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THE SOCIAL AND CULTURAL CONTEXT OF  
HEALTH DELIVERY IN RURAL EL SALVADOR:  
IMPLICATIONS FOR PROGRAMMING

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## CHAPTER I

### INTRODUCTION

#### Introduction

The objectives of the present study were two in number. The first was to understand more precisely, through the use of anthropological field techniques, the ways in which socio-cultural factors diminish the desired impact of Salvadoran health programs, particularly in rural areas. The second was to transform that understanding into program interventions more harmonious with these same socio-cultural factors and thus more potent and far-reaching in their benefits.

The motivation for the study was the perception on the part of the Salvadoran Ministry of Health that there is a substantial discrepancy between the level of statistical generalities about health service delivery and the level at which those services are actually delivered. Some form of health facility is available to over 85% of the population. Hospital occupancy rates range between 75 and 90%.

There is relatively even distribution of health facilities across the country, a country which furthermore has a rather extensive transportation system. Yet over half the population dies without having seen by a physician, over 70% of all births take place outside a health facility, and the total population has an average of only 0.5 contacts per year with the public health system. This fast figure drops to 0.2 contacts per year in rural areas. High disease and mal-

nutrition rates, still higher outside the country's urban centers, attest still further to the suspicion that the mass of El Salvador's population still does not have access to, or will not seek, modern medical care.

#### THE RESEARCH QUESTIONS

The central question becomes, then, why is this the case? If the assumption is accepted that the problem lies in the lack of contact between the supposedly available health facility and the client, what inhibits this contact?

There are four principal, possible inhibitions: 1) spatial distance, 2) economic distance, 3) social distance, and 4) intellectual distance. This study asks which of these is the main deterrent to the adequate delivery and full utilization of health services in rural El Salvador and hypothesizes that it is in matters of social and intellectual distance that at least some of the answers may be found. The study also asks what, in terms of programs, can be done to reduce that distance.

Social and intellectual distance are, for the time being at least, more easily considered together, as a complex of elements: of hierarchies of roles, their implications, and the connections between them; of attitudes, knowledge, understanding, and emotions; of beliefs about the way the world is and should be; and of the manner in which all these are expressed, systematically, in human behaviors and relationships. If we admit at least as hypothesis that the key problems in both the delivery and receipt of health care in rural

El Salvador are related to these components, then we arrive at the emphases of this research:

- 1) the quantity and quality of the personnel staffing fixed facilities, and the appropriateness of their roles and behavior to the needs of the client population.
- 2) the experience of that population with that staff and those facilities in terms of satisfaction with the services provided, with the human quality of the health contact and with the level of mutual understanding.
- 3) the non-clinical behavior of rural dwellers -- campesinos -- with regard to health, and the beliefs and knowledge that underlie that behavior via-a-vis four major health components: disease management, maternal-child health nutrition, and the control of family size.

Despite these emphases, the realities of spatial and economic distance were not discounted; in fact, they were kept very much in mind. No single human predicament has a single cause; it is usually a matter of which factor seems most important at a given point in time.

#### METHODOLOGY

The Data of approximately 12 kilometers from the regional cabecera of San Miguel. Two kinds of data had to be gathered in order to respond adequately to the research objectives: quantitative data that would reduce the chances of the study being considered simply as a one-case health post estudio de caso, and most basic institutional units of analysis and which would enhance its chances of replicability; public health services, inaugurated in February 1973.

† Except for the volunteer workers in the Malaria Eradication Program.

qualitative data which would provide the sort of flesh for the statistical bones that has hitherto been largely lacking.

#### The Site

The research site was chosen according to criteria agreed upon by Ministry of Health representatives and the researcher. This site was to be: rural, in response to current Ministry priorities; not so rural that it would constitute a marginal instance; a locality with reasonable access to at least minimal public health services; an area with enough population density so that observation and contact could take place with relative ease and speed, given the restricted time available; and located in the Ministry's Eastern Health Region (la Región Oriental de Salud), until recently the most neglected sector of the country in terms of benefit from national development activities. A final criterion was the presence of someone resident in the community with the disposition and competence to assist with the administration of an interview schedule, in order to cope with a sample of adequate size; it was also most important that this be someone who enjoyed the confidence and regard of the community.

The site finally selected, after a field survey in the Eastern Region, was the municipality of Uluazapa, with an 'urban' population of 1500, approximately 12 kilometers from the regional cabecera of San Miguel, over a difficult road which made actual travel time approximately 30 minutes by car; with limited bus service; and with a health post (Puesto de Salud), the most basic institutional unit of public health service,<sup>1</sup> inaugurated in February 1975.

<sup>1</sup> Except for the volunteer workers in the Malaria Eradication Program.

### The Methodological Components

The techniques used, once residency in the site had been established and appropriate liaison made with regional and local authorities, were the following, roughly in the sequence in which they occurred:

1) Participant observation.

This was simply the standard approach of anthropologists which involves becoming a member of the community (insofar as this is possible for one not born into it), through being present at the daily activities of its inhabitants. Watching, listening, and sharing the everyday life and thought of a community in an unstructured fashion, provide the depth, context, and confirmation for the quantitative data gathered through more structured and more focused interviewing. The comedor, the street, the river bank, the tienda, the pharmacy, the church -- all the places where people gather -- are sources of data and, more importantly, understanding.

2) Interaction analysis.

This was the observation and interpretation of the way community residents related to one another and, more specifically in this instance, how they related to the staff of the Health Post and other non-clinical health personnel in the community, as well as of the interactions within that total universe of health personnel. This

entailed a fair amount of time during the early stages of the research, simply being in the health post, noting the nature and sequence of events, including doctor-patient and nurse-patient consultations, lectures (charlas), and courses for midwives (parteras empíricas).

3) Structured Interviewing.

This process comprised a number of steps:

- a) the preliminary design of a set of questions tied both to Ministry program concerns and to the realities of the community as they had unfolded during the preliminary observational period.
- b) the testing of the first format of this interview schedule on a limited sample, including consultation with key informants on its strengths and weaknesses
- c) selection of the full sample
- d) revision of the schedule
- e) consultation with the Regional Health office and still further modifications
- f) duplication
- g) administration of the schedule to the full sample
- h) reviewing the completed interviews on site, so as to diminish the risk of lost data
- i) coding, tabulating, and analysis.

The process also included the instruction and supervision of the male Peace Corps Volunteer who had been hired to do

the interviewing of the men in the samples.

4) Additional observation.

The Health Post has among its activities two outreach programs, the identification and contact of delinquents on its vaccination rolls and the school fluoridation program. These, too, were observed and evaluated.

5) Additional semi-structured and unstructured interviews.

These included discussions with the following:

- a) Clinic staff at all levels
- b) Paramedical personnel in the area, such as the
  - Pharmacist(s)
  - Malaria worker
  - Midwife
  - Dentist (Mecánico dentista)
- c) Other key informants, such as the
  - Schoolteacher(s)
  - Priest
  - Extension workers
  - Peace Corps Volunteers
  - Owners of tiendas
- d) Housewives Clubs (Clubes de Amas de Casa) and selected members thereof, at the municipal and cantonal levels.

6) Analysis of existing data.

Three principal sources of additional information were searched. One was the existing, admittedly not large, body of ethnographic material on Salvadoran rural life. This

consisted mainly of a few books and a number of theses, the latter the work of Año Social doctors during the 1960's when a dissertation was required for fulfillment of the doctorate.

Another was the clinic records themselves, which were examined both for background material and to see if analysis from different points of view would yield new insights into the nature of the clinic function and of the client population. Another objective was to identify elements which could be modified or added to existing modes of record-keeping to enhance future monitoring and evaluation. A 1-in-10 sample of the whole-year 1975 and first-quarter 1976 patient dossiers provided the core for this component. Finally, a variety of program documents from the Ministry of Health, the USAID, IICAP, and other Central American health programs were studied for orientation and evaluation purposes.

At the end of the one-month field stay, three subsequent activities furnished additional perspective and a frame of reference for the total research endeavor. The first was a week's involvement in the routines of two health circuits in another Region, an involvement of somewhat the same pattern as the earlier on-site clinic observation in Uluazapa, though without the depth that greater time affords.

The second was a three-day evaluation of the Health Leaders (Líderes/Ayudantes de Salud) in three sites -- Sesori, San Luis de

la Reina, and Nuevo Edén de San Juan -- in the northern reaches of the department of San Miguel. The procedure in this instance was to design a short interview schedule, administered under close guidance by the researcher, which was immediately analyzed for use as the basis for the general discussion which followed.

The third was a day spent visiting rural health outreach activities in the province of San Ramón, Costa Rica. This comprised four health unit visits and unstructured interviews with program designers and supervisors, as well as with outreach auxiliaries.

The first and third activities were undertaken at the initiative of the researcher. The purpose was to find some sort of empirical yardstick for a more objective appraisal of a rural Health Post.

The second activity took place at the invitation of the Sub-Director of the Eastern Health Region.

9) The Interview Schedule and and stability, preference for stability

The full interview schedule is attached herewith as Annex 1.

The only necessity here is to list briefly the topics to which the schedule addressed itself. These were:

(1) Background data on the interviewee and his/her family -- age,

sex, number of children, achievements in formal and non-formal

education, occupation, household construction, household goods;

consic level of sanitation; form, as well; something of a pre-

(2) Experience with and attitudes toward the Health Post (quality of

this treatment, preference for type of contact, level of knowledge

cognit of available services) in Latin America suggests that the

yes/no format, rather than a scalar design for individual ques-

tions, is easier for rural respondents to deal with. Questions were

- 3) Perceptions of own family's health and definitions of good health
- 4) Perceptions of, and methods, timing, and sequence of curing four most common afflictions (parasites, diarrreas, colds, and aches and pains in general)
- 5) Attitudes toward and experience with other representatives of both modern and traditional health systems
- 6) Concepts of preventive medicine
- 7) Nutritional attitudes and behavior
- 8) Attitudes toward family planning in general and family planning methods in particular; use of methods
- 9) Concepts of ideal family size and decision-making about family size
- 10) Feelings about pregnancy and childbirth; preference for midwife- or hospital-attended childbirth
- 11) Desire for non-formal education in health, nutrition, family planning
- 12) Ideas about improvement of existing health services and disposition to use paramedical personnel.

The questionnaire was not rigidly pre-coded since it was considered, even in its final form, as still something of a pre-test. Suggestions for these refinements are made at the end of this report. There was a deliberate attempt at a binary structure; cognitive research elsewhere in Latin America suggests that the yes/no format, rather than a scalar design for individual questions, is easier for rural respondents to deal with. Questions were

both closed and open-ended; open-endedness, with all the coding difficulties it implies, was emphasized in order to expand the interviews from the mechanical to the personal, to permit richer data, and to provide categories for a subsequent redesign of the interview schedule for possible replication in a larger sample.

The Sample

Because of limitations of time and personnel, the decision was made to limit the survey to the urban sector of Uluzapa which is sharply defined geographically and smaller numerically than the outlying rural sector. Contact with the scattered, more distant cantons which formed that rural sector would be through unstructured interviewing and informal relationships. 'Urban' should be understood here as a structural term rather than a social-cultural one.

The urbanism of Uluzapa inheres in the fact of residential concentration and the availability of certain facilities; the dominant modes both of thought and subsistence are rural and its residents define themselves as such.

The 1975 estimated census calculates the urban population of Uluzapa as 1246, the rural population at 4696, a total of 5942.

The 1970 census put the urban population at 1500<sup>2</sup> and Alcaldía

records show that this 1500 figure was composed of 192 families, for

<sup>3</sup> An average family size of 7.01. Dividing the current estimated population of Uluzapa by 7.01 yields a figure of 192 families. If these figures are accurate, then there has been substantial out-migration, an increase in the mortality rate, and/or a drop in the birth rate in Uluzapa, resulting in a net population loss of 354 or 23% over a five-year period.  
PROGRAM. San Salvador, February, 1975. p.2.

population by that family size figure<sup>3</sup> produces a figure for the estimated number of families in Uluazapa in 1975 of 150.

Again because of limited time and personnel, the determination was made to accept an il of 40 families, representing 25% of all the families in the urban sector. The 40 families for the sample were then selected through standard procedures of systematic random sampling, using as a base a modified croquis of the urban concentration. Since it was felt important to get a substantial male representation, the sample was stratified by sex on a 50/50 basis, in correspondence with the national percentages by sex according to the census.

#### FORMAT OF THE REPORT

Because the intent of this research was ultimately operational, the corresponding report has been organized, as the table of contents indicates, according to programs and program components, rather than in any fashion customary to traditional ethnography. A profile of the sample is presented first, followed by findings which apply across the whole health delivery spectrum. Existing health programs are examined next, followed by experimental and potential programs. Each

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<sup>3</sup> According to the GOES Statistical Bureau, the national average family size is 5.5. However, several recent studies of the rural area have revealed that a more accurate range is from 6.7 to 8, depending on the zone. The use of 7.01 as a factor is quite plausible in this light. The family size figure which surfaced in the 40-family survey of 7 is then somewhat below the 1970 calculation but still well within the revised rural range. (Ref.: USAID/San Salvador. INTERIM REPORT ON THE PROPOSED SMALL FARMER TENURE AND PRODUCTION PROGRAM. San Salvador, February 1975. p.2, footnote.)

section will be made up of two major parts: first the findings produced by the survey and the other techniques used in the study, and second, what these findings suggest in the form of recommendations. These recommendations are recapitulated at the end of the report. Tables are used where they were thought important; otherwise data are summarized in narrative form.

CHAPTER 11

PROFILE OF THE SAMPLE POPULATION

General Background

Uluazapa is one of 20 municipalities of the Department of San Miguel and all of the 20 municipalities have health facilities, the smallest being the Health Posts, the largest the regional hospital, San Juan de Dios, in the city of San Miguel itself. The estimated population of the department, as given in the Anuario Estadístico of 1972 (Vol.11), was 343,302; the crude birth, death, and infant mortality rates were 41.2, 7.6, and 51.51 per thousand, respectively.

National and local institutions in Uluazapa include the standard complement of municipal officials, elected and appointed; a public school which offers nine grades and which is under the Plan Básico system of the Ministry of Education; a Roman Catholic church with a newly resident priest; an Evangelical church; a CEIITA (Centro Nacional de Tecnología Agropecuaria) extension office, with two male and one female extensionists; an agricultural cooperative, a Club de Amas de Casa, and a Club de Jóvenes, all linked to CEIITA; a parent-teachers group, largely composed of women; a Patronato which has responsibilities to and for the Health Post; and a fledgling school of music run by the local music teacher. Though there had been at one time, there is not at present any FOCCO or Caritas activity. The town has 10 tiendas of varying size and prosperity; one pharmacy of considerable prosperity; a basketball court in the central plaza; and a soccer field adjoining the school grounds.

Marital Status

TABLE II. MARITAL STATUS BY SEX

SEX	MARITAL STATUS					
	Single	Married	Consensual Union	Widowed	Separated	Divorced
MALE	15%	55%	25%	-	5%	-
FEMALE	5%	55%	10%	15%	15%	-
Total Sample Population	10%	55%	17.5%	7.5%	10%	-

These figures are striking in the high proportion of married couples in a country where approximately half the couples live in consensual union (acompañados). Even in the San Miguel-Morazán had sample surveyed in a recent study,<sup>5</sup> where married couples also outnumbered those living in consensual union (31.03% married and 13.45% in consensual union), the difference is not so large.

Family Size and Number of Children

The average size of the domestic unit<sup>6</sup> in the Uluazapa sample was 7, with a range of from 2 to 15 persons per unit.<sup>7</sup> The average number of live children per couple was 5.

With respect to the age of the most recently born child, the percentages were as follows:

again in a larger sample, such data should be

<sup>5</sup> Grupo Multidisciplinario, Región Oriental de Salud. DIAGNOSTICO BASADO EN LA ENCUESTA EN EL AREA SAN MIGUEL-MORAZAN. San Miguel, El Salvador. April 1976.

<sup>6</sup> Domestic unit is here defined as the number of people living in a single dwelling, whether as a nuclear or extended family.

<sup>7</sup> This average is somewhat lower than the calculation for the sample of 7.01.

San Miguel-Morazán sample which had a similar

Couples whose most recent child was under 2 years = 35% of the sample.

Couples whose most recent child was between 2 and 13 years = 55% of the sample.

Couples with no children = 10% of the sample.

This distribution is compatible with the age and marital distribution presented above.

Because of comments made during early unstructured interviewing and in the pre-test interviews, men were asked about the number of women by whom they had had children. Of the sample, 15 declared that they had had children by only one woman, two said that they had had children by two women, and only one claimed having had children by three women. Given the lack of further data, the most that can be said on this point is that there appears to be some discrepancy between the claims made on the streetcorner and in the cantina, and the responses given to researchers.

#### Income

Because of the relative homogeneity of the sample in terms of socioeconomic status, no income data were taken in the interviews. However, should this instrument, or one similar to it, be administered again in a larger sample, such data should be gathered. They would constitute an addition which would be important for purposes of building useful correlations. Nonetheless, there is no reason to believe that the Uluazapa sample would vary meaningfully from the San Miguel-Horazan sample which had a substantial proportion of

coverage of rural municipalities. Uluazapa is quite similar from the standpoint of topography and modes of subsistence to Morazán and the southern third of the department of San Miguel.

The San Miguel-Morazán survey<sup>3</sup> produced the following income data, which may then be reasonably understood as representative of income levels in Uluazapa:

Monthly Income	Percent of Sample
76 - 100	14.61
101 - 125	7.08
126 - 150	6.73
151 - 175	2.14
176 - 200	2.50
201 - 225	2.67
226 - 250	2.49
251 - 275	1.16
276 - 300	1.22
301 and over	2.61

The average monthly income per family unit for this sample was \$87.50, the monthly per capita income \$13.21, an amount truly limiting

on the real acquisitive capacity of the majority of the area's population.

Occupation	17.5%	17.5%	10%	7.5%	12.5%	2.5%	12.5%	4.07 grades
Ten of the men in the Uluazapa sample earned their living, in most instances at the level of bare subsistence, through a combination of...								

<sup>3</sup> The bulk of agricultural endeavor in the Eastern Region is in corn, sorghum (molejillo), beans, and rice production, in order of importance. A few people grow beans in the Uluazapa area, but most limit their crops to staple varieties of corn, sorghum, and some dry rice. Grupo Multidisciplinario, op. cit., p. 7 and 8. Some families own a few chickens, pigs, and ducks; some own a few head of cattle but small numbers of these own quantities large of the population owns under five manzanas and over 50% of all landowners have no

tion of agriculture and livestock herding.<sup>9</sup> Five worked as day laborers (jornaleros) at a variety of agricultural tasks on land not their own, in carpentry or masonry, or in the nearby ports of La Unión and El Triunfo. The other five had such miscellaneous jobs as salesman (comerciante), motorist, and letter carrier.

All but three of the women stated domestic duties as their principal occupation. The other three were teachers in the local primary school. However, nine women worked additionally at sewing, braiding palm (trenzar palma), washing and ironing, and local vending, either by having a tienda or selling prepared food and/or produce door-to-door. One woman helped her husband significantly in his dairying operation.

Formal Education

TABLE III. FORMAL EDUCATION BY AGE AND SEX

SEX	EDUCATION								Mean
	No Ed	With 2 Grades	With 3 Grades	With 4 Grades	With 5 Grades	With 6 Grades	7/8-9 Grades	With over 9 Grades	
MALE	20%	30%	10%	5%	10%	20%	5%	-	3.15 grades
FEMALE	10%	5%	25%	15%	5%	5%	-	25%	5 grades
Total Sample Population	15%	17.5%	17.5%	10%	7.5%	12.5%	2.5%	12.5%	4.07 grades

<sup>9</sup> The bulk of agricultural endeavor in the Eastern Region is in corn, sorghum (maicillo), beans, and rice production, in order of importance. A few people grow beans in the Uluazapa area, but most limit their crops to criollo varieties of corn, sorghum, and some dry rice. Cultivation and plancing is largely by oxen and estaca, with some insufficient and inefficient use of chemical fertilizers. Most families own a few chickens, pigs, and ducks; some own a few head of cattle but small numbers of these own quantities large of the population owns under five manzanas and over 90% of all landowners have no access to water for irrigation.

With regard to education, the Uluazapa sample is at variance with the San Miguel-Horazán survey data which indicate a percentage of illiteracy of 44.61, 49.61% with between 1 and 6 grades of schooling, and only 5.70% with 7th grade and over. Three of the women interviewed in Uluazapa were primary school teachers with a minimum of two years additional to ninth grade, one had two years of office training beyond ninth grade, and another had her bachillerato. Even the most superficial impression of rural life in El Salvador would indicate that such a high percentage of education

beyond sixth grade for campesino women is unrepresentative and would surely be reduced substantially in a sample which incorporated the outlying cantons. If, for instance, we eliminate these five women and calculate the mean for the rest of the female sample, the average number of years of education for that sample becomes 2.8, contrasted with 3.15 for the men, a more normal distribution for a rural area.

Looking at education from the standpoint of literacy, 90% of the men considered themselves as having basic reading competence, as did 85% of the women. Eighty percent of the men and 85% of the women felt they could claim writing competence. Since the national percentage of illiteracy is currently estimated at close to 47%, the Uluazapa sample is considerably more literate than the national, and certainly the rural, norm. This may at least in part derive from varying definitions of what constitutes truly functional literacy.

Such local variations in educational levels indicate that the commonly-held assumption that the campesino is an utter tabula rasa is not completely well founded. On the other hand, averages of 3.15 and 2.8 grades (adjusted) would support the appropriateness of relatively simple and straightforward tools and methods for health-related training.

#### Non-Formal Education

Only one man and six women had had any training beyond that received in school. The man had had some family planning education through Acción Cívica Militar. Five of the women belonged to the Club de Amas de Casa organized by the CEJITA educator (educadora) and one woman had gone to the now-defunct campesino training program at Castaños. This very low percentage accords with the San Miguel-Morazán data.<sup>10</sup>

Interestingly-and revealingly- only one respondent (a woman) considered that the charlas on health, nutrition, and family planning at the Health Post constituted additional education of a stature worth mentioning, while the pláticas given by either the Evangelical or Catholic church were cited with some frequency as representing "training". This raises the question of the need to, in effect, formalize non-formal education, to ritualize in some way whatever local-level training the Ministry of Health might provide so that its prestige is enhanced in the eyes of the campesino.

<sup>10</sup> Grupo Multidisciplinario, pp. 14-15.

Home Ownership

Seventy-five percent of the total sample owned their own homes, 10% rented, 12.5% lived in houses loaned to them, and 2.5% were colonos.<sup>11</sup> The percentage of home ownership corresponds neatly to the percentage of 77.35% in the San Miguel-Morazán study,<sup>12</sup> with a slight variation in the number of renters and colonos.

Home Construction

TABLE IV. HOME CONSTRUCTION

ROOF	% HOUSES	WALLS	% HOUSES	FLOORS	% HOUSES
Teja	92.5	Adobe	50.0	Dirt	52.5
Paja	7.5	Adobe w/ plaster	22.5	Polished cement tile	20.0
		Caña/palo	10.0	Unfinished cément	15.0
		Brick	10.0	Brick	10.0
		Bahareque	5.0	Adobe	2.5
		Cement Brick	2.5		

This housing picture coincides with one's visual impression of Uuazapa: houses mostly roofed with tejas, with walls of adobe, and dirt floors. The principal variant is the straw-roofed, cane-walled

<sup>12</sup> This conclusion proved as general conclusion. The same for the study

<sup>11</sup> A colono lives on an estate and works a piece of land in return for a rent or some sort of personal service or periodic amount of labor.

<sup>13</sup> Grupo Multidisciplinario, op. cit., pp. 31-32.

rancho, found mostly at the perimeters of the urban concentration.

42.5% of the houses had two rooms, 30% had one room, 20% had three rooms, and 2.5% had five rooms. A 'room' was defined as having fixed, structural partitions; areas divided by rough, incomplete divisions were not considered 'rooms' by either the interviewers or interviewees. The latter were quick to point out, in fact, that division per se did not create what they deemed a proper room.

#### Household Effects

55% of the sample population had radios, 52.5% had connections for water<sup>12</sup> and electricity, 35% had sewing machines, 22.5% refrigerators, 17.5% television, and 20% had some mode of transportation which included horses and the car of the travelling salesman.

#### Household Sanitation

45.5% of the sample had latrines, well above the percentage of 24.97% reported for the San Miguel-Morazán sample which in turn coincides with the national average.<sup>13</sup> However, as stated, the Uluazapa survey did not cover its more remoted, dispersed cantons, which would lower this percentage, as well as the percentages of consumer goods listed above, by better than half. At the same time, 52.5% used no sanitary facilities (usaba campo libre), and

<sup>12</sup> This question provoked general derision. The pump for the municipal water system had broken down well over a year ago; there was no water in the homes of Uluazapa that was not hauled in cántaros at considerable human cost.

<sup>13</sup> Grupo Multidisciplinario, op. cit., pp. 31-32.

2.5% to some fixed open site, to take care of their necessities, a total of 55% which was not employing adequate measures to dispose of human wastes. The percentage total of over 100% is due to the respondent who used both latrine and campo libre, a not uncommon practice, where convenience overcomes any understanding of hygienic principles. Informal conversations and observation indicate that the reasons for lack of more generalized latrinification in Uluazapa correspond with those encountered in the San Miguel-Tiorazán study, in which 51.91% of a sample of 287 families gave economic reasons for lack of sanitary facilities and another 31.74% indicated either ignorance or lack of concern.

A subjective appraisal by the interviewers of the level of domestic hygiene in the houses visited harmonizes with the data on latrine use. 37.5% of the homes were appraised as displaying a low level of hygiene, 35% as in the middle range, and 25% as relatively high. The criteria used for this appraisal included: water and food containers covered; presence or absence of animals, especially pigs; preparation and presentation of food, including breast and bottle hygiene for infants; and general personal and domestic cleanliness.

The interviewers tried to frame their evaluation within the realities of a life without easily accessible water; domestic structures which encourage the entrance of animals and insects; and the wind and dult of the dry season.

An attempt to see if any connection existed between levels of education and levels of hygiene and latrinification revealed that

It is appropriate to add at this point that throughout the study there was a constantly high degree of warmth, interest, and

there is no meaningful correlation between education and hygiene levels until at least fifth grade has been attained, with a still more significant correlation between the seventh and eighth grades. A similar correlation obtains between educational level and latrification, which probably also has not a little to do with income level as well. One might assume from this that within that sector of the population with at least five grades of education and optimally seven or eight, matters of hygiene will in effect take care of themselves, or at least promotional efforts will fall on quickly fruitful ground. Not unsurprisingly, it appears that it is in the marginally educated population that strenuous instruction will have to take place, with the economic factor taken well into account.

#### Cooperation and Comprehension on the Part of the Sample

In general, the female component of the sample was positively desirous of cooperating (80%). The males fell largely in the category of "generally cooperative", with only one male demonstrating a real lack of interest; he was at least not hostile, only amused.

