extension work. Programme after programme to "bring health to the rural areas" has failed.

First, graduating medical students were obliged to perform a year of rural service. When this proved inadequate, a series of attempts were made to train village health aides and auxiliary nurses.

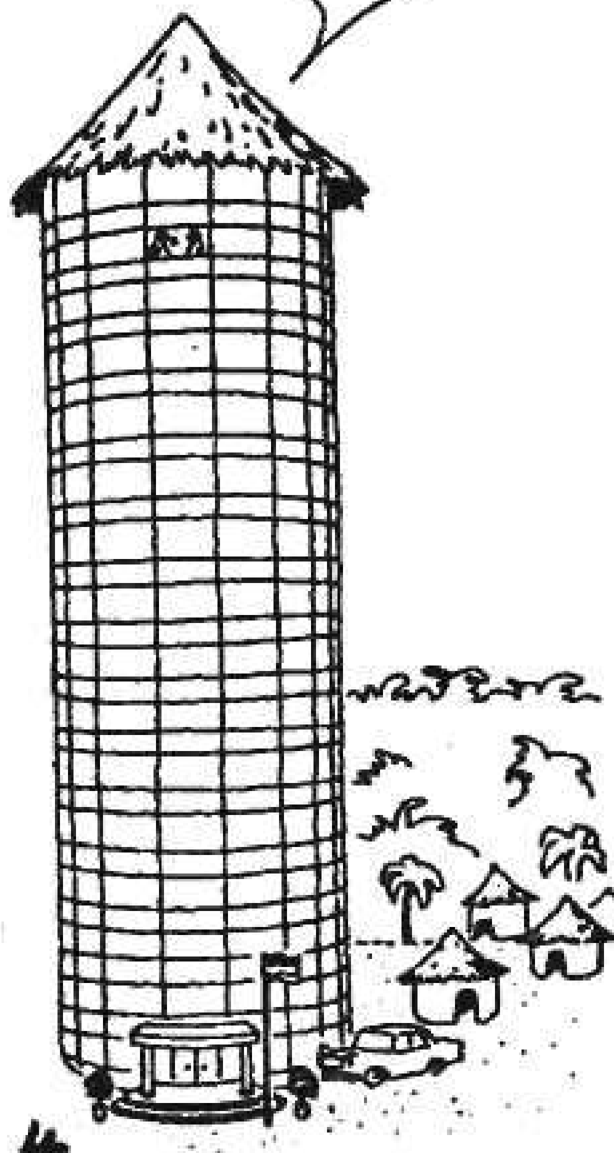
When these gave poor results, a massive effort was made to place young doctors in 2,000 prefabricated, absolutely standardised, rural health posts, which had been rapidly set up with what was imaginatively termed "community

participation". However, communities were often non-cooperative and many doctors were frequently absent, and others were extremely corrupt. The impact was marginal and in some ways negative. Preventive measures were mostly neglected, and misuse and over-use of medications was horrendous!

Today, the Ministry of Health is again about to launch a new programme with two levels of village health workers. This training will be 2 weeks long for workers from villages with less than 500 people, and 3 months long for villages of more than 500 people. But will this succeed?

Success of health workers at the community level depends on how much responsibility the people themselves take - or are permitted to take - for their own wellbeing.

In Mexico, government is tightly and centrally controlled by a single political party - the so-called Institutionalised Revolutionary Party. Although it has a strategic facade of social reform, it in fact represents the interests of a powerful minority of large land owners, industrialists, politicians and professionals - including doctors.



Effective community health work involves community awareness and decision making. It involves popular organisation. If common people join together to gain greater control over their own health, this is the beginning of such an awakening. They may begin to organise to gain more control over things such as land, production, and decisions that affect their lives.

This would be a threat to those in power. Therefore, care is taken that social reforms and agricultural or health extension work serve to create greater dgpendency on government assistance, rather than to promote true self-reliance. The goal is to placate unrest.

