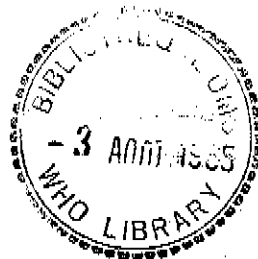


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ORGANIZATION OF HEALTH SERVICES IN RURAL AREAS

by

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Public health service is the instrument used by the state to promote, to protect and to restore people's health. The organizational pattern and the principles on which it is based vary from country to country, according to the social structure, political system, economic conditions, advances in medicine and other very diverse factors. Differences in principles and organizational patterns of public health services can be noticed not only between individual countries but they also exist between the individual regions of one and the same country. These differences are for the most part justifiable. The principles and organizational forms of the health service in an urban area cannot be identical with those in a rural area. However, between rural areas too there are great differences in regard to the principles and organizational patterns of health services, and they are due to the differences in health problems, economic conditions, geomorphological conditions and a number of other factors encountered in individual rural areas. To a rural area consisting of a great many small, scattered villages and hamlets, quite another organizational form and quite different principles of health services have to be applied than to an area with large, crowded villages and good communications. For this reason, principles and organizational forms of public health service should be adjusted to real needs and conditions in which a given population lives. A great mistake is made by those who make plans for the organization of health services at their desk, far from real life. The principles of organizational forms of public health services should be the reflection of actual needs and actual conditions. In view of this principle, it is just rural areas to which every action should be applied with maximum flexibility. Any schematic approach can bring much harm to the health of rural people.

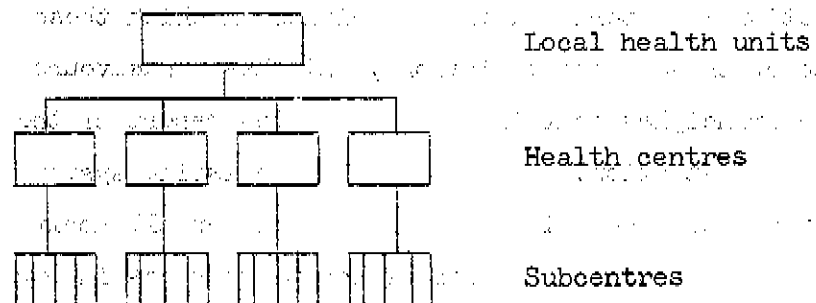
Considerations concerning the organization of health services in rural areas should in the first place be made from the point of view of the population which the service is meant to serve. The following question is to be asked: What is the structure of the given rural population? The structure of a rural population depends on how we define it: whether according to its location (town/village), or its occupation, or some other characteristics (economic status, land ownership, etc.). But regardless of the definition, one thing is certain: the rural population is not homogeneous. Within it there are land owners, rich and poor peasants, individual farmers, labourers working on collective or state farms, cash and share tenants, share croppers, migrating labourers, and finally those who do not live on land but stay in rural areas as public servants, teachers, tradesmen, craftsmen, etc.

The rural population considerably differs from the town population in birth- and death-rates, sex and age structure, as well as in other vital statistical data. Economic differences should also be mentioned. The annual income of the rural population is, as a rule, lower than that of the urban population. It is not stable either, because it depends on the local market, export, good or bad harvest, and a number of other factors. Living conditions in villages as regards housing, sanitation, educational opportunities, communication, transportation and nutrition essentially differ from those in towns. These differences are particularly conspicuous in developing countries. What should also be borne in mind is a specific physical, chemical and biotic environment to which the rural population is exposed, for instance climatic hazards (insolation, rainfall, etc., during land cultivation) or permanent contact with domestic animals (anthropozoonoses). Cultural needs and opportunities for their manifestations, living habits and attitudes of the rural population vary substantially from those of the town population. Owing to all these specific living conditions, the health services in rural areas should be specific too.

In addition, lack of knowledge in health matters, fatalistic attitude towards disease, superstition and similar factors characteristic of the rural population must be considered just as much. And finally, there is one more very important factor: the rural population is geographically isolated from prominent health institutions set up almost invariably in towns. It will suffice to have a look at the distribution of hospitals, health centres, laboratories, dental clinics, X-ray units, rehabilitation and other health institutions to realize in what a discriminating situation the rural

population of almost all countries of the world is. As if it were according to a certain rule, the health services provided for the rural population are the poorest as regards their personnel, institutions and equipment. These health services are very often only a substitute. A particularly hard situation can be found in rural areas with small, scattered settlements and no proper communications, which is a common feature of many developing countries. This situation and this attitude towards the health services in rural areas is the result of a number of the afore-mentioned factors. It would be unreal to believe that the existing state of affairs could be changed overnight and that it is possible for us to offer the rural population just the same health services as are organized in towns. There are few countries in the world which could meet this requirement. For this reason a realistic attitude should be formed in connexion with the health services in rural areas, and it can be formulated as follows: The rural population should be provided with the essential health services on the basis of the complete coverage. In rural areas it is better to provide modest health services for the entire population than highly developed health services for a small part of that population. Led by this principle, consideration should briefly be given to the main subject of this presentation: the organization of health services in rural areas.

