

THE PRESENT AND FUTURE OF PRIMARY HEALTH CARE IN IRAN

- A Compilation*

[About Iran: Iran ranks sixteenth among the larger countries of the world, spanning an area of over 1,648, 000 square kilometers. It is located in south – west Asia, in the Middle East region. Iran is bounded by Republics of the former USSR to the north; by Turkey and Iraq to the west; Afghanistan and Pakistan to the east; and finally, the Persian Gulf and Oman Sea to the South. Administratively, the country has 25 provinces, 227 districts, 497 cities, 596 towns and over 66,000 villages. The capital is Teheran and the country is constitutionally an Islamic Republic.

Approximately, 90% of the country lies upon the ‘Iranian Plateau’ and thus justifies its designation as a mountainous country. Over half the land is covered by mountains, a quarter is desert and less than one fourth is arable land. The mountains take the form of four ranges; Northern, Western, Southern and East – Central. The Alborz mountain range, spanning from Turkey to Afghanistan in the north, includes Mt. Damavand, the highest peak in the country (5671 meters). The Western range is named the Zagross and stretches from the Northwest to the Southeast.

The arrangement of the great mountain ranges of Alborz and Zagross is believed to be pivotal in shaping Iran’s diverse climate. This variety in the environment has entailed dramatic variations in the socio- economic state of the people; along with differences in health, ecological and epidemiological conditions; from the prosperous, fertile green fields and forests of the humid north, to the dry, unfriendly desert sands of the center. (2)]

INTRODUCTION

A new national health system was designed beginning with meticulous analysis of the status-quo, and based upon what came to be recognized as the Primary Health Care (PHC) approach. The inherent logic of PHC with its characteristic stratification of services, well-developed infrastructure, and emphasis on community participation and intersectoral cooperation, was considered to be a firm basis for drawing-up rational policies and strategies. Modifications were made to accommodate the particular problem of a thinly distributed population. Thus came the emphasis upon integration of services and the development of multipotential human resources.

PHC NETWORK (2)

PHC Networks have reached a considerable degree of expansion in Iran. Between 1985 and 1991, over 8,800 Health Houses, 600 Rural Health Centers, 430 Urban Health Centers and 147 Behvarz Training Centers have been built and has grown from 4,236 (in 1985) to 19,468 (in 1991). Today, over 94% (1997) of the population is covered by PHC services via the network. All these accomplishments (which have been achieved at a cost of 3,600 million rials to the National Budget from the Ministry of Health and Medical Education’s allocation) still remain at a vulnerable and fragile stage. Their preservation and expansion requires continuing political commitment and support of the kind, which brought the networks into being in the first place.

STRENGTHS (2)

The most prominent merits of Iran’s Primary Health Care networks are:

- ⇒ A firm and rational basis on which to found the stratification of services and the distribution of facilities (exemplified by the Master Plan for expansion of PHC networks).
- ⇒ Assured easy accessibility of every health service facility.
- ⇒ A strong programme of behvarz training, which produces efficient community health workers who have frequently been acclaimed for the quality of their work (The female behvraz and the male behdahst yar)
- ⇒ Considerate behvarzes and enthusiastic instructors who have made it all possible.
- ⇒ The valuable asset of a small number of experienced senior health workers who help sustain these efforts.
- ⇒ Relatively good intra – sectoral coordination at the highest levels of planning and decision-making.
- ⇒ Availability of reliable information and statistics regarding the rural areas of the country.
- ⇒ Provision of a medium for health system research by scholars interested in the subject.

In addition, a few more relevant features were (1):

- ⇒ Merging Medical Education with Executive health affairs so that the present Ministry of Health and Medical Education links the two sectors educational and executive closely and effectively.
- ⇒ Setting up a council for expansion of PHC networks.
- ⇒ Active continuing education of personnel within the health network.
- ⇒ Integration of vertical programme into the health system.
- ⇒ Training medical students in the Health Network through Community Oriented Medical Education (COME) in universities of Medical Sciences.

- ⇒ Potential for use of the health networks for the purpose of applied research, which has been effective in promoting a community – based style and methodology of research and learning-by-doing. Results of these studies have also been very helpful in identifying areas of weakness.

WEAKNESSES

The PHC networks at the at the same time suffer from a number of weaknesses (2):

- ☞ Most of the credits gained so far have been by virtue of the outstanding efforts of Health Houses; other facilities are as yet lagging behind.
- ☞ Insufficient support of Health Houses by the Rural Health Centers has so far hindered implementation of an efficient referral system. While the cooperation of hospitals in accepting referrals from Rural Health Centers has been dismal. The prevailing attitude of indifference by hospitals to the networks has been depressing and detrimental.
- ☞ As mentioned before, in the absence of appropriately – trained managers (i.e., new Iranian medical graduates), Rural Health Centers have not yet acquired the capacity to support and guide Health Houses. Given this situation, health technicians have not lived-up to what is expected of them either. Frequently, lack of proper workspace and laboratory facilities further aggravate the problems.
- ☞ Urban Health Centers (UHC) must tackle even more serious constraints. It is hard to see how the problem of limited building space in the cities can be overcome in the near future with the present amount of government support. The structure of today’s UHCs have essentially remained unchanged from yesterday’s ‘clinics’ which they have replaced, and the exhausted staff usually have difficulty in coping with the new demands. Furthermore, the ‘passive’ method of delivering services at urban facilities cannot be expected to rival the striking accomplishments of the ‘active’ services, characteristically offered by the Health House. At the present time, even immunization and care of high-risk groups is handled in a passive manner at UHCs. To this must also be added the overwhelming presence of the private sector (with its complicated transactions), and frequent absence of basic lab and radiology facilities in many of today’s UHCs.
- ☞ Higher levels of the PHC network are still very unfamiliar with the spirit of community participation and Inter – sectoral collaboration and little has been done to address this problem so far.
- ☞ In spite of all the efforts made at training and education, programs are running at Regional and District Health Centers, in which former advocates of this or that vertical project are apparently working together, but actually far apart!
- ☞ To this day, no organized attempt at training well-informed managers has approached the stage of implementation, and as long as this situation is unchanged, efficient and brilliant managers will come and go like brief flashes of fireworks in an otherwise bleak sky, with no guarantee of replacement.
- ☞ PHC networks must frequently rely on external aid (received on a case – by – case basis), for providing many of their needs, especially those materials, which must be obtained abroad. This liability too, shall persist until sustained and organized provisions are guaranteed.
- ☞ The PHC network – somewhat out of necessity – has so far operated outside of the policies of curative services; apart from the public insurance system and separate from the larger body of health services in our country. This situation is obviously unsustainable, and can only be replaced by a rational reunion of health services, which in turn calls for a greater degree of support and deeper consideration on the part of the national authorities.