In this context, care is taken to select and train community health workers in such a way that they feel greater allegiance to those in power than to those in need. It is not surprising that the village health worker is often the daughter of the headman, or the dutiful servant of a land-owner.

It is no accident that the tasks of the health worker are narrowly and rigidly pre-defined, that she is required to wear a uniform that gives her the look of an outside authority, or that she spends her time filling in endless forms. Care is taken that she is kept subservient and unquestioning - a lackey, not a liberator.

If in Mexico the latest plan for reaching the rural population through the training of village health workers goes amiss, it will be because those now in positions of control are as yet afraid to redistribute political power. They fear the chain of events that might take place if rural and working people are permitted to organise and take charge of factors that determine their health.

CENTRAL AMERICA

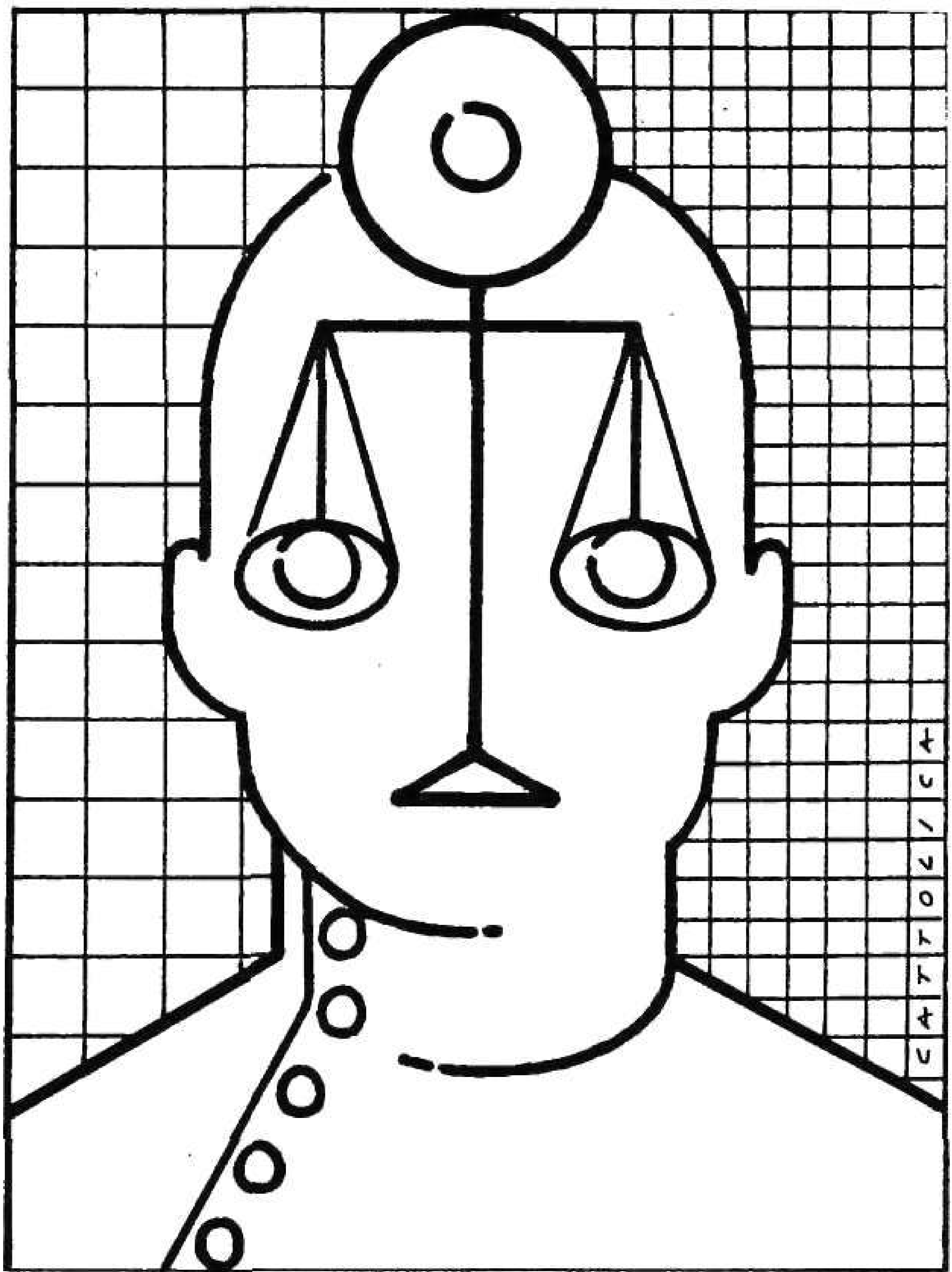
Governments that do not truly represent the people take care to form health workers that do not truly represent the people. Such precaution is strategic, for it is well known that in many countries, non-government community-based health workers have played, and continue to play, a key role in accelerating social transformation.