At a session of the Expert Committee on Public Health Administration (Wld Hlth Org. techn. Rep. Ser., 1954, 83), within discussions on the methodology of planning an integrated health programme for rural areas, the organization of health services for rural population was considered as well. The Committee presented local health services for rural population in the following way:



The local health unit was defined as an organization providing or making accessible, under the direct supervision of at least one physician, the basic health services for a community, providing the following activities:

- maternal and child health;
- communicable disease control;
- environmental sanitation;
- maintenance of records for statistical purposes;
- health education of the public;
- public health nursing; and
- medical care.

The health unit was regarded as an organization of health centres and subcentres for an area, corresponding in function as closely as possible to some political or administrative units, and forming a close link with other local services (education, agriculture, etc.). The health centre, on the other hand, was regarded as a place in which the appropriate basic services were rendered. The Committee felt that, in order to provide the greatest efficiency, the unit should have, in addition to the physician, some five to 10 nurses, several sanitarians, and a substantial number of auxiliary health workers. The Committee agreed that in certain remote areas, even at health centres as sub-units, a few beds should be provided for urgent cases, for normal maternity, or for temporary accommodations while a patient was awaiting hospital treatment.

If we consider the organization of health services in rural areas in individual developed and developing countries, we can notice great differences in both the organizational pattern and the principles on which these services are based. However, in spite of these great variations, all these endeavours are more or less in accordance with the principles contained in the quoted report of the Expert Committee on Public Health Administration. A review of the existing systems of health administration in rural areas would certainly be very useful for all health administrators engaged in the solution of the complex problem of health services in rural areas, as well as for us, who are discussing this problem, but such a review would take up hundreds of pages and would be beyond the scope of this paper. For this reason I shall only touch upon one

of the most delicate questions of health administration in rural areas - the question of the rural subcentre, a health unit which comes into the closest contact with the rural population. According to my own observations and experience, what is the hardest nut to crack for all health administrations in organizing health services in rural areas is the problem of subcentres. I shall limit myself by presenting only some organizational aspects of this problem. First it should be emphasized that the subcentre represents the health institution responsible for the health of a given population living in a given, defined area. At the same time, the subcentre is the integral part of the health centre, its arms, so to speak, extended to the local level and, consequently, bringing health services near the people. The population and the territory are the two basic elements which should be taken into consideration when organizing the subcentres. Considered from the economic and personnel aspects, a subcentre should cover about 3000-5000 inhabitants. The radius of its area is recommended not to be over 10 km, which even if the transport is bad allows uninterrupted communication between the subcentre's health workers and the people. Of course there are, and can be, no strict rules in this connexion. The organization of subcentres should be flexible, both as regards the population and the territory. In certain cases, owing to geographical, personnel, economic or other important factors, the need may arise for the organization of subcentres for a far smaller number of inhabitants (for a few hundred) or for covering the area far larger than proposed.

As regards the health personnel, in addition to a number of auxiliary health workers, a subcentre may have:

one or more full-time physicians and other professional health workers; or

a physician coming to the subcentre two to three times a week or at shorter intervals; or

a nurse or a midwife (without the physician); or

a mobile health team coming to the subcentre at certain intervals; or

a specially trained auxiliary health worker (without professional health workers) who works under the guidance and supervision of a professional health worker.

In all these cases, but especially when the subcentre functions without the physician, provision should be made for referral to health institutions on a higher level of all the cases of health and disease which cannot be attended in the subcentre.

Without dealing with other details of health organization in rural areas, it may be useful and interesting to recall some of the basic principles of health organization in rural areas (and in other areas as well):

right of every man to health;

wholeness of medicine in approaching and solving all problems of health and disease from curative, preventive and social aspects;

complete coverage of the total population based on the principle of regionalization in public health administration and services;

bringing of health services as near to the people as possible by decentralization of the health administration and health institutions;

responsibility of the community for all public health services including medical care;

realistic planning of public health programmes (as a part of the social, economic and cultural development of the area) as regards funds and personnel available;

application of scientific methods and team work in public health practices;

active community participation and collaboration with other public services;

permanent possibility to refer all cases when indicated to the higher level (intermediate or national health services);

responsibility of public health administration for education and post-graduate training of health workers.

Owing to limitations in space and time, all these principles cannot be discussed, but one of them - active community participation and collaboration with other public services - which, in my opinion, is the key question for a successful functioning of health services in rural areas, deserves special attention.