As for comprehension, the women showed considerably more understanding of most of the questions asked. However, the total comprehension for both males and females was 92.5% with only 7.5% having real problems of understanding what was asked them. As might be expected, these correlated with very low levels of education.

It is appropriate to add at this point that throughout the study there was a constantly high degree of warmth, interest, and

willingness to help, both with the study in general and the researcher in particular. If this had not been the case, it would not have been possible to gather any quantity worth having of valid, enriched data in such a short field stay.

CHAPTER III

GENERAL ATTITUDES TOWARD HEALTH

Definitions of Good Health

Clará de Guevara, in a recent paper, offers a campesino definition of good health derived from her considerable ethnographic research. It is to feel good; to have physical and spiritual strength, the will to work, good appetite, good humor, good appearance, beauty, and goodness; to sleep well ("sentirse bien; tener fuerza física y

	espiritual,	buena disposición para el trabajo,	buen apetito,	buen			
	sueño,	buen humor,	buena apariencia,	belleza,	y bondad!	To be ill	
	is to feel	worthless,	without the	zest;	to perform	one's daily activi-	
	ties (sentirse	desvalido,	sin ánimo	de efectuar las actividades ru-			
	tinarias!)	To be ill	is to	not be able to work;	anything else is		
	simply not feeling well	(tener malestar),	as one might feel with a				
HASC.	50%	50%	15%	10%	5%	5%	10%
	common cold.	To be healthy is to be in a state of equilibrium;	to				
FAM.	50%						25%
	be ill	is to be in a state of violation of that equilibrium, a					
TOTAL	50%	50%	15%	10%	5%	5%	17.5%
	violation which must be redressed.						This does not vary significantly

from the now-standard World Health Organization definition of health as a complete state of physical, mental, and social well-being, not simply the absence of disease or illness ("un estado de completo equilibrio"). They also enjoyed such a state of equilibrium (see Table VI below).

The women defined their own health and that of their companions as a complete state of physical, mental, and social well-being, not simply the absence of disease or illness ("un estado de completo equilibrio"). They also enjoyed such a state of equilibrium (see Table VI below).

14. Concepción Clará de Guevara. CREENCIAS Y PRACTICAS EN LA MEDICINA TRADICIONAL DE EL SALVADOR. Paper presented in the Public Health Section of the Sixteenth Central American Medical Congress, San Salvador, December 1975. (Trabajo presentado a la Sección de Salud Pública, XVI Congreso Médicos Centroamericanos). Oddly perhaps, the majority of women perceived their children's health as

bienestar físico, mental y social, y no simplemente la ausencia de afecciones o enfermedades").

The population of Uluzapa would disagree neither with Clará de Guevara's consensus definition or with that of the INIO. Their interpretations, their categories of states of feeling, are clear enough in the following table so as not to require further elaboration.

TABLE V. DEFINITIONS OF GOOD HEALTH

SEXO	Estar alen- tado; feliz; galán; bien	no es- tar enfer- mo; no pa- decer de en- ferme- dades	Estar tran- quilo; no te- ner pro- blemas; confer- me	Tener servi- cio de salud cerca; no fal- tar agua y comida	Dormir bien; tener buena comida; descan- sar al medio- día	estar bueno para traba- jar	Tener un am- biente bueno y sano	Tener buen carác- ter	no sabe; no entendió
MASC.	50%	-	50%	15%	10%	5%	5%	-	10%
FEM.	35%	20%	10%	-	5%	-	-	5%	25%
TOTAL	42.5%	10%	7.5%	7.5%	7.5%	2.5%	2.5%	2.5%	17.5%

#### Perceptions of Family Health Status

On the other hand, few of the families interviewed felt that they actually enjoyed such a state of equilibrium (see Table VI below). The majority defined their own health and that of their companions (compañeros de vida) as only fair (regular), their children's as positively poor (mala), an appraisal which concurs with national statistics on the quality of child health in El Salvador. Oddly per- haps, the majority of women perceived their children's health as



TABLE VII. TREATMENT OF PARASITES AND WORMS: SOURCES AND CHARACTERISTICS OF MEDICATION EMPLOYED (TRATAMIENTO DE PARASITOS Y LOMBRICES: FUENTES Y NATURALEZA DE LAS MEDICACIONES EMPLEADAS)

SEXO	Personas usando un solo recurso de la medicina moderna			Personas alternando recursos de la medicina moderna <u>16/</u>		Personas mezclando recursos de la medicina moderna con la tradicional		
	La Clínica	La Farmacia <u>15/</u>	Un Médico Particular	Clínica y/o Farmacia <u>17/</u>	Médico Particular y/o Farmacia	Clínica y/o Médico Particular y Medicina Tradicional <u>18/</u>	Farmacia y Medicina Tradicional	Clínica y/o Médico Particular y Farmacia y Medicina Tradicional
ASC.	5	5	2	7	-	1	-	-
FEH.	6	6	2	5	1	2	1	3
TOTAL	11	11	4	12	1	3	1	3

15/ In reality the pharmacist, especially in rural areas, occupies a middle ground between traditional and modern medicine, between elemental comercio and paramedicine. Dealing often in the essences (esencias), waters (aguas), and oils (aceites) his clientele demands, at the same time he prescribes antibiotics, also on demand. The pharmacist is the transitional man. Nevertheless, taking the stock of most pharmacies as justification in terms of percentages of modern versus traditional remedies, they must be defined as pertaining to the realm of modern as opposed to traditional medicine.

16/ The intent here is to record the mix of purchase and prescription that takes place in the pharmacy at the initiative of a client, additional or prior to contact with a clinic or private physician, as distinguished from simply going to the drugstore to have a legitimated prescription filled.

17/ The pharmaceutical remedies mentioned by the respondents were the following: Verminol, Mel de Faniila, "papeles" de bismuto, castor oil.

18/ The traditional remedies cited by respondents included items purchased at the drugstore or from neighbors who manufactured them on a contraband basis -- esencia coronada and esencia de menta -- as well as homemade remedies which included: hojas de naranjo, orégano, or raiz de quaco, en agua hervida; horchata; agua de coco; hoja de ruda seca con guaro applied as a poultice on the nape of the neck.

Regimen: (Dieta)

In addition to the medications applied or ingested, 37.5% of the total sample believed it necessary to adopt a special diet which embraced the following elements, listed in order of the frequency with which they were mentioned:

- 1) Eliminating meat, vegetables, fats, beans, sweets; acid, spicy, or salty foods (comidas ácidas, picantes, y saladas),
- 2) Substituting liquids, clear soups (sonas sencillas), dry cheese (queso seco), eggs, and/or tortillas,
- 3) Eating nothing the day of a purge,
- 4) Avoidance of exposure to sun (no asolearse),
- 5) Not getting wet (no mojarse) or bathing until three to five days after a purge, or else. The symptoms may be presented:  
6) Purging only on the fifth or sixth day of the new moon or three or four days before the moon disappears (purgar solamente en el quinto o sexto día de la nueva luna, o tres días antes de que se va la luna).

Nonetheless, a clear majority made no noteworthy behavior modification related to the curing of parasites.

Point at Which Modern Medical Assistance Is Sought

Doctors who have worked at Health Posts have often claimed that

Dieta is not just a question of modifying food patterns in response to a given medical problem. It subsumes as well a number of changes in life style which are also thought to be therapeutic. The English word closest in meaning is regimen.

determining precisely what is wrong with the patient is essentially detective work, for several reasons -- because the patient himself is without the disposition or skill to diagnose or even to accurately perceive his own symptoms or those of his children; because he adds the complaints of other members of his family to his own in order to be prescribed certain medicines he understands to be desirable, whether or not they are appropriate; because he has no concept of time; and so on. If any of this is true, it is only partially true. Campesinos are aware of sets of symptoms, or syndromes, which correspond to certain ailments affecting certain parts of the body; the problem with conveying their sense to the clinic doctor may well be a communications problem as much as anything else. The syndromes may be presented incompletely or in different terminology or with a different concept of cause-and-effect when the time comes for the anamnesis, but they do exist, as Table VIII reveals.

TABLE VIII. POINT AT WHICH MODERN MEDICAL ASSISTANCE IS SOUGHT, INCLUDING DETERMINING SYNDROMES 20

	"Al Principio" Síndrome a)	"Grave" sin definición	Síndrome a)	Síndrome b)	Síndrome c)	Síndrome d)	Síndrome e)	Síndrome f)	Síndrome g)
SEXO									
KASC.	2	5		1		2	2	2	1
FEII.	5	2		1		3	1	1	1
TOTAL	7	7		2		5	3	3	2

20 Syndromes, in the respondents' own terminology:

- a) Stomach ache
- b) Nausea; diarrhea; fever
- c) Insomnia; grinding teeth at night; sleeping stomach down and restlessly
- d) Worms visible in feces or discharged through the mouth; swollen abdomen
- e) Head cold with cough; fever; child whiny, without appetite
- f) Thin; pale; without appetite; swollen abdomen
- g) Vomiting; fever; diarrhea

The syndromes listed above not only serve to define the disease itself for the physician, the pharmacist, or the patient himself, but also act as markers in a disease trajectory which alert the patient to the need for different kinds of medical assistance. The whole issue of when this assistance is sought and from whom is, of course, a major concern for the health delivery system. It will be discussed more fully at the end of this section, after all the disease behaviors have been presented.

In the instance of parasites, examination of patient dossiers and responses to the relevant interview questions reveal that respondents rarely thought of themselves as suffering from worms or parasites. Their level of awareness in this regard was primarily related to the ailments of their children. In this respect it appears that one-third of the women felt that they were bringing their children in for anti-parasitic treatment at the very onset of the ailment, the marker symptom being stomach ache. The balance, however, did not seek clinical attention until those symptoms emerged which are generally associated with a rather advanced stage of an infestation: disturbed sleep patterns, visible worms, abdominal distension, and anorexia. Diarrhea is considered as a separate disease entity in itself. As will be discussed later, it has its own system of diagnosis and treatment, one of the elements of which is employing duration as an indicator of degree of gravity; this in turn limits the value of the diarrhea symptom as inducement to seek early treatment no matter what the ailment with which it is associated.

Treatment of Most Prevalent Diseases: Diarrheas

Medication and Source

TABLE IX. TREATMENT OF DIARRHEAS: SOURCES AND CHARACTERISTICS OF MEDICATION EMPLOYED  
(TRATAMIENTO Y NATURALEZA DE LAS MEDICACIONES EMPLEADAS)

SEXO	Personas usando un solo recurso de la medicina moderna			Personas alternando recursos de la medicina moderna		Personas mezclando recursos de la medicina moderna con la tradicional		
	La Clínica	La Farmacia	Un médico Particular	Clínica y/o Farmacia 21/	Médico Particular y/o Farmacia	Clínica y/o médico particular y medicina Tradicional 22/	Farmacia y medicina Tradicional	Clínica y/o médico particular y medicina tradicional
MASC.	1	0	-	0	2	1	3	4
FEM.	3	8	-	6	1	-	2	-
TOTAL	4	16	-	14	3	1	5	4

21/ The pharmaceutical remedies mentioned by the respondents were the following: Bisrutina, Yodoclorina, Enterovioforma, Enteroguanil, Pastillas Phillips, Tetraciclina, Intestonicina, Acromicina, Terramicina, Pepto-Bismol.

22/ The traditional remedies cited by respondents included the following homemade items: fresco o agua de coco; agua de guaco; orégano en agua cocida; cáscara de mangozano; horchata; limonada; bicarbonato con limón.

One respondent indicated that he did not consider having diarrhea as truly being ill; he resorted only to home remedies and dietary restrictions for cure. Another said he bought what he needed to deal with diarrheas in the tienda (still another source of health services), since the ailment was not even worth a trip to the drugstore. In both cases, diarrhea was accepted as a separate category of affliction, whatever its seriousness.

#### Regimen (Dieta)

70% of the males and 55% of the females, a total of 62.5%, believed in the need to make some changes in the foods they ate as a control tactic. Despite this majority, there were still 30% of the men and 45% of the women who said that diarrheas did not require any such modification, an attitude of interest for medical or paramedical personnel attempting to cure such an ailment, particularly in a child.

There were some differences in the food modifications effected by men and women. The elements of the male diet were the following, in order of frequency mentioned:

- 1) eliminate milk, fats, eggs
- 2) substitute: dry cheese, sometimes with tortillas and salt; rice or water from boiled rice (Jugo de arroz); french bread with apple juice

The women recommended:

- 1) eliminating primarily milk
- 2) eliminating fruit, meat, beans, fats
- 3) eliminating eggs, fish, and pipián (a highly condimented stew)

- 4) substituting rice or the water from boiled rice
- 5) substituting dry cheese
- 6) substituting boiled potatoes (papas sancochadas) or atoles

Thus, while more of the men believed in the necessity of dietary modifications, the women, perhaps because of their culinary role, were more detailed about precisely what those modifications were.

Point at Which Modern Medical Assistance Is Sought

Again there is a difference between the male sector of the sample and the female sector, with regard to disease management, a distinction which demands two different tables (see X and XI).

TABLE X: POINT AT WHICH MODERN MEDICAL ASSISTANCE IS SOUGHT, WITH DETERMINING SYNDROMES: MALES<sup>23</sup>

PRINCIPIO	"CUANDO ESTA GRAVE"						
Ningún síndrome explicado	Síndrome A	Síndrome a)	Síndrome b)	Síndrome c)	Síndrome d)	Síndrome e)	Síndrome f)
		1	2	2	3	4	

<sup>23</sup> Syndromes, in the respondents' own terminology:

- A. Very liquid feces, coffee-colored; stomachache; feeling bad
- B. Frequent defecation at short intervals
  - a) 2-3 times a day
  - b) 3-4 times a day
  - c) 4-5 times a day
  - d) Every 30 minutes
  - e) Every 15 minutes
  - f) Every 5 minutes

... as viewed as a sign of a serious condition perhaps, excess that women are largely responsible for bringing children to the clinic for attention -- the same women who in the majority predicate their decisions to seek that attention on a disease duration of three

TABLE XI. POINT AT WHICH MODERN MEDICAL ASSISTANCE IS SOUGHT,  
WITH DETERMINING SYNDROMES: FEMALES<sup>24</sup>

"AL PRINCIPIO"		"CUANDO ESTA GRAVE"				
Síndrome a)	Síndrome b)	Síndrome c)	Síndrome d)	Síndrome e)		
3	3	4	3	4		

<sup>24</sup> Syndromes, in the respondents' own terminology:

- a) One-day's duration
- b) Loose stools
- c) Two-days' duration...
- d) Duration of three days or more
- e) If no improvement

One notes two major differences between the male and female samples. First of all, men tend to a more precise, more detailed diagnosis than do women. Since a number of male respondents mentioned that this particular infirmity interfered on occasion with their ability to carry on their agricultural activities, one may conclude that the detail of their calculus may be related to the impact of the ailment on their very subsistence.

Secondly, men appear to base their diagnoses and their consequent remedial behavior on the factor of frequency, while women diagnose and act in the light of duration. Thus although both men and women are trying to determine whether they are dealing with something serious (grave) or with something merely fleeting (pasajero), their criteria are at variance. This might be viewed as a cognitive curiosity perhaps, except that women are largely responsible for bringing children to the clinic for attention -- the same women who in the majority predicate their decisions to seek that attention on a disease duration of three



TABLE XII. TREATMENT OF COLDS: SOURCES AND CHARACTERISTICS OF MEDICATIONS EMPLOYED

SEXO	Personas usando un solo recurso de la medicina moderna			Personas alternando recursos de la medicina moderna		Personas mezclando recursos de la medicina moderna con la tradicional		
	La Clínica	La Farmacia	Un médico Particular	Clínica y/o Farmacia <sup>25/</sup>	Médico particular y/o Farmacia	Clínica y/o médico particular y medicina Tradicional <sup>26/</sup>	Farmacia y medicina tradicional	Clínica y/o médico particular y farmacia y medicina tradicional
WASC.	1	4	-	5	4	1	5	5
FEII.	3	7	1	3	<u>127/</u>	3	4	<u>129/</u>
TOTAL *	4	11	1	8	5	4	9	6

40

25 The pharmaceutical remedies mentioned by the respondents were the following: Gripola, Desenfriol, Majoral, Vitagrip, Colofin, Febrinase, Formula 44, Rehetina, Zorritone, Azahifn, Canfoliptol, Conmal, Aspirina, Rodines, Sulfato de Estreptomicina; Injections of Ostacilina, Pulmcalcio (also in pill form), Tetraciclina, Arcopulmin, Discriticina, Penicilina (also in pill form).

26 The traditional remedies cited by respondents included items purchased at the drugstore -- agua florida and pomada de menta - as well as home-made remedies which included: limonada, en fresco o caliente; agua de hojas de naranjo; té de gengibre; agua de zacate de limón, granitos de anís, raíz de cola de alacrán; aceitilla de maicena con miel blanca; semillas de balsamito de alre; aceite de canfor mezclado con grasa de gallina (en la mollera con una porra).

27 Another case of alternating tienda with the pharmacy as a source of medications.

28 This respondent used home remedies only.

### Regimen (Dieta)

45% of the men and 75% of the women, a total of 50%, modified the form and content of their diet when they caught cold (cuando se les pegó un catarro). Despite the differences in percentages, the two groups adopted approximately the same modifications, as follows:

- 1) Almost the total sample indicated that they eliminated acid, spicy, and 'cold' foods (comidas ácidas, picantes, y heladas).<sup>29</sup>

In the 'acid' category were cited:

- limón
- mango verde
- naranja agria
- jocote
- marañón
- piña

These foods leave a sour taste in the mouth, irritate the throat, and are believed to cause bronchitis.

In the category of spicy foods, only pimienta and chile were listed. These irritate the nasal passages and provoke sneezing.

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<sup>29</sup> The complex of hot and cold foods is general throughout Latin America and is found elsewhere in the world as well. 'Hot' and 'cold' are not necessarily, though sometimes they are, concepts of temperature. They are rather concepts of qualities inherent in foods which harmonize with or violate certain bodily conditions. Harmony maintains equilibrium; violation, as indicated earlier, disturbs it or aggravates it. The hot/cold syndrome is often discounted as outdated folklore. This is an error; this research and other recent investigations elsewhere testify that concepts of hot and cold are alive and well, at least in Latin America.

In the category of 'cold' foods were:

- jocote (note that jocote, marañón, and piña are also classified as 'ácidos')
- marañón
- piña
- sandía
- mango duro
- frijoles blancos
- leche, especialmente cruda
- mariscos
- carne de cerdo
- charramuscas

'Cold' foods not only aggravate a cold but are often suspected of having caused one. It is worth noting that this study took place at the height of the season of mangos, marañones, and jocotes, which grow in great profusion in the area. Furthermore, because of the dryness and heat, the charramusca (a small plastic bag, frozen, of fruit-flavored water, most refreshing on a hot day) was a very popular item. One might expect that, given this kind of competition, a mother who had a child afflicted with a cold might have problems maintaining his diet. This was not the case; children had been so socialized to the concept of the right diet for a cold that they generally refused offers of fruits, soda pops, and charramuscas, saying that these would be bad for them.

- 2) Another group, somewhat smaller but significant, commented that it was also their custom to eliminate certain foods considered

'hot'. These cause a sensation of heat in the abdominal area and induce or aggravate diarrheas. As a result, they leave one in an agitated condition and cause insomnia, which aggravates the cold still further. The foods deemed most treacherous are eggs, fats, and beef. The last also has the property of exacerbating an existing cough.

3) Only three respondents said that they added something to their diets. Two, without explanation, ate cheese; only one made explicit reference to the need to increase the ingestion of fluids. However, over half did emphasize their dependence on different teas -- of limón, hojas de naranjo agrio, gengibre -- often and lemonades. Other elements of a cold regimen were; not getting wet or taking the hot bath; staying out of the sun (no asolearse); bed-rest; dressing warmly (abrigarse bien); and not opening the refrigerator. Violation of any of these is believed to make an existing cold worse or engender a new one.

#### Point At Which Modern Medical Assistance Is Sought

No clear pattern emerged in this segment of the survey as to what the normative behavior was in relation to the management of colds. In

<sup>30</sup> general there was little tendency to seek help from a clinic or a private physician, especially at the beginning of a cold. The preference was for medications purchase in the pharmacy or for home remedies.

<sup>31</sup> Medical attention was sought only when the patient was in serious condition; however, each respondent had his or her own definition of what constituted 'serious' -- inability to sleep well, stuffed-up nose, and cerebrovascular disease.

temperature and loss of appetite, body aches with much sneezing, and/or sore throat with headache, in an almost random array of variations. The only consensus (55%) was on the syndrome composed of fever, problems, with vision (calor en la vista), inflammation of the tonsils, general malaise, and over three days of general bodily sensitivity (tener delicado el cuerpo). There is again the tendency to define gravity according to the impingement on one's capacity to work.

Having a cough was not cited once as part of the syndrome of gravity, even though, as noted above, it was included in dietary considerations; this would tend to support Canelo's hypothesis that often a cough is considered a disease entity in itself.<sup>30</sup> In clinical consultations, it is more frequently the case that the doctor elicits the reporting of cough symptoms, rather than a case of the patient spontaneously reporting it.

#### Treatment of Most Prevalent Diseases: Body and Headaches

The inclusion of aches and pains as a prevalent disease may seem at first blush both arbitrary and inaccurate. It does not accord with either the national-level statistics on disease prevalence<sup>31</sup> or with

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<sup>30</sup> Menandro Alcibiades Canelo. LOS SERVICIOS MEDICOS RURALES DE SALUD PUBLICA Y LA MEDICINA POPULAR: ESTUDIO DE CINCO COMUNIDADES DEL DEPARTAMENTO DE SAN MIGUEL. Doctoral dissertation, University of El Salvador, Faculty of Medicine. San Salvador, December 1964. p. 163

<sup>31</sup> P.O. Woolley, Jr., et al. SINCRISIS: THE DYNAMICS OF HEALTH -- EL SALVADOR. Washington, D.C.: U.S. Department of Health, Education, and Welfare, October 1972. p.6. In 1968 these diseases were the most prevalent in El Salvador, listed in decreasing order of importance: enteric diseases, broncho-pulmonary diseases, perinatal morbidity and mortality, measles, malnutrition, malignant tumors, and cerebrovascular disease.

the list of perceptions of most frequent ailments reported by the respondents in the San Miguel-Morazán survey.<sup>32</sup> However, it does correspond to the clinical reality as that emerges in patient consultations and records, and to the actuality "on the street", where in ordinary conversation the number of references to aches and pains is large indeed. Furthermore, while aches and pains do not in themselves constitute a disease, they are the most commonly mentioned symptom<sup>33</sup> and, real or imagined, they must be heeded.

#### Medication and Source

See Table XIII on next page.

#### Regimen (Dieta)

There was a consensus that aches and pains did not require (ocupar) a special diet. A small minority thought that it was better to stay out of the sun and not get wet, to stay in at night, to avoid acid and spicy foods, and get some rest.

#### Point at Which Modern Medical Assistance is Sought

As Table XIII indicates, the tendency of the large majority of the sample was to seek relief for aches and pains with medicines from the pharmacy, with some slight recourse to home remedies. There were two ways of pacing the cure, quite well defined, each with approximately the same number of proponents. One was to attack the pain the minute it began; another was to simply endure it and seek relief only when it did not

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<sup>32</sup> Grupo Multidisciplinario, p. 22. In decreasing order of importance: bronchopulmonary diseases, gastrointestinal diseases, malaria, arthritis, skin diseases, eye infections, 'others' which included diphtheria, paralysis, cardiovascular diseases, anemia, malnutrition, cancer, diabetes, and tonsillitis.

<sup>33</sup> Canelo (op. cit., p. 164) also observes that among adult clinic patients, aches and pains constitute the most common motive for consultation, but does not elaborate.

Medication and Source

TABLE XIII. TREATMENT OF ACHES AND PAINS: SOURCES AND CHARACTERISTICS OF MEDICATION EMPLOYED

Sexo	Personas Usando un Sólo Recurso de la medicina moderna <sup>34</sup>			Personas alternando recursos de la medicina moderna		Personas mezclando recursos de la medicina moderna con la tradicional		
	La Clínica	La Farmacia	Un médico particular	Clínica y/o farmacia <sup>35</sup>	Médico particular y/o farmacia	Clínica y/o médico particular + medicina tradicional <sup>36</sup>	Farmacia + medicina tradicional	Clínica y/o médico particular + farmacia + medicina tradicional
HASC.	-	9	-	7	-	-	3	-
FEM.	3	11	2	3	1	-	7	-
TOTAL	3	20	2	10	1	-	10	-

<sup>34</sup> Two respondents commented that there was nothing one could do for aches of head or body but endure (aguantar). They recommended the cantina as the best cure for all ailments of this genero.

<sup>35</sup> The pharmaceutical remedies mentioned by respondents included the following: Pastillas SAS, Nerviosina, Majoral, Aspirina, Tiamina, Cafoliptol, AlkaSeltzer, Conmel, Ganol, Calmaven, Dolofin, Ceserol, Deganine, Cerebrina; Injections of Dipirona, Vita-hígado; Collirio, Sal Inglesa, Parches Salompaz, Purga Mexicana, Linesanol, Alcohol, Pomada Vicks, suero oral.

<sup>36</sup> The traditional remedies cited by respondents included esencia coronada purchased at the drugstore, and the following home-made remedies: hojita de vitano mezclado con canfoliptol, caliente, en la cabeza, con un pañuelo; echar limón por la nariz; café puro; hojas de oregano cocidas; limonadi; pañuelo socado; tajadas de plátano en la cabeza, con un pañuelo.

disappear or when one began to have vision problems.

The whole matter of the management of aches and pains, their meaning as symptoms for the patient and their utility as diagnostic tools for the clinician, is complex and contradictory. The list of medicines sought for this type of relief at the pharmacy is the longest of all the lists compiled in this part of the study. Empirical observation and analysis of patient dossiers indicate, at the same time, that, as Canelo observed, aches and pains constitute the most important motivation and most frequent symptom related to clinic visits. What may prevail is a condition of mutual obfuscation, where neither the patient nor the physician is sure what they are dealing with, a confusion made worse by the limited understanding on the part of the campesino about the mechanics of his own body and his use of a different lexicon for identifying its parts and their interrelations.<sup>37</sup> The campesino patient also may not be permitted by the physician, due to the prevailing educational model to be discussed in Chapter IV, to fully articulate what he knows and feels.

