Islamic Republic of Iran: Primary Health Care and the Rural Poor

Rural households in Iran have traditionally been the most disadvantaged segment of Iranian society, not only in terms of income and political power but also in accessing basic public services, including health. A major achievement of public policy in Iran over the past 20 years has been the improvement of rural health and the near elimination of health disparities between higher-income urban populations and the rural poor. For example, in 1974 the infant mortality rate was 120 and 62 per thousand live births for rural and urban areas, respectively. By 2000, however, both the level and the differential of infant mortality had declined considerably, to 30 for rural areas and 28 for urban ones.

The primary health care system in Iran

The Iranian primary health care (PHC) system was established to improve access to health care for the disadvantaged and reduce the gap between health outcomes in urban and rural areas. To improve access in remote areas in the face of shortages of human and capital resources, the system has relied on three main components: (1) establishing health houses in remote and sparsely populated villages; (2) staffing the health houses with health workers, known as behvarzan, recruited from local communities; and (3) developing a simple but well-integrated health information system.

The health house, usually the only health facility accessible to the rural population, is the most basic unit of the Iranian PHC network. Located in individual villages, it is designed to cover a target population of about 1,500; each health house also serves several satellite villages selected with careful attention to their cultural and social compatibility. The distance between the village in which the health house is located and the satellite villages served by it is typically, by design, no more than a one-hour walk.

Tasks performed by the health house include record keeping and data collection; public health education and promotion of community participation; antenatal, perinatal, and postnatal care; care of children under five and of school-age children; family planning services; immunization; and disease control services. The second and third levels in the hierarchy of the rural health network provide backup for the rural health houses, offer diagnostic and treatment services, and refer those needing more specialized care to district health centers or hospitals. There are also urban counterparts of these organizations.

One male and one or more female health workers (behvarzan) run each rural health house. The health workers are chosen from among local people familiar with the households in the village. Such a close relationship between the behvarz and his or her community facilitates the accurate collection of health information, among other things. Behvarzan have had a pivotal role in the success of Iran’s PHC network.
Although the primary responsibilities of the health workers are divided along gender lines, with the female behvarz generally responsible for tasks performed within a health house and the male behvarz for tasks outside the health house, both genders are trained for and expected to cover all duties, as necessary. Training occurs at the district level; students receive free training and financial support throughout the two-year training period. In return, they are formally obliged to remain and serve at the village health house for a minimum of four years after completing their study.

The health information system (HIS) enables the behvarzan to collect detailed information on rural communities. The main components of the HIS are the household file (containing demographic and health information), various logbooks in which daily activities are recorded, and monthly report forms.

The impact of the PHC system

If we judge the effectiveness of resources invested in the PHC system by reference to the improvements in the health status of the Iranian population in general, and the rural population in particular, the results are impressive. The PHC system is funded entirely by the national government, and the pattern of public health spending is oriented toward rural public health services—a fact that may partly explain the good performance with respect to rural infant mortality rates. The specific measures taken by the PHC system are almost certainly responsible for reducing infant and child mortality, eliminating major infectious diseases of childhood, and improving the health of mothers. These measures include the promotion of healthy attitudes and behaviors; the universal immunization of children; and encouraging mothers to breastfeed, use iodated salt, and provide appropriate treatment for children suffering from diarrhea and acute respiratory infections (ARI). A Multiple Indicators Cluster Survey (MICS) conducted in 1997 suggested a narrowing gap between urban and rural areas in terms of basic health interventions, including immunization coverage and infant, child, and maternal health care intervention. Despite these advances, however, some disparities remain, for instance in areas such as health insurance coverage.

The presence of the community-friendly behvarzan in the village, with their constant interaction with the community, has helped to ensure that health messages have not gone unheeded. Moreover, the ability of the PHC system to support the health messages by providing easy access to the means needed (vaccines, oral rehydration therapy, essential drugs, and so on) where and when they were required has also helped to bridge the gap often found between knowledge, attitudes, and practice.

The family planning program in existence before the 1979 Revolution was revived in 1989. The program has been extremely successful. By 1996, more than 74 percent of eligible couples were using a contraceptive, and the total fertility rate had dropped from 6.5 to 2.6. The traditional gap between urban and rural areas has also been substantially narrowed. Iran is making good progress toward the Millennium Development Goals, especially Goal 4, which aims to reduce child mortality and Goal 5, which aims to improve maternal health.
Factors for success: political commitment and institutional innovation

Two factors have been critical to the success of the Iranian experience. The first is the political commitment for change after the Revolution, expressed in a Constitutional mandate to provide universal access to basic health services. This political commitment has been combined with institutional innovation and the broader involvement of communities and local governments in rural health system decisions.

These factors have helped Iran to develop a primary health care system distinguished by culturally sensitive and cost-effective service delivery features—rural health houses, the behvarzan, and the simple health information monitoring system. Each of these institutional elements has been adapted and implemented in a way that has improved the chances of success. Without the locally recruited behvarz, staff turnover, absenteeism, and lack of knowledge about local circumstances could have rendered the physical facilities of the health houses much less effective. Simple health status tracking methods have made it possible to keep up with the evolving health needs of individuals as well as to detect village-level trends and disparities.

Problems to overcome

There are some weaknesses in Iran’s PHC system. Most of the improvements seen so far are the result of outstanding efforts of the workers and health houses; other facilities are lagging behind. Also, institutions at the second and third tiers of the system do not support the health houses sufficiently. Urban health centers must tackle even more serious constraints, and the problem of limited building space in cities can be overcome only with increased government support. Finally, there is no transparent policy for collaborating with the private sector, training managers, and providing a sustainable mechanism for improving the quality of services.