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Notes

8 pp
The paper, by Zofia Sierpinski, Programme Officer, outlines Costa Rica's endeavour to extend basic services to urban and rural populations in the 1970's. Community participation and the role of women are discussed, and communication and information inputs are traced, and UNICEF's are listed.

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Workshop on Communications for Social Development
Mallards Beach Hyatt Hotel, Ocho Rios, Jamaica
22 to 29 April 1981

Primary Health Care
Costa Rica

Zofia Sierpinski
Programme Officer, Guatemala

PRIMARY HEALTH CARE

COSTA RICA

In September 1978 the international conference on Primary Health Care held in Alma Ata brought forward a Declaration which states, among others, the following:

I. "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."

IV. "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

In Costa Rica such concepts and others listed in the Alma Ata Declaration have been adopted already to a great degree since 1970, on the basis of their national Health Plan for the decade.

In 1980 Costa Rica is selected as the only country in Latin America to provide the JCHP with a study on its Primary Health Care system.

BASIC DATA

UNICEF Group III

Area:	50,700 sq. km.
Population density (1978):	41/sq. km.
Total population (1980 est.)	2,213,000
Children 0-6 (1980 est.):	396,000
GNP (1977):	US$2,870 M
GNP per capita (1977):	US$1,390

The infant mortality for 1968 was 81‰; by 1976 the rate was reduced to 33.3‰; the most recent rate stands at 19‰.

OBJECTIVES

1. To provide basic services to rural and urban population in order to improve their health conditions and contribute to an integrated development.
2. Develop mechanisms for a systematic and permanent participation of the communities in health activities.
3. Assist in health and other sectors beneficial to the population.
4. Improve the programming, administration, supervision and evaluation systems.

The specific objectives included the reduction of mortality and morbidity rates due to infectious diseases; provision of services for mothers and children; reduction of malnutrition in young child group; provision of basic sanitation and domiciliary visits by health workers.

ACTION

The responsibility for health sector has been assigned to three institutions: the Ministry of Health, the Social Security and the Institute for Water and Sanitation.

In the 1960s the Government started to expand Social Security coverage which became universal during the 1970s, covering mainly insurance for maternity cases and treatment of diseases for over 80 per cent of the population. Some 90 per cent of its budget comes from taxes on employment and sales.

The Ministry of Health concentrated its activities on policy, formulation of norms, sectoral planning and coordination as well as overall directives of health services.

With an objective to reach the entire rural population with basic health services, the government established its legal and budgetary basis for the necessary extension of services, mainly to train the personnel and build the network of health posts and nutrition centres. For external assistance the government turned to UNICEF, WHO, UNDP, USAID and CARE. The external assistance started in 1971; by 1977 the government assumed entire responsibility for its health system.

The Institute for Water and Sanitation, an autonomous body, assumed the responsibility for provision of sanitary conditions, particularly drinking water, to all the rural population.

Simultaneous country-wide actions in primary and secondary levels of education for all school age population, as well as provision of electricity, road building and decentralization of agro-industry,all are considered to have produced an impact on the level of health and standard of living. The pre-school child population receives regular balanced nutrition in rural nutrition centres which also serve as kindergartens. The schools provide meals to all pupils, usually supplemented by their own sources of garden and poultry projects. Poor families receive dietary supplements for mothers and children. Oral rehydration salts are provided either to health centres or directly to the families. Regular services of immunization are provided through domiciliary services. The health care includes mobile dental services for child population.

The impact of these services is measured in changes of mortality and longevity rates as well as change of health patterns. Proportionally to the acquired coverage of health services the infant mortality would reach an average of 19‰(to 7‰ in some areas). The life expectancy for 1965-1970 of 65 reaches an average of 72 during 1980-1985. The eradication of communicable diseases having been practically reached, the main causes of infant mortality are premature birth,congenital malformations and gastro-intestinal problems.

COMMUNITY PARTICIPATION

The prototype for national health services became the local model of community medicine programme known as the "Hospital without Walls", established in 1971 as an experience in integrated social development. The project, organized in San Ramón, serves some 4% of the country's population, predominantly rural. The system is based on full participation of the community, including the organizational and financial support for the construction and equipment of 44 health posts. The health actions went beyond the preventive and curative aspects of health, to tackle and resolve the problems affecting the standard of living: housing, water and sanitation, electricity, employment and cultural activities.

The organizational system has a community at its base which includes each family. Organized into health committees, their elected representatives participate in development association. In the middle of the pyramid exist the district health association; at the head is the regional hospital with the Community Health Association. At each level these organizations receive official government support in funding for community projects and technical advisory services.