It may also be that the campesino finds less in his arsenal of traditional medical beliefs which can explain either individually or as part of syndromes, the many pains and aches which afflict him. Parasites, gastroenteritic ailments, bronchopulmonary infections, skin and eye diseases, fevers, urinary and genital infections, anemias, glandular disorders, all have folk explanations and corresponding preventive behaviors and cures, whether or not these accord with those offered by modern

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<sup>37</sup> See Canelo, op. cit., pp. 107-100, for a discussion of folk anatomy. The campesino divides the body approximately the same way as does the contemporary anatomist. What is different is the terminology employed and the degree of understanding of internal connections among the body parts.

medicine. There seem to be, at least at this stage of research, fewer folk explanations and behaviors which are specific to specific types of pain. We lack at this point any kind of systematic understanding of how the rural patient perceives his or her own pain; to what, if anything, it is attributed; what sorts of pain are viewed as perilous and what only ephemeral; what is seen as endemic in one's life condition and what is avoidable or curable; and how current patterns of perception and behavior differ from traditional patterns, if at all. So far the only consistent and generalized observation one can make is that long duration of any pain, as a single symptom or as a component of a syndrome, will motivate a campesino to seek medical assistance. How long a duration and under what circumstances are still unknown quantities.

#### Concepts of Preventive Medicine

It has been said on occasion that campesinos have no concept of preventive medicine. The current research would indicate that this flat generalization, like any other, is oversimplified and incomplete.

In truth, the concept of preventive medicine is inherent in the whole set of rural attitudes relating to diet discussed above. All efforts to maintain equilibrium in the physical self -- not getting wet, staying out of the sun, not sitting on hot rocks or opening the refrigerator door,<sup>38</sup> eating certain foods and avoiding others under prescribed circumstances, not overeating (surely a very adaptive regulation in an environment where food is scarce!), wearing amulets -- are nothing less nor more than preventive medicine. What they are not is the modern preventive medicine which currently emphasizes such things

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<sup>38</sup> This belief seems somewhat anomalous; there are very few refrigerators in Uluazapa aside from those in tiendas. Still, this belief component is found in much of Latin America.

as vaccination, hygiene, sanitation, safe water, and a pure environment.

The following Tables, XIV and XV, summarize the level of belief among the respondents in the sample about the possibility of avoiding illness, as well as their ideas about how one can manage this.

TABLE XIV. BELIEFS ABOUT THE AVOIDANCE OF ILLNESS

Sexo	¿Es posible evitar Parásitos y Lombrices?		¿Las Diarreas?		¿Los Catarros?		¿Los Dolores?	
	Si	No	Si	No	Si	No	Si	No
MASC.	80%	20%	100%	-	60%	35%	50%	45%
FEM.	70%	30%	55%	45%	30%	70%	10%	90%
TOTAL	75%	25%	77.5%	22.5%	45%	52.5%	30%	67.5%

There emerges from Table XIV a certain level of conviction that the illnesses most common in the rural area can be avoided. Nonetheless, it is mostly the men who share this faith; the women are much more doubtful, particularly with regard to colds and miscellaneous aches and pains. Public health institutions have generally placed their faith in the housewife as their messenger of educational tidings; it is painful but perhaps instructive to see that the messenger lacks faith.

An examination of Table XV offers some clues as to where part of the difficulty might lie.

before it becomes full-fledged.

TABLE XV. METHODS OF AVOIDING THE MOST PREVALENT ILLNESSES

Modo de Evitar	Parasitos: y Lombrices:	Diarreas:	Catarros:	Dolores	Procedo del Total
Medidas realmente preventivas <sup>39</sup>	17.5%	21.67%	7.5%	0%	11.56%
Medidas realmente curativas <sup>40</sup>	21.25%	25.00%	15.00%	15%	19.06%
Medidas que com- parten conceptos preventivos y curativos <sup>41</sup>	5.00%	10.00%	17.5%	10%	10.52%
No sabe/ilo res- ponde <sup>42</sup>	56.25%	43.33%	60.00%	75%	50.54%

First of all, we note that only 17.5% and 21.67%, respectively, of the sample had any fairly well-formed idea of how to prevent gastroenteric diseases. The remainder had an erroneous idea and approximately half the sample had no idea at all. In addition, the interviewers noted that a fair

<sup>39</sup> These subsume the methods generally considered by the modern public health community as truly preventive, in other words those mentioned above -- vaccination, sanitation, etc.

<sup>40</sup> These subsume the methods which are really ex post facto, essentially curative rather than preventive.

<sup>41</sup> These are the methods which signify the campesino's effort to unite whatever concept he might have of prevention with what he understands as modern ways of dealing with any pathology. This is expressed most commonly in taking some sort of cure right at the onset of an illness before it becomes full-fledged. It is comparable to "a stitch in time" as apposed to "closing the barn door after the horse has fled."

<sup>42</sup> No Answer (N.A.) No Sabe (N.S.)

number of those who did have some reasonable approach to prevention did not practice what they knew.

Secondly, what emerges through its very absence in respondent commentary, is that there is scant understanding of contagion as a mechanism in disease. Only a small proportion of respondents gave any explicit indication of comprehending disease pathways -- from soil to human, from human to human, from animal to human. Several analysts of Latin American folk medicine have suggested that lack of credence in contagion derives from disbelief that someone close to you would wish to do you harm. This study produced no evidence to support that theory; attitudes toward contagion seemed more closely related to a sense of environmental fatalism, proximity, lack of water for hygiene purposes, wind-blown dust, all the elements that play host to gastroenteritic and bronchopulmonary disease, make contagion inevitable. What seems to be the case, then, is not so much that the campesino has no sense of preventive medicine; he does. In fact, this is probably whence arises his conviction that prevention is possible at all. What is lacking is either a knowledge of modern preventive methods; an understanding that they are in the same conceptual family as amulets and hot and cold foods; a sense that the forces of one's milieu can be successfully combatted; and/or very practical, systematic information on how he can manage this on little or no money in an antagonistic environment. There is also a possibility that the campesino has absorbed to some degree one of the concepts basic to modern medicine until very recently, that of the physician as primarily a curative technician functioning in situations of crisis, an orientation which by its very nature militates against preventive and maintenance behavior.

UTILIZATION OF MEDICAL RESOURCES, TRADITIONAL AND MODERN

The data so far have already shown that rural dwellers attempt to maintain or restore health through a variety of adaptive strategies in variable sequences and combinations. This section examines this behavior from other perspectives and in more detail. The emphasis here is on what institutions or agents of health delivery, modern or traditional, are used by campesinos; to what extent; by which sex and age groups; for what purposes; and with what degree of satisfaction. The relevant tables will be presented in a group, to be summarized and analyzed together at the end of this section.

Utilization of the Health Post

TABLE XVI. USE OF THE LOCAL HEALTH POST

Sexo	¿Ha ido al puesto de salud?		¿Por qué no ha ido al puesto de salud?		
	Si	No	No había necesidad	Por vivir o trabajar fuera de la comunidad	Razón económica
MASC.	60% <sup>43</sup>	40%	50%	33.3%	16.66%
FEM.	95%	5%	100% <sup>44</sup>	-	-
TOTAL	77.5%	22.5%	75%	16.66%	8.33%

<sup>43</sup> Only three-fourths of these had gone to the clinic for attention to their own problems; the balance referred to visits by their children or companions (compañeras de vida). If male clinic patronage is calculated without this group, the percentage of users among the male sample drops to 40%.

<sup>44</sup> This woman also commented that she neither liked to wait nor to bother busy people for small complaints. She felt that much clinic time was wasted on what amounted to health trivia.

In terms of satisfaction with the service received at the health post, 90% of the men felt that in general their needs had been satisfied, but only 75% of the women agreed. Reasons given by clients for dissatisfaction were: a) treatment (trato), which was interpreted in several different ways -- as lack of understanding, in both the intellectual and emotional sense; lack of adequate consultation time; inadequate explanation of the nature of the disease, its causes, and the proper use of the prescribed medication; b) unsuitable medicines (medicinas que no cayeron bien); c) overly long waits; d) lack of permanent presence of the doctor; and e) insufficient medicine.

TOTAL While respondents were not asked directly the motivation for their every visit to the health post, the 10% sample of 1359 patient dossiers (expedientes or cuadros) for February through December 1975<sup>45</sup> indicates that over one-fourth of all client first contacts were related to gastrointestinal illnesses; one-fifth involved bronchopulmonary ailments; another third was divided evenly between anemias, syndromes diagnosed as 'neurotic', and skin diseases. The balance consisted of female disorders urinary infections, and a miscellany of malnutrition, tonsillitis, miscellaneous aches and pains, eye and ear infections, malaria, arthritis, and assorted traumas.

men and women -- animal bites -- tiny minor -- minor com-

47 reasons

45 c) above  
The Atlix health post was inaugurated in February 1975; these are then, in effect, whole-year figures.

Utilization of Other Services of the Ministry of Health

TABLE XVII. USE OF MINISTRY OF HEALTH SERVICES AND DEGREE OF SATISFACTION.

Sexo	Uso		¿Cuál?		¿Satisfecho?	
	Si	No	Hospital <sup>46</sup>	Otro Puesto	Si	No
MASC.	60%	40%	91.66%	8.33%	83.33%	16.66%
FEM.	60%	20%	100%	—	68.75%	31.25%
TOTAL	70%	30%	96.43%	4.16%	75%	25% <sup>47</sup>

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The illnesses for which the respondents sought hospital care were the following, in roughly equal proportion except for childbirth, by far the largest percentage, and except for the men who went to the hospital on an emergency basis for wounds, animal bites, and the like: surgical interventions, fevers, and pain of long duration; severely malnourished children. A tiny minority went to the hospital for "everything" or for minor complaints.

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Reasons given for lack of satisfaction were: a) long waits; b) unduly rapid consultation without adequate examination; c) broken diagnostic machinery; d) high prices; e) lack of frankness on the part of the doctor; f) death of the patient.

Utilization of Private Physicians

TABLE XVIII. USE OF PRIVATE PHYSICIANS AND DEGREE OF SATISFACTION.

Sexo	Uso		¿Satisfecho?	
	Si	No	Si	No
HASC.	35%	65%	100%	
FEM.	65%	35%	76.92%	23.07%
TOTAL	50% <sup>48</sup>	50%	85%	15% <sup>49</sup>

The pricing systems of the several indigenous healers to whom respondents had gone were quite variable. The most popular healer in the area, Don [Name], charged a standard fee for his services. He is currently using the services of an injectionist on a repeated basis,

in some cases to handle the injections prescribed at the Health Post.

50 Not surprisingly, the figure skyrockets when reference is made to usage before the clinical services became available. Most respondents' dissatisfaction by a factor of of medicine, and with respect to the degree of satisfaction in greater or lesser degree. 48 Reasons for dissatisfaction were: a) doctor's manner brusque; b) no improvement in patient's condition; c) inappropriate fees; medicines (no cayeron bien); d) high prices. 49 The complaints for which patients sought the services of a private physician were, in descending frequency: a) all ailments; b) stomach problems; c) fevers and diarrheas; d) emergency treatment for trauma; e) persistent pains; f) urinary tract infections; g) skin infections; h) parasites; i) spontaneous abortion; j) prepartum control, twins.

went to the pharmacy for injections.

In almost all cases, the standard price of an injection was 25 centavos. No one indicated that, with the exception of the clinic, any one injectionist was any better than any other; the task is perceived as a purely mechanical one.

Utilization of Indigenous Healers (Curanderos o Médicos Parcheros)<sup>50</sup>

Only 10% of the men in the sample had gone to a curandero for solution to a medical problem, while 45% of the women had done so. In all cases, satisfaction was complete. Help had been sought for persistent headaches, general aches and pains, fever, kidney ailments, nausea, rheumatism, alcoholism, cardiac ailments, and post-partum debility which was diagnosed as a desiccated womb due to too much exposure to sun.

The pricing systems of the several indigenous healers to whom respondents had gone were quite variable. The most popular healer in the area, Don Daniel ("El Guegucho") in Chinameca, not far from San Miguel, charged a standard 50 centavos a liter for his potions. Others charged as

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<sup>50</sup> Canelo (*op. cit.*, p. 173) defines the art of indigenous healers, curanderismo, as "the complex of non-medical schools and systems whose representatives dedicate themselves to the treatment of illness without having earned the title of physician through accreditation by a faculty of medicine, and who eschew the norms of academic medicine or adopt them only in greater or lesser degree." ("Curanderismo es el conjunto de sistemas y escuelas no médicas, cuyos representantes se dedican al tratamiento de las enfermedades, sin poseer el grado de doctor acreditado por una facultad de medicina, apartándose por completo de las normas de la medicina académica o haciendo uso de ellas en mayor o menor grado.")

Canelo (*Ibid.*, pp. 173-176) discusses and classifies the varieties of indigenous healers in El Salvador and elsewhere. For purposes of this study, curandero is understood as a generic term, interchangeable with médico parchero, for someone who concocts potions and poultices, diagnoses infirmities, and prescribes his own medicines and/or rituals as he deems suitable.

much as three times that. Another, a spiritualist, charged only a consultation fee.

Utilization of the Pharmacy

TABLE XIX. USE OF THE PHARMACY, DEGREE OF SATISFACTION, AND MOTIVATION

Sexo	Uso		Satisfecho?		¿Para Qué?			
	Si	No	Si	No	Compras medicamentos para cualquier enfermedad	Recetar, "pasar consulta para cualquier enfermedad"	Emergencias cuando está cerrada la clínica	
MASC.	100%	-	35%	5%	30%	20%	45%	5%
FEM.	100%	-	90%	10% <sup>51</sup>	40% <sup>52</sup>	55%	5%	-
TOTAL	100%		92.5%	7.5%	35%	37.5%	25%	2.5%

<sup>51</sup> Reasons for dissatisfaction: dermatological reaction to a prescribed drug and insufficient shelf stock.

<sup>52</sup> Of this group, all without exception stated explicitly that one ran a risk in permitting a pharmacist to diagnose and prescribe for one's ailments.

Summary

If we examine as a totality all these various modes of coping with ill health on the part of campesinos, some patterns stand out (see Table XX).

First of all, with the exception of the pharmacy, men use any and all health services less than women do. The gap in utilization between

TABLE XX. COMPARISON BY SEX OF USE OF MEDICAL AND PARAMEDICAL SERVICES IN RURAL AREAS.

Sexo	Servicio Usado						
	Farmacia	Puesto de Salud	de Partera	Otros Servicios Ministerio de Salud	Médico Particular	Inyectador	Curandero
MASC.	100%	60%	70%	60%	35%	40%	10%
FEM.	100%	95%	85%	80%	65%	60%	45%
TOTAL	100%	77.5%	77.5%	70%	50%	50%	27.5%

the two sexes is greatest when it comes to the Health Post and the curandero; less with private doctors; and least of all in the case of other Ministry of Health facilities and injectionists. The reasons for this pattern are not hard to find, aided by some additional observation and conversation. Health post hours are not conducive to male visitation; the 10% sample of patient first-contact records contains a female adult percentage of 40.74 and a male adult percentage of 14.31.

In the instance of the curandero, it would seem that the resistance to use derives more from a scientific appraisal than from logistical difficulties. The men interviewed displayed considerably more cynicism about curanderos than did the women; one respondent summed it up by saying, "They cure with water." ("Tratan con agua.") Several women interviewed, in the sample and outside of it, expressed a desire to go to see Don Daniel for a variety of ailments which had been unresponsive to modern medical

care, but a trip to Chinameca, with all the costs involved, was considered a luxury. Geographical distance and economic reality had inverted cultural tradition and the curandero, once the campesino's first line of defense outside his home, has become a medical resource for the relatively more affluent believer. Thus the least-used medical possibility, particularly by males, is the curandero, contrary to the urban perception of the rural dweller as having a persistent dependency relationship with indigenous healers which supposedly inhibits his disposition to seek the balm of modern medicine.

As for private physicians and other Ministry of Health facilities, access to these and, consequently, their use is much easier for men than it is for women. Men are more mobile, simply by virtue of following the labor market and being free from the need to care for children. For the men whose work schedule conflicts with that of the clinic, the injection-rapist and the pharmacy are logical choices. Finally, in terms of satisfaction (see Table XXI below), the pharmacy

TABLE XXI. DEGREE OF SATISFACTION WITH MEDICAL AND PARAMEDICAL SERVICES, BY SEX.

Sexo	Farmacia				Puesto de Salud	Inyectador	Otros Servicios
	Farmacia	Curandero	Partera	Particular			
MASC.	100%	100%	92.85%	100%	90%	100%	83.33%
FEM.	100%	100%	100%	76.92%	75%	100%	68.75%
TOTAL	100%	100%	96.42%	88.46%	82.5%	100%	76.04%

the injectionist, and the curandero get a 100% vote of approval, followed in turn by the midwife, the private physician, the Health Post, and other Ministry of Health facilities. The Ministry of Health facilities most used were urban-based hospitals and while there was not the hostility to hospitals described by Harroquín in his ethnography of Panchimalco,<sup>53</sup> the attitude that predominates is that, except for childbirth (see Chapter IV), the hospital is a place to avoid.

When all is said and done, however, the clear winner in terms of both utilization and satisfaction is the local pharmacy, patronized by 100% of the total sample which is also 100% satisfied with the services rendered.

The data both on disease management and on utilization of medical and paramedical resources point to the pharmacy as the key medical entity in Uluazapa -- and research elsewhere attests to a similar pattern in similar rural areas<sup>54</sup> -- in terms of utilization and satisfaction at every stage of different disease carriers.

Nor has the presence of a clinic in Uluazapa reduced overall pharmacy business, at least to date. In fact, the pharmacy is viewed by some as not being as expensive as the clinic, a perception utterly ungrounded in fact. Furthermore, some respondents considered the pharmacy as essentially more service-oriented than other entities, primarily because of the hours

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<sup>53</sup> Alejandro Dagoberto Harroquín. PANCHIMALCO, INVESTIGACION SOCIOLOGICA. San Salvador: Editorial Universitaria. 1959.

<sup>54</sup> The respondents in the San Miguel-Morazán study used available health services as follows: Unidad de Salud, 34.17%; pharmacy, 22.27%; auto-medication, 10.29%; hospital, 17.45%; private clinics, 5.01%; and curanderos, 2.83%. Frequency of utilization and degree of satisfaction were not recorded. The researchers in the Grupo Multidisciplinario were surprised by the low incidence of use of curanderos, particularly in a large sample covering a large area.

Its facilities were available, the provision on occasion of emergency assistance, the performance of health-related errands in the city, and the informal warmth of the personal encounters.

Nevertheless, 'satisfaction' must be interpreted with some care. Although the attitudes toward the pharmacy are indeed favorable, the fact that respondents combined its use with recourse to other services suggests that it is viewed as necessary, adequate to some circumstances, but not sufficient in itself. This conclusion is supported by the number of respondents, approximately half, mostly women, who were explicit about not using the pharmacist as diagnostician. There is a faint correlation between a higher level of education and unwillingness to look to the pharmacist for diagnosis, but this is suggestive at this point, nothing more.

The Uluazapa case is only one, of course, and does not warrant the assumption that all pharmacies are valued as highly. However, a similar relation between the pharmacist and the community was observed in a number of other towns visited. The evidence is mounting that the sequence of health management observed by earlier researchers<sup>55</sup> -- home treatment, followed by resort to curanderos, thence to the pharmacy, and finally to agents of modern medicine such as clinics, private doctors, and hospitals -- is rapidly changing. The sequence now evolving is: pharmacy and

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<sup>55</sup> René Virgilio Comejo Granados. CONSIDERACIONES SOBRE DIEZ MESES DE SERVICIO SOCIAL EN LA CIUDAD DE ATQUIZAYA. Doctoral dissertation, University of El Salvador, Faculty of Medicine. San Salvador, September 1959, p. 11. -Alvaro Alfonso Sánchez Lemus. CULTURA Y MEDICINA: EXPERIENCIA DE UN AÑO DE SERVICIO SOCIAL EN LA UNIDAD DE SALUD DE OPICO. Doctoral dissertation, University of El Salvador, Faculty of Medicine, San Salvador, August 1967, p. 18. -Harroquín, op. cit., p. 362.

automedication, the sequence and combination depending on the ailment; followed by the clinic, followed by the hospital, with the last resort the curandero. The model may be modified somewhat in areas where access to a curandero is less costly in terms of time and money than it is in Uluazapa and similarly remote areas, but informal conversations with campesinos suggest that the value placed on modern medicine is increasing. Faith in traditional healers may endure but, as competition from other sectors increases, it is utterly and ruthlessly dashed.

The overall sense rural health behavior gives to the observer is that of a population casting about among whatever services are available, in sequences perceived as appropriate to the illness in question, with predispositions to one solution or another based primarily on availability and the quality of the personal encounter, rather than on any prejudice against modern medicine per se or any nostalgic predilection for traditional solutions.

#### SUMMARY OF FINDINGS AND PROGRAM RECOMMENDATIONS

##### Findings

##### Finding 1.

Campesinos do have a full-fledged concept of what constitutes good health which does not vary meaningfully from that commonly accepted by the modern health community. Furthermore, contrary to myth current in that same community; they are not utterly fatalistic about the inevitability of disease. While some diseases are so prevalent as to seem part of the landscape and while that very landscape offers some inexorable adversaries -- dust, wind, scant water, poor housing, soils and climates which foster

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<sup>56</sup> See Marroquín, op. cit., p. 293, for a similar observation almost twenty years ago in an indigenous Salvadoran village.

hostile microbes -- campesinos nevertheless exploit a wide variety of stratagems to contend with that environment and those diseases. They recognize that they are, in the main, lacking good health and are not unwilling to act.

Finding 2.

The problem in disease management for healer and patient in a rural population is not a question of simple resignation (conformismo). It would seem instead to be a problem of timing, a sense of urgency which does not coincide with the scientific realities of any given disease trajectory and the implications of certain symptoms. Women do not perceive their children as ill when they well might. Patients as a whole do not grasp the totality of any particular disease syndrome, or which symptoms usually signal gravity. Some illnesses are not viewed as true illnesses. Bases for diagnosis are variable, even between sexes. Causes for illness are not clearly understood or are understood in different ways. Strategies for coping with illness are frequently inconsistent, becoming more a matter of thrashing about and grasping at straws than a thoughtful analysis followed by thoughtful action.

Finding 3.

The only marker in all the disease trajectories investigated which consistently motivates campesinos to seek the help of modern medicine is its duration. Any additional signals which are needed are generally those associated with later, rather than earlier stages of disease. Definitions of dangerous duration vary from illness to illness, but a minimum of three days of suffering seems required before the majority of campesino clients seek assistance. This is partly just hoping the

ailment will go away by itself or respond to auto-medication of some sort; it is also a question of lack of consistent knowledge of the early -- or at least earlier -- warning signals of most ailments.

#### Finding 4.

Patient dossiers, clinical consultations, and observation indicate that often that duration is considerably longer than three days. However, existing information is fragmentary and to some degree suspect, because campesino clients, for reasons of shame, fear or being chastised, or imperfect observation and recall, report disease duration in the vaguest of terms and usually only under pressure. They appear unaware of the diagnostician's need for more precise chronologies.

#### Finding 5.

The causes and implications of bodily aches and-pains, particularly those unrelated to known disease syndromes, are mystifying to the campesino even in traditional terms. As a result, the anamnesis which is taken by the diagnostician is frequently incomplete or even erroneous.

#### Finding 6.

There is no single available health service, traditional or modern, which is not patronized to a meaningful degree by rural residents where they are at all available. Most frequented is the pharmacy (for consultation as well as purchase), followed by the health post, the midwife, other Ministry of Health facilities, private doctors, injectionists, and indigenous healers. Furthermore, the first line of defense is not, as it once was, the home remedy and/or traditional healer, but a mix of pharmacy and clinic, with use of home remedies not an automatic generality but an ailment-specific technique. Private doctors and hospitals are sought

later in a disease trajectory or in situations of true crisis.

It also appears that in the short run, and perhaps in the long run, rural dwellers will continue to capitalize on all available services, varying according to several criteria. It also appears that the institutional competence to legislate against and supervise abuses by pharmacists and indigenous practitioners will be for some years insufficient to the magnitude of the task.

Finally, there is evidence that in many instances pharmacists and, to a lesser extent, indigenous practitioners provide services which are felt to be needed, enjoy a high degree of confidence, and perform their tasks with a notable amount of dedication.

#### Finding 7.

Decisions to use one service as opposed to another are made primarily on the basis of perception of the gravity of the ailment in question. The other variables commonly cited as influencing rural health decisions -- economics, available time, and geography -- are inconsistent in their importance. The economic factor weighs heavily when a campesino cannot go to work due to illness and thus is moved to seek medical assistance. It further determines the disposition to seek the help of private physicians. Its effect in decision to use either clinic or pharmacy is overshadowed by attitudinal considerations. Patients generally content with clinic services tend to perceive the clinic as less costly, in terms of money if not of time; those not so satisfied tend to see the clinic as more costly in terms of both.

The social variable, however, weighs heavily. Where the quality of social relations between practitioner or institution and client is high,

the economic, temporal, and geographical factors are noticeably discounted. Where that quality is low, these other factors are promoted in value. The distance a campesino must travel over difficult terrain with limited available transportation, as well as the travel and waiting time involved, matter less if the quality of personal and medical treatment is at least acceptable. This will be discussed more fully in the next chapter in the context of clinic use.

#### Finding 8

Health behavior varies according to sex. Men are more inclined to use doctors, hospitals, and injectionists than women do and are less likely to use clinics and curanderos. In general men use all health facilities, except for the pharmacy, less than do women. The reasons offered were lack of time due to job responsibilities, a disposition to ignore the non-incapacitating ailments, and lesser responsibility for child care.

Men also tend to see their children as less healthy than do their wives or companions.

In general, women are less satisfied with all available health services than are men. They also have more reservations even about the use of the most enthusiastically accepted facility, the pharmacy, with regard to diagnostic competence.

Finally, women have less faith in the possibilities of preventive medicine than do men.

#### Finding 9.

Contrary to current technology, campesinos do understand the underlying concept of preventive medicine; it constitutes, as a matter of

fact, much of their traditional belief and behavior system. Furthermore, a number of existing traditional preventive techniques coincide with contemporary scientific procedures:

What is lacking is a sense that there is an analogy between prevention as conceptualized traditionally and as it is conceptualized in modern medicine. There is also considerable ignorance about the techniques of modern preventive strategies, with the exception of vaccination, where the technology is in any event not in the hands of the patient.

Finding 10.

Recommendations  
Campesinos do continue to hold a number of beliefs and behave in ways which are prejudicial to health, primarily in relation to personal hygiene and nutrition. However, a number of beliefs and behaviors, whatever their history, are fully compatible with contemporary definitions of optimum health behavior, or at least not counter-productive.

intelligently seen.

Recommendations.

Recommendation 1. (Education)<sup>57</sup>

Recommendations  
Incorporate into all levels of medical and paramedical training the perception of the campesino as a "health strategist", exploiting a variety of traditional and modern services to find solutions to his or her health problems, whose criteria are not so different from clients in urban or more developed areas.

Attempts to efface perceptions of campesinos as essentially unaware of basic health needs or as fatalistic to the point of immobility.

adequately understood.

~~and therefore the~~

<sup>57</sup>As the reference in capital letters in parentheses is to the program or program area related to a given recommendation.

