Growth of the Health Center Idea

Tracing the development of health centers in Latin America since the beginning of the bilateral health program in 1942, the evaluators find evidence of significant advances. They conclude that the health center projects of the Servicios have had an important influence on the development of public health services to meet the varying needs of the countries.

SIGNIFICANT advances in the development of health centers in Latin America have been made since the inauguration of the cooperative health programs of the Institute of Inter-American Affairs and Latin American countries in 1942. The physician, the nurse, the statistician, the health educator, the social worker, the nutritionist, and the laboratory technician have all made contributions. The health center idea has been so convincingly demonstrated that Latin American health administrators have almost unanimously accepted it. Latin Americans attending schools of public health both in their own countries and in the United States have been exposed to it, and upon their assignment or reassignment to action programs they have usually become apostles of the concept.

This is the fourteenth in a series of excerpts from the report of the Public Health Service's evaluation of a decade of operation of the bilateral health programs undertaken by the Institute of Inter-American Affairs in cooperation with the governments of the Latin American Republics. A complete list of excerpts is given on page 135.

War and Postwar Concepts

During World War II, medical posts were set up to give medical care to the people near military installations and to workers and their families in vital war materials projects. These centers provided primarily for treatment of diseases and inoculations and vaccinations of various kinds. The traditional preventive services were crowded out by a combination of a lack of personnel and the emergency situations which demanded attention.

With the exception of these medical posts, however, a large percentage of the health centers are providing maternal and child health, communicable disease control—including tuberculosis and venereal disease control—health education, and laboratory services. Some of the centers are operating programs in environmental sanitation, nutrition, and vital statistics, and a few have laundries and bathhouses.

Administration

In some of the countries—Chile, for example—*Servicio*-constructed and *Servicio*-operated health centers are integrated into the health structure of the country. In others—

Bolivia, for example—they are completely independent. Although arguments for and against both concepts were presented, it is agreed that the aim should be the operation of the centers by the country itself as a part of the appropriate (national, state, or local) health service. Unless the health center becomes the focal point for the administration of health services to the area in which it is located, there is the possibility that there will be disunity or duplication of effort.

The problem of integration is sometimes complicated by the fact that in many countries there are special programs, usually concerned with the control of specific diseases, which are not administratively tied in with local health administration and health centers. These special programs—such as those for the control of malaria, yaws, pinta, typhus, and yellow fever—have developed because of the tremendous economic and social losses resulting from these diseases and the urgent need for their control.

Construction and Operation

Except in Brazil, Mexico, and Chile, little progress had been made in developing health centers before the initiation of the bilateral health and sanitation program. About the same time that this program was begun, however, the Rockefeller Foundation extended its public health activities from Brazil and Mexico to other Latin American countries, and the programs of this organization and those of the *Servicios* have at times supplemented and complemented one another. A survey of health center construction and operation gives factual evidence that the health center has become an integral part of the public health programs of a majority of the Latin American countries in which bilateral health programs have been in operation.

In El Salvador, a few health centers were in operation before the *Servicio* developed its program of health center construction. Twelve centers constructed by the *Servicio* were turned over to the national health service for operation almost as soon as they were completed. Following the revolution of 1944, the *Servicio* had the nominal responsibility for operating several centers for 2 years, but it is clearly evident that the Government of El Salvador is able to operate its health centers without assistance from the *Servicio*.

In Chile, at Valparaíso, Antofagasta, and Temuco, the centers are being administered by the national health service through the *Servicio*. Actually the *Servicio* exerts a strong influence on their operation. The Quinta Normal Health Center in Santiago, however, is being operated by the provincial health service, and the influence of the *Servicio* is more remote. It is apparent that the health center idea has been accepted in Chile, and the national health service is planning to develop centers in Santiago and the other large cities. It seems probable that in the smaller communities preventive services will be related closely to hospital and outpatient services which will be provided under a new law relating to the fusion of medical and welfare services.

In Ecuador, the center constructed in Quito has been turned over to the national health service for operation. The level of administration of the public health program is limited by lack of funds and personnel, but the center is well managed and is giving a high standard of service.

In Mexico, six centers have been constructed and two are under construction. Two of the six centers were operated by the *Servicio* for approximately 4 years, but are now being operated effectively by the health services of the country.