In Nicaragua, many courageous "promotores de salud" became village organisers in the struggle that led to the overthrow of the Somoza dictatorship.

In Guatemala and El Salvador, village health workers have become prime targets for disappearances and torture by both military and paramilitary forces. In Guatemala it has reached the point where to be caught with a first aid pamphlet can be a crime punishable by death.

Health workers at every level, from doctors to village aides, can be important political agents - either for or against the people. Following independence or a popular revolution, you would suppose that both the health ministry and its workers would work to help the people gain more power and control over their own health. However, this is not always the case.

The system of health workers that have been adopted in China and Cuba provide interesting case-studies of differing approaches to making health care more accessible to the community, but not necessarily leading to a greater degree of control over the services by the community. (These issues are discussed in more detail elsewhere in this edition of Critical Health.)

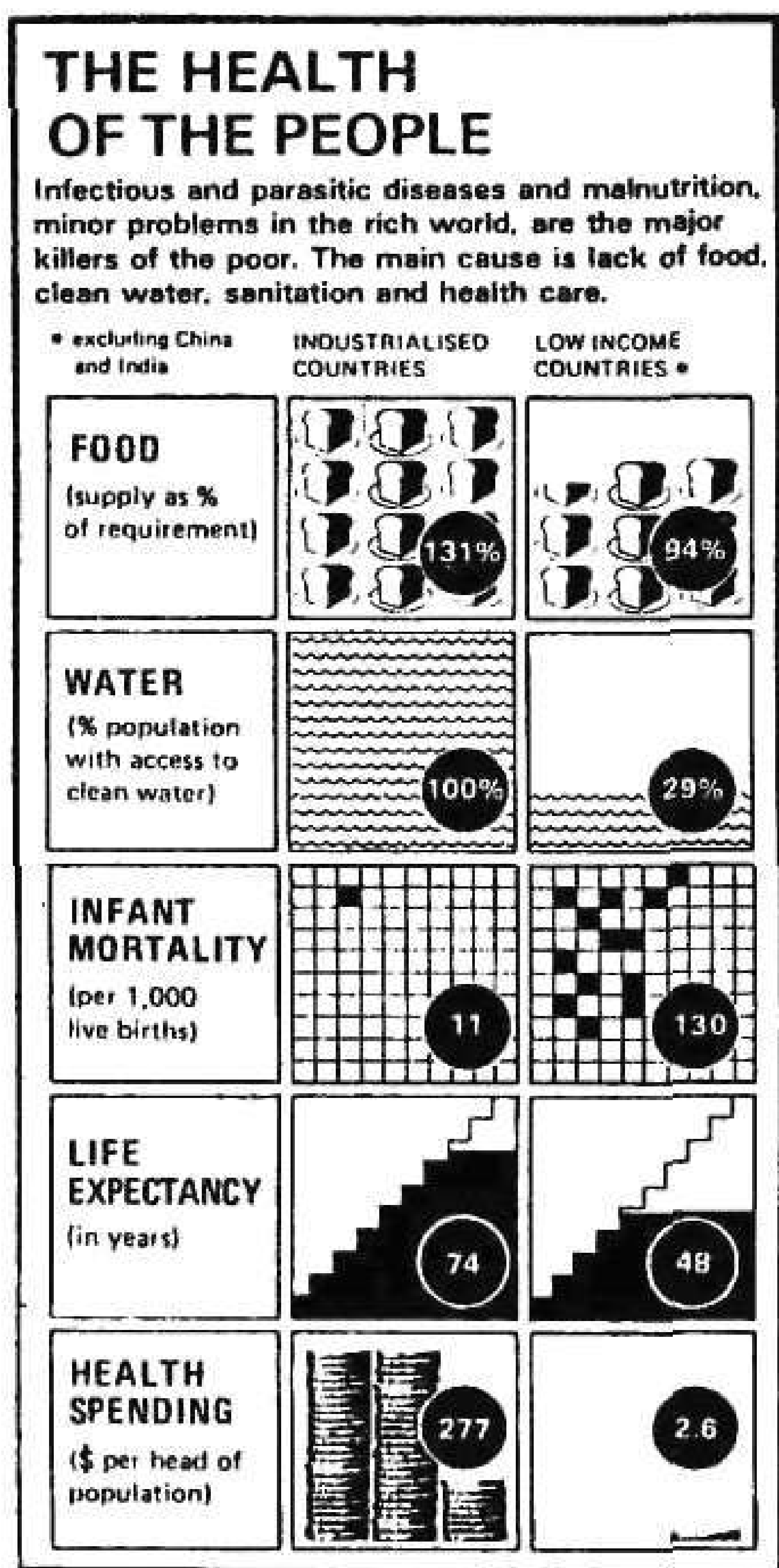


NICARAGUA

Following the overthrow of Somoza in Nicaragua, the state was faced with an exodus of physicians, and the new Ministry of Health had to, in part, be formed by leading physicians who remained. The Sandinistas were at first determined to totally restructure the health services as had been done in China, to emphasise primary care and the training of community health workers.

However, with the acute shortage of medical personnel, hundreds of Cuban doctors were invited in, not only to fill the gap, but to serve as advisers in planning the new health system. Unfortunately, the Cuban doctors recommended the same top-heavy apppoach as had been applied in Cuba. The community base of the proposed health pyramid was pulled out from under, and the focus shifted to training more and better doctors.

Fortunately, however, the community base of health brigadistas in Nicaragua was already fairly strong. Many had been popular leaders and community guerilla medics during the struggle. They continued to collaborate with the new Ministry of Health, but made it clear that they were accountable first to their communities.