The projects are based on socio-economic surveys of the families. Each health post has a map of the area, showing the public and family housing, pinpointing the particular health problem in each case: pre-natal, newborn, malnutrition, negative sanitation, pathology, etc. These cases receive home visits by nursing aides. Regular medical, nursing and social

workers' visits to the health post follow up on treatment or referral cases to the hospital. The child nutrition centre provides two daily meals, health follow-ups and pre-school education. The village volunteers serve as the liaison between the families and nursing aide, they also cooperate in cleaning of health post preparation of materials, fund-raising activities, etc. They cooperate with the medical staff, Alcoholics Anonymous, Community Development Associations, educational and cultural groups which maintain libraries, organize sport and art activities. Other community activities include: low-income housing, electrification and telephone services, highways and rural roads, land tenancy, employment in milk and coffee cooperatives, handicrafts, education and better clothing.

The women's role and participation is significant in all activities, shared with that provided by men (although no specific data are available on this subject).

Drastic changes in health pattern became visible soon after the project started to operate, particularly in infant mortality rate being cut down to one third of the national average. This unique for Latin America systems became a training ground for the rest of the country; also, hundreds of foreign visitors interested in social development come to study the programme.

The application of community-based health system like that of San Ramón is one of the main national objectives. Through the existing health posts, the communities are being organized to participate actively in the designing of their priorities such as communication system, better health services and nutrition. In 1979 the government started conducting more intensive "popular participation", through sessions attended by the President of the Republic, members of Congress and the cabinet. The purpose of such approach is to decentralize the decision-making process and to make the communities more involved and responsible for the shaping and upkeep of the services.

COMMUNICATION AND INFORMATION INPUTS

In addition to the above-mentioned national efforts and inputs (which fulfill the advocacy role), the Costa Rican press follows the issues through a wide coverage.

A growing number of national professional and technical personnel has made the country not only self sufficient in developing the social sectors but also many of the national experts provide technical assistance to other developing countries.

UNICEF's information inputs are known to be:

1. Financing of government pamphlet for the Alma Ata Conference on Primary Health Care.

2. "A successful Health Project in Costa Rica" - an article by Aina Bergvall published in UNICEF News issue 99/1979/1.

3. "Costa Rica's Boy Rabbit Farmer" - by Aina Bergvall, published in UNICEF Information SFS/79/3.

4. "Costa Rica PHC Study" - submission to the 1980 JCHP Conference, prepared by the Costa Rica team with UNICEF financing (under preparation for publication).

5. "Situation of Children" - a study for Central American countries (including Costa Rica) sponsored by UNICEF under IYC programme. Designed and developed by national teams. Not completed to date.

6. "La Sociedad es como un árbol. ¿Qué es planificar?." A popularized approach to planning for teachers and secondary-level of education. Developed by Costa Rican Ministry of Planning, financed by UNICEF.

7. "Necesidades Educativas Básicas - de la población rural del área centroamericana," includes a case study of a rural community in Costa Rica. The booklet is prepared jointly by UNESCO/UNICEF, financed by UNICEF.

PROFESSIONALS BEHIND THE PSC

None on UNICEF side.

TRAINING

The training in community education has been described under "Action" and "Community Participation", as developed by the government.

NGO training input includes mainly some activities of "4-H Club" in family rabbit care and preparation of food.

MONITORING

The government has a system of follow-up for each of the results of "popular participation" sessions. The discussions include questionnaires, tabulated in order of priorities established by each community. The implementation process is assigned to the respective community leaders and government agencies: health, education, agriculture, housing, etc.

BUDGET

No specific allocation for PSC or information has been included in the programme commitment which ended in 1976.

SUMMARY

Within the context of national Ten Years Health Plan, the achievement of its objectives has been met and in some cases the targets have been exceeded. The government not only maintains but also considers it quite realistic to provide health for all by the year 2,000.

The main problems to reach the final objectives can be summarized as follows:

- While the rural coverage is nearly completed, the urban sector of the population, and particularly the peri-urban areas remain with the largest deficit of PHC coverage (of under 70%). It remains to be seen whether the urban population can be organized into communities as easily as the rural ones.

- The country has been facing some serious economic problems which reduce the government's potential for the budgetary support to the health and other social services. There are no funds for the upkeep and maintenance of health equipment provided several years ago. This might well result in the breakdown of efficient services and health authorities are concerned about possible reversals on health pattern of child population (particularly immunization services)

- According to UNICEF's policy on assistance, the Costa Rica's GNP reduces the ceilings of our assistance down to a practically symbolic figure of $20,000 per year. Such situation is of concern to the government ("We are a poor developing country, yet we managed to provide everybody with health and education services; we don't spend any of our money on arms and defense; 46% of our budget goes to health and education; we help other countries to plan and set-up their services for children; with the economic breakdown we shall have to reduce our programmes. The UN system helped us to set it up and now it should help us through the difficult years.")

Given the extraordinary achievements during the last decade, the government is now working to maintain the services at practically zero growth level. To cope with the economic shortages, it has turned again for assistance to foreign sources, such as AID and UNICEF. Our own plan of special assistance has been submitted to the 1981 Executive Board, for noted funds to maintain the cold-chain required for immunization.

Zofia Sierpinski
Programme Officer