In Bolivia, nine centers have been constructed and put into operation by the *Servicio*, but the national budgetary resources are so meager that it seems improbable, considering other health needs, that funds can be found for their operation without outside assistance.

In Paraguay, where 5 centers have been constructed and 4 are being operated by the *Servicio*, a similar situation exists insofar as national finances are concerned. The question which logically arises is whether the *Servicio* is justified in demonstrating a health center program of the usual type in countries with very limited economic resources. Would it not be better to try to find a method of providing health services more in keeping with available funds?

In Brazil, the cooperative program is oper-

ating 45 health centers, 12 medical posts, and 30 subposts. Although few of these facilities have been turned over to the national or state health services, full responsibility for their administration is vested in Latin Americans, and only a small percentage of the operating expense is being carried by funds contributed by the United States.

In Colombia, four health centers have been constructed by the *Servicio*. Two of these were turned over to the Government immediately, and two were operated several years before being put under national direction. Approximately 30 medical posts and health centers operated by the *Servicio* during the war period have also been turned over to the Government.

In Costa Rica, 10 centers have been constructed by the *Servicio*, and all have been turned over to the Government for operation. All but 2 were operated by the *Servicio* for periods varying from 1 to 3 years.

In Guatamala, 6 centers have been constructed 4 of which were operated by the *Servicio* for 3 years before being turned over to the national health service for operation.

In Haiti, 3 centers have been constructed, 1 of which was operated for 3½ years before being turned over to the national health service.

In Honduras, 3 centers have been constructed. One was operated by the *Servicio* for 2 years before being turned over.

In Nicaragua, 7 centers have been constructed, all of which were operated by the *Servicio* for periods ranging from 2 to 3 years before being turned over to the national health service.

In Peru, four centers constructed by the *Servicio* are being operated by that organization. No definite plans have been made for turning them over to the national health service, although there are apparently no fiscal barriers.

In Uruguay, six centers have been constructed and are being operated by the *Servicio*. Here, as in Peru, fiscal barriers against turnover were reported as minimal, but in spite of efforts by the chief of field party, it has thus far not been possible to negotiate an agreement for turnover to the state or local health services.

Only in Venezuela, Panama, and the Dominican Republic was the construction or operation of health centers not a part of the *Servicio* program. In the latter, however, the national health service placed in operation approximately 20 health centers and medical posts between 1937 and 1951.

Planning the Health Center Program

Basic to planning a health center program are (*a*) a working knowledge of the specific health needs and the disease problems of an area and (*b*) an understanding of the cultural and social development of the people to be served, as well as the economic potential of a community.

Location

Since one of the fundamentals of the health center concept is accessibility to the people to be served, a survey of the health needs of a country should be the basis for determining the location of a health center. Several instances were noted in which the location of a health center was dictated by a gift of property, and two in which a health center was planned as a part of a national health administration building, despite the fact that these locations were outside the area to be served.

Curative and Preventive Services

Health center services should be closely coordinated with the curative services available in the area, and in most instances the centers themselves should provide some curative services.

Only in a few countries—Uruguay, for example—was the preventive concept rigidly adhered to in the health centers. However, the curative services provided in most countries were usually a concession to the demands of the people and were made available only because the people would not utilize the center unless these services were provided. A need for better balance between preventive and curative services in the health centers visited was clearly apparent.

Mobilization of Resources

Planning of a health center program should include a study of all the health and welfare resources in the area to be served. This is particularly true since in most areas of Latin America these resources are rarely sufficient to meet

even the minimum needs. It is therefore essential that the best possible use be made of what is available.

A working relationship between the agencies and institutions giving health and welfare services, especially the health center and the hospital, should be developed. In some of the health centers, prenatal case histories are made available to the maternity hospital for the information of the physician or midwife responsible for delivery of the baby, and sometimes information from the maternity hospital is made available to the physicians and public health nurses of the health centers. Such arrangements, however, seem to be too infrequent.