For example, when a team of village health workers from Mexico was in Nicaragua in 1982 conducting a course on training methods, the local brigadistas and "multiplicadores" suddenly received orders from the Ministry of Health to change their plans and interrupt their course. The health workers replied that they would always seriously consider suggestions from the Ministry, but that they took their orders from the community. The community Committee for the Defense of the Revolution voted not to interrupt the course, and the health workers followed the community's request.

The fact that the local community and its brigadistas had the courage to stand up to the Health Ministry is impressive. The fact that the Ministry accepted thier decision is even more encouraging and gives hope that in time the Ministry of Health will move toward decentralised control and a stronger community base. In fact, within the last year this is happening; an official decision has been made to give high priority to the training of several new levels of community brigadistas.

In Nicaragua, without doubt, the social revolution is still alive. The young government is struggling to serve its people equitably and well.

ZIMBABWE

It takes a visit to post-independent Zimbabwe to realise how comparatively good things are in Nicaragua.

The so-called "independence" of Zimbabwe has done much less than was hoped for to transform the inequities of that neo-colonial state, and Zimbabwe is still very far from genuine social change.

The enormity of the obstacles was driven home by a visit to a training program - run by an elderly

German doctor - to "upgrade" the training of those who had been "medics" within the guerilla liberation army, presumably a spirited group committed to the ongoing struggle for their people's rights.

Here, a short discussion with this group is quoted:
"Are there still many people in Zimbabwe who are hungry?"
"Oh yes, many", replied the ex-guerilla health workers.
"Why?"
"Because the people are lazy," they answered. "Because they are ignorant." "Because they don't like to work." "Because they drink ..."

