PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XX PAN AMERICAN SANITARY CONFERENCE

XXX REGIONAL COMMITTEE MEETING

ST. GEORGE'S, GRENADA
SEPTEMBER - OCTOBER 1978

Provisional Agenda Item 35

CSP20/30 (Eng.)
5 September 1978
ORIGINAL: SPANISH

SOCIOCULTURAL OBSTACLES TO HEALTH SERVICE DELIVERY

(Item proposed by the Government of Ecuador)

Introduction

In the last few years Ecuador has entered upon an active process in the health field carried on by the State through the Ministry of Health. On many occasions this process has been hindered by sociocultural impediments that have diminished the social effectiveness of the health measures offered to the community. Because of this, and because other countries in the subregion are facing similar problems, at the V REMSAA Ecuador presented a study on this subject that was fully accepted by the Member States.

The countries of America are interested in extending the coverage of their health services and enlisting the participation of the community in them. Work done in this direction in several countries has demonstrated the existence of sociocultural obstacles that prevent the proper utilization of existing services.

In the present situation, therefore, the countries of the Hemisphere find that they must turn their attention to the beneficiaries of health measures in order to find out how they view health and disease and behave in relation to the formal and informal health service structures and, in the end, to determine the nature of the existing barriers.

Against this background and that of Resolution II adopted by the 80th Meeting of the Executive Committee of PAHO, it is felt that the Ministers of Health of the Hemisphere should consider the present proposition during this Conference and, if possible, provide for, in such ways as they may deem convenient, the conduct of research to identify the sociocultural obstacles that impede the delivery of services.

The Ecuadorian Situation

In 1974 Ecuador had 6,521,710 inhabitants, for a population density of 25.64 inhabitants per km^2. Natural increase is rapid, mainly because of a high birth rate (37.5 per 1,000 inhabitants), which has not slackened significantly in the last few years.

The Ecuadorian population is young and more than half rural (58.72 per cent), and a steady demographic implosion is in progress caused by migration from the countryside to the principal urban centers.

Another salient feature of the population is its dispersion. Of the total population, 46.48 per cent is economically active. The illiteracy rate (23.715 per cent) is still an important problem, which is seen to be worse when the distribution of the population by level of schooling is considered, for many people do not complete their primary schooling.

Another characteristic of the Ecuadorian population is its underemployment.

The Ecuadorian Area

Ecuador is the second smallest country in South America. The Andean Cordillera traverses it from north to south and so divides it into three markedly dissimilar regions: the coast, the sierra and the eastern (jungle) region; there is also the region of the Galápagos Islands. The three mainland regions are inhabited by populations that are culturally distinct.

The country is endowed with a good system of internal communications. In the field of sanitation services, substantial gains were made between 1972 and 1977 in water supplies and sewerage. Thus, the population enjoying water supply services rose from 31.4 per cent of the total in 1972 to 46 per cent in 1977, and that served by sewerage facilities from 23.6 per cent in the former to 36 per cent in the latter year.

In the telecommunication field, in 1977 the national network had 960 microwave channels and one two-way television transmission channel. The national network covers all the provinces, and an extensive rural communications plan to offer services to 400 population centers is now in preparation. There is also an international communication service via satellite.

The national public information system consists of more than 280 radio broadcasting stations, 16 television stations, 10 wide circulation daily newspapers and 40 provincial periodicals.

The Ecuadorian Economy

The economy of Ecuador, like that of other Latin American countries, is highly dependent on foreign trade.

Following the discovery of new petroleum deposits, and mainly when the petroleum began to be extracted in 1972, the country entered a period that is novel in some respects because the substantial increase in cash income has made the public sector the financial hub of the country's growth, and a powerful engine of development.

About 30 per cent of the crude oil produced is used locally and the remaining 70 per cent is exported, which makes the petroleum sector the principal source of foreign exchange generated by exports. In 1976 it took in US$556.2 million in foreign earnings.

Gross investment rose 183.3 per cent between 1970 and 1976, and public investment 275 per cent over the same period.

To summarize, petroleum has been a decisive factor in the growth of the national product, the generation of income, the balance of payments situation, the public budget, the financing of economic and social development programs, and in every part of the national economy.

Health

The Ecuadorian life expectancy at birth, 51.04 and 53.67 years for men and women, respectively, in 1972, rose to 59.5 and 61.8 years in 1974. General mortality is in outright decline; it was particularly so in 1975, when it dropped to 7.8 per 1,000 inhabitants, significantly below the 12.9 in 1962 and 9.9 in 1974. This decline was caused chiefly by a concurrent drop in infant mortality, which in 1975 underwent a significant reduction--to 57.6 deaths per 1,000 live births.