The development of community health centers which provide other services as well as health services has a great deal of merit and should be considered in planning a program for a given community. In San Felipe, Chile, traditional health services are provided at the health center and at the related clinics of the social security organization, a few blocks away. In addition, the health center has an office for representatives of the National Department of Agriculture, who are assisting in the organization of homemakers' clubs, garden clubs, and 4–C clubs (corresponding to the 4–H clubs in the United States). The interest of the people in the health program is apparently greatly enhanced by the consideration and attention given these auxiliary operations by the health center. Moreover, these clubs have resulted in the development of gardens, vineyards, orchards, and poultry and pig raising, which augment the food supply of the low-salaried workers. They have also stimulated an interest in home sanitation, resulting in the replacing of dirt floors with concrete, the building of simple furniture for homes, and the providing of sanitary privies and other facilities—all tending to raise the level of health of the people in the area.

Integration

The health center program should include, in every possible instance, plans for making the health center an integral part of the indigenous health program of the community. Although it may be difficult to fix an exact date for turning the health center over to indigenous health services, a date should be included in the agreement. If necessary, the date can be changed as the occasion demands.

Physical Structure

Plans for the physical structure of a health center should not be started until a decision has been reached as to the services to be included in a health center. Physicians, nurses, and sanitation personnel, preferably those who will be responsible for the operation of the center, should be consulted early in planning the design of the health center.

The experience already gained by the *Servicios* can be of great assistance in planning future centers. Through this experience the mistakes of the past can be eliminated and the best features of the centers in the various countries can be utilized. This emphasizes the need for architectural consultative services early in the planning, before working drawings are commenced.

Structural design of health centers built by the *Servicio* is generally adequate. In some instances, the actual construction has suffered because of lack of skilled workmen and the necessity for using unfamiliar materials, which gave some structures a rather crude appearance. In one country, roof design for centers was of an untried type not conforming to the general architectural pattern of the country. Leaky roofs necessitated rather perplexing and expensive repairs.

As a Training Center

A primary objective of the bilateral health program has been the training of health workers; physicians, nurses, sanitary engineers, and others. Health centers have played an important part in training, as was pointed out in the section of this report on that subject (December 1953 issue of *Public Health Reports*, pp. 1243–1250).

The importance of planning for the training program early so that adequate space will be provided in the center has been demonstrated. At the Beatriz Velasco de Aleman Center in Mexico, for example, it has already been found necessary to add a new section to provide adequate space for the nurse training program.

Plans must also be made to provide a staff sufficiently large to handle training. Experience both in the United States and in Latin America has shown that a training program cannot be simply added to the regular services of the health center. A minimum ratio of training personnel to trainees, depending on the kind of training and the content of the training courses, should be worked out.

Quality of Service

In general, the services available in *Servicio*-operated health centers are of high quality. A few instances were noted of the use of outmoded drugs and of carelessness in hand washing after the examination of infectious patients, but the practices were generally sound.

One of the problems thus far not solved is that of keeping and using records. In some centers, patients' records are sketchy and inadequate. Physicians and nurses are often unable to obtain information regarding past treatment of a patient without time-consuming search. In some centers, a beginning in developing satisfactory records has been made; in others, there is a tendency to make records too complicated. The whole problem of records in health centers deserves immediate study and the development of a basic plan which can be adapted to use under varying conditions in the different countries.

In most of the countries studied, the collection of vital statistics has not been developed to the point where it is possible to relate health services to mortality and morbidity rates.

Evidence of decreasing infant and maternal mortality in the areas served by maternal and child hygiene facilities has been gradually accumulating. This was noted in San Salvador and Santa Ana, El Salvador; Quito, Ecuador; Lima, Peru; Santiago, Chile; and in other areas.

Programs of immunization have been successful in stopping epidemics of whooping cough, diphtheria, and smallpox. There is little resistance to these programs because the people themselves can see the importance and value of protection against these diseases.

Multidisciplinary Training in Public Health

The general plan and structure of our [public health professional] educational program is sound. It is based on a conception which we, in the United States, are apt to take for granted, but which is strange and unfamiliar in most other countries. This is the concept that public health is not a branch of medicine or of engineering, but a profession dedicated to a community service which involves the cooperative effort of a dozen different disciplines. The fact that doctors and dentists and nurses and engineers and health educators and microbiologists and statisticians and nutritionists sit together in our schools and take the same degrees is of incalculable importance. It is based on bold assumptions; but it has worked. It provides the only sure basis for true cooperative community service in the future. It constitutes one of the most significant contributions of the United States to the basic philosophy of public health.

—C.-E. A. Winslow, Dr.P.H., in The Accreditation of North American Schools of Public Health, American Public Health Association, 1953.