Recommendation 2. (Education)

Incorporate as well into that training an understanding of the factors responsible for non-compliance or inappropriate usage of modern medical facilities: 1) different definitions of gravity of any given disease or stages of gravity within a given disease; 2) lack of knowledge about health danger signals in general and specific syndromes in particular; 3) variance of concepts about disease management among men and women.

Recommendation 3. (Education)

Emphasize in paramedical and campesino-level training very specific techniques for symptoms and syndrome identification, particularly with regard to the most common rural diseases, with the objective of making a better diagnostician out of the campesino so that he can more intelligently seek the appropriate level of health care. Consider design of simple, intensive, rurally-sited short courses and perhaps radio spots or programs on disease management for campesinos.

Recommendation 4. (Education)

Training in symptom-syndrome determination should also include issues of duration and their implications for important and frequent diseases. Both these emphases should also be incorporated into the educational components of clinical consultations.

Recommendation 5 (Research)

In-depth research of a qualitative and quantitative nature to adequately understand and deal with the nebulous concepts the campesino, and therefore the diagnostician, have about bodily aches and pains not associated with known syndromes.

Recommendation 6. (Research, Education, Institutional Modification)

Undertake a targeted census of pharmacists and indigenous practitioners in key or pilot areas, including data on utilization rates, community perceptions, physical environment in terms of hygiene level and available space, receptivity to further training, and educational and skill levels.

Provide training to carefully selected pharmacists and indigenous practitioners emphasizing disease danger signals and referral needs, basic first aid, continuance of beneficial practices and elimination of those deleterious to patient health, malnutrition identification, community health development, and family planning technology. Pilot only on regional basis.

Recommendation 7. (Education)

Embody in all training curricula, especially those at upper professional and administrative levels, the importance of social and cultural variables, through mandatory theoretical and applied study of social-cultural factors in the delivery and receipt of health services.

Institute special training courses in the social sciences for key personnel who lack study in those disciplines.

Recommendation 8. (Education)

Continue to emphasize the health education of women, not merely in the light of presumed ignorance but taking into account apparent reservations about all available health services and a lesser degree of confidence in a capacity to exercise control over one's health destiny.

Recommendation 9. (Education, Research)

Identify strategies of traditional preventive and curative medicine which are beneficial and those which are harmful. Restructure non-formal

educational programs to reinforce the former and supplant the latter.

Make explicit in all training programs the "prevention analogy", i.e., that the maintenance of health equilibrium shares the same core concept with modern preventive medicine; it is the technology that is variable.

Consider utilizing the "satisfied-user" approach in village-level training, on a discussion group model, in which those who have abandoned traditional behaviors prejudicial to health testify to the benefits of change.

In both samples, then, over twice as many females went to the health post for their first medical consultation than did men. This differential is doubled in another 20% sample of 406 patient records for the first three months of 1975, which reveal that only 8.14% of patient first-contacts in those months were made by men, compared to the 41.86% made by women. This sharp drop may be due to heavy agricultural demands in those months which make it difficult for men to spend the time necessary to go to the clinic and should not therefore be considered representative of a whole-year trend. Nevertheless, it does serve to underscore what was observed earlier -- that the hours of the clinic do not encourage its utilization by adult men. There is no notable difference in the types of illnesses reported by men as opposed to women in both clinical samples, except for a tendency among men to report fewer gastroenteritic ailments, and a faint indication, about which it is hard to be conclusive due to incomplete data, that men appear at the clinic when an ailment has been long-lasting or is disabling.

#### Geographic Origin

One of the greatest surprises that emerged from the clinical data concerned the geographic origins of clinic clients; two out of three of all first-contact patients in 1975 were from the cantons of Uluazapa; the rest were from the municipality itself. This imbalance increased to three out of four in the first three months of 1976. What is still more surprising is that of all the men in the total 1975 sample, 85% were from the cantons; in the 1976 sample, all the men making first contact with the clinic were from cantons. Again there is no notable difference in the nature of patient complaints; those from the municipality and those from the cantons report the same types of ailments at roughly the same stages

of gravity and duration. However, as indicated earlier, data on time lapse in disease reporting are incompletely recorded in patient dossiers.

The reason for such a high cantonal representation in clinic attendance is not immediately obvious. However, visiting cantons and discussing health problems with its residents, one becomes persuaded that the issue is one of available alternatives. There are in the cantons few other real options, except for the possible presence of a malaria volunteer and perhaps a curandero. The cantons of Uluazapa do in many instances have the services of a malaria volunteer but these services are as a rule limited to the diagnosis and treatment of that disease alone. One of the most remote cantons was reported to have a curandero but there was little reference to him. In most cantons there is also someone who will give injections, a service which is much appreciated. Perhaps most crucial is that the cantons in general lack pharmacies or even minimal first aid kits (botiquines).

The campesino's options, then, are to endure (anuntar), use home remedies, or to go outside the canton for help. If a campesino is going to walk or pay to ride a truck over long, hot, bumpy, dusty roads to get medical assistance after his traditional remedies and leftover medicines have failed him, it is not illogical that he will seek the best care he can get to justify the effort. Whatever the complaints may be about modern medical services, they nonetheless enjoy great prestige, even among those most wedded to traditional beliefs and behaviors. Thus the canton resident who embarks on a long journey to solve a health problem will not settle for the pharmacy and will see the most appropriate alternative as the health post. It is a simple matter of demanding return on one's

investment. The municipal resident has options which he can more easily exercise from the onset of an ailment; the clinic thus becomes one alternative of several and the percentage of municipal clinic use drops accordingly.

#### Attendance Pattern

Further scanning the 1975 dossiers, we encounter a pattern of a steady increase in the number of first contacts and services rendered. At the same time, there is a high percentage of those first contacts which are only that; 38% of all first contacts did not return for subsequent medical consultation.

One has to regard these data with some reservations. First of all, there is the question of time lag; a certain proportion of non-returns may simply not have gotten sick again and only time will tell how much dropoff has actually occurred. Second, it is virtually impossible to determine how many of that 38% might have returned for consultations with the auxiliary nurse on any of the four days when the doctor and graduate nurse do not visit the clinic.<sup>58</sup> These consultations are logged in a separate ledger; correlation between that book and the patient dossiers is a major investigative undertaking. As a result of this archival separation, there is no way of arriving at an accurate statistical picture of the rate of continuance among health post clientele. Nonetheless, it is unlikely that there would be enough return visits for consultation with the auxiliary to discredit the data completely, and there still may be

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<sup>58</sup> Uluazapa is visited by a doctor and a graduate nurse on two days, Thursday and Saturday (a short working day where the time spent in travel is often equivalent to the actual time spent in seeing patients, a situation of doubtful cost-effectiveness). The other posts on the circuit receive one visit per week.

cause for concern.

General Clinic Functioning

The observation has already been made that the clinic schedule is not conducive to male attendance. The farmer's work day begins at about 6:00 a.m. and ends at 3:00 or 4:00 p.m., hours which coincide with the time the clinic is open. The perception, a reasonably accurate one, that most clinic visits on the days the doctor is present involve a half-day from the time one arrives to wait for a number to the time one leaves with a prescription, keeps most males away from the clinic.

There is another distortion produced by the schedule viewed globally: the clinic is in effect over-utilized on the days when the doctor and graduate nurse are available; it is notably under-utilized on the days when they are not present. The clinic load on a Thursday in Uluazapa runs around 60 patients for medical consultation and program controls. The attendance on other days, determined by repeated observations, ranges from as few as 12 to as many as 20, rarely more. The effect of this is to reduce the opportunities for quality medical service on those heavily-attended days, and yet to tie the auxiliary to the clinic for relatively unoccupied hours the rest of the week, a real loss in terms of cost and effectiveness.

Finally, the structure of services on consultation days is such that no single set of professional and personal skills is fully exploited. The largest proportion of the patients seen by the doctor have routine ailments which could be adequately diagnosed and prescribed for by an appropriately-trained graduate nurse. The time of the graduate nurse on those same days is primarily occupied with program control consultations, again of a

TOTAL	60	50	7.00
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routine nature, which could be handled by the auxiliary, with perhaps some additional training. The auxiliary's time is fragmented into numerous supervisory and distributive chores which could be assumed by a suitably prepared aide. The driver of the Ministry vehicle is, in general, idle, except in some areas where staff size permits him to take an auxiliary for vaccination tasks. The pattern in general is not peculiar to one health post alone; observation in other posts and discussions with health service personnel elsewhere suggest that it is close to pandemic.

These findings lend support to the researcher's not very original hypothesis, based on acquaintance with other health programs, that only if traditional patterns of roles are revised can rural health delivery become satisfactory for practitioner and client alike. In anticipation of suggestions for role modifications, respondents were asked the following question, intended to provide indicators of potential patient receptivity to changes in the system: "When you go to a clinic, whom do you prefer to see -- the doctor, the nurse, or the auxiliary?" ("Cuando va a una clínica, a quién prefiere ver: al Doctor, a la Enfermera, o a la Auxiliar de Enfermería?").

The responses and their justifications were as follows in Tables XXIII and XXIV:

TABLE XXIII. PREFERENCES REGARDING CLINICAL CONSULTATION, TOTAL INTERVIEW SAMPLE (N = 40)

Sexo :	El Médico :	Enfermera : Graduada :	Auxiliar : de : Enfermería :	Sin : Preferencia :
HASC.	30%	5%	5%	-
FEM.	70%	5%	10%	15%
TOTAL	80%	5%	7.5%	7.5%

TABLE XXIV. REASONS FOR SUCH PREFERENCES

	Más conocimiento: experiencia, uno: tiene más seguri: dad, confianza :	Puede examinar : más, dar mejor : consulta :	Dá mejores : medicinas :	Mejor para : cosas graves :
MASC.	73.60%	21.05%	5.26%	
FEM.	57.14%	14.29%	21.43%	7.14%
TOTAL	65.41%	17.66%	13.34%	3.57%

the community development needs of the health post. Those few respondents who did not have a strong preference to see the physician qualified their answers. If it were something 'serious' (grave), then a medical consultation was called for; routine and minor complaints, they felt, could be attended to adequately by the graduate nurse or auxiliary.

Such a majority preference, echoed in attitudes and behaviors displayed in other health posts, places a double burden on the health system. First, it will require a task of re-education for existing clientele who, to some degree accustomed to using indigenous paramedical services prior to or simultaneously with newly available modern services, are now becoming accustomed to the latter. Revisions in the health delivery system which involve training or retraining of paramedical personnel to fill in the geographical and quantitative gaps in that system, may have to take these newly-created expectations into account. Secondly, such expectations place an additional burden on the clinic and physician himself. As discussed above, the health post doctor sees a

multitude of routine cases for which he is in effect over-trained. After years of highly technical training, the medical responsibilities encountered in a rural health post can come to seem trivial, tedious, and even pointless given the inexorability of the rural environment. Thus the Año Social is transformed into a professional hiatus instead of being seen as an opportunity for service and creative community health work. When the idea of community action is suggested, the not-unjustified response is that doctors as presently trained are prepared neither for their multiplex role as physician, nurse, administrator, and sometimes janitor, nor for the community development modes of thought and activity required for rural public health programs. Further, circuit scheduling, transportation difficulties, and distance, combined with consultation demands, make establishment and maintenance of productive contact with four or five communities a formidable task for all but the most dedicated. And even the most dedicated could only affect the rural municipalities serviced by the health posts; the cantons would remain effectively out of reach.

Finally, while there is no major dissatisfaction among health staff interviewed with the responsiveness of the regional offices to their technical and logistical demands, there is a sense of being left out of the planning for program revisions or the design of new programs.

#### Clinic Programs

One of the difficulties in thinking of health delivery as a system is disengaging one component from all the others for purposes of neat and orderly discussion. This difficulty is exacerbated by the fact that all clinic programs are affected by a common factor: that of the attitudinal and educational models which govern both recruitment of clients to those

programs and motivation of clients to continue in them. In order to satisfy demands of order and yet address issues of commonality, client recommendations and findings on individual programs will be presented first, followed by the attitudinal and pedagogical issues which pertain to all program components. The family planning program discussion will be considered in a separate chapter because of its size, complexity, and special nature. This section as a whole encompasses findings derived from ~~all health posts visited, as opposed to the preceding section which~~ focussed almost exclusively on the Uluazapa clinic.

#### Patients' Suggestions for Clinic Modifications

Respondents in the survey sample had some rather definite ideas about how clinic services could be modified qualitatively or quantitatively ~~to better fulfill what they perceived as personal or community health needs.~~ These cut across the totality of clinic offerings and appear here by way of preface to more specific findings; they are presented in Table XXV.

The picture presented in Table XXV does not fully reflect the main concern which surfaced in several ways through interviews at several sites, that is, the sense of distance and even hostility some campesinos felt permeated their relationships with health personnel. The frequently heard phrase, "The clinic medicines didn't help me" ("No me cayeron bien las medicinas de la clínica"), often masked a lack of confidence which derived in turn from brusque treatment and lack of understanding. The former more often than not originated in the latter; misunderstanding, differences in terminology and time frames, and non-compliance, provoked an irritation

validity. Patient compliance with prescribed regimens, or at least more To be sure, the distinction between 'quantitative' and 'qualitative' is often elusive, but it seemed important to emphasize that the client population thinks of 'better' rather than simply 'more'.

TABLE XXV. CLIENT SUGGESTIONS FOR MODIFICATION TO CLINIC FACILITIES OR SERVICES (N = 32)<sup>60</sup>

Rango	Mejoramiento Cuantitativo	Rango	Mejoramiento Cualitativo
1	Más medicinas	1	Trato más comprensivo
2	Servicio de emergencia Médico permanente	2	Mejores medicinas Consulta más seguido Precios más bajos Más intercambio entre la clínica y el pueblo
3	Venir el médico más días Más aparatos	3	Más tiempo con el médico
4	Camillas para partos, casos graves Más personal	4	Que todos vean al médico
5	Visitas domiciliarias Más cursillos "Más de todo" (más grande con más servicios)		

<sup>60</sup> Eight individuals responded "Don't know", or that the health post was fine the way it was, or that the functionaries of the Ministry of Health knew better what to change and how to change it.

in clinic staffs, already under pressures of time and sheer numbers. One informant commented, "The medicines work better when you're treated right" ("Cayen mejor las medicinas cuando está bueno el trato"). This may not always be scientifically accurate but it has an undoubted psychological validity. Patient compliance with prescribed regimens, or at least more sincere attempts at compliance, correlated strikingly with the presence

or absence of certain attitudes and pedagogical approaches which will be discussed in the section on the educational aspects of clinic programs.

One persistent problem in the provision of health services of any kind, anywhere, is that of patient identity and recognition, which is nothing more than the patient sensing that he or she has a name, a family context, and a past, all of which are known to the pertinent health staff. This is hard to achieve in a high-volume, high-speed health operation, with a certain turnover in personnel, but there are devices which can reduce the impersonality of the health service relationship and, incidentally, contribute to the formation of an overall community health picture which is crucial if an integrated rural health program is to become the desired reality.

#### Maternal-Child Health Programs

When asked which clinic programs they considered most valuable, the women in the Uluazapa sample ranked maternal-child health programs a third in importance behind medical consultation and vaccination, and only slightly ahead of supplementary feeding. Men did not even mention those programs in their rankings. These attitudes are echoed in the inscription and dropout rates at the clinic: of the 42 women enrolled in the Maternal Hygiene program between end-October 1975 through March 1976, only 25 were still active in the program, 17 were behind schedule in their control visits, and only one was recorded as having had her baby and not yet enrolled in the Infant Hygiene program. Of the 62 infants enrolled in the Infant Hygiene program, 37 were still participants, 25 were behind schedule, and 1 was recorded as terminated for reasons unknown. Rates of enrollment loss and non-compliance with appointments were even higher in two other clinics. According to a number of informants, the pattern is

one of ready acceptance of enrollment in control programs but a high attrition rate in fulfillment of control schedules. The reasons suggested by those informants were lack of initial conviction that the control was necessary, unwillingness to give a negative response to an authority figure, child-care problems, time, and distance, all of which are substantiated by random client observations.

At the same time, 50% of the female interview sample had been in prepartum control for at least one pregnancy, though not necessarily in the Uluazapa clinic, and of the 50% who had not been, half said they would do so or would have done so, given the presence of a health post at reasonable distance. The reasons given for not having enrolled in a control program were: lack of time and money,<sup>61</sup> inconvenience, and problems of leaving other children at home unsupervised.

Some additional reasons for lack of higher inscription and continuance in maternal-child health programs emerge from unstructured conversation and observation. A very structured question in the interview schedule, "How do you feel when you think you are pregnant?" ("Cómo se siente/sintió cuándo sabe/supo que está/estaba embarazada? Feliz, triste, los dos, conforme?"), gave rise to some very unstructured answers. In fact, the respondents themselves created a new category not in the original question, i.e., "worried" (preocupada). Only 15% of the respondents had felt unadulterated happiness upon discovering they were pregnant and these were without exception women without children or with very few, due to gynecological impediments. A startling 75% said that they had felt sadness, ambivalence, resignation, or concern when they knew they were pregnant.

Beyond this, 70% of these women admitted to being fearful of child-

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<sup>61</sup> These referred to a time when Uluazapa had no clinic and money and inconvenience were more crucial considerations.

birth or, at best, resigned to it. Among these there were two schools of thought: those who had been happy and fearless with the first child, only to be sad and worried with later pregnancies; and those who were apprehensive with the first child, less so afterwards. Both groups attributed their fearfulness to their admitted ignorance about their bodily mechanisms and the psychological, physical, and practical realities of child-bearing.

[It also became obvious, after being present during over 100 gynecological consultations and numerous conversations that there was one aspect of that event that was virtually invariable. This was the embarrassment and discomfort related to the physical examination, symbolized by a gesture, the forearm thrown across the eyes, that stood for a lifetime of socialization to a certain kind of modesty. In clinics where no drape whatsoever was provided, the indignity was more acute and the sense of shame was palpable. The effect of the tension so generated is, of course, to render the examination itself even more uncomfortable.

Informal conversations with a number of campesino women confirmed this observation and supplemented it. The issue was, they said, also a matter of the degree of comprehension (comprensión) on the part of the doctor, not one of maleness per se. Only the younger women felt that it was difficult to confide their problems to a young male doctor.

Added to this is the element discussed earlier, the scant awareness of concepts of modern preventive medical behavior, coupled with a seeming lack of perception of the real state of health of one's children unless an ailment of some duration evidences unmistakable signals of seriousness.

Finally, there is the disincentive originating in the fact that many

campesino women continue to be assisted in childbirth by midwives. A recent study<sup>62</sup> of a sample of 97 midwives throughout El Salvador records a significant degree of ambivalence among members of this profession about recommending, with persistence and enthusiasm, that their clients seek prenatal and postnatal clinical control for both mother and child. The one authority figure with the experience, prestige, and license to speak openly on sexual matters, who could best break down inhibitions regarding the pelvic examination, is apparently unwilling or feels unable to do so in any vigorous way. And with respect to post-partum care and education, the content of midwife visits emphasizes umbilical care with slight attention to other mother/child health needs. The midwife in the post-partum situation does not even offer what other indigenous personnel provide under other circumstances, i.e., an alternative mode of health care.<sup>63</sup>

There are then, at least five factors that come into play when a woman reaches the point of deciding to enroll and/or continue in maternal-child health programs: fearfulness and lack of knowledge; modesty and physical discomfort; unawareness of need; in some cases lack of enthusiastic proselytizing by figures of confidence, such as midwives; and perhaps even an unwillingness to confront the fact of pregnancy. Obstacles of time, money, convenience, and household responsibilities, whatever their validity, would seem tangential compared

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<sup>62</sup> María Elena Claros Calderón, et al. ALGUNOS CASOS CULTURALES DE CIEN PARTERAS INDICADAS TRADICIONALES DE EL SALVADOR. Thesis, Ministry of Education, School of Social Work. San Salvador, May 1975. pp. 112-123.

<sup>63</sup> Claros et al., op. cit., pp. 110-111.

to the social-psychological impediments which must be reckoned with.

Nutrition Education and Supplementary Feeding:

One of the hoariest health legends is that people do not know how to eat well simply because they have little money to spend on food. In the entire Uruazapa sample, not one respondent displayed major degrees of ignorance about the components of a good diet, in response to an open-ended question which gave no guidance whatsoever. The following table presents the rankings respondents ascribed to those components.

TABLE XXVI. COMPONENTS OF A GOOD DIET

H O M B R E S		M U J E R E S		T O T A L	
Rank	Alimento	Rank	Alimento	Rank	Alimento
1.	:Carnes y pescados	1.	:Carnes y pescados	1.	:Carnes y pescados
2.	:Leche	2.	:Huevos	2.	:Leche
3.	:Huevos	3.	:Frijoles	3.	:Huevos
4.	:Frijoles	4.	:Carbohidratos <sup>66</sup> :(arroz, maíz, "harinas")	4.	:Frijoles
5.	:Sopas (de carne)	5.	:Leche	5.	:Sopas (de carne)
6.	:Quesos	6.	:Verduras	6.	:Verduras
7.	:Verduras	7.	:Sopas (de carne)	7.	:Carbohidratos
8.	:Carbohidratos <sup>64</sup> :(arroz, maíz, papas)	8.	:Quesos	8.	:Quesos
9.	:Reconstituyentes	9.	:Frutas	9.	:Reconstituyentes
10.	:Frutas	10.	:Reconstituyentes	10.	:Frutas
11.	:Otros <sup>65</sup>	11.	:Otros <sup>67</sup>	11.	:Otros

<sup>64</sup> Rice in first place, but not by much

<sup>65</sup> Canned fruit juices, vitamins, atoles.

<sup>66</sup> Rice constituted 83% of this category, corn and starches share the other 17%.

<sup>67</sup> Canned fruit juices, fats.

When asked, however, if this were the diet their families actually consumed, only 50% responded positively. The reasons given by the 40% who did not enjoy such a diet were economic inability (50%) and difficulty in obtaining locally, on a regular basis, the highly valued meat and somewhat less valued vegetables (40%). The nearest market to Uluazapa is San Miguel and these items are acquired by local vendors in small quantity and are often of poor quality, at prices which are high for most rural pocketbooks.

The result of restrictions on access to an even adequate diet produce the following reality, recorded among 2044 families in the San Miguel-Morazán sample.<sup>68</sup> The actual consumption pattern among those families assumed the proportions given in Table XXVII.

TABLE XXVII. PERCENTAGE OF FAMILIES CONSUMING GIVEN DIETARY COMPONENTS: SAN MIGUEL-MORAZÁN SAMPLE (N = 2044)

COMPONENTS OF DIET	% OF FAMILIES
Corn and beans	100.00
Rice	07.82
Eggs	78.77
Sorghum	60.52
Milk	32.39
Cheese	27.20
Meat	18.88
Others	4.91

<sup>68</sup> Grupo Multidisciplinario, op. cit., p. 30.

Of these families, 75% were able to spend only between £1 and £3 daily on food, which would with difficulty provide a basic adequate diet for one person.

The inevitable result of such limitations is malnutrition, identified in 73.4% of the San Miguel-Horazán sample, and evident enough in the many cases of malnourished infants and anaemic adults which reach the clinic. However, malnutrition is exacerbated by other factors. The ubiquitous gastroenteric diseases impede proper absorption of the already minimal nutritional value in the available diet. Social-cultural factors constitute the coup-de-grace.

First of all, campesinos in the large majority do not consider malnutrition a disease; it is not reported until it is relatively well-advanced -- the majority of patient dossiers record Grade II malnutrition -- and when such cases arrive at the clinic, they are usually reported in the guise of other ailments, customarily as anorexia. It is not clear whether this results from ignorance about the indicators of malnutrition, the most probable reason, or from a sense of shame in reporting, in effect, that one's child is inadequately provided for.

Second, certain foods which have high nutritional value are devalued for a variety of reasons. Fruit in Uluazapa is a good example. While a fair variety is easily available in the area in some seasons, and the exchange of fruit is a customary and cordial social act, fruit was low on the list of valued dietary items (see Table XXVI). Furthermore, most fruit is withdrawn under a variety of disease conditions, in accordance with traditional proscriptions, one of the most disconcerting being the elimination of Vitamin C-rich items under conditions of bronchopulmonary infections.

Fourth, food preparation, primarily overcooking, diminishes exchange of fruit is a customary and cordial social act, fruit was low on the list of valued dietary items (see Table XXVI). Furthermore, most fruit is withdrawn under a variety of disease conditions, in accordance with traditional proscriptions, one of the most disconcerting being the elimination of Vitamin C-rich items under conditions of bronchopulmonary infections.

Third, dietary proscriptions prevail under other conditions where they are, from a nutritional perspective, counterproductive. It is still not uncommon for women to follow special regimens when menstruating (avoidance of acid or 'cold' foods, eggs, cream, and avocado; consumption of cheese and toasted tortilla), or post-partum (avoidance of acid and spicy foods, melons, papaya, coconut, eggs, fats, milk, fish, pork, rice, beans, shellfish, and avocado; consumption of cheese, chocolate, toasted tortilla and, if the baby was a boy, chicken (callina)). All of the prohibited foods are supposed to be prejudicial in some way to the health of the mother or infant.<sup>69</sup> Such special diets are part of the sexual socialization of the young female by her female elders, in some instances. It is suggested by informants, the only sexual socialization. They may therefore endure as part of a complex of deep-rooted-beliefs, as do regimens related to certain sorts of illness, as discussed in Chapter III. An everyday, run-of-the-mill, "modern" diet which one learns about in schools and clinics does not touch such intimate social and personal systems as sex and disease. It may be, too, that special diets imposed with some frequency respond to conditions of scarcity. Some cross-cultural studies have argued for a correlation between very limited and hard-won food supplies and very rigid dietary regulations.

Fourth, food preparation, primarily overcooking, diminishes existing nutritional content. Machine milling of maize as opposed to metate grinding reduces once-available calcium.

Fifth, eating patterns themselves are limiting. Campesino families

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<sup>69</sup> Grupo Multidisciplinario, op. cit., pp. 25-27; Claros et al., op. cit., pp. 113-116; Canelo, op. cit., pp. 60-62; researcher's own findings.

rarely sit down to eat all together in a fixed spot. Because of different schedules of family members and often because of lack of space, mealtimes are usually eaten in series, sometimes as standup snacking, but almost always in the sequence of adult males, young males, young females, and adult females. Infants (tiernos) of either sex operate on their own schedules. Since the amount of food is limited, the females often get the worst, last, and least; a cultural pattern attested to clinically by the large number of adult female anemias recorded. It also may be that where diet is repetitious and quantities restricted, the cultural sense is that there is little to ritualize. In Uruazapa, ritualistic consumption of food is limited to special, religiously-associated occasions, except for the hospitality rituals; it is rare that a welcome guest is not offered something to eat or drink on arrival, in even the most humble home. In the Sixth, the impact of supplementary feeding programs is sometimes abated for a variety of cultural reasons. Promotional and educational activities at the clinic level are sometimes not as vigorous as they might be. The program seems not to enjoy the priority among the clinic staff accorded vaccination, maternal-child health, or family planning, so that inscriptions are lower, particularly among pregnant and lactating women. Although the program was ranked second in importance by the men in the Uruazapa sample, only slightly behind medical consultation on the women, it ranked it a very poor fourth. Several informants commented that they sensed a stigma attached to recipients within the feeding program; even were that quite incorrect, it is real enough for the recipients. Furthermore, auxiliaries and informants alike reported that instead of being reserved for those in the family who needed it most, the supplement is

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reserved for those in the family who needed it most, the supplement is

frequently used in food preparation for the entire family and its impact on the most needy is thereby dissipated.