In regard to health manpower, in 1974 there were 4.8 physicians, 1.2 nurses and 0.9 dentists per 10,000 inhabitants. These ratios have risen considerably since then.

The coverage of health services is being progressively extended. In 1975, medical certificates were issued for 50.2 per cent of all deaths; though still low, this proportion compares favorably with the 42.8 per cent of 1971. The proportion of births with professional attendance increased from 22.6 per cent in 1969 to 38.7 per cent in 1974.

The volume of physical implementation in prospect is substantial and has made the State, through the Ministry of Public Health, the deciding force in the health sector. The importance of the public sector contribution is attested by such indicators as the number of hospital beds and health establishments. Four years after it was set up, the Ministry of Public Health had scarcely 381 beds (1971); this figure rose to 7,682 beds in 1977, and the aim is to reach 11,000 by the end of the decade. This significant increase was obtained by incorporating into the Ministry the "Servicios de las Asistencias Sociales" (Social Welfare Services), the Ecuadorian Antituberculosis League (LEA), and other agencies, and by implementing an agressive plan of hospital construction which replaced obsolete hospital facilities with modern installations and provided new hospital beds as well. This construction process is not only extending the services, but is affording a substantial improvement in the quality of hospital medical care as well.

The great importance of the Ministry of Public Health in the health sector does not derive from its hospital facilities alone.

Between 1971 and 1975 the number of the Ministry's health establishments increased significantly to conform to the geographic dispersal of the population and meet its urgent health needs. Under the Rural Health Plan large numbers of operational health units were established in the rural sector, at the post, subcenter, and inpatient center levels.

Thus, the delivery of health services in Ecuador is now undergoing substantial change. There has been a radical shift in the social orientation of medical practice.

Over the remains of the charity medicine concept, which had prevailed since colonial times, there is rising a new concept of medical care as a civil service, being developed mainly by the ministerial subsector, which is gradually becoming the dominant force throughout the country.

Institutional Upgrading

One of the most notable developments in the institutional upgrading process has been the bringing of the Ecuadorian Institute of Sanitary Works, which is responsible for environmental sanitation programs, into the orbit of the Ministry of Public Health.

In response to the requirements and urgency of the Health Plan, operations are going forward concurrently along three main lines of activity that are mutually interactive.

On the one hand, there is the planning of the nationwide health network to create the network of health establishments, organize all outpatient and inpatient units on a regional basis, and propose the establishment of new units with which the health coverage is theoretically extended. This infrastructure is capable of handling more than 300,000 inpatients and more than eight million outpatient visits a year. By the end of 1977, four new hospitals, the expansion and remodeling of five existing hospitals, and 38 inpatient health centers, 14 urban health centers, 61 rural health subcenters and 10 health posts had been completed.

The program in execution in 1978 includes 15 new hospitals, 17 remodelings and expansions, 31 inpatient health centers, 7 urban health centers, 66 rural health subcenters, and 14 health posts.

The Investment in Health

This briefly described health sector program has imposed a major economic effort on the country. The regular budget of the Ministry of Public Health totaled 1,598 million sucres, or 9.37 per cent of the Government's General Budget in 1977, up from 3.48 per cent in 1972. As a result the Ministry's budget increased 593.4 per cent and the General Budget 284.3 per cent. When it is considered that the GDP rose 167 per cent during the same period, it is seen that developments in the health sector have been particularly brisk, in keeping with the urgency of the situation.

A total of 348,509,469 sucres was invested in construction for health establishments in 1977, or an increase of 255 per cent from the 1974 level. The investment projected for the years 1978-1979 for those establishments comes to 1,686,235,424 sucres, and the investment in sanitation works will be 2,893,000,000 sucres.

When it is considered that the per capita expenditure of the entire health sector was US$1.63 in 1964 and that of the Ministry's subsector alone was US$8.52 in 1977, it can be seen that, though major progress has been made, the magnitude of the needs remaining to be filled continues to impose major economic efforts on the country.

Community Participation

While community participation has been on the increase in rural localities over the last two years, there is still much to be done.

In urban communities, integration of the services of the former Social Welfare Boards (Juntas de Asistencia Social) eliminated what little part the community had had in the management of the services in each health region, which has done nothing to improve services.

Awareness-building and motivational work in advance of the establishment of services has been meager, with the result that what demand there has been for the services of the facilities is solely of the spontaneous kind and subject to variation with the quality of the care provided.

There has been no concrete public information programming to assist in the assimilation of the health service into the cultural fabric of the community.

Reflections of the Current Process

Major efforts are now in progress to transform the health situation in the country.

This study has addressed some of the most important aspects of these efforts, particularly those that stand out for the financial expenditure they involve.

A policy decision has been taken to develop and improve the present health services with a view to setting up in the immediate future a modern national service suited to actual conditions in the country.

