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RECENT PROGRESS IN THE PROGRAM FOR EXTENDING HEALTH SERVICE COVERAGE TO RURAL MEXICO[1]

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Mexico has embarked on a new program that seeks to provide health coverage for all of its people. This article describes the basic framework and initial progress of that major endeavor.

The Background

Mexico's Program for Extension of Health Service Coverage to rural and suburban areas is based on two fundamental points. These are:

1) The experience acquired by Mexico since 1938 through its programs for providing comprehensive health services in rural areas; and

2) The decisions of the III Special Meeting of Ministers of Health of the Americas, which in 1972 recommended that the Ten-Year Health Plan for the Americas begin by setting up mechanisms enabling the health systems of all countries in the Region to provide complete coverage for their populations.

Policy Development

In December 1976 the Government of President José López Portillo initiated important health sector changes—changes incorporated into an administrative reform program with the following aims:

1) To extend health service coverage to the rural population and the underprivileged groups in large cities.

2) To take maximum advantage of the installed capacity of medical and health services.

3) To promote community participation in health programs.

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Rural hospital providing third-level health care as part of extension of coverage. (Photo: courtesy of the author.)

4) To strengthen preventive health activities, health promotion efforts, and measures directed at environmental improvement.

5) Above all, to strengthen family planning programs.

Basic Strategies

In accord with these policies, the Ministry of Health and Welfare, upon instruction by the Minister, called for expeditious modification and expansion of its health care structure based on the following strategies:

1) To build up a multidisciplinary team of teachers providing health instruction at the national, regional, and local levels.

2) To seek community participation by training selected local residents, with the aim of incorporating them into health programs.

3) To reactivate or expand health units at municipal centers constituting principal foci of social, political, economic, and cultural development for the rural population.

4) To reactivate, expand, and construct type "B"[3] health centers for the purpose of developing them into regional rural hospitals capable of supporting the rural clinics and type "C" health centers existing in their respective zones of influence.

Activities

In order to create the forementioned multidisciplinary team of health instructors, cooperation and support was requested and obtained from both internal and external institutions—including the School of Public Health of Mexico, the National University of Mexico, and the Pan American Health Organization. With this sup-

[3]Type "A" health centers are located in cities of 20,000 or more inhabitants; their principal functions are promotion of health, and preventive medicine. They do not have hospital beds, and personnel is related to the programs they develop.

Type "B" health centers are rural hospitals located in communities of 5,000-15,000 inhabitants. They have a health team and provide general medicine and surgery, training, supervision, and evaluation.

Type "C" health centers are located in communities of 1,000-3,000 inhabitants. They are the minimal unit in the formal system, having two medical/social services and two auxiliary nursing personnel, a vehicle, and sometimes temporary hospital beds.

Rural clinic providing second-level health care. (Photo: courtesy of the author.)

Nutrition education as part of the first-level extension of coverage activities. (Photo: courtesy of the author.)

port, five courses were conducted at the national level in 1977. These courses prepared 31 nurse-instructors in comprehensive health care at the state level, 31 instructors in provision of hospital care, 31 instructors in sanitary work, 104 community family physicians for rural hospitals, and 57 head nursing trainees who gave instruction to other personnel at the local level.

A basic task of the training team was to plan the training of four types of personnel serving the rural community: the health auxiliary providing primary care services in the areas of preventive medicine and family planning; the auxiliary trained in basic sanitation working to improve the rural environment; the empirical midwife retrained to provide improved care during normal childbirth and in matters of family planning; and the socioeconomic promoters assigned to act as a catalyst promoting community development.

Between March and December 1977 training was provided for 2,300 health auxiliaries nominated by an equal number of rural communities with over 500 inhabitants. In addition, a program to prepare health promoters of community development was formulated; a program for retraining of empirical midwives was begun; and 983 auxiliaries received training in basic environmental sanitation.

With regard to the second strategy of the extension program (community participation), emphasis was placed on having individual communities construct the facilities needed at the local level by the auxiliary team responsible for implementing the primary care program. At present 2,300 facilities of this kind are available.

In accord with the program's third strategy (strengthening municipal health centers), rural clinics and type "C" health centers providing the second level of health care are being relocated, remodelled, constructed, or reorganized in accord with programs entrusted to teams consisting of two physicians engaged in social service and two auxiliary nurses. These teams are responsible for surveillance of health conditions in a given number of localities within their established geographic areas of jurisdiction, and they possess the means of transport needed to accomplish this task. Of the 1,500 second-level medical units planned as a medium-range goal, 250 were in operation as of January 1978, and over 400 as of June 1979.

And finally, to promote the fourth strategy (strengthening of type "B" health centers), 47 type "B" centers are being constructed, remodelled, or re-equipped as rural hospitals in order to support community services within their jurisdiction in matters

relating to health care assistance, social organization, and personnel training.