Outreach Programs: Vaccination

The climate has changed a good deal since Araúz Aguilar wrote in 1959: "Every illness a child might contract after vaccination is attributed to having been vaccinated" ("Toda enfermedad que contraiga el niño posterior a la vacunación la atribuyen a la misma".)<sup>70</sup> By the mid-1960's both Canelo<sup>71</sup> and Sánchez Lemus<sup>72</sup> found little resistance to vaccination. Now, ten years later, any recalcitrance is minimal and customarily manifested in mothers' concerns about post-vaccination fevers and an occasional believer in a causal relationship between vaccinations and colds. The residual resistance, whatever its cause -- and it is frequently simply forgetting -- is still enough to require considerable expenditure of time by the auxiliary nurse identifying and making house calls on those who fail to comply with their vaccination schedules. Because the house call provides only the injection and is infrequently exploited for additional observation and education, the rate of return in health terms is therefore low.

There is also a tendency among auxiliaries not to provide emergency service after clinic hours for a variety of reasons; economic and personal reasons, and fear of accusation of malfeasance, are those which have been offered by informants.

Finally, the demands of the clinic schedule itself, as presently structured, limit the time available to the auxiliary for home visits. Where

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<sup>70</sup> Op. cit., p. 39.

<sup>71</sup> Op. cit., p. 21.

the clinic staff does not involve itself in or promote community activities related to health, and when the Patrónato is not supportive, the net result is that the amount of out-of-clinic health contact between staff and community is scant indeed; that between the staff and the canton population is virtually nil.

Outreach Programs: School Fluoridation

The effectiveness of this program resides perhaps less in the hands of the Ministry of Health than any other. Whatever the supervisory input of the clinic auxiliary, the success of the therapy depends on the capacity of the teacher in charge to convey understanding, generate commitment, and maintain order. Where this capacity exists, one feels confident of the program's efficacy; where it is lacking, the health measure as such can be said not to have been taken at all.

In addition, the supervisory visits of the auxiliary represent, like the vaccination house call, an opportunity for health education beyond the administration of a technology. It is not clear that this opportunity is always being exploited.

Educational Aspects

Inherent in every staff/patient contact at the clinic level is an occasion for health education. Yet this potential often remains unfulfilled, primarily because of two prevailing assumptions: that limited quantity, in this case quantity of time and personnel, makes quality health delivery difficult to impossible; and that campesinos are not only uneducated but uneducable. If we consider these as sorts of public service hypotheses, then they remain to be proved. There is an alternative hypothesis that, if appropriate attitudes and pedagogic tactics prevail, then quality can

be achieved and education can occur. Those who have put it to the test find it a valid and productive hypothesis which merits further testing.

### The Physician/Client Consultation

Patients and physicians alike have observed that there is no other single point in the health delivery system where social-cultural factors impact as clearly and decisively as in the physician/patient consultation. Traditions of social hierarchies, intellectual differentials, pedagogical approaches, language (idicma) and gesture, all merge to create a social distance which can be vast. It is ironic and somewhat contradictory that this is so. Table XXIII above recorded respondents' strong preferences to see the physician when they went to the clinic, principally because his or her greater schooling inspired trust. As discussed above, although the quality of the interpersonal relation may be inadequate, the physician in the campo comes to his post with a sort of cultural bank account, that is, the confidence invested in his expertise by the campesino. Campesino informants themselves say that as long as the doctor does not contaminate his claim to scientific expertise, patients will gradually adjust to his style and continue to demand his particular brand of skill. They may, however, seek it later in a disease career and tend to avoid contacts of a routine maintenance or prevention character. They may also have only been cured, restored to health but not educated to it.

There are several factors in addition to time limitations -- pedagogic traditions, attitudes, mutual perceptions, customary relationships -- that surfaced through participant observation and interaction analysis, which enter into the physician/patient encounter and reduce its potential educational quality:

1) The patron-client tradition. The physician is the patron, the campesino the client. The pattern is of a one-way flow of authority and a return flow of deference.

2) The pedagogic tradition. a) The pattern is of a one-way flow of information, the content of which is determined by the source and unquestioned by the recipient; b) Reiteration is lacking or by rote instead of "by inspection," i.e., subjected to selective clarification in response to specific patient demand.

3) The medical model. Four elements compose this model: the what, the why, the how, and the when. In its most extreme negative form,

the physician's advisory to the patient contains none of these elements; in its most positive form, it contains them all.

a) Why. Anthropological theory has long held that traditional medicine arose in part from a basic human need to explain physiological and psychological afflictions, as well as to cure them. Traditional medicine endures, often side-by-side with modern medicine, precisely because of that explanatory function. The crucial tool in the kit of the traditional healer, like the curandero, is the surety that an interpretation of the ailment will be forthcoming at some point in the treatment.

Not a little of persistent client faith (fe) in the traditional curer and his cures springs from the fact of seeing one of life's major riddles, illness, attributed to some identifiable cause, and receiving some prognosis. If the contemporary physician does not offer a similar commodity, he loses the chance to help the patient understand why he might have become ill and how further illness might be in some measure avoided. He also loses the chance to replace or join the traditional healer in the client's system of medical belief and behavior, and himself become an object of more than technological faith.

b) What. It is not unusual for campesino clients to emerge from medical consultation without knowing the name of what they suffer from. It is unusual for them to appear puzzled and unsatisfied upon dismissal and to discuss this afterwards with fellow patients in the waiting room. They have been blocked from entering the matter of the hall of modern medical terminology where diseases and symptoms may have different names, other causes, and other cures. Thus precise knowledge of the ailment is not the primary concern of the curer. Another, perhaps corollary, is that of eliciting a report from clients of what they are complaining with prescribed regimens. Therefore, it is often not clear whether the persistence of illness is due to physiological or behavioral lack of response.

campesinos are effectively forced to remain in a traditional conceptual and behavioral system for which they are then criticized.

The consequence is that two systems of thought and language and, correspondingly, of behavior, continue along parallel lines. Doctors say: "These people don't understand what I tell them." Clients say: "The doctor doesn't listen to me and he doesn't tell me anything." This is often true enough, but the issue is more than lack of acquaintance with the campesino's health lexicon, nosology, belief system, and modes of curing. Not infrequently, health personnel do know at least some of the colloquial terminology and health behaviors encountered in rural settings.<sup>73</sup>

What is absent is a sense of respect, an acceptance of the legitimacy of a system of thought and action which, as a strategy for survival, has proved valid through generations of arduous human and environmental circumstances. What is more, a number of elements of that system continue valid, not only for their psychological efficacy but because they are scientifically sound.

c) How and when. Often patients are prescribed medicines and regimens unaccompanied by clarification about which drug corresponds to which ailment and what drug is called; what possible side-effects might be expected, and if a special timing or synchronization is prescribed, why this is necessary. Nor are they given a sense of the time in which they might reasonably expect to see results or, indeed, what chances are of any improvement at all. So it is that campesinos complain that they did not get enough medicines ("me dieron muy pocas medicinas") or that the medicines did not suit them ("no me cayeron bien las medicinas de la clínica"), which may mean either that there were unpleasant and un-understood side-effects, or that there was no visible improvement on a nebulous time frame. In addition, if "how" and "when" explanations are provided, they do not always take into account the campesino's own time frames such as the appropriate timing for purges, bathing, and dietary adjustments. Finally, when health behavior changes do occur, they are not rewarded verbally.

The end result is often, not illogically, non-compliance<sup>74</sup> or non-return. While the consensus of recent research on medical compliance is that repetition, especially written repetition, is the crucial factor, repetition in a cultural vacuum will continue to be insufficient.

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<sup>73</sup> The present study has not included a systematic compilation of folk terminology, nosology, diagnosis, and behavior, in the belief that the Canelo and Claros studies constituted a more than adequate base for such a compilation.

<sup>74</sup> The whole issue of non-compliance is a knotty one. In addition to the matter of cultural context, there is the problem of lack of firm and precise knowledge on the part of practitioners that patients are not, in fact, complying. Another, perhaps corollary, is that of eliciting a frank report from clients on whether and how they are complying with prescribed regimens. Therefore, it is often not clear whether the persistence of an ailment is due to physiological or behavioral lack of response.

### Control Consultations by the Graduate Nurse

The function of the control consultation is principally one of monitoring and maintenance. For this reason there is a redundancy in a day's series of such encounters and in the prescriptions for relevant regimens. These are dutifully recorded, repeatedly, by the graduate nurse for each encounter, a process which involves considerable writing and a parallel loss in the quality of the interpersonal relationship. Because of this repetitiveness and because of time pressures, there is sometimes an inconsistency in points covered and key elements can be overlooked.

Although some of the patterns noted above display themselves in the nurse-patient consultation, they are less frequent and less dominant. Perhaps because the encounter customarily is between two females, because more graduate nurses are closer to rural backgrounds than are physicians, or because the patron-client tradition is tempered, the exchange of information and inquiry is more evenly balanced. Despite this, there is still a tendency for rural clients not to assert themselves, demand understanding, or express dissent in encounters with persons of higher social status unless the relationship is an emotionally comfortable one.

### Health Talks (Charlas)

Health education at the clinic level has depended to a great extent on the vehicle of the 'talk', given by doctor, nurse, auxiliary, or sanitation inspector. There are signs that as a medium for conveying health information in a complete and enduring way, the charla as presently constituted has limitations. These limitations are four in number:

- 1) The ambience on days when the visiting staff come to the clinic is hectic, noisy, and distracting, with health personnel and clientele busy at a number of tasks -- patient preparation, consultations, delivery and receipt of medicines, injections,

payments, paperwork, administration -- and there is little time or tranquility for effective transfer of knowledge. Under such conditions, commanding attention is difficult without a very forceful personality and vocal apparatus, and a very tightly-organized presentation bound by clear logic.

- 2) In general the circumstances do not encourage, nor does the teaching tradition, the asking of questions.
- 3) Many of the clients are themselves ill or busy keeping children, well or sick, relatively pacified.
- 4) The one person who has the unquestioned prestige to overcome this environment is also the one person who rarely gives charlas -- the health post doctor.

In view of all these factors, what gets transferred are random bits of half-heard, half-understood data, sometimes more theoretical than practical, which lack the impact to compete with existing conceptual frameworks or which ultimately recombines into misinformation or mythology. It is perhaps for this reason that, as mentioned in Chapter II, charlas are not considered proper training by campesinos.

If the statements of the respondents in the Uluzapa sample are any indication, the lack of regard for the charlas and their relative lack of impact, does not originate in a basic indifference to learning. Table XXVIII below registers respondents' desires in this respect. Their preferences for scheduling were, for the men, evening hours from 6:00 on, and for the women from 2:00 to 5:00 in the afternoon, with slightly more flexibility during the day than the men but with little interest in nighttime hours. Reasons for lack of interest in training were: child-care demands, lack of time, age and poor vision, general lack of interest, and an unwillingness to be committed without knowing what would be offered.

TABLE XXVIII. DISPOSITION FOR FURTHER TRAINING AND PREFERRED SUBJECT MATTER

¿Interés?:		Materia			
Sexo	Si : No	Asuntos : Médicos : (los Auxiliares, enfermería)	Cualquier : cosa, todo : (Nutrición, Costura)	Leer, : escribir	Preparación : de : Comida
MASC.	100% - 45%	55%			
FEM.	70% - 30%	10%	50%	10%	10%
TOTAL	85% - 15%	27.5%	52.5%	5%	5%

audiovisual materials in nonwasteful ways that would have an

Use of Audio-Visual Media

There are two major problems related to the use of audio-visual media for health education: 1) acquiring the necessary materials and 2) using them. The comment was frequently made at the staff level that it was very difficult to get and maintain a supply of such materials, but upon investigation, material, sometimes in quantity, turned up in desk drawers, tucked away at the rear of shelves, or, in the instance of hardware like projectors, in the regional office and reportedly little used for reasons of time and logistics. Brochures languished unused, it seems, for essentially attitudinal cause: the assumption that the rural dweller is illiterate and therefore disvalues written material, even the simple, largely pictographic items designed for the unlettered. The time pressures prevailing in clinical consultations were also viewed as limiting.

Claro et al., op. cit., passim.

Although there is sometimes a real dearth of audio-visual hard- and software, especially in areas of more recent emphasis such as nutrition and midwife training, and though there continues to be a need for new and imaginative materials and technologies, the true obstructions to appropriate use of audio-visual media seem to be more attitudinal than mechanical. In the case of very basic tools such as pamphlets, there was simply not enough commitment to their use to overcome the sense of time pressures and cynicism about the possibility that campesinos would use them. In the case of more seductive technology such as films, about which everyone was very enthusiastic, the difficulties of acquisition and scheduling were perceived, correctly or incorrectly, as monumental.

There was also the feeling, confirmed by observation, that health personnel were not comfortable in their level of expertise in how to use audio-visual materials in non-wasteful ways that would have maximum impact.

#### Midwife Training Programs

Partially because of time limitations but mainly because of the existence of the thorough investigation carried out by Claros et al, this study basically dealt with this issue from the standpoint of client perceptions and behaviors. The approaches used were survey questions on use of midwives and patient preferences, presence during midwife training, and in-depth, unstructured conversations with such key informants as midwives, pharmacists, graduate and auxiliary nurses, and women soon to give birth and those who had recently done so.

The Claros research produced the following profile of the midwife population as represented by their sample:<sup>75</sup>

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<sup>75</sup> Claros et al., op. cit., passim.

- 1) 64.9% over 50 years of age; only 7.2% under 30
- 2) 59.0% illiterate, concentrated in the age group between 50 and 70
- 3) 62.9% have practiced for 20 years or more, 42.3% for 30 years or more
- 4) 17.5% devote themselves primarily to midwifery; 50.5% are primarily housewives with midwifery constituting a part-time activity
- 5) 73.2% attended 1 to 6 births a month
- 6) 41% earn between \$8 and \$10 per birth; modal charge \$4 to \$5
- 7) 75.3% had some Ministry training
- 8) 39.2% learned their trade on their own; 24.7% were trained by a relative
- 9) 60% were disposed to additional training
- 10) 20.9% were not disposed to additional training for reasons primarily of age and health

11) 50.8% used public health facilities for health needs of themselves and their families

12) 50.8% attended births on an emergency basis, motivated by a sense of humane and professional responsibility.

The overall picture of Salvadoran midwives is one of a group of advanced age; low educational level; long years in practice but of a largely part-time nature; taught principally by tradition or experience, with some additional more formalized training and only moderate enthusiasm for more; some personal experience with public health facilities; and a certain mystique of dedication, corroborated by relatively low and flexible fees and supportive attitudes and behaviors during birth itself.

The view clients have of the midwife reiterates this last component of the profile. Of the 70% of the total Uruazapa sample who had used a midwife for one or more deliveries, only one individual evidenced dissatisfaction provoked by a breech birth with an unhappy end. The rest

felt they had been well served and confirmed the perception of another elderly key informant who said to the researcher: "If I had it all to do over again, I'd be a midwife; it is an honorable and important profession" ("Si yo fuera joven, yo estudiaría de partera. Es una profesión honorable e importante.")

At the same time, when asked where they would prefer to have any future children, 65% opted for the hospital and only 25% for a midwife-attended childbirth in their own homes. The consensus of the pro-hospital group was that in such facilities one received better care in general; from better-trained personnel; particularly in the event of any birth anomaly; under better conditions of hygiene. The hospital was also more convenient if one desired sterilization and, furthermore, one arrived home in a condition of health. Of this group, half expressed fear of having their babies at home, due to concerns about a difficult birth and lack of personnel adequately trained to confront such an eventuality.

The 25% who preferred to have their babies at home with the help of a midwife shared sentiments of confidence and even friendship, whose psychological importance in such a major life event is not only recognized by clients but increasingly by students of the whole birth complex. For a clientele with limited economic resources, friendship also played a key role in fee-setting; almost half the respondents who had used midwives said that the price they paid was affected by considerations of poverty and/or friendship. If, however, attitudes engendered in educational programs come to prevail, this aspect of the attraction of the midwife will diminish, at least for trained midwives; one of these asserted her resolve to never again accept less than Z10.

The pro-midwife contingent also expressed some antipathy toward the hospital because of crowded conditions, including bed-sharing; impossibility of following traditional regimens of bed-rest, bathing, and food; and the very practical consideration of not being able to get to the hospital comfortably and on time. Interestingly all of this group had used the same midwife, a respected resident of the community who had participated in several midwifery and general health training programs and who at the same time of this study was one of the more faithful participants in an ongoing course at the health post. She was, in fact, referred to by one respondent as having a "license" ("patente"), and for that preferable to the several other midwives in town.

It would appear, then, that an increasing number of women will prefer to have their babies in a hospital if at all feasible. This trend is magnified by the tendency at the clinic level to recommend to pregnant women that they have their babies in a hospital, even when there is no reason to expect other than a normal birth.

Recruitment

The Claros study found no correlation between the fact of having had some training and the number of childbirths attended by a given midwife.<sup>76</sup> On the other hand, a significant correlation was found between number of births attended and years of experience. However, these correlations are calculated on the basis of respondents' statements on the number of childbirths attended. If of advanced age, practiced, not dependent on a number of other variables, such as accuracy of recall, general level of demand, competition from other midwives in the area, accessibility of perhaps the only incentive that would inspire higher

<sup>76</sup>Claros, et al., op. cit., pp. 30-41.

hospital facilities, degree to which the fact of training was known to the client population, fee schedules, and the extent to which experience overlapped with training. The question remains open as to whether the majority of the client population includes level of training in their decisions about choice of midwife, or whether they are even conscious that a given midwife has received additional education. We do not know what cultural weight is assigned by consumers of services to experience as opposed to specialized professional instruction, or whether the two enter together into decisions for use. The value placed on education and therefore the educated in Uluazapa and other rural areas is high and the hypothesis suggested by interview and observation is that, given equal experience among several available practitioners, some preference will be manifested for that midwife known to have some additional claim to expertise and reliability derived from training. This remains to be tested.

Furthermore, it is not clear, if this hypothesis does prove valid, that midwives as a group perceive the existence of such a marginal; they do not seem to view themselves as acquiring through training some sort of earned paraprofessional ranking legitimized by the Ministry of Health which would be highly motivating in client choices.

The effect of this is to diminish what is already apparently a low motivational level. As noted above, the universe of midwives identified by the Ministry if of advanced age, practiced, not dependent financially on midwifery, trained by tradition and experience but also in the majority already exposed to some non-formal Ministry training. For such a group, perhaps the only incentive that would inspire higher enrollment and correct the high attrition rate in existing training programs would be a perceptible

enhancement of status. There is good reason to suspect that the difficulties in recruitment and, even more, of maintenance in clinic-based courses noted by field personnel, may reside very simply in the appraisal by the midwife population that there is nothing in it for them. This is especially the case in the cantons where the competition from other paramedical personnel and institutional facilities is even less.

This remains true even if a decision is made to expand the training universe beyond the midwives already identified by the Ministry. Whether it is older women already relatively confident of their competence, with an established clientele; somewhat younger women for whom the practice of midwifery will have to compete with demands of homemaking and child-rearing or still younger women with no children who may have to overcome cultural inhibitions related to age and sex; the motivation will have to be real, substantial, and tied to prestige-enhancing factors. It does not seem that, for a while at least, the economic motivation can matter very much. Campesino pocketbooks cannot expand sufficiently to pay fees too much higher than the currently prevailing \$10, nor will practitioner and client alike easily abandon the value attached to midwifery as a humanitarian community service rather than commercialized medicine.

The Claros and San Miguel studies, confirmed by the researcher's own observation, testify to the tenacity of traditional beliefs and behaviors among midwives, some of them recipients of earlier Ministry training courses. Some of these are beneficial and some innocuous, but others are decidedly prejudicial to the health of both mother and child. The San Miguel-Horazán study found 60% of the midwives interviewed continuing to practice various types of massage (scbada) prior to delivery and 90% applying abdominal pressure during the birth process.<sup>77</sup> 50.9% of the Claros sample

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<sup>77</sup> Grupo Multidisciplinario, op. cit., pp. 15-17.

also practiced the sobado, the objective of which was to manipulate the fetus into a suitable birth position.<sup>70</sup> Varying but significant percentages were unaware of the causes, meaning, and appropriate responses in the event of such danger signals during pregnancy as vomiting, exaggerated weight gain, edema, urinary disorders, fainting and convulsions, as well as birth defects and such post-partum complications as tetanus and hemorrhage.<sup>79</sup> To some extent this is a matter of ignorance of preferred practice, to some extent a commitment to traditional beliefs which have not yet been supplanted by newer information. We do not know in any systematic way to what extent in any given assistance the impediment is lack of knowledge of alternative behaviors or greater confidence on traditional procedures. For instance, does the sobado reflect a belief that it softens the womb (ablanda el vientre) or improves the position of the fetus, or does it reflect nothing more than the lack of understanding of the perils involved in such manipulation? Does the use of essentially septic materials for umbilical treatment represent a true commitment to the healing powers of traditional remedies, or the lack of economic or practical access to antiseptic means? The Claros study has identified the areas where prejudicial behaviors occur; what remains is to discover through training, research, and evaluation what proportion of responsibility is borne by traditional preference and what by lack of information. Until these are identified, training for midwives runs the risk of being unresponsive to its target population.

In addition to the foregoing, the impact of training is diminished

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<sup>70</sup> Claros et al., op. cit., p. 66.

<sup>79</sup> Ibid., pp. 134-141 and passim.

by exigencies of time, space, and personnel. The graduate nurse is virtually forced by scheduling considerations to squeeze a free hour out of an already crowded clinic day under conditions when space is even more in demand than usual; the midwives must wait until she finds that hour. Course-related lectures are customarily programmed at 15-day intervals which sometimes become one-month intervals, diluting the effectiveness of the material, reducing recall and the opportunity for constructive feedback, and further serving to make the training seem more a random occurrence than an organized educational program. The fact that no system is yet in place for regular on-the-job evaluation of trained midwives, (nor does the present health circuit schedule permit the intricate and flexible logistics that would be required for such evaluation), eliminates any possibility of reinforcement and correction in actual midwife practice.

Finally, the material offered in midwife training does not appear to follow any standard curriculum which systematically takes into account the gaps and emphases of the sorts identified in the Claros study. To be sure, the educator faces a real problem in having to deal with trainees who range from no previous training to experience with several programs. This suggests the need for training at different levels in different sites for different sorts of trainees.

Sanitation Programs Chapter 141, there is little evidence of a determination sense because there was no sanitary inspector assigned to the area in which the field study was carried out, it was not possible for the researcher to appraise in any systematic or thorough way that might be termed a sanitation program, from either the standpoint of the delivery of such services or the client population. However, to ignore this important

preventive health component would be to imply, incorrectly and inappropriately, some sort of marginality. Thus the following comments are included; they are derived from observation of sanitation needs and behaviors at the village level and from discussions with sanitation personnel.

Chapter II reported a higher level of latrification in Uluazapa than the average encountered in the San Miguel-Morazán survey, but only a quarter of the homes where interviews were given displayed what could be defined as a high level of domestic hygiene. High levels of hygiene and latrification correlated with educational levels at a minimum of fifth grade, optimally at 7th and 8th grades. No correlation was attempted between income levels, hygiene and latrification, but an impressionistic conclusion was that, with scant exception, the homes which apparently had the poorest incomes also had the poorest levels of general hygiene. These conclusions correspond with the San Miguel-Morazán study.

The constraints on domestic hygiene are not only those of lack of money and lack of education. There are also environmental and cultural constraints. The environmental factors have already been severally discussed and there is no point in reiterating them. The cultural factors comprise a variety of attitudes affecting matters both of domestic and personal hygiene.

As mentioned in Chapter III, there is little evidence of a determining sense of the implications and mechanisms of contagion or of the requirements of basic antiseptics. The dearth of water discourages whatever might exist of such a sense, in any event. Animals have the free run of many houses. Pigs particularly are ubiquitous and highly regarded; campesinos have many names for pigs, somewhat in the same way Eskimos have for snow.

Pork is an important and valued protein source, although like many foods it is tabooed under some conditions. To control this also very important source of disease involves not only calculations of porcine brute force and ingenuity, but of economic resources and the cultural values which will limit possible sanitary solutions.

Another limiting cultural factor is the custom of completely closing up the rural house at bedtime. This derives not only from health concerns about protection from the night air, but from concerns about privacy and safety which are deeply ingrained. Attempts to modify such behavior will be most difficult.

Personal hygiene, as clinic encounters repeatedly attest, is also affected by very persistent beliefs. Certain disease syndromes, symptoms, and behaviors, e.g., diarrheas, temperatures, colds, purges for parasites entail restrictions on bathing which are counterproductive from the standpoint of total health. There are also bathing proscriptions related to menstrual and post-partum periods which are similarly counterproductive, exacerbated by habits of feminine protection during those periods which are not hygienic and which contribute to the large number of vaginal infections reported. Another critical conviction relates to the cutting of infant fingernails which, it is believed, will cause mutism while, in fact, it generates a plethora of infant diseases.

Amidst the many components of rural belief system, such beliefs seem to be among the most durable and prevalent, and the most resistant to modification. This is an area where health educators may find the "satisfied-user" approach to be the most effective pedagogical technique for persuading clients to risk violating traditional taboos for which the

expected consequences are considered grave. Discussion groups may well be the optimum educational setting for dealing with such issues; evidence is that the authorization modal is without effect.

From the institutional standpoint, reports on the obstacles to effective sanitation services delivery and education are of quite another genre, though they are not without their cultural aspects. Staff commentaries listed the following problems:

- 1) Lack of integration of sanitation concepts, personnel, or programs into the administrative process, the educational process, or operations at the field level.
- 2) Insufficient outreach into rural areas and frustration at the multiplicity and boundlessness of urban sanitation efforts.
- 3) Overly complex, numerous, and fragmented responsibilities without adequate personnel or logistical and financial support.
- 4) Supervision which overly emphasizes quantitative indicators of achievement and does not account for qualitative accomplishments of the time they consume.
- 5) National norms which were not always compatible with regional needs.
- 6) Insufficient preparation for supervisory responsibilities.
- 7) Status problems springing from fewer years of training compared to doctors and nurses and a relationship of institutional dependency.
- 8) Less access to in-service training and upgrading of skills.