The community response in terms of demand for and use of the services apparently does not measure up to the magnitude of the national investment and effort. No other conclusion can be drawn from the fact that the installed outpatient capacity could handle more than the 0.35 visits/inhabitant/year serviced in 1976 and than the 64 per cent occupacy attained by the inpatient facilities.

However, the number of consultations compares favorably with the 0.22 recorded only four years before.

There are reliable data to show that the demand is even lower in rural areas.

While some of the reasons for this are known, particularly in relation to the composition of the supply, nothing is known of most of the many problems that give rise to this situation on the side of the community.

Thus, an extensive program of research in this field should be undertaken so that strategies can be charted for improving utilization of the services.

For this program it is also necessary to know about the experience of other countries of similar relative development in the subregion.

Social Communication and the Utilization of Health Services

As previously noted, in Ecuador there is an important correlation between latent and manifest health needs and health resources, a significant part of the infrastructure for which has been built by the Government on a priority basis in a relatively short time. However, there are also some sociocultural problems that have concerned us and are worth analyzing here today because of their possible importance for international cooperation programs, both because of how other countries may have regularly dealt with them and because of the approach we are taking to them in ours.

This concern refers to the "cultural" obstruction inspired by the presence of this culturally highly indiscriminating infrastructure and services in rural areas and regions of highly differentiated cultures. Its effects are apparently creating serious problems that considerably weaken the basic premises underlying the national health system, one of these premises being that the community is a willing recipient of the benefits of that system.

In this section we will mention some aspects of our situation in this field, some of the approaches we have taken to its analysis, and the tasks the Ministry of Public Health has set itself in its attempt to deal with some of the consequences of this situation, in the light of new advances in applied social research.

One of the most persistent phenomena to have emerged in the rural settlements in Ecuador where health services are being installed has been an at times very serious shortage of demand for those services relative to the real or estimated capacity of the facilities, as previously noted. Some attempts have been made to find an explanation for this phenomenon which, as the scale and capacity of the health system infrastructure increases in these areas, is becoming so pronounced that the negative statistical significance of the cost-effectiveness ratio for the use of these resources is steadily mounting.

Research in this area of behavior of demand has been neither very sustained nor systematic. There is practically no interest any longer in identifying the medical-social multifactor causes of this situation, and very little is known about them today. Recent approaches are discovering very useful ways of improving the cost-effectiveness of health services, which is the great interest of the moment, and are providing new data highly useful for estimating cost-benefit ratios for the entire system. These approaches are based on social communication and on what has come to be referred to as community participation, a concept that is today backed up by new informational, theoretical and technological resources that make it more suitable for application in our situation.

The common premise in most aprioristic attempts to explain problems of insufficient public demand for health services has been associated with modernization theories that assert, among other things, that peasantries, steeped in a fatalism that excludes the outsider and springs from the circumstances of the life they lead, have become acutely fearful and suspicious of outsiders, have taken no "interest" in programs imposed from above, and mistrust both physician and health services.

It was endeavored to rectify this situation, which resembles the problems that the agricultural, education and other rural development programs have had to contend with, by many techniques that addressed the symptoms rather than the causes of this cultural reaction, and yielded inconsistent results.

These efforts have been praiseworthy in themselves, as attested by the enormous volume of work done through the so-called community development and "development animation" subprograms that international agencies have been promoting in our countries. But the present evidence of low demand for installed services shows that there was something wrong with that approach.

In the case of Ecuador, we must admit, these activities have so far been carried on through the health education extension service, whose postulates have been grounded in traditional theoretical propositions about teaching, which were known as stimulus-response models. When the work shifted to nonformal action in the educational sense, it was proposed to stimulate populations that had cultural "prejudices" against modern medicine and health services through an information process that was and is mostly unidirectional and has very little of a dialogue about it.

It was endeavored to "teach" the usefulness of scientific medicine and to make it habitual to need the physician to "cure" visible diseases and prevent diseases latent in the environment. Persuasion as an end in itself was the result of the educational efforts, and the participation that was "required" of the community was that of "giving" all it could of itself in the sense of renouncing its "cultural values," of admiring "the outside thing" and of giving of its substance in the form of physical labor, money and materials. In the end, total cultural surrender was required in the form of demand for medical service to help make the cost-effectiveness ratio positive. This is how so-called community participation in health programs has been encouraged, and other Andean countries have apparently had the same experience.

This has given rise to a very particular situation in the problems of extending the coverage of services to rural areas in our countries. On the one hand, as was previously asserted, there is a concern that the health services themselves are already a cultural "intrusion" in these areas and so provoke their own total or partial rejection. It has been

endeavored to check this rejection with a counter-offensive of stimulation. To this end, a new element of cultural intrusion has been added to the problem, that is, the education and information apparatus to which we have referred.