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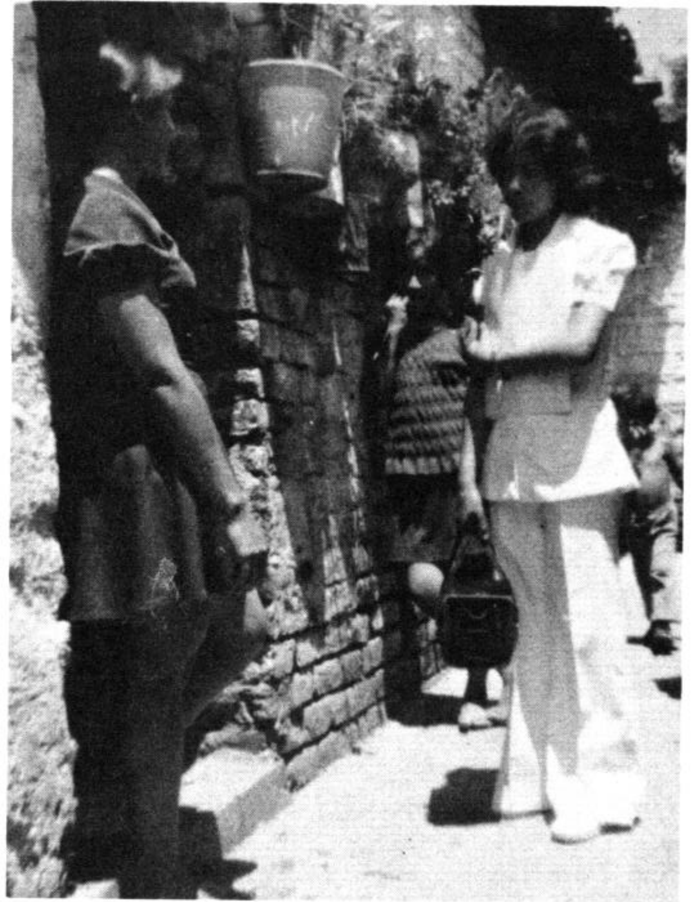

Health auxiliaries interview housewives in a program of extension of coverage in the community. (Photo: courtesy of the author.)

Mexico is currently confronted with the fact that 13 million people, the vast majority from rural areas, have settled in underserved outlying areas of large cities under conditions of extreme social poverty. That is, there is a "combination of unemployment and underemployment, low educational levels, unhealthy housing, poor sanitation, malnutrition, deteriorating health conditions, social apathy, and above all a consequent lack of will and initiative to contribute to improving the situation".* To help these conglomerations of people, the Ministry of Health and Welfare is promoting decentralization of material and human resources in the urban type "A" health centers and general hospitals. This decentralization is directed at creating primary health care units capable of achieving better utilization of resources at the neighborhood level. The cities of Acapulco, Chihuahua, Guadalajara, Juárez, Monterrey, San Luis Potosí, and Veracruz provide good examples of urban centers where this process has reached the consolidation phase.

Health committees, for both rural and urban areas, each with a limited but specific program of basic tasks, have been organized and are operating in each of the communities covered by the described extension program. These are providing strong and efficient support to the medical units and their staffs.

The Ministry of Health and Welfare has accorded priority status to its Program of Maternal and Child Health Care and Family Planning. Given the importance of this program for the regulation of Mexico's demographic growth, the General Bureau of Maternal and Child Care and Family Planning and the General Bureau of Coordinated State Public Health Services have proceeded to coordinate the use of their human, material, and financial resources. To help achieve this objective, personnel from both bureaus are being trained under a single program. The resulting pool of human resources has made it possible to provide a larger number of communities with the full range of activities being implemented by the extension of health coverage and family planning programs. The improved utilization of resources thus achieved will make it possible to reduce the time needed to attain the stated objectives.

*World Health Organization. Report of the Director-General, Document A/29/29. Geneva, 12 April 1979.

At present the 900 localities served by the family planning program have been added to the 2,300 served by the extension of coverage program—bringing the total number of rural communities served to 3,200.

In sum, 1977 saw the following achievements:

1) Planning and programming based on formation of an integrated technical team at the national level.

2) Creation of teams of instructors at the national, state, and municipal levels.

3) Training of the following human resources: (a) 93 instructors of health and sanitation auxiliaries; (b) 104 community family physicians; (c) 57 nurse-instructors trained in nursing assistance at the rural hospital level; (d) 2,300 health auxiliaries and 983 sanitary auxiliaries trained to serve at the level of the rural community.

These recently trained personnel all began their primary health care work on 1 January 1978, inaugurating the first action phase of Mexico's national program for extension of health coverage.

SUMMARY

Mexico has begun a major national program designed to provide universal health service coverage. The program envisages extension of health services to rural and deprived urban dwellers; more efficient use of existing medical and sanitary services; increased community participation; strengthening of preventive health, health promotion, and sanitation measures; and, above all, the strengthening of family planning services. Achievements to date include creation of teams of health personnel instructors at the national, regional, and local levels; preparation of 57 nurse-instructors, 104 community-oriented family physicians, 2,300 rural health auxiliaries, and 983 rural sanitation auxiliaries. Most of these personnel began their new work in early 1978, thereby inaugurating the first real operational phase of this campaign to provide health services for all.

WHO/UNICEF JOINT MEETING ON INFANT AND YOUNG CHILD FEEDING

This meeting, which is being sponsored jointly and organized by the World Health Organization and the United Nations Children's Fund will be held at WHO headquarters in Geneva from 9 to 12 October 1979. The purposes of the meeting are to bring together participants reflecting a representative group of governments, the U.N. agencies, nongovernmental organizations, health and other workers, the infant food industry, and other interested parties to: a) summarize the current state of knowledge concerning appropriate infant and young child nutrition, and factors affecting it, and b) consider what activities could be undertaken to improve infant and child feeding practices.