## SUMMARY OF FINDINGS AND PROGRAM RECOMMENDATIONS

### Findings

#### Finding 1.

As indicated in Chapter III, women in rural areas use the health post over twice as much as men do, primarily because clinic hours coincide with the male work day. No significant differences in types of diseases were reported, except for a slight tendency on the part of men to report fewer gastroenteritic ailments and to report somewhat later on a disease carrier.

#### Finding 2.

Precision in these data is difficult to achieve because cumulative record sheets do not provide for a breakdown by age of the clinic population, but not by sex.

#### Finding 3.

Two out of three of all patients who made first contact with the clinic were from outlying cantons; the other third were from the municipality itself. No significant variation was noted in types of disease reported and data were not sufficiently complete to come to any conclusions about differences between canton and municipal residents in the points in disease carriers when clinic help is sought. The preponderance of cantonal representation in health post attendance appears to be due to the lesser number of health service options available to the canton resident, primarily the absence of a pharmacy.

#### Finding 4.

There appears to be a pattern of a high percentage of non-returns among first-contact clients. However, because of a short time depth and an archival separation between patient dossiers which record medical consult-

istrative, and community public health duties.

**Finding 9.**

The structure of circuit schedules does not encourage involvement of either the doctor or the graduate nurse in the several communities to which they are linked through their health post responsibilities. Contact with the cantons is still further inhibited.

**Finding 10.**

Health post staff, while generally content with the technical and logistical responsiveness of regional offices, feel left out of decision-making and planning processes.

**Finding 11.**

Client suggestions for modifications to clinic services included the following quantitative changes: more varied and larger supplies of medicines; emergency services; a permanent physician or more consultation days; more equipment, emergency beds; more staff; home visits; and more educational opportunities. Qualitative changes included less waiting, lower prices, more contact between clinic staff and the community; longer consultation times; the opportunity for everyone to see the doctor. The emphasis was, however, on a desire for more sympathetic treatment.

**Finding 12.**

Men ranked clinic programs, in terms of personal and community value, as follows: 1) curative activities and consultation; 2) supplementary feeding; 3) vaccination; 4) (but low) family planning. Women ranked them as follows: 1) curative activities and consultation; 2) vaccination; 3) maternal-child health programs; 4) supplementary feeding.

**Finding 13.**

Dropout rates and non-compliance with control appointments are high.

The principal reasons seem not to be so much time, money, convenience, or household responsibilities, as they are social-psychological reasons: 1) discomfort about pregnancy and childbirth; 2) apprehensions about the gynecological examination, due to modesty, lack of knowledge, and concern about physical discomfort; 3) inadequate awareness or commitment about the necessity for such programs; 4) lack of vigorous proselytizing by potentially effective figures such as midwives.

Finding 14.

There is, contrary to conventional wisdom, adequate understanding of the constituents of a good diet on the part of the campesinos interviewed. Nevertheless, a good diet is not what the majority of those campesinos regularly consume. The principal inhibitions are insufficient economic resources and difficulty in obtaining quantities of meat and produce at reasonable prices in a relatively remote rural area.

Finding 15.

While economic and market realities appear to be the prime causes of poor or malnutrition, these conditions are exacerbated not only by the adverse effects of the ubiquitous parasitic and gastroenteritic diseases, but by cultural factors. These include:

- a) Malnutrition is not considered a disease and is customarily reported in the guise of other ailments.
- b) Foods valuable nutritionally are devalued or proscribed under certain health conditions, in accordance with traditional beliefs, principally about hot and cold foods and their disequilibrating effects. These same foods are not devalued or prohibited under conditions of normality that these traditions themselves function as cultural rationales or

regulators under conditions of scarcity.

c) Modes of food preparation often detract from available nutritional value.

d) Mealtimes are generally unritualized. The most noteworthy regularity involves women being at the end of the feeding line.

e) Supplementary feeding programs are not optimally effective because of lower clinical priority and improper domestic use of the supplement itself.

Finding 16.

There is relatively little recalcitrance about vaccinations on the part of adults. There is enough, however, to necessitate a fair expenditure of time by the auxiliary nurse on identification and house calls. The cost effectiveness of such an effort is low when the house call is not exploited for the additional monitoring and educational opportunities it presents.

Finding 17.

Health-related contact between clinic resident staff and the community appears to be scant; such contact with the cantons is virtually nil. The main impediment, at least at this point, seems not to be a matter of indisposition but rather one of conflicting scheduling demands.

Finding 18.

School fluoridation programs and, by extension the new antiparasitic program, are at the mercy of the competence of the teacher in charge, with regard to explanation, motivation, education, and discipline.

Finding 19.

School supervisory visits by the auxiliary nurse offer another opportunity for health education which is not always exploited.

Finding 20.

Two assumptions about rural health service impede its most effective delivery: 1) that lack of quantity is by nature insurmountable; and 2) that campesinos are not only uneducated but uneducable.

Finding 21.

Social and intellectual distance is the most prominent negative factor in physician/patient relations, despite the high prestige campesinos ascribe to the physician. This distance comprises three cultural traditions:

a) The patron-client tradition, which involves a one-way flow of authority from patron to client and a return flow of deference from client to patron.

b) The pedagogic tradition, which involves a pattern of a one-way flow of information, the content of which is determined by the source and unquestioned by the recipient.

c) The medical tradition, which involves resistance to sharing the why, what, how, and when of disease management with the patient. The consequence is the maintenance of two separate systems of belief and behavior and poor compliance with the regimens prescribed by modern medicine.

Finding 22.

Archival and attitudinal factors tend to atomize the patient population, in ways that thwart the attainment of a complete community health picture.

Finding 23.

The controls managed by the graduate nurse are by necessity redundant involving repetitious recording which diminishes the quality of personal contact between practitioner and patient.

Finding 24.

The charla, because of its pedagogical style and the infelicitous environment in which it must usually be delivered, is perhaps not the most appropriate vehicle for the transmission of health information.

Finding 25.

Campeños, men more than women, sustain a high interest in further education in medical matters, nutrition, household skills, and literacy, in descending order of importance.

Finding 26.

The profile of the midwife population suggests a group which can best be motivated to further training by legitimization and enhancement of professional status. Current rates of enrollment in training courses appear to be relatively low and attrition rates high.

Finding 27.

There is a significant preference on the part of the women interviewed for hospital delivery, for reasons of better overall care, higher levels of hygiene, capability of response to emergency, and convenience for sterilization. Those who preferred midwife-attended delivery cited reasons of emotional support and economic flexibility, as well as concern about hospital conditions, especially those which militated against maintenance of traditional post-partum regimens.

Finding 28.

Customary clinic practice is to refer even women with prospects of a fully normal delivery to the hospital.

Finding 29.

The question of further training of midwives as an inducement to

composing women to increase use of their services is unresolved. The hypothesis that quality training will be persuasive to either the client or practitioner population remains to be tested.

Finding 30.

Midwives continue in traditional patterns of belief and behavior to a considerable extent. It is not clear whether this is a question of cultural preference or inadequate understanding of alternative procedures.

Finding 31.

Midwife training programs at present are of reduced effectiveness for reasons of erratic scheduling and curricula, and impediments of time and space. Lack of time and personnel also inhibit the potential for evaluation of midwives on-the-job. Finally, the variability of past training among participants make it difficult for the trainer to efficiently target and pace her material.

Finding 32.

Beliefs and behaviors relating to domestic and personal hygiene are among the most prevalent and durable to be found in rural areas. They have been particularly resistant to traditional pedagogical models.

Finding 33.

Problems related to audio-visual materials are not only those of availability, but knowledge of most effective use. There is always need for more and better material, but there is also a need for training in optimum utilization.

Recommendations

Recommendation 1. (Institutional Modification, Evaluation)

Test, on a pilot format, perhaps on one or two health post circuits.

a revised schedule which incorporates the following modifications:

a) Elimination of consultations and controls on Saturdays, the

Saturday half-days to be used on a rotating basis for the following:

- Physician contacts with the community which could encompass the following:

Scheduled meetings with the Patronato, including on occasion local leaders, representatives from FOCCO, CE:ITA, U:IC, the churches, and any other entity relevant to community health. The focus of these meetings would be the identification, planning, and implementation of solutions to community health problems.

Monitoring of community health activities as the head of the community health team.

Discussion groups on sexual responsibility and family planning with men only.

Separate meetings for liaison and problem-solving with any of the entities listed above.

Meetings with the pharmacist regarding any additions or changes in prescription patterns.

Graduate nurse-managed and operated training and discussion groups for any of the following audiences and purposes:

Midwives

Mothers of malnourished children and/or to present to do vaccinations.

Participants in maternal-child health programs, on occasion incorporating the services of a visiting nutritionist or sanitation inspector, or advanced students in either of those professions, including appropriate demonstrations.

Task-specific training for health aides, graduate and auxiliary nurses, aides engaged in community health and training activities as indicated above.

Family planning.

Adolescent sex education.

Review and planning sessions for past and forthcoming week's activities, problem-solving, with health aide (ayudante de salud) through random review of clinic records, should be included in baseline data and in monitoring on modified cumulative record sheets.

incorporating existing nurse data, ongoing monitoring, and ex-post evaluation to appropriate planning sessions for past and forthcoming week's activities, problem-solving, with health aide (ayudante de salud).

Meeting with schoolteachers and health aide to discuss school-related projects.

Administrative, logistical, and recording tasks.

Emergency coverage for traumas and acute illnesses only.

b) Close health post one weekday morning and open it that same afternoon, with promotional emphasis on new availability of clinic services to men (with the awareness that this flies in the face of male expressed preference to see the doctor).

c) Close clinic the day after consultation day, which tends to light attendance as a rule, to permit auxiliary to make house calls in the municipal area.

----- A sample week according to this revised schedule might look something like this:

Monday	7:30 - 2:00	Clinic open, auxiliary in charge
Tuesday	2:00 - 8:30	Clinic open, auxiliary-in charge
Wednesday	6:30 - 2:30	Clinic open, physician and graduate nurse present
Thursday		Clinic closed (or open when health aide, suitably trained, can be present to do vaccinations, injections, basic first aid). Auxiliary making house calls.
Friday	7:30 - 2:00	Clinic open, auxiliary in charge
Saturday		Clinic closed except for traumas, acute illnesses. Doctor, graduate and auxiliary nurses, aide, engaged in community health and training activities as indicated above.

Pilot should be accompanied by meticulous baseline evaluation, incorporating existing clinic data, ongoing monitoring, and ex-post evaluation to appraise impact and spread effect. Male attendance, arrived at through random sampling of clinic records, should be included in baseline data and in monitoring on modified cumulative record sheets.

Pilot should be preceded by careful and thorough publicity in affected communities.

Recommendation 2. (Institutional Modification)

Restructure patterns of responsibilities for days on which doctor and graduate nurse are present at the clinic for consultation, adjusting with task-specific training as deemed appropriate by staff and Ministry.

The restructuring would incorporate the following adjustments:

- a) Careful pre-screening of patients by auxiliary nurse before doctor and graduate nurse arrive, to identify routine and non-routine cases.
- b) Doctor sees assigned cases of more-than-routine nature, unsolved chronic problems, minor surgery, pelvic examinations, IUD installation, primiparas, psychiatric problems, etc.
- c) Graduate nurse sees routine cases, selected controls as determined by physician, problem maternal-child health and family planning controls referred by auxiliary.
- d) Auxiliary pre-screens patients, sees routine maternal-child health and family planning controls.
- e) Health aide takes blood pressures, temperatures, weighs babies, handles injections, and distributes medicines.
- f) Vehicle driver assists health aide, brings invalids identified by auxiliary.

Recommendation 3. (Institutional Modification)

Schedule meetings in regional offices in areas where pilot programs are contemplated and in the design stage, which include the health post personnel to be affected by any program modification. Facilitate periodic problem-solving and -sharing meetings with other health staff personnel in region.

Recommendation 4. (Education, Motivation)

That physicians incorporate into first gynecological consultations preliminary discussion of the purpose, necessity, and mechanics of the

pelvic examination.

That a robe or at least a drape of efficient size be supplied and that, if clinic space permits, a private disrobing space be provided or furniture be arranged to allow for privacy.

That the physician maintain sensitivity to the fact that campesino women are not invariably pleased by the fact of pregnancy, often experience high anxiety, and may be highly sensitive to disapproval.

Recommendation 5. (Education)

Include in maternal-child health training and controls explicit and practical information on danger signals for mother post-partum and during pregnancy, as well as those for crucial infant illnesses, especially malnutrition, diarrheas, parasites, and respiratory infections. Emphasize that diarrheas and malnutrition are illnesses. Emphasize audio-visual use.

Recommendation 6. (Education)

Stress in nutrition training not the generalities of good diet but the need for specified foods at specified times such as menstruation, pregnancy, lactation, and certain illnesses. Reinforce advantageous or innocuous traditional dietary practices.

Incorporate awareness of cultural components into nutritional education, suggesting ways to modify mealtime patterns, especially sequence prejudicial to female nutrition.

Include in training instructions on ways of preparing foods which better preserve nutritional content; use of supplement, especially in ways which will more efficiently benefit mother and child; how to compensate for seasonal variations in food supplies.

Recommendation 7. (Institutional Modification)

Encourage auxiliary and health aides to work with schoolteachers and

CEITA personnel on nutrition-related projects such as school gardens, soy-bean germination, gandule planting.

Recommendation 8. (Institutional Modification)

Permit use of health post scale on out-patient basis for mothers to monitor more closely the weight of malnourished children. Teach to log weight gain on own weight-for-height chart, if at appropriate educational level, as method for integrating into health process.

Recommendation 9. (Research)

Sponsor or participate in research, perhaps with INCAP, which will

- 1) provide more specific data on the correlation between persistence in use of special diets, level of education, economic level, and patterns of health service use; and 2) investigate the reasons for late or non-reporting of child malnutrition, consistent with order and leadership structure, family health personnel, and other factors.

Recommendation 10. (Education, Institutional Modification)

Assign priority to task-specific training of both older and new health aides, so that they can eventually substitute for auxiliary in the handling of routine tasks, vaccinations, injections, in the clinic and in their own cantons, of recording solutions.

Recommendation 11. (Education) ideology and methods

Through mini-motivation courses, in the regional offices or on-site encourage and teach auxiliaries to exploit to the maximum the educational opportunities inherent in all single-purpose contacts such as vaccinations, school supervisory visits, and emergency calls, and other community opportunities such as meetings of Clubes de Amas de Casa or Clubes de

Jóvenes or auxiliary nurse. Use pool of structured sequences.

Recommendation 12. (Institutional Modification) current recommendation

to permit possibility of permitting the auxiliary, at her discretion,

providing her on a credit basis a fundamental emergency kit.

Recommendation 13. (Education)

So that there is less learning on the job and fewer problems of orientation and comprehension, introduce the following components into medical training:

- a) Anthropological and sociological theory and methodology, including
  - Rural value and belief systems, especially as related to health issues.
  - Rural lexicons, nosology, and patterns of health behavior, with identification of beneficial, innocuous, and counter-productive elements.

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Rural subsistence patterns and their economic and social implications.

Field work in area of prospective circuit assignment, including participant observation, unstructured interview and survey techniques, preliminary contacts with power and leadership structure, indigenous paramedical personnel, and existing outreach workers in other entities.

- b) Public health motivation, concepts, and approaches, emphasizing ideology and practices related to the concept of the community health team, modes of operation, dynamics, and preventive health components. Specific training in basic nutrition, sanitation, and mental health. General concepts of social and economic benefit-cost analysis, health problem identification and design of matching solutions.
- c) Community development ideology and methodology.
- d) Pedagogical techniques emphasizing two-way exchange and discussion formats and group dynamics. Substitute medical model which provides client with adequate explanation of causes and management of disease, prognosis, feedback on compliance, and verbal reward for compliance and/or behavior change.

Recommendation 14. (Institutional Modification)

Design outline in form of checklist for all control consultations by either graduate or auxiliary nurse, with goal of structuring sequences, assuring coverage of key points, and reducing redundant recording so as to permit more personal contact between practitioner and client.

Recommendation 15. (Institutional Modification)

Consider restructuring of clinic archives or establishment of different system for new health posts, on pilot basis, so that dossiers are maintained by families rather than by individuals, providing better clinical picture of health level of family unit. Dossiers could be keyed to working map of area for which health post is responsible. Area would be divided by sectors for systematic coverage by health aides and auxiliary. Color codes and push pins would mark progress in attention to main health foci, such as vaccination, deparasitization, and latrinization, and individual health problems such as pregnancy, newborns, and special control cases.

Recommendation 16. (Institutional Modification)

Design one family carnet to be held and maintained by mother, which would substitute for various, frequently lost cards and slips which constitute current system. Carnet would follow a calendar model with space for appointments for vaccinations and all controls and training. Contemplate small fine for loss. Sponsor research, perhaps by university level students of botany and traditional medicines, especially those

Recommendation 17. (Education)

Consider abandoning random charla technique, substituting more ritualized training sessions and providing simple diplomas for faithful attendance and completion of course.

Recommendation 18. (Education, Research, Institutional Modification)

Consider the following modifications to midwife training programs:

a) Establishment of goal of trained, licensed, and supervised midwives with explicit ties to health post.

Recommendation 19. (Education)

b) Provision of one bed in health post and permission for use by such midwives for deliveries when conditions of hygiene in the home of the parturient present high risks to health, or when delivery complications arise too late for hospital assistance.

- c) Expansion of trainee universe to younger women, identified by midwives themselves and by health post staff, and to paramedics such as injectionists who are interested and motivated to expand their health skills.
- e) Intensive training in regional offices, with per diem and travel allowances, for carefully selected midwife trainees. Precede training with baseline test on beliefs and knowledge so that, if number of personnel permit, the less- and more-advanced can receive the education which accords with their needs. Learning should also be tested during and at end of course and through selective field monitoring.

Emphasize areas identified in Claros study as particularly weak, especially danger signals, referrals to clinic or hospital, recommendations for controls, family planning, and sex education. If courses are not to be held in regional office, design standard curriculum for clinic teaching use which includes summary of Claros findings.

- e) Provision of basic tool kits (scissors, gloves, clock, nailbrush) on credit at low cost, including checklist of other basic supplies, contraceptives, and cap/apron/pin bestowed at end of successfully completed course.
- f) Provide pregnant mothers who are going to use midwife with list of necessary and desirable equipment for both mother and midwife, and promote use of known, trained practitioner.
- g) Sponsor research, perhaps by university level students of botany and/or pharmacy, into traditional medicines, especially those related to pregnancy and childbirth, with the goal of identifying beneficial, harmless, and dangerous ingredients and uses.
- h) Sponsor investigation into reasons why midwives continue in traditional beliefs and behaviors, the central research question being the degree to which the maintenance of these derives from conviction and the degree to which it derives from lack of knowledge of alternative procedures.

#### Recommendation 19. (Education, Sanitation)

Attempt the discussion-group approach to motivating changes in beliefs and behaviors among campesinos related to domestic and personal hygiene.

#### Recommendation 20. (Education)

Add to new patient dossiers, and to old patient dossiers as they appear, information on grade level, for better targetting of audio-visual

materials and educational approach in general.

**Recommendation 21. (Education/Audio-visual)**

Offer tightly-focussed, practical mini-courses on the technology and techniques of the use of audio-visual software and hardware, to all health personnel with training responsibilities.

**Recommendation 22. (Education/Audio-visual)**

Design simple, economical black-and-white pamphlet/posters on nutrition, sanitation, and dental care, which teachers can use for instruction and discussion in elementary school, have children color carefully and take home.

**Recommendation 23. (Education/Audio-visual)**

Target out-of-clinic distribution of materials, e.g., small, simple, two-color posters on basic nutrition for tiendas, CENTA offices, comedores, and distribute as appropriate to auxiliaries, health aides, and any other personnel trained by the Ministry. Revise as necessary to accord with Ministry policies and changes in family planning considerations.

**Recommendation 24. (Education/Audio-visual)**

Design and test in one-area use of low-cost slide-tape presentations on: identification and handling of malnutrition; low-cost domestic and

community sanitation procedures; specific community health tasks such as

building of pig pens, latrines, enclosures for chickens, compost piles;

proper procedures, equipment, danger signals, for use in midwife training;

small-scale, labor-intensive rural agro-industries, etc.

Use in education of health workers, health aides, and auxiliaries.

**Recommendation 25. (Education/Audio-visual)**

Establish schedules for use of slide projectors and cassette recorders for slide-tape presentations, and film projectors; take Ministry vehicle on consultation days, permitting one- or two-week use by community where health post located, to permit easier and yet disciplined use by auxiliary.

Recommendation 26. (Education/Audio-visual)

Use film as motivation for community health discussions. Divide audience after showing into discussion groups under leadership for auxiliary health aide, CEIITA or FOCCO workers.

Recommendation 27. (Education/Audio-visual)

Make and use through Plan Básico ETV system low-cost video-tapes on such subjects as: successfully enacted public health efforts such as fluoridation and deparasitation programs under the aegis of effective teachers who combine discipline and health education; basic first aid, midwife training elements; health danger signals; appropriate home remedies and their proper and improper use; community sanitation activities, etc.

Recommendation 28. (Education/Audio-visual)

Translate Donde No Hay Doctor into Salvadoran vernacular, use as text and distribute as appropriate to auxiliaries, health aides, and any other personnel deemed suitable by the Ministry. Revise as necessary to accord with Ministry priorities (vide chapter on family planning). Consider distribution to carefully identified pharmacists.

Recommendation 29. (Education, Research)

Using Canelo and Claros theses as base, write manual of campesino health terms, beliefs, and behaviors which, again, incorporates identification of existing productive and counter-productive ideas and procedures. Use in education of administrators, doctors, nurses, and auxiliaries.

CHAPTER V

FAMILY PLANNING

Knowledge of Family Planning  
and Use of Methods

The findings in this chapter and the recommendations flowing from them derive from the data gathered principally in Uluazapa through survey, observation, and unstructured interviewing.

The first finding, presented in Table XXIX below, is that almost twice as many women (90%) than men (55%) had some knowledge of the existence and general thrust of the national family planning program, a total of 72.5%, somewhat under the 89% found in the San Miguel-Morazán sample.<sup>80</sup> Men got their information primarily from the radio and women from the health post, not surprising given the low male attendance at ways to a woman's health. The women, on the other hand, did not even the clinic. However, the second most important source of information was the radio as a rationale for a negative position. For men the for women was also the radio.

TABLE XXIX. KNOWLEDGE OF FAMILY PLANNING PROGRAM AND SOURCE OF INFORMATION, TOTAL SAMPLE (N = 40)<sup>81</sup>

Sexo	Conocimiento		Fuente del Conocimiento				No Recuerda
	SI	No	Radio	Clínica	Amigos(as)	Otras Fuentes	
Masc.	55%	45%	36.36%	18.18%	18.18%	27.27% <sup>82</sup>	
Fem.	90%	10%	27.78%	33.33%	11.11%	5.55%	22.22%
Total	72.5%	27.5%	32.07%	25.75%	14.64%	16.41%	11.11%

<sup>80</sup> Grupo Multidisciplinario, op. cit., p. 28.

<sup>81</sup> Even though we are dealing with a sample of 20 men and 20 women, it must be remembered that the data refer to the family planning attitudes and behavior of 40 couples, allowing for the widowed and single.

<sup>82</sup> Grupo Multidisciplinario, op. cit., p. 28.  
<sup>83</sup> a) Health Instructor, Military Civic Action (Acción Cívica Militar);  
 b) his children; c) brochures distributed at work (cotton cooperative).

<sup>85</sup>

As for their overall appraisal of the value of family planning (see Table III), 70% of the men and 85% of the women considered it desirable (compared to 73.4% for the San Miguel-Morazán sample<sup>83</sup> and 75% in the Sánchez Lemus sample<sup>84</sup>), and for both groups the main rationale was an economic one. "Economic" was defined either broadly, in terms of the general income restrictions on the average campesino family, or in terms of the wish to be better able to feed, dress, educate, and care for the children one had. Health considerations constituted a rationale for only one man but were meaningful for one-fifth of the women.

Ironically, when it came to the group that was not in favor of family planning, health considerations mattered very much to the men, who felt that the various methods were detrimental in a number of ways to a woman's health. The women, on the other hand, did not even mention health as a rationale for a negative position. For them the weightiest factor was the religious one: family planning was a sin. Still, these represented a small proportion of the total sample, comparable in size to Sánchez Lemus' findings almost ten years ago.<sup>85</sup>

TABLE XXX. ATTITUDES TOWARD FAMILY PLANNING IN GENERAL

OPINION		¿PORQUE ES BUENO?			¿PORQUE NO ES BUENO?		
Es Bueno	No es Bueno	Situa- ción Econom.	Mejor edu- car, cuidar los hijos.	Salud de fami- lia, especial- mente la mujer	Daña la salud de la mujer	Es Pecado	Otras Razones
70%	30%	57.14%	35.71%	7.14%	66.67%	16.67%	16.67%
85%	15%	57.14%	21.43%	21.43%	-	66.67%	33.33%
78%	22%	57.14%	28.57%	14.28%	33.33%	41.67%	25%

<sup>83</sup> Grupo Multidisciplinario, op. cit., p. 28

<sup>84</sup> Sánchez Lemus, op. cit., p. 24.

<sup>85</sup> Ibid.

When it came to the question of how many children per family was ideal (see Table XXXI), 50% of the men and 45% of the women believed that an average of 3 to 4 children was the optimum. Nevertheless, if these data are correlated with the data on the actual number of children each family had, we find that, preference aside, 30% of the families in the sample had surpassed their own ideal. Furthermore, of that 30% all had expressed themselves as being in favor of family planning, yet at the time of the interviews none of those men or their wives were using any contraceptive method. Of the women, one had begun using Deproprovers and was considering sterilization; two more were using nothing but were also considering sterilization; two were on the pill, one of them with apprehension; and another had been taking the pill but had stopped because she was "hemorrhaging." In other words, almost all the women who had a larger family than they considered desirable were prepared, in varying degrees, to act on their preferences; the men apparently were not.

TABLE XXXI. PREFERENCES FOR FAMILY SIZE

SEXO	NUMERO IDEAL DE HIJOS											Los que Dios manda	Depende
	1	2	2-3	3	3-4	4	4-5	5	5-6	6-7	7		
Masc	5%		30%	20%	5%	5%	5%				5%	10%	15%
Fem.			5%	30%	15%	15%			15%	5%		10%	5%
Total	2.5%	2%	30%	17%	10%	2%	3%	8%	2%	2%		10%	10%

Further examining that same combination of data, we find that a substantial percentage of the sample, 55%, had either the number of children they considered ideal (12.5%) or less than that number (42.5%). Table XXXII displays the ways in which these families had arrived at that achievement; less than one-third had done so through deliberate family planning using contraceptive methods.