Successes of public health services in no small measure depend on active community participation. In many countries large financial means are spent on the establishment of health institutions and sanitary facilities but the people do not use them as much as is expected. In all such cases it has been proved that these institutions and facilities are brought from outside and pressed upon the community. On the other hand,

there are very modest health institutions and facilities which are fully used by the people and which have a very favourable effect on the community which they serve. To the question why it is so, the reply is always the same: the latter institutions and facilities have been established by the community itself, by its own initiative, by its own forces. This human quality, i.e. that we appreciate, use and are keen far more on what we have done by ourselves, has long since been known just in connexion with the promotion of public health. It is interesting to note that in the very first forms of health organizations and in the most ancient health legislation, traces of the idea of active community participation can be found. As examples, let me mention local boards of health set up in England in the first half of the last century, health councils (consigli di sanità) in function in Venice in the nineteenth century, or the Austrian law from 1870 requiring from any commune a health committee, or the appearance of the first forms of rural health services in Russia in the eighties of the last century (zemskaia medicina), or the German law on district physicians from 1899 decreeing sanitary commissions, etc. Needless to say, in all these cases there was no active community participation in the present-day sense of the word. Most often there were appointed health commissions which had little connexion with people. But with regard to the given social conditions it was impossible for these committees to be more social in character. Just as they were, they clearly show that the idea of the participation of the population in the protection of health was behind them and manifested itself in a form acceptable in the social conditions of that time. Advanced forms of active community participation in health protection and medical care can also be noticed in the first workers' voluntary insurance organizations which appeared in industrially developed countries as early as the eighteenth century. These institutions were not only managed by workers, but the workers also carried out numerous technical duties, collection of subscriptions, control of patients, routine administration, etc., and this may be one of the reasons why a great number of these institutions were so successful in the field of the control of disease and workers' health protection. Similar successes can also be seen in the work of peasants', craftsmen's and other health co-operatives where the main factor of success is again the initiative and active participation of the population.

The forms of community participation in questions of health which are pressed upon the population from above, which have not developed spontaneously from below, come to grief very soon and give very poor results. To activate the population is one of the hardest tasks of the health service; it has to be approached very carefully, step by step, and according to a minutely elaborated plan. In so doing three phases should be distinguished. In the first phase the population should be stirred by a certain concrete task. In the second phase, collaboration assumes some more defined forms, while in the third phase a planned tackling of the most important problems takes place.

The first contact with the population is of paramount importance. The health workers responsible for establishing this contact should talk to individual population groups in a free, informal way, and find out what health problems weigh upon the population most heavily. Talks should not be abstract in nature, they should relate to actual problems. Then, among them, a task which is simple, limited in time, and very likely to be solved successfully, should be skilfully picked up. This task need not necessarily relate to health directly. It may relate to the construction of a village road, or to the building of a common well or cistern, or to the construction of a school, public bath, the repair of some farm buildings, manure pits, drying up some marshy grounds, etc.

It is important that the working plan in connexion with the solution of this first task should be realistic and that the health administration should give its share and fulfil all its promises and obligations. The community contribution must be concrete and simple. For instance, if a well is to be built, the villagers should be asked to carry out digging, to secure the transport of the building material, and the like, while the health administration should secure technical guidance and the material not locally available. It is good if as many inhabitants as possible should participate in the action, even with a modest effect. What is essential is that the whole community feels that they, as a whole, are building something that will be their common property and of common use. When the object is built (or the task carried out), the first phase of the activation passes over into the second phase: the organization of the population. This is the moment when confidence - the prerequisite for further permanent collaboration between the population and health administration - is established.

In the course of the first phase no permanent committees or fixed organizational forms should be set up, but an eye should be kept on those community members who show interest in problems of health and qualities for team work. Such members should skilfully be included in village health committees. Within the committees, working teams should be formed in connexion with the third phase of community activation. Working teams should be composed of the community members who were the most active in the tackling of the first task, women with completed courses on home economics or other courses, teachers, and other public workers who enjoy people's confidence and are willing to be active in the improvement of public health. Efforts should be made to include in committees and working teams as many inhabitants as possible, so that one day all the population finds itself united, organized and aiming at a common goal: to protect its health. According to my experience, the leaders of the working teams and committees should be chosen from among the most active village folk, not among health workers who in the whole action should behave unassumingly, as a ferment causing active community participation in the solution of their health problems.

The organization established in this way is only the beginning of a further, continuous community participation. This is the phase of an organized and planned action in which the community participation is used as a permanent component in the realization of the plans made. This is the moment when some more complicated, long-term tasks can be coped with. In this phase the health committee can also take over some legal responsibilities and privileges which, however, depend on the social conditions and the forms of general and local administration.