FUTURE CHALLENGES (3)

- ◆ Need for establishing efficient organizational structures and managerial systems for health development
- ◆ Increasing demand for improving the quality of care
- ◆ Prioritizing nutrition and food safety
- ◆ Improving referral support
- ◆ Matching community health needs and development of human resource
- ◆ Matching the problem of a large number of refugees
- ◆ Increasing burden of non-communicable diseases due to epidemiological transition
- ◆ Ensuring the quality of essential drugs and rationalizing their use
- ◆ Ensuring the relevance of human resource development to the health needs of the community.
- ◆ Launching a broad based health system research (HSR) where health workers have a direct role in its implementation as a problem-solving tool.
- ◆ Integrating PHC with a BHN Approach (see Box 2)

Source:

1. King Maurice (Ed), 1983.
The Iranian Experiment in Primary Health Care: The West Azerbaijan Project (Principal investigations, Dr. Amni and Dr. M.A. Barzgar et al),
School of Public Health, Ministry of Health and Social Welfare, Teheran, Oxford University Press, Oxford, UK.
2. Shadpour, (1994)
The PHC Experience in Iran
The Council for Expansion of PHC Networks, Ministry of Health and Medical Education, UNICEF, Teheran
3. Ministry of Health and Medical Education, 2003.
Health Situation and Trend in the Islamic Republic of Iran, Teheran 2003

Box 1

PHC Coverage (%)		
INDICATORS	YEAR	VALUE
Population with safe drinking water	1999	92
Population with adequate excreta disposal Facilities	1999	86
Population with local health care	1997	94
Women attended by trained personnel During pregnancy (at least 2 times and over)	1997	77
Deliveries attended by trained personnel	1997	86
Infants attended by trained personnel	1997	62
Women of childbearing age using family Planning (Modern Methods)	1997	56
Infants fully immunized against: Tuberculosis (BCG)	2000	97.4
Polio (OPV3) 2000	99	
DPT (DPT3) 2000	97	
Measles 2000	99	
Hepatitis (HBV3) 2000	82	

Source (3)

Box 2

THE BASIC HUMAN NEEDS (BHN) APPROACH

Fostering serious community participation and a broad-minded approach to the concept of development, which can promote the active commitment of all sectors in the society; has been one of the greatest challenges facing any socio-economic development scheme.

In recent years, a new approach has been applied in rural (and urban) settings, of which community participation and Inter-sectoral collaboration are characteristic *inherents*. This has come to be known internationally, as the effort for **Basic Minimum Needs (BMN)**. Since Iran is generally developed beyond the stage of minimum needs, this project has been promoted nationally as the **Basic Human Needs (BHN)** approach.

The first step in this scheme is to secure low-interest or interest-free loans which removes the people's principal objection to participation in developmental projects : namely, the shortage of funds. These funds are used for establishing income-generating projects, with the aid of locally available materials, know-how and skills. Income from these productive activities is then allocated for:

1. Returning the loans within an agreed time-frame.
2. Distributing profits to those people who have helped run the project.
3. Investment in cash-consuming projects of public interest.

Almost all communities take it for granted that public projects (such as building schools, employing teachers, supplying safe drinking-water, leveling and paving streets, provision of medicine and health-care, collection and disposal of wastes, etc.) are the government's responsibility. Whereas, through BHN, the people themselves will finance such undertakings with their own extra income. In other words, if this approach is promoted across a substantial number of communities, an enormous drain will be taken off the financial and executive resources of the government, freeing these up to be used mainly for large-scale projects which are beyond the people's means (such as the construction of dams, roads, highways, telecommunications, etc.)

This achievement, however significant, is nevertheless dwarfed by the much more important gains of promoting self-reliance, mutual trust and team-work. People come to realize that by using their own potentials and funds, they can embark upon essential projects without having to wait for the government to take action. Being rooted in the community itself, such activities will enjoy a firmer guarantee of sustainability and will form a fertile ground for fostering managerial skills, efficient marketing and enterprise, and prospection. They will also give the less seriously involved members of the society (i.e., women and children), a better chance to express their capabilities.

All of these are neither unrealistic dreams, nor unfounded claims. Numerous vivid and convincing examples of fully operational programs can be found across both Islamic and non-Mostem countries of the world. (eg., Somalia, Djibuti, Jordan, Thailand....)

This whole scheme hinges on the very fundamental issue of **loans**. Loans which are given today will free tomorrow's society from beggars, and change it into a trustworthy partner for the government in moving towards the goal of development. **Thus, the country's banking system should take the crucial first step in this approach.**

Source (2)