All typical answers of the oppressed, who have been taught tc blame only themselves for their problems!

Only one feiry-eyed young women finally spoke out and said, "Not true!". Our people are hungry because all the good land is still in the hands of a few wealthy owners. The poor people have been pushed into land that that is worthless. They are forced to work on the large plantations at starvation wages. They are herded together into tiny shacks. If they drink it is because..."

At this point the feiry-eyed young woman was interrupted by the German doctor. "I'm sorry," she apologized to me. "Remember that these people are all cowards who betrayed their country, Rhodesia. But we are slowly retraining them."

MOZAMBIQUE

In contrast to Zimbabwe, Mozambique appears to have gone much farther in the direction of equity and social justice.

Soon after her liberation, the new Ministry of Health made the rural area its first priority. Roughly 70% of the health budget was allocated to setting up a network of health and dental workers to provide primary care thoughout the rural area.

As a result, the level of health of the rural population improved dramatically.

However, things are never as straight-forward as they appear. By allocating its major resources to the rural area, the Ministry of health was forced to make severe cut-backs in the urban hospitals. As a result, better-off families in the cities could no longer get all the costly secondary and tertiary care that they were used to.

There were protests, including some from the wives and families of top decision makers.

Now an increasing percentage of the health budget is again being allocated to the cities.

Whatever the case, it is indisputable that Mozambique has made great strides in the direction of health for all. Village health and dental workers have played a key role in the process. Their success has depended on the political will of the nation. (See detailed article on health in Mozambique.)

POINTS TO CONSIDER IN SOCIETIES IN TRANSITION

Perspectives from several countries that have recently become liberated have been presented. It is clear that the approach to restructuring the health systems and the roles for health personnel in these countries has varied widely.

Can anything be learnt from all this that might help countries that are about to be liberated, such as Namibia, to plan a strategy for health care, or to decide how to select, train, and assist health workers to best serve their people?

A country may become "free" suddenly, following a long struggle, but her people become free from oppression slowly. Oppression exists not only in the national and international context, but also "closer to home".

Often, each village and each family has its own oppressors and its oppressed. Even individual persons may be oppressed - or depressed- by their own low self-image, lack of confidence or loss of hope.

All this takes time to change. If it does not change, national liberation will prove hollow and short-lived.

There are always those hungry for power and privilege who await their chance to take advantage of a situation. And unless those who are weakest in the family and the community learn to organise and defend their interests, new oppressors, with new forms of oppression, will emerge.

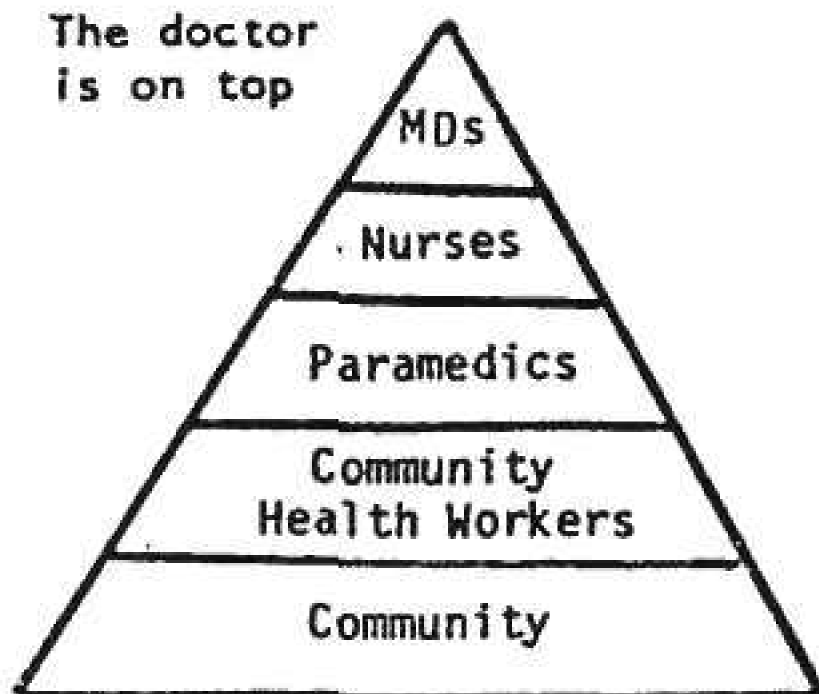
Health workers can become "leaders of change" in helping those who are most subject to oppression within a village or family to gain the confidence, skills, understanding and unity they need to safeguard their health and rights.