I have very often heard questions and doubts as to whether this principle can be applied in socially and economically developing countries. True, active community participation in public health services can easily be materialized in a community organized on democratic principles or in socialistic countries where the principle of community participation is the basic law in all fields of public life. However, considerable success in connexion with community participation in the promotion of public health can also be achieved in socially and economically developing countries. In these countries particularly good results of active community participation have been recorded in connexion with the control of widespread infectious diseases, vector control,

improvement of basic hygienic conditions, and similar activities. It is obvious that in countries with the feudal system, illiteracy, superstition, poverty, or economic or social insecurity, the health workers should encounter great difficulties in activating the population, but in just such conditions, where there is a shortage of health workers and also of financial means, it should be remembered that almost nothing can be done on the promotion of health without active community participation.

Another factor which, in connexion with the activation of the people, should not be disregarded is such mass organizations as the Red Cross and Crescent, societies for the protection of children and youth, anti-alcoholic associations, women's organizations, trade unions, societies for the control of cancer, tuberculosis, etc. The health services should never neglect such and similar organizations, they must include them in a common plan of collaboration. Sometimes it is the only way of securing success in the improvement of public health. Unfortunately, a great many health administrations underrate this force.

One more thing should be pointed out. In all phases of active community participation the main moving force should be health education, because there is no interest in health without health education.

The principle of active community participation in the protection of health is also internationally supported. In the WHO Constitution it is formulated as follows: "Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people." For this reason health administrations should never forget that the health of the people is built by the people itself.

As has already been mentioned, the health services are the instrument in the hands of the state by which measures for the promotion of health are carried out. However, it is quite clear that the state cannot build the health of the people by the health service alone. From the definition of health as formulated in the WHO Constitution it becomes apparent that in the promotion of health all national forces meant to improve people's socio-economic, physical and mental conditions should take part, which practically means a co-ordination of all efforts made in the fields of education, agriculture, industry and other economic branches, public works, social welfare, human and veterinary

medicine, or in other words, a close collaboration of all public services. It is easy to prove that in many countries a rapid improvement of health conditions was achieved through the development of industry, agriculture, cattle-breeding, and other economic activities, without active participation of medicine which at the same time stood aloof, on the position of classical curative medicine. In many instances the health of the people was built by teachers, engineers, agronomists and veterinarians, while physicians played quite a passive role. It is not hard to prove that a great many building, school and industrial programmes, water supply objects and other projects were carried out without the participation of medicine. Of course, in many such cases these actions produced consequences which affected people's health, and led to unnecessary economic losses, but this occurred just because medicine stood apart, whereas the forces which were engaged in these actions disregarded the factors which accompany economic developments and are deleterious to health. This passive attitude of medicine is in no sense surprising. Until recently, the main content of health services in most countries was cure, which in most cases is only the mitigation of the consequences of environmental factors affecting people's health. Not long ago the health services in most countries paid little attention to ecologic factors and their effect on human health, nor did they try to participate in the building of healthy environment and the removal of harmful environmental factors endangering people's health and life.

The collaboration of the health service with other public services should be constituted on all state administration levels. On the national level all plans for the promotion of education, housing, agriculture, cattle-breeding, industry and other economic branches should be developed in collaboration with the health service, and vice versa, all plans for the promotion of public health should be developed in collaboration with other public services. This collaboration can be established without any particular difficulty by means of ordinary administrative measures. This collaboration should not be temporary or limited to the exchange of information and sporadic assistance, it should have a permanent character and it should be planned. There appear greater difficulties in establishing collaboration between the health services and other public services in rural areas. On this level, collaboration increasingly loses its administrative character and assumes concrete forms in which

public servants of various branches, such as teachers, agronomists, veterinarians and others take part. At the moment when this collaboration exceeds the administrative boundaries, there appear the problems of human relations, and these are very often the main obstacle to the establishment of a permanent collaboration of public services in rural areas.

In practice it often occurs that in the same village the physician is on very good terms with the agronomist or the veterinarian, that they meet every day, but that they never discuss the agricultural or health problems of the region in which they work as the technicians responsible for the welfare and health of the respective population. Without their closest collaboration and a common working plan it is hardly possible to imagine any valid solution of a number of health problems. As an example I shall mention nutrition. If the physician comes to the conclusion that the population is inadequately fed and that it suffers from alimentary deficiency diseases, all his efforts will be in vain unless in his endeavours he is supported by the veterinarian and agronomist. Deficiency diseases are not controlled by medical advice and drugs, but by the improvement of milk production, poultry-breeding, gardening, fruit-growing and other farming activities. The physician should be the active moving force of all these actions against disease, for the achievement of positive health. Equally, the fight against anthroozoonoses will fail unless it is carried out jointly by the physician and the veterinarian. These and similar examples show the importance of the collaboration of all public services in the promotion of people's health. In rural areas, without close collaboration with other public services, no health service can successfully protect and improve people's health.