TABLE XXXII. MANNER IN WHICH IDEAL, OR LESS THAN IDEAL, FAMILY SIZE HAD BEEN ACHIEVED (N = 22)

N = 22 (55% of total sample)	SEXO	R A Z O N E S			
		Usando método anticonceptivo	Casualidad No se decidió	Solteras o Separadas	Todavía jóvenes
Número de hi- jos ideal N = 5 (12.5%)	Masc.	2	1	1	-
	Fem.	-	1	-	-
Menos del número ideal N = 17 (42.5%)	Sub- Total	2	2	1	-
	Masc.	3	2	2	-
	Fem.	3	3	1	4
	Sub- total	6	5	3	4 <sup>86</sup>

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All of these indicated interest in contraception or sterilization when they had reached the family size they wanted.

TABLE XXXIII. KNOWLEDGE AND USE OF CONTRACEPTIVE METHODS:  
DIFFERENTIAL BETWEEN MALE AND FEMALE  
REPRESENTATIVES IN THE SAMPLE

SEXO	PASTILLA				D I U				INYECCION			
	Conocimiento		Uso		Conocimiento		Uso,		Conocimiento		Uso	
	Si	No	Si	No	Si	No	Si	No	Si	No	Si	No
	%	%	%	%	%	%	%	%	%	%	%	%
Masc.	35	65	10	90	15	85	5	95	25	75	5	95
Fem.	85	15	25	75	75	25	5	95	75	25	5	95
Total	60	40	18	82	45	55	5	95	50	50	5	95
Difer. Masc/ Fem.	50		15		60		-		50		-	

SEXO	PRESERVATIVO				ESTERILIZACION			
	Conocimiento		Uso		Conocimiento		Uso	
	Si	No	Si	No	Si	No	Si	No
	%	%	%	%	%	%	%	%
Masc.	35	65	15	85	55	45	10	90
Fem.	70	30	5	95	80	20	-	100
Total	53	47	10	90	68	32	5	95
Difer. Masc/ Fem.	35		10*		25		10*	

Table XXXIII above records the difference between the men and women interviewed in light of what they knew as individuals about contraceptive methods and the degree to which they used them. "Diferencia" (see bottom row of table) refers to the advantage held by the female component of the sample over the male component in terms of knowledge and use of methods. In cases where the men hold the advantage, the relevant box is marked with an asterisk. For example, the first column shows 35% of the men and 85% of the women with knowledge of the pill, a knowledge advantage of 50% on the part of the women.

Taking an average of the advantage in terms of total knowledge displayed by the female component, we arrive at a percentage of 44. In other words, the women of the sample are 44% better acquainted with

contraceptive methods than are the men.

Yet, turning to the matter of use of such methods, we find a curious phenomenon: even though the percentages of utilization of any method are for the two samples quite low, the males have the advantage over the females as users. Examining Table XXXIII still further, we see that the couples represented by the female group have used the pill only 15% more than the couples represented by the male group; they are equal in the use of the IUD and Deproprovera; and they use condoms and are sterilized 10% less.

The question must be asked: why the contrast? One speculation might be that the men have received more effective education or orientation. TABLE XXXI indicated that the women in the sample were better acquainted with the existence of a national family planning program than were the men. However, the majority of men got their information on the radio, the women through the clinic, with the radio in second place as a medium of information about family planning. This suggests the need for a sharper look at the impact of clinic-generated education programs.

Another possibility is that once a man receives information and is persuaded of its utility, he is more disposed to act on it or to persuade his wife or companion to do so. If this is so, it is a hopeful sign for any program which emphasizes the education of men in family planning methods.

#### Decision-Making

This brings us to the knotty question of the process of decision-making involved in the planning of family size and spacing. Table XXXIV summarizes this process as reported in Uluazapa: the majority of couples

were in accord on issues related to family planning and the majority said that any decisions that had been made together. Nonetheless, one looks in vain for any significant correlation between family size, the mode of decision-making, and the use of any family planning method.

Paradoxically, in the 30% of the sample mentioned above who had surpassed their ideal of the proper number of children, only one responded that he and his companion had made a joint decision. In the group which had reached their ideal or less, more than half said that they had made no decision on the matter; what had happened had simply happened, for traditional societies have more power at the domestic level. A variety of reasons. The only anomaly in that group that is worth noting is that in four instances it had been the woman who had taken the decision to use contraceptive measures. In those four cases, the women, for longer or shorter periods, are heads of household. The report was made by women in the sample, which suggests that a cultural suspicion of men being essentially unwilling to admit that such decisions are made by women, no matter how vociferous they might be, may have some validity.

El Salvador still do not have the last word. They have some and resilience and even some domestic power, but they do not.

TABLE XXIV. DEGREE OF ACCORD AND MODE OF DECISION-MAKING

SEXO	MANERA DE TOMAR DECISIONES							
	Acuerdo		Sin acuerdo		En desacuerdo		N.A.	
Intención	Si	No	Si	No	Si	No	Si	No
	%	%	%	%	%	%	%	%
Masc.	65	15	20	60	5	15	25	5
Fem.	65	15	20	45	5	15	25	10
Total	65	15	20	52.5	5	15	20	7.5

There is also another factor which muddies the survey waters: the suspicion that there is enough acculturation to urbanity with regard to male-female relations, so that it is now more prestigious, particularly with North American interviewers, to say that decisions at the family level are made jointly, rather than in exercise of any male prerogative.

These two considerations, in addition to the lack of clear women who has undertaken to use a family planning method...

correlations in the survey data, make it wisest to place more trust in the unstructured interviews and observed medical consultations, which were numerous and informative. There the evidence is rather persuasive that, whatever the disposition of the female -- and that disposition is often very fragile -- the final decisions on contraception are either made by men or, if they are made by women, it is with the acquiescence of the male member of the pair.

Recent studies on women and power have proposed that women in more traditional societies have more power at the domestic level than hitherto thought, whatever their weakness in the public arena... This may be so, especially under conditions of temporary or permanent migration by men where women, for longer or shorter periods, are heads of households. But power is not authority and it would seem that, if Uluazapa is at all representative, no matter how vociferous they might be, women in rural El Salvador still do not have the last word. They have enormous strength and resilience and even some domestic power, but they do not, in general, hold the reins of authority.

#### Intention to Continue Use of Contraceptives

In the male sample, the seven respondents and their female companions who were using contraceptive methods expressed no reservations about continuing with them. On the contrary, of the seven women, as described earlier, the great majority were apprehensive, particularly regarding the pill.

This contrast in degree of commitment has at least three possible explanations: one was mentioned earlier -- that the man who is part of a couple using contraceptives is more disposed to continue doing so, once the decision has been made. Or it may be that the simple fact that a woman who has undertaken to use a family planning method does not mean

that she will keep on with it; she might have begun with a conviction less than firm, having succumbed to pressures at the clinic or hospital to which she was unwilling to say a flat "no." Or she may have begun with a method which proved incompatible with her physiology.

#### Beliefs About Family Planning Methods

What is most likely, and the research results are persuasive here, is that mythology about family planning methods have triumphed over any level of commitment to the ideology of family planning that might have existed. The overwhelming majority of formal and informal discussions that even remotely touched on contraceptive methods turned up one rumor after another, to a greater or lesser -- mostly lesser -- degree based on scientific fact. At their most innocuous, these constituted questions in the mind of the actual or potential user; at their most obstructive, they constituted real terror. Table XXIV below lists all the claims that were made about the dangers of contraceptive methods encountered during the field work. They are listed, from top to bottom, in the order of frequency with which they were encountered.

It should be noted that some of these beliefs were encountered among outreach workers responsible in some measure for health and/or family planning education. While some of these workers were suspicious about the medical validity of the beliefs, they were unsure about the degree of truth they contained and still more unsure about how to respond to them. Clinic staffs also expressed a desire for refresher courses which would specifically enable them to confront these beliefs and the technological issues related to them with more confidence.

Anthropological cynicism, born of the conviction that often what people say is not what they mean, leads one to ask if the mythology does

not conceal a deeper truth. Are the technological excuses only modernistic euphemisms for a more basic resistance to limiting procreation, which derives in turn from well-socialized values about human relations and reproduction, from traditional beliefs in the ultimate economic returns of many offspring, from the realities of male dominance, or simply from the love and enjoyment of children?

There is cogent evidence that, while all these factors matter to varying degrees in individual instances, they are in the main overridden by what has become a genuine belief in the benefits of smaller, if not small, families.

One set of factors which makes this conclusion more than impressionistic is that related to the feelings about pregnancy and fears of childbirth described in Chapter IV. Tied to these attitudes and apprehensions is a high rate of what is clinically recorded as "neurosis" among women. Participant observation and scrutiny of patient dossiers revealed a considerable number of women reporting headaches, pains in neck and shoulder, stomach aches, sleeplessness, forgetfulness, "nerves" (nervios), and general malaise and weakness. These were generally recorded as tension headaches (cefalea tensional), pre-ulcerous conditions (síntomas pre-ulcerosos), and anxiety, under the rubric of "neurosis."<sup>87</sup> While this syndrome was often a product of overwork, poor

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<sup>87</sup> During his Año Social, Arauz found a high percentage (85%) of his sample with what he defined as "psiconeurosis con síntomas somáticos." While some of the symptoms Arauz defines as neurotic are no longer so considered, the fact that the general pathology was observed in a rural clinic almost 20 years ago is of interest. (Carlos María Arauz Aguilar. EXPERIENCIAS DE UN AÑO DE SERVICIO SOCIAL EN LA UNIDADES DE SALUD DE COATEPEQUE Y TEXISTEPEQUE. Doctoral dissertation, Universidad de El Salvador, Facultad de Medicina. September 1960. pp. 51-52.)

TABLE XXXV. BELIEFS ABOUT FAMILY PLANNING METHODS

THE PILL	I.U.D.	CONDOM	INJECTIONS	STERILIZATION	ALL METHODS
Causes cancer ( <u>Da cancer</u> )	Causes hemorrhage during menstruation	Causes urinary infections	Causes hemorrhaging	Pains the woman ( <u>Arruina la mujer</u> /men only/)	Pain the woman ( <u>Arruina la mujer</u> )
Causes urinary infections ( <u>mal de orin</u> )	Causes cancer	Damages or tears the womb ( <u>daña/rompe la matriz</u> )	Causes menstrual disorders ( <u>trastornos en la menstruación</u> )	Requires special regimen ( <u>ocupa dieta</u> )	lowers the number of red corpuscles ( <u>plátulos rojos</u> )
Causes hemorrhage during menstruation ( <u>flujo abundante en la menstruación</u> )	Causes uterine pain ( <u>dolores del vientre</u> )	Causes headache	Causes stomach ache	Makes the woman incapable of performing her household duties for a long time	
Requires extra food/vitamins because debilitating ( <u>Requiere alimentos porque debilita</u> )	Causes vaginal infections ( <u>da picazón</u> )		Causes uterine pain	Requires strong blood	
Causes infection of the uterus ( <u>dá infección en el vientre</u> )	Causes urinary infection			Requires blood transfusions	
Causes headaches				Wound hurts for months	
Causes pains in the neck				Uses electricity on one's body	

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nutrition, anemia, domestic strain, economic worries, poor physical condition, and carrying heavy objects for long distances on one's head, it was often associated as well with concern about being pregnant or about an imminent birth. Further, when women in the interview schedule pre-test sample were asked by the researcher what they would like to see added to the questionnaire, the unanimous request was for an opportunity to talk about their personal problems, among which they included having too many children and the anxieties and state of nerves this occasioned.

Another indicator of level of commitment at least to the idea of family planning, if not the available technology, was the surprisingly high interest in rhythm. Two of the women in the sample were using this method and while they characterized it as difficult and full of surprises, one felt that it was at least safe from a health standpoint as opposed to other methods; the other used it because of a religious conviction that any other methods were sinful. The pharmacist reported that an average of ten women a month asked how it worked, which suggests 1) that the pharmacy is not an unlikely place to consider as a point of dissemination for family planning information, and 2) that there is continued interest in the rhythm method as a family planning technique, whatever its margin for error.<sup>89</sup>

Additionally, there was high interest in sterilization. Despite the fears related to it, it was the method that occasioned the most frequent positive comment, primarily among women, who saw it as "the best

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<sup>89</sup> One of the problems with the use of rhythm as a contraceptive approach has been the teaching model employed in some rural areas, which uses vaginal flow (flujo mucoso) as an indicator of a woman's unsafe period. In an area where, according to an estimate derived from 1975 clinic records, at least 20% of all women suffer from vaginal infections of various sorts, using vaginal flow as an indicator of anything is decidedly perilous.

way" (la mejor manera) once desired family size had been achieved. It is interesting that concerns about the effects of sterilization are associated with temporary disruption of health, rather than the permanent and/or continuing damage associated with other methods. Only men claimed that sterilization "ruined" woman (arruina la mujer), at the same time they were unable or unwilling to define what they were unable or unwilling to define what they meant by that. The rather cynical analysis of some of the women with whom this was discussed was that "ruination" was related to male fears of newfound sexual freedom for their spouses or companions. It should be noted here that it was not uncommon to encounter clients and health workers alike who were unaware of the recent revisions in the approval system for sterilization.

Finally there was considerable articulateness about the socio-economic rationale for smaller families. The relevant concepts were well understood and were reinforced by a high commitment to education as a mobility ladder for children, access to which was reduced in overly large families.

Thus three factors—somatically and psychologically expressed anxiety about pregnancy, birth, and child-rearing; high interest in both rhythm and sterilization as relatively acceptable methods; and apparently genuine understanding of the economic and social repercussions of excessive family size—support the contention that the major problem in family planning program success is not one of basic motivation but of apprehension about adverse effects of the technology on female health.

#### Desire for Family Planning Information

Despite apparently real motivation, there was a low level of interest in more family planning education. 50% of the men and 35% of the women were interested in further information; of these, 45% of the men and 25% of the women felt that their spouses or companions would share this interest. The reasons, given for lack of interest were:

- 1) Already using a method, whatever its flaws
- 2) Had lost faith
- 3) Past the age where necessary

- 4) Already had enough information and had made a decision for or against
- 5) Bachelor, separated, or widowed
- 6) Family planning is bad.

The picture is one of an essentially disenfranchised female population which will be harder to reach for purposes of re-motivation and re-education, but a male population which, in the majority, is still curious, yet another reasons for concentrating promotional efforts on the rural male. In this regard, 80% of the men and 60% of the women responded to an admittedly somewhat leading question, that they thought it would be more effective if men educated men in family planning and women educated women. The rest felt that there was no meaningful difference in effect. The consensus was that men would pay more attention to a masculine figure, especially one of professional status.

#### The Health Post and Family Planning

According to health post control files, of the 31 women enrolled in the family planning program between late April 1975 through March 1976, 80% are still designated as active participants. This is a high continuance rate compared to other clinics, where attrition ran as high as 33%, and if late-reporters are computer, attrition, or at least lack of enthusiasm, can be reckoned at almost 90%. At the same time, a total enrollment of 31 is low compared to the total potential population. According to Ministry of Health calculations, the female population of fertile age constitutes 22.1% of the total national population.<sup>89</sup> 22.1% of the total urban-rural population of Uluazape (5942) is 1313; calculating only for the urban population (1246), the number of women of child-bearing age is somewhat

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<sup>89</sup> Ministerio de Salud Pública y Asistencia Social, Dirección General de Salud. NORMAS Y PROCEDIMIENTOS PARA LOS SERVICIOS NACIONALES DE SALUD. May 1974.

around 275. Thus an enrollment of 31 out of an urban-only potential of 275 is 11%, a low figure under circumstances where geographical distance and convenience are not factors; to be sure, an additional percentage of that 275 is getting family planning technology from other sources.

It is very difficult to arrive at a clear and total portrait of either the qualitative and quantitative success of family planning programs through clinic records, since there is no single archival site where the program is monitored. The relevant data are divided among patient dossiers, record books, card files (tarjetas), and cumulative tabulation sheets (hojas acumulativas). Follow-up on late-reporters and dropouts is intricate and time-consuming, so that more often than not, there is no recorded information on why women return late or never for scheduled appointments. Sterilization,<sup>90</sup> use of the rhythm method, or use of any other method

supplied by the clinic are not recorded cumulatively, if at all. As a result, the reasons for low enrollments and often high attrition in 30% of the sample had surpassed their ideal, 10.5% had achieved it, and 42% had fewer children than they would have liked. There was no correlative activity outside of those programs, have to be pieced together between use of contraceptives and family size for the total sample. from patients' evaluations, staff commentaries, and observation. The

conclusions derived from these will be presented below as part of the total findings concerning aspects of the national family planning program as they appeared in the researcher's field site.

<sup>90</sup> One clinic visited was noting sterilizations referred on its monthly cumulative sheets, but it was not clear whether this resulted from a Ministry or Regional prescription. In either case, there was no cumulative indication of how many sterilizations referred had actually taken place.

interviewing, however, indicated that the impression that men either

SUMMARY OF FINDINGS AND PROGRAM RECOMMENDATIONS

Findings

Finding 1.

Almost twice as many women know about the existence and general thrust of the national planning program than do men.

Finding 2.

Women's first source of information is the health clinic; for men it is the radio.

Finding 3.

70% of the men and 85% of the women considered family planning desirable. Men who felt that it was not desirable cited health of the female as their rationale; the few women cited religious reasons.

Finding 4.

Approximately 50% cited as ideal family size between 3 and 4 children. 30% of the sample had surpassed their ideal, 12.5% had achieved it, and 42% had fewer children than they would have liked. There was no correlation between use of contraceptives and family size for the total sample.

Finding 5.

While women know more about contraceptive methods and men less, the men who did have information were more disposed to actually use a method.

Finding 6.

There was no reliable conclusion that could be drawn from the survey about the relationship between family planning decision-making patterns and the use of contraceptive methods. Observation and unstructured interviewing, however, indicated that the impression that men either

make or must concur in such decisions, is still the general rule in the campo.

Finding 7.

Male members of couples using contraceptives appeared to be more disposed to continue using them than did female members in the sample.

Finding 8.

Rural women display a high degree of what is clinically described as "neurosis," often in relation to pregnancy and child-birth. Interest is relatively high in both sterilization and the rhythm method. Commitment to the idea of family planning seems genuine. Thus the main obstacles to the use of family planning methods are beliefs, of varying accuracy, about the effects of those methods on female health.

Finding 9.

These beliefs are widespread, shared both by actual and potential users, and their substance is a cause for concern and perplexity even among those with some educational responsibility for family planning.

Finding 10.

Almost twice as many men as women were both interested in receiving family planning information and of the opinion that their spouses would be similarly interested. The total interest in more education, however, was still less than half of the sample. The consensus regarding appropriate pedagogy was that it was more effective for men to educate men, and women women, in this particular subject matter.

Finding 11.

Enrollment in clinic family planning programs is low compared to

the eligible population and attrition is high, attrition being defined as a combination of dropout and repeated late-reporting for control appointments. The structure of clinic record-keeping and lack of time for consistent follow-up on dropouts make firm conclusions on the reasons for high attrition rates difficult to identify.

Finding 12.

Observation and discussion, however, suggest that the principal causes for low enrollment and high attrition relate to the following factors:

- a) Mythology, rumor, and part-truths about methods and their effects on female health.
- b) Lack of assurance on the part of some educators on how to deal with these.
- c) Cultural, psychological, and physical discomfort related to the gynecological examination and lack of supportive staff responses.
- d) Tendency toward an authoritarian motivation and teaching modal in consultations and charlas, both ultimately counter-productive, given the ambiance and the subject matter.
- e) Infrequent attempts to use medical consultations with men to mention family planning.
- f) Predominantly female composition of the clinic staff and virtual non-participation of most circuit physicians in any family planning promotion beyond individual medical consultations with women.
- g) Reluctance by midwives to promote family planning with any vigor, for reasons as yet unidentified.
- h) Reservations on the part of some pharmacists to sell methods given away by the clinic, despite evidence that clients sometimes feel more comfortable obtaining these from the pharmacy than from the clinic.
- i) Lack of awareness about recent modifications in legal requirements for approval for sterilization.
- j) Apparent lack of adequate quantities of audio-visual materials, which are appraised as well-designed and useful.

Recommendations

Recommendation 1. (Education)

Emphasize education and proselytizing of men, addressing issues both of motivation and methodology. Use male educators as much as possible. Exploit the medical consultation as a vehicle for education. Give out condoms at meetings of men on the subject of family planning.

Recommendation 2. (Education)

In the education of women, stress the technology and physical implications, comparative physical and socio-economic risks, and utilize a pedagogical approach which permits full and comfortable airing of questions. Identify and incorporate "satisfied users" into these discussion groups.

Recommendation 3. (Education, Research)

Design simple and straightforward educational materials for educators, outreach workers, and pharmacists, which confront beliefs about methods as real, if not necessarily accurate, and help them formulate a set of adequate but honest responses to parish priests, pharmacists.

Recommendation 4. (Evaluation)

Follow this model on one circuit, taking baseline data from clinic records on program history. Monitor over a six-month to one-year period to evaluate effectiveness of subject matter emphasis and teaching model.

Recommendation 5. (Education/Audio-Visual)

Continue use of the radio as a medium of information transfer, but consider emphasis on technology and comparative risk messages. Include information of new approval requirements for sterilizations. Consultations begin.

Recommendation 10. (Institutional Modification, Evaluation)

Aggregate clinic records on family planning activities so that

**Recommendation 6. (Education, Mental Health)**

Inaugurate clinic discussion groups, in privacy, led by the graduate nurse, which would deal not only with family planning but which would permit women to discuss their personal and family problems and find some counsel for them, or at least some psychological support.

**Recommendation 7. (Mental Health, Education, Institutional Modification)**

Consider a pilot project using a clinic-based psychiatric nurse or social worker, with responsibility for a limited geographical area and resident in that area, whose duties would be primarily counseling and organizing discussion groups among women and adolescents of both sexes, as well as training auxiliaries in the initiation, dynamics, and management of such groups.

**Recommendation 8. (Education/Audio-Visual)**

Develop, or distribute more vigorously if available, very clear, simple materials on the rhythm method. Proselytize as fallback method when recommendations for use of other methods are firmly or consistently rejected. Make the same sheets available to parish priests, pharmacies, CENYA educators. Analyze evaluation of rhythm method promotion undertaken at San Lucas.

**Recommendation 9. (Education)**

Abandon, or at least reduce emphasis on, the family planning charlas as the educational focus, and concentrate on scheduled group discussions in a more hospitable ambiance than the clinic on consultation days. The only exception would be charlas given by the health post physician to clinic patients on a regular basis, perhaps once a month, before consultations begin.

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**Recommendation 10. (Institutional Modification, Evaluation)**

Aggregate clinic records on family planning activities so that

a clear picture of success or lack of success in promotion, use, and continuance of use of methods is more quickly obtained. Use health aides not only to follow dropouts and late-reporters but also to record reasons. Compile this information at the end of a six-month period and analyze.

**Recommendation 11. (Institutional Modification, Evaluation)**

Try, on one clinic circuit, to mix family planning patients in with other patients after sick children have been seen, in a way that does not call attention to them. Make explicit to patients that this is being done, depend on them to publicize. Monitor over at least a six-month period.

**Recommendation 12. (Research, Institutional Modification)**

Undertake census in the municipalities of one department to see if the pattern observed of pharmacies dropping from stock those contraceptives distributed by public health facilities is a generalized one. If so, in collaboration with such activities initiated by such agencies consider short-term subsidy arrangement with pharmacies for those items under certain circumstances, the parish offices to induce them to keep them in stock. Coordinate all efforts in distribution of low-cost contraceptives so that all those selling them at low cost are making the same profit.

**Recommendation 13. (Education, Evaluation, Research)**

Research the feasibility of using market networks of curanderos and generators to distribute selected contraceptives, and simple educational materials.

Intensify efforts, in one geographical area, at training and motivating pharmacists in the promotion and sale of contraceptives. Provide them with promotional materials. Evaluate, using as baseline past year's sales.

Do a longitudinal study in one health circuit, or even one parish, to attempt to persuade selected pharmacists to log acceptors who return for replacements to trace continuance.

Attempt to persuade selected pharmacists to log acceptors who return for replacements to trace continuance.

**Recommendation 14. (Education, Institutional Modification)**

Have health aide in some areas for similar data. Intensify family planning considerations in midwife training.

as discussed in Chapter IV. Give trained midwives contraceptives for their kits and permit same sales profit as for UNIC and health aides.

Recommendation 15. (Research/Evaluation)

Admit, as policy, the reality of the belief about the pill that it requires a level of food intake beyond the reach of campesino economic resources. Test, as a culturally compatible health intervention, the simultaneous distribution of a supplement of a type both medically acceptable and highly regarded by campesino clients, such as Hemostyl Jarabe or its equivalent.

Recommendation 16. (Education)

Contemplate the program possibility of discussion groups for adolescents on human sexuality and responsible parenthood, as a legitimate activity for a rural health post, either as an independent activity or in collaboration with such activities initiated by CENIA educators or, under certain circumstances, the parish priest.

Recommendation 17. (Research)

Research the feasibility of using market networks of curanderos and especieros to distribute selected contraceptives, and simple educational materials, at a profit.

Recommendation 18. (Research)

Do a longitudinal study on one health circuit, or even one health post, carried out by an interested doctor and graduate nurse, the goal of which is to calculate the average number of promotional efforts at the clinic level needed to persuade a patient to accept and continue with contraceptive methods. Have health aide in same area log similar data.

Recommendation 19. (Research)

Sponsor research into characteristics shared by men who have vasectomies. Use as basic data source sterilization clinic records. Take random sample and follow back for structured interviews which will be designed to account for the following: educational level; income; occupation; marital status; number of children (living and dead); religiosity; mobility; concepts of ideal family size; attitudes toward male-female relationships; family decision-making vis-a-vis family planning; source of information and motivation re vasectomy; attitudes toward the operation, before and after; and disposition to proselytize.

CHAPTER VI

HEALTH AIDES PILOT PROGRAM

Evaluation: Goal and Purpose

The goal of the requested evaluation of the health aides pilot program in the Eastern Health Region was to complement qualitatively a more quantitative evaluation already undertaken by the Regional Office. The purpose was to arrive at some understanding of how the aides saw themselves; their level of preparation; their degree of success; their relationships with the Regional Office, the health post, and the community; as well as their ideas about possible changes in the program. This same research purpose also responded to what have been stated as the assumptions underlying the program,<sup>91</sup> i.e., not only that it is a needed link in the health system, but that 1) the services provided by health aides will be acceptable to the population; 2) that existing categories of health workers will cooperate with and support the outreach system; and 3) that people appropriate to the tasks will be recruited, trained, and placed, and will continue in their new roles.

Methodology

The methodology used for the evaluation involved half-day meetings in each of the three field sites, held on three consecutive days. After a brief introductory discussion of the purposes of the meeting, each aide was given a copy of a simple attitudinal questionnaire; the questionnaires were then filled out under the guidance of the researcher, who then rapidly

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<sup>91</sup> USAID/El Salvador. PROJECT IDENTIFICATION DOCUMENT (PID), RURAL HEALTH DELIVERY SYSTEM, 1978-79 (Project No. 519-0179). San Salvador, April 1976.