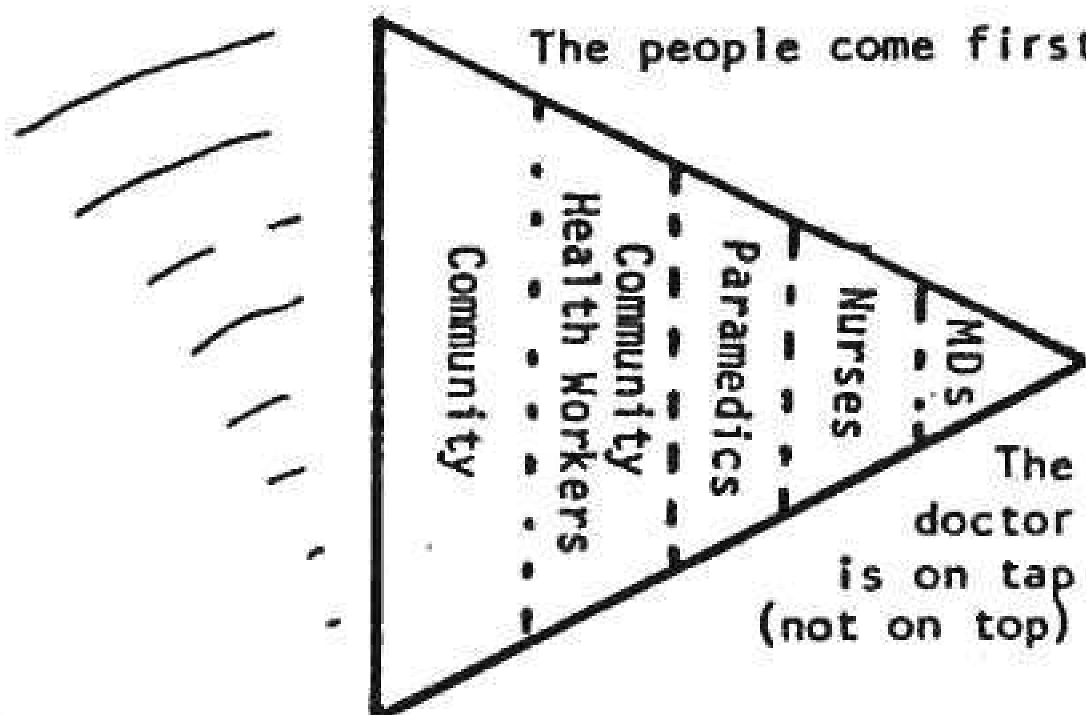
Health workers can serve this function better if the government's health system is restructured in a decentralised, people-supportive way.

Here are some suggestions for structuring a people-centred health system:

1. Tip the "health pyramid" onto its side so that the community comes first and is no longer on the bottom. Have community health workers together with mothers, school-children and

other community members play the leading role in health care, so that the medical professionals become the auxiliaries : on tap and not on top.





2. The largest, most important body of health workers should be community or village health workers. Invest more in training and providing for community health workers than doctors.

3. Be sure that community health workers are selected by, and are representative of, the poorer, or more oppressed, members of the community.

4. *Explore alternatives for ensuring that the* health workers are accountable primarily to their own community, especially to the workers in their communities.

5. Make sure that the Ministry of Health acts as co-ordinator, supplier and adviser, rather than a "controller" of the community health workers. As much as possible, control and supervision should come from the community and involve a democratic group process.