We have recently become concerned about this situation in Ecuador, and there is information to show that this concern is shared by other countries in the Region and that a thoroughgoing review of the problems should be undertaken as soon as possible so that the major new underlying variables in our situation may be analyzed from this standpoint.

There is some evidence in Ecuador--and it may also be present and more pronounced in other countries--that the problems of social or popular participation in development programs are rooted in highly cultural situations in which factors of social structure have been considerably influential. Because of this, it is felt that the way in which the problems of popular participation in public health are addressed must be consistent with the nature of those other general programs, although this may apparently require us to start from classical propositions which, though we do not disparage their scientific validity, do not hold in our situation.

In seeking the best way to visualize the problems of popular participation, the first step is to rethink the implications of such participation in the light of the criticism that is constantly leveled at the models of development planning from above, and the culturally "intrusive" health and education services to which we have referred.

This proposition is essentially consistent with the empirical observations made in Ecuador and other countries, that where there are good levels of popular participation in social communication processes, there are also good levels of popular participation in development programs.

The theoretical justification starts from the same theories of social learning that have had such wide currency during the last two decades, in which knowledge is the basic requisite for generation of the individual change that leads to active participation. The new propositions we are considering differ from these theories about the source for the generation of that knowledge.

We are not trying to invent new communication methods, much less revolutionary communication techniques, but rather to modify the conceptual justification for using those methods. We are not trying to do the former because we are quite aware of the problems of standardization in the use of communication in societies that are culturally highly heterogeneous, and we are trying to do the latter because we are convinced

that the axiomatic principles underlying the public health programs of Ecuador are designed to benefit the popular majority which, because of a myriad factors, has been cut off from the benefits of development.

Our approach here has been to seek ways in which the people can participate in the research, planning, conduct and evaluation of communication carried out on practical health matters. Thus, we feel that knowledge generated in the stage of communication research in connection with health problems gives individuals better ways of selecting among alternative solutions to these problems and instruments for implementing them, and of evaluating them in terms of needs they themselves have identified and in accordance with their own cultural equipment for dealing with an interactive communication system designed by themselves.

There are experiences in our country that give us the certainty of being able to use these new propositions permanently in the future. For the present, we must recognize that the models are not yet developed to their fullest dimension precisely because of certain traditionalisms, some of them technological and bureaucratic.

We are seeking a reconciliation between communication processes and instruments so that there will be popular participation in both. As has been said, participation in the communication process implies participation in the health programs and in the use of the instruments, an identification of the problems and rationalization of the alternatives best suited to solve them. Put differently, our effort is directed at providing instruments for popular organization so that a proper community may arise through communication, which in Greek means "to establish community."

Popular participation will determine the community organization, which in turn will determine the means of communication for setting in motion a macroprocess of communication to assist in its own development.

When the problem is viewed in this perspective, we discover that processes and instruments of communication have to be stimulated without regard for chronological sequence, and the existence of the one is conditioned by the existence of the others. We do not want to convey the mistaken idea that the problems should be identified by the community and solved by someone like the State. What we want is to find a point at which the cold schematism of institutional planning could be blended with the heated programming of a community alive to its own problems and potential.

We know for a fact that it is difficult to establish this type of influence in an area, but the practice of participation at progressively higher decision-making levels guarantees the axiomatic postulates of the health system of Ecuador.

In practice, we are stimulating the experimental development and testing of new forms of intracommunity communication as instruments of utility for the macroprocesses of social communication. At the same time, we are encouraging better forms of community participation in the use of modern communication instruments that will shape the macroprocesses of communication, and we are not neglecting the development of traditional communication instruments that will provide better cultural expression for individuals in the framework of the communication processes that we have here described.

We know it is hard to determine quantitatively the boundary between communication macroprocesses because of the multiformity and complex dynamics of communication, and our aim is therefore to assimilate the experiences carried on in our countries under similar canons. Moreover, we know there is an infinity of forms of communication and a host of forms of participation, depending on the content of the messages and the channels of communication used. It is not feasible to establish standardization formulas in advance, but we believe that exchanges of experiences are revealing new ways of applying them, with appropriate adjustments, in other situations.

It is under this proposition that we have considered social communication as a pillar of the national health system we are implementing and, while its structure, form and workability are not yet as conceived in the original idea that gave rise to it, we do feel that, with the work we are doing and with international cooperation, we will answer more and more of the questions that arise in the course of its practical application.

This is no reason to reject everything we have been doing in the public health field, since to do this would be to deny our own selves in our work and our responsibility for the health of our peoples. Our concern is for the social and cultural damage we must avoid, to the extent possible, by timely action.