<sup>92</sup> The topic is still

compiled the results.<sup>92</sup> The questions and concerns which emerged in the responses to the questionnaire were then used as the outline for a group discussion which was also open to any other concerns the aides had which had not been reached through the questionnaire.

### Findings

#### Health Aide Perceptions.

As a group, the health aides were unanimous in their appraisal of the importance of the program and all its components, so that the question relating to that perception was dropped after the first day. Without exception, the program was seen as crucial and valuable. Also without exception, the aides defined themselves as happy and comfortable in their work; nevertheless, they also expressed feelings of inadequacy, isolation, and frustration, the former originating in their preparation, the latter the chronic ailment of the community development worker.

Health aides also saw their relationships with the Regional Office the health post, and the community in a generally positive light. They expressed a desire for more frequent contact with representatives from the region, but saw the level of interest and quality of supervision as high. The relationship with the health post in their area was, in the great majority, marked by interest, respect, a disposition to cooperate with and have the help of the aides. The only indication of resistance was some unwillingness to collaborate in educational efforts.

As for the community, the aides felt that they were seen as leaders, as offering a valuable service, as representing help in case of emergency,

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<sup>92</sup> The total N for the three sites was 17, the number of health aides still active out of the original 20.

and as people of confidence (gente de confianza). On the other hand, the responsiveness of the community to health aide promotional efforts was very slight in the case of family planning and only somewhat greater in the area of domestic and community hygiene. The aides felt that there was more responsiveness to suggestions regarding nutrition and general health behavior.

The most interesting result of the questionnaire was the perception the aides had of their own level of preparation and competence for what they understood as their responsibilities. Some of them felt, incidentally, that it would be useful to have those responsibilities and general program goals spelled out more clearly, although this was not a major problem area for them.

The aides felt that in general the training program had been far too short. In particular they felt themselves incompetent, on the whole, to deal with sanitation education, to handle small curative demands, to do injections or vaccinations, or to give first aid.<sup>93</sup> They saw themselves as somewhat better equipped to deal with family planning education and contraceptive distribution, though they wanted more precise education regarding the advantages, disadvantages, and beliefs about methods, as well as with the identification of malnourished children. They felt their greatest competence, however, to lie in tracking dropouts and late-reporters for clinic controls, carrying out surveys, and educating in a general and basic way about nutrition and health.

already recognized by the regional staff, was the wide disparity in educational level and general intelligence: this emerged, at least in

<sup>93</sup> These skills had not been part of basic training, but were included in the questionnaire at the request of the Regional Subdirector as a way of identifying areas of felt educational need.

Not surprisingly; the aides' evaluation of their degree of success coincided with what they saw as the adequacy of their preparation. They perceived their greatest success, as differentiated from competence, as having occurred in followup of delinquents, survey administration, general health and nutrition education, and patient referrals.

When asked what they saw as their greatest problems in addition to need for further training, the aides listed, in order of importance: lack of audio-visual materials and working supplies; salary, which they saw as incommensurate with the demands of the job; and the obvious difficulties of distance and communication with which, nevertheless, they were coping. The aides had devised work plans which enabled them to respond flexibly to campesino work-days and habits, so that while schedule synchronization was a problem, it was one with which they seemed to be dealing satisfactorily. Aides further expressed a need for more meetings within and among groups of aides for mutual problem-solving. At the same time that they wanted opportunities for group deliberation among themselves, they did not see the discussion format as an appropriate teaching tool and continued to feel that the charla and the home visit were the best and most familiar models at their disposal.

#### Researcher's Perceptions

To the aides' view of themselves and their program must be added the researcher's perceptions of the aides. The most salient fact, one already recognized by the Regional staff, was the wide disparity in educational level and general intelligence; this emerged, at least in part, in the relative ease or difficulty evidenced in responding to the

questionnaire. At the same time, it must be said that educational level did not always correlate with the leadership qualities displayed or with degree of dedication to the job. Therefore, while it is agreed that minimum educational requirements for health aides will have to be higher than they were for the pilot group, educational level will not be sufficient in itself to determine eligibility.

The second observation was that the female aides as a group do not seem to be as effective as the male aides. The qualities of leadership, of dynamism and self-assurance, were simply not as evident as one might have hoped. The commitment to continue in their work presented more problems for the women than it did for the men. And, with scant exception, the women tended to be so self-effacing in a largely male group that their impact at their own paraprofessional level was diminished, along with their potential for reaching the generally unreached male component of the rural population.

The third comment does nothing more than echo the aides' own perceptions. Admittedly limited observation of the aides' capacity to deal with health material in charita form and the extent of their articulateness on given health subjects, strongly suggests that four weeks of rather generalized training that is not followed by a closely-supervised field practicum period will not be sufficient to launch aides into a cantonal environment with skills adequate to community priority needs.

The fourth observation is that the experimental mode of the program necessitated a somewhat random approach to candidate selection which, in the next stage of the program could be more standardized, employ more sharply defined selection criteria, and an expanded universe of potential trainees.

Total 02-55 10-55 55 35-35 55 16-50

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The third comment does nothing more than echo the aides' own they would feel about seeking the services of newly-trained community perceptions. Admittedly limited observation of the aides' capacity to deal with health material in charla form and the extent of their articulateness on given health subjects, strongly suggests that four weeks of rather generalized training that is not followed by a closely-supervised field practicum period will not be sufficient to launch aides into a cantonal environment with skills adequate to community priority needs.

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02-55	10-55	33-35	50	16.608
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Community Perceptions

Time did not permit the one evaluation component which is essential for the successful expansion of the health aides' programs, i.e., the investigation at the community level which would provide the client view of health aide activity and utility, actual and potential. Among other things, there is a very real question in the researcher's mind as to the quality and force of leadership being displayed by the health aides in the community, and whether the affected communities really perceive the aides as health leaders.

It is useful to look at the responses to the survey question asked in Uluazapa about receptivity to new paramedical personnel. When asked how they would feel about seeking the services of existing paramedical personnel (pharmacists, injectionists, midwives, and curanderos) with additional Ministry training, the majority of respondents, women more than men, indicated willingness (see Table XXXVI). Nevertheless, when asked how they would feel about seeking the services of newly-trained community

TABLE XXXVI. DISPOSITION TO USE THE SERVICES OF PARAMEDICS WITH ADDITIONAL MINISTRY TRAINING.

Sexo	¿Dispuestos a Usar?			¿Por qué no?		
	SI	No	?	Uno pueda confiar más en el médico	Hay Clínica	No son Capaces
Masc.	75%	15%	10%	66.66%	-	33.33%
Fem.	90%	10%	-	-	100%	-
Total	82.5%	12.5%	5%	33.33%	50%	16.66%

members, respondents qualified their answers heavily (see Table XXXVII).

**TABLE XXXVII. DISPOSITION TO USE THE SERVICES  
COMMUNITY HEALTH LEADERS WITH BASIC  
MEDICAL TRAINING.**

Sexo	Dispuesto a Usar?		Condiciones del Uso				
	SI	No	Calidad de entrena- miento y lo sacado	Emergen- cias y último recurso	Han estu- diado y tam- bién practica- do	Citas, razones de	No sabe, no entien- de
Masc.	95%	5%	47.36%	5.26%	15.79%	15.79%	15.79%
Fem.	95%	5%	31.50%	31.50%	10.53%	5.26%	21.05%
Total	95%	5%	39.47%	18.42%	13.16%	10.52%	18.42%

on basic health services and fundamental technology follow:

Masc. 95% 5% 47.36% 5.26% 15.79% 15.79% 15.79%

Fem. 95% 5% 31.50% 31.50% 10.53% 5.26% 21.05%

If this separate analysis is admitted for male and female centers, and a second assumption is accepted that the center

priority, then training of health aides will have to be a high priority with different emphasis in sequence and subject matter.

Total 95% 5% 39.47% 18.42% 13.16% 10.52% 18.42%

the current training curriculum which, in the view of staff alike, The consensus of the response was that use would depend on the quality of the training given and how much of that training had actually been absorbed and practiced by the trainees. Even assuming those given utilization would be on an emergency disaster resort basis. In other words, the fact that there is a tradition in rural municipalities to depend to some extent on paramedics such as pharmacists, dentists, midwives, and curanderos (where they are accessible) does not necessarily imply that new paramedics will be automatically accepted. This, combined with

the high value placed on fully-trained physicians and clinic facilities

in areas which have developed some sort of dependency on them, would

suggest that the probability of a similar dependency relationship develop-

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ing with a health aide will be relatively slight, at least for the near future. An acceptable role for health aides in these circumstances would be one that would combine liaison and promotional activities with supportive clinical skills and emergency competence.

On the other hand, contacts and observation and the cantonal level imply a different set of needs and correspondingly different roles. Difficulty of access to fixed health facilities will, in effect, invert the health aide's role content, so that priorities for cantonal aides would be on basic health services and fundamental technology, followed by liaison, with promotion important but last.

If this separate emphasis is admitted for rural municipalities and cantons, and a second assumption is accepted that the cantons merit first priority, then training of health aides will have to be a two-track process with different emphasis in sequence and subject matter. If this is so, then the current training curriculum which, in the view of staff and aides alike, has the best equipped cantonal aides for liaison and promotion, would have to be adjusted.

In either case, expressed cultural values accord with the latest Ministry program outline<sup>94</sup> which includes as an important component uniforms and equipment; these will ritualize and symbolize the professionalism which the Ministry hopes to achieve in its new paramedical corps and serve to reassure and motivate the rural clientele with such a corps is intended

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<sup>94</sup> Ministerio de Salud Pública y Asistencia Social. LINEAMIENTOS PARA LA ELABORACION DEL PROGRAMA DE PENETRACION RURAL A TRAVES DEL AYUDANTE DE SALUD RURAL. División Materno-Infantil y Planificación Familiar. San Salvador, El Salvador, Abril 1976.

to serve.

#### Summary

The necessarily limited findings of the field evaluation suggest that the three fundamental program assumptions stated at the beginning of this chapter are only partially supported by the experience of the pilot program. First, the validity of the assumption about community receptivity depends on whether the community is cantón or municipality; rural municipal receptivity is qualified and the assumption of receptivity at the cantonal level has been based on a perception of an indubitable need for intermediate health services, but not as yet on any research into the preferences and perceptions of cantonal residents.

Second, the assumption that existing categories of health workers will be cooperative and supportive appears, at least at present, justified.

The pilot group of aides saw no significant problems and clinic staff interviewed by the researcher were quite positive in their attitudes toward the possibility of paramedical support personnel.

Third, the assumption of the appropriateness of the trainees recruited, the adequacy of their training, and their continuance with the program, is not yet substantiated. The recruitment criteria and nature of the trainee population have already been recognized by some Ministry staff to require adjustment, the training component to need both refinement and expansion, and the problem of continuance to be real and unsolved.

#### Recommendations

(Note: Many of these recommendations coincide with the program components presented in the Ministry "Lineamientos" referred to above. The coincidences will be recognized. However, the present recommendations were arrived at independently during the research process.)

ship and service structures, at both the municipal and cantonal levels.

Recommendation 1. (RECRUITMENT)

Expand the possible trainee universe to include individuals already acting in a paramedical capacity -- CEIAP botiquinistas, injectionists, midwives who wish to deal with broader health issues, pharmacists' wives and assistants, mecánicos dentistas, nurses (enfermeros or enfermeras), and community members who have been through the San Lucas or Castaños training programs. Many of these are, in effect, trained, but as formal health aides they become integrated into the rural public health system and form an explicit part of the health team.

~~--- If an appropriately motivated and well-regarded~~ curandero can be identified who is disposed to participate in the health aide program, bring into training on an experimental basis. It is not certain, assuming that the perceptions of various rural observers are correct, that most curanderos are motivated, economically, culturally, or medically, to become participants in modern public health programs.

As in the case of education, the fact of paramedical competence does not imply leadership competence, and the two criteria should be incorporated into selection decisions.

Recommendation 2. (RECRUITMENT)

Standardize the network of contacts in each community for the selection of future cohorts of health aides. From the standpoint of a program still in the process of experimentation, such standardization will introduce more control into the evaluation process, in addition to contributing more consistency and efficiency to the selection process itself. A policy decision should be made about those who will be interviewed in the leadership and service structures, at both the municipal and cantonal levels,

for suggestions about program candidates, including the very real possibility of self-selection. A decision should also be made about the technique to be used for getting some input from key community members regarding candidate selection. The chosen technique will depend on time and funds available, but the optimum would be a random sample, using a tightly-focused questionnaire, of the minimum statistically acceptable size. Such a questionnaire would request respondents to name existing paramedical personnel and to rank them on leadership and confidence dimensions, as well as others in the community who could be called leaders in terms of previous activity, of authority and respect, of confidence and admiration, and/or of degree of skill in dealing in the cantonal, municipal, and urban worlds. Training and orientation period, followed by tasks: Recommendation: 3. (RECRUITMENT) supervised field practice allow. If women are to continue to be recruited, and they certainly should be for a number of very strong reasons, the following compensations should be made for certain cultural realities:

a) Additional training emphasizing leadership skills, motivation, and self-assertion, group dynamics, plus reinforcement in subject-

a) Scatter areas where any special weakness is felt;<sup>95</sup>

b) In one cantonal area, as a closely controlled experiment,

formation of a health aide team composed of women only, so that

they derive strengths from one another and are not inhibited in

their team functioning by the rural cultural tradition of self-

affacement in target male groups, especially in the case of

young women entering of clinic roles (see Chapter

a) Basic first aid and use of simple medicines for

<sup>95</sup> A possible training model might be that used by the Center for Social Promotion at the Catholic University.

Recommendation 4. (RECRUITMENT)

Reconsider the criterion for a 40-year age limit. This is particularly discriminatory against women who 1) finally have most of their children at some level of self-sufficiency, 2) are not so invariably part of the 'old guard' (la vieja ola) that they are statistically unlikely to have reached sixth grade, 3) have the weight of some age and experience, and 4) still have enough vigor and years of work potential to justify the training investment.

Recommendation 5. (EDUCATION)

--- In addition to a training program longer than four weeks, contemplate ---  
a training sequence which is essentially incremental, i.e., a basic general training and orientation period followed by task-specific and syndrome-specific mini-courses, with supervised field practicums which will allow for skill-testing and immediate correction of misunderstanding or error.

Recommendation 6. (EDUCATION)

The retraining priorities for existing aides suggested by the evaluation are:

- a) Sanitation, including community, domestic, and personal, hygiene. Health aides, as members of the community but also as supposedly 'satisfied users' of more healthful hygienic practices, are particularly suited as motivators of behavior change in an area of strong cultural resistance.
- b) Injections and vaccinations. Goal is to offer a skill which will permit restructuring of clinic roles (see Chapter IV).
- c) Basic first aid and use of simple medicines for symptomatic treat-

ment.

- d) Family planning, with emphasis on methodology, related beliefs, and problems.
- e) Identification and emergency treatment of malnutrition.
- f) Training in use of audiovisual materials (assuming a supply), with emphasis on utilization with a client population of low literacy.
- g) Training in the group dynamics/discussion group teaching model, emphasizing role-playing/psychodrama techniques.

Recommendation 7. (EDUCATION)

The findings of the whole field study indicate that there is a need for eventual inclusion of the following skills and subject matters. Given the probability that there will continue to be a certain percentage of the cantonal population which will not accede to the complete cycle of maternal-child health care, as well as a percentage of midwives who will be ineffective in referrals, health aides should know:

- a) The fundamentals of well-baby care, using as guidelines the same outlines for maternal-child health interviews referred to in Chapter IV. Because the program has experienced the same difficulty known so well of new babies, the use of referral slips, evaluation has
- b) Danger signals of pregnancy.
- c) Basic expectations for desired midwife procedures.
- d) Syndromes of most common child and infant diseases, not only for purposes of symptomatic treatment but for referrals at appropriate danger points.

Recommendation 8. (INSTITUTIONAL MODIFICATION, LOGISTICS)

Contemplate the eventual provision of portable radio transmitters to health aides for scheduled and emergency consultation with fixed facility in order to establish emergency consultation with fixed facility (by too high in numerical terms), existing aides should not only log number

staffs.

Recommendation 9. (EVALUATION)

Each community to be affected by health aid programs should be surveyed by the aide at the outset through a standardized tool which is basically the same nationally, with space allowed for additional, regionally identified data needs. This survey would have a family code number tied to health post files and control map, and would record basic social and economic information, family composition, minimal migration data, education levels, occupation, income, household goods, vaccinations, resources sought when ill, use of communications media, community action and attitudes, sanitation-related data, major family problems, notation of participation in or eligibility for clinic control programs, et cetera. This will provide Ministry and Regional staffs with consistent baseline data for rural health program identification and planning, as well as for evaluation of the health aid program itself.

Recommendation 10. (EVALUATION)

Because the pilot program has experienced the same difficulty known so well by health posts, i.e., the loss of referral slips, evaluation has been hampered. Either such slips should be made more official-looking, or the health post should seek and log these data as part of daily and cumulative record-keeping, or both. Otherwise it will be difficult to gauge the impact and spread effect of the referral and compliance components of the health aid program.

Recommendation 11. (EVALUATION, RESEARCH)

In order to establish realistic program objectives (which are presently too high in numerical terms), existing aides should not only log number

of home visits and group meetings, but the number of visits required to achieve compliance with a given health recommendation. Such a compilation would also fill a major research gap; programmers still have only the vaguest idea of how many contacts, on the average, of what type and length, are needed in programs of motivation and education to produce behavior change and sustain it.

Recommendation 12. (EVALUATION, EDUCATION)

If it is a ministry objective that the evaluator-supervisor be able to provide on-the-job training in addition to supervisory responsibilities, the level of his or her training and experience may have to be more advanced than that currently contemplated. Such personnel should also have some specific training in supervision and evaluation, rather than the almost exclusively empirical base which has been the norm.

Recommendation 13. (EVALUATION)

Evaluation of community-level acceptance and impact of health aides should be standardized and its mode established at the outset. The ideal would be small-scale random surveys in the impacted communities, with a few, in-depth, unstructured interviews with a standard set of key informants to supplement the survey data.

CHAPTER VII

SUMMARY

Restatement of Objectives

The central assumption of the Salvadoran Ministry of Health which engendered this study was that delivery and utilization of public health

services in rural El Salvador has been less effective than it might have been. The logical research question then becomes: why? Four factors were suggested as possibly responsible: spatial distance, economic distance, social distance, and intellectual distance. The core hypothesis for the

research was that a combination of the last two factors, social and intellectual distance, constituted the most probable impediment to program

Impact. This hypothesis was to be tested through the use of anthropological field techniques by an anthropologist resident in a rural site.

The study also asked what program modifications or additions could be devised that would diminish the hypothesized distance. The research

- a) The timely and accurate diagnosis and reporting of disease emphasizes were: 1) the quantity and quality of the staffs of fixed facilities, in terms of their responsiveness to rural health needs; 2) the technology, through not the underlying concepts, of modern rural experience of rural residents with that staff and those facilities from the standpoint of social and cultural compatibility; and 3) the behavior and beliefs of campesinos as related to disease management, nutrition, maternal-child health, and family planning.

The following findings and recommendations summarize and cut across

- e) Reluctance to change some behaviors related to domestic and personal hygiene.
- f) Compliance with clinic control programs.

## Major Findings

### Finding 1.

Campeños are not, contrary to conventional wisdom, so wedded to traditional beliefs and habits that they are culturally indisposed to the use of modern medical facilities. In fact, rural residents have already developed, despite social, economic, and spatial impediments, a considerable dependence on modern medicine; the trend in treatment of a number of illnesses is away from an initial reliance on auto-medication and traditional practitioners toward a reliance on a combination of clinic and pharmacy. Traditional medicine and modern medicine continue side-by-side, perceived as valid in varying ways, both tools with which to cope with the perplexity of human illness.

### Finding 2.

The factors of social and intellectual distance between health deliverer and recipient matter in all aspects of rural health delivery, but they constitute determining factors in the following:

- a) The timely and accurate diagnosis and reporting of disease trajectories and symptoms.
- b) The technology, though not the underlying concept, of modern preventive health.
- c) The educational impact of all health program components.
- d) Reluctance to change nutritional behavior under circumstances of certain diseases and specific points in the female life cycle.
- e) Reluctance to change some behaviors related to domestic and personal hygiene.
- f) Compliance with clinic control programs.

- g) Adoption of and continuance with family planning methods
- h) Motivation of existing paramedics to the upgrading of their medical skills.

**Finding 3.**

More pragmatic economic factors constitute determining factors in:

- a) Male decisions to report illness
- b) Use of private physicians.
- c) The consumption of what is correctly perceived as an adequate, well-balanced regular diet
- d) The disposition to undertake sanitation measures which involve financial cost.

**Finding 4.**

**Finding 5.**

Spatial considerations, defined as a combination of geographical and temporal distance are relevant, but not determining, in:

- a) Decisions to use hospitals for accouchements.
- b) Male use of the clinic as a health resource.
- c) Utilization of the health post by cantón residents.

**Finding 6.**

Clinic schedules and role responsibilities militate against client/practitioner satisfaction, as well as against the potential for outreach activity.

**Finding 7.**

The key master and accessible, is

**Finding 8.**

The sense of a rural health team, either as a concept or as a reality

**Finding 9.**

in field operations, is as yet in its infancy. The average health worker

**Finding 10.**

does not see him or herself as a member of a total system embracing both

**Finding 11.**

clients and a wide set of potential colleagues. those of avail-

Finding 7.

One of the highest priorities cited by health post clientele was the development of fuller contact between staff and patient population in terms of time, expanded facilities and services, educational content, and, of highest importance, mutual understanding and sympathetic treatment.

Finding 8.

Curative and consultative services, together with the highly prestigious presence of a doctor, were considered by clients to represent the clinic's most important function. This suggests at least some initial resistance to clinic role modifications, to emphasis on new paramedical personnel, and to expansion of essentially preventive control programs.

Finding 9.

Existing individual and group contacts between modern health practitioner and rural client are inadequately exploited as educational possibilities. The main obstacles to effective exploitation are essentially those of social-cultural and intellectual distance, i.e., the patron-client tradition, the pedagogical tradition, and the medical tradition, all of which represent imbalances in control of power and knowledge which impair information exchange.

Finding 10.

The key health entity in rural and semi-rural areas, where it is accessible, is the pharmacy, for a combination of pragmatic and cultural reasons.

Finding 11.

Constraints on the utilization of audio-visual media are not only those of availability but of a perceived lack of expertise in the use of

communications hardware and software

Finding 12.

The main reason for resistance to adoption and/or continuance in the use of family planning methods is not lack of commitment to the desirability of planning family size and spacing, but beliefs about the effects of those methods on female health.

Finding 13.

The largest single category of the population essentially unreached by the health delivery system, and yet the potentially most receptive and rewarding audience in program terms, is the rural male.

Finding 14.

The health needs of cantón and rural municipality are distinctive enough to require different emphases and priorities in the training of paramedical personnel.

Finding 15.

The mental health of campesino women appears to represent a problem which merits further investigation and clinical attention.

Finding 15:

Supervision and evaluation activities are biased toward use of quantitative indicators and logistical considerations, a bias which detracts from Ministry of Health capability to fully appraise the impact and quality of health service delivery.

Major Recommendations: Education,

Recommendation 1.

reference:

Integrate into all levels of professional and administrative training awareness of the campesino as a health tactician, into whose calculations

and whose adoption of modern health behaviors depends to a great extent on the understanding and respect of the health service deliverer. Include as well recognition of traditional behaviors which are beneficial and merit reinforcement, together with identification of traditional practices which are detrimental to health and the most culturally compatible ways of modifying such practices.

Recommendation 2.

Establish priority target populations and differential training emphases as follows:

- a) Rural women. Emphasize symptom and syndrome identification and disease management for major children's illnesses; motivation and practicums related to maternal-child health and hygiene; the mechanics of family planning and the comparative risks entailed.
- b) Rural men. Emphasize family planning motivation and methodology; symptom and syndrome identification and disease management; procedures for domestic and community hygiene.
- c) Rural pharmacists. Emphasize updating of diagnostic skills and knowledge of pharmaceutical arsenal; basic first aid; community health development; family planning technology.
- d) Rural health aides. For cantons, emphasize basic health expertise, followed by competence for referral and community health promotion. For rural municipalities, emphasize clinic support skills and emergency health competence.
- e) Midwives. Emphasize identified counterproductive practices, referral motivation, family planning methodology, with principal training motivation the potential for professional status.

Recommendation 3.

Institute training in alternative pedagogical models which stress exchange and feedback models, discussion and seminar formats, and the "satisfied-user"-participant, particularly in the areas of hygiene, nutrition, family planning, sex education, and mental health.

Recommendation 4.

Incorporate into university-level medical training the following:

- a) Anthropological theory and methodology, including field work in prospective area of Año Social.
- b) Public health ideology and practice.
- c) Community development concepts and approaches.
- d) Basic administrative and supervisory procedures.

Recommendation 5.

Offer on-site mini-courses on use of audio-visual technology.

Major Recommendations: Institutional Modifications

Recommendation 1.

Restructure clinic schedules and role responsibilities to permit better use of available skills, more opportunities for outreach activities, and better access to rural male population.

Recommendation 2.

Encourage as policy the team concept, not only among medical and para-medical personnel, but among all representatives of outreach entities in the rural sector whose activities may affect rural health.

Recommendation 3.

Modify archival system to reflect family rather than individual health profiles and key these to a control system for total community health

management.

Major Recommendations: Research and Evaluation

Recommendation 1.

Research priorities should include attention to the following:

- a) Identification of beneficial and detrimental traditional therapies.
- b) Census of pharmacists and indigenous practitioners in retraining pilot program areas.
- c) Reasons for persistence in special diets and late- or non-reporting of child malnutrition.
- d) Investigation of reasons for family planning dropouts and delinquencies, through health aide follow-up activity.
- e) Characteristics of the male population disposed to vasectomy.
- f) Campesino beliefs about the causes and meaning of bodily aches and pains.
- g) Community perceptions of health aide program activities.
- h) Factors, impact, and possible therapies for mental health problems of rural women.

Recommendation 2.

To improve the utility of clinic records for evaluation purposes, the following should be added:

- a) Cumulative data on proportion by sex of clinic clientele.
- b) Time element in disease reporting, in anamnesis section of patient dossiers.
- c) Sterilization referrals and completions.
- d) System for unified logging of patient call-backs and returns.

Recommendation 3.

Develop qualitative indicators -- or quantitative indicators which more accurately reflect issues of time, continuity, and content of contact between practitioner and client -- as well as supervision schedules which permit observation of quality of service. Indicators should measure not only delivery but program impact.

Recommendation 4.

To be economical and conducive to rapid feedback, evaluations in general should be small in scale, tightly focused, and of a quasi-experimental design which tests the social and economic costs and benefits of a given health intervention.

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