

Communication in health care delivery in developing countries: which way out?

Abstract: Most governments in developing countries have adopted frameworks for health development which stressed community-based initiatives and intervention at all levels of the health pyramid (WHO, 1992). But even today, most of the rural communities in these countries are still not developed in terms of available health facilities. What then is/are responsible for these failures? Various authors have come up with various reasons, principal amongst which are inadequate resources, lack of planning, insincerity/non-commitment of the governments, lack of modern information technology, etc. This paper examines some of these factors in relation to how they accentuate or hamper healthcare delivery in developing countries, using African rural communities as a study field. The resultant suggestions are a consortium of varying factors, some of which are economic in nature, policy changes, human resources development, and re-orientation of social and government attitudes towards achieving meaningful results in healthcare delivery, particularly in the rural communities.

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Introduction

The Alma Mata Declaration in 1978¹² envisaged, in the name of social justice and equity, the reorientation of the health policies of countries with a view of attaining the social objective of health for all by the Year 2000, through the approach of the Primary Health Care particularly in developing countries. Accordingly therefore, in the face of generalised crisis and in order to accelerate the thrust towards this health for all, African leaders adopted a framework for health development which stressed community - based initiatives and interventions at all the levels of the health pyramid².

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all" would depend very largely on good information, information (through communications) that is needed for internal operations as well as for exchange with the external environment in Health Care programmes, especially in developing countries. For instance, hospitals would need efficient records systems, medical personnel would require systems that will assist them in the performance of their duties (diagnosis records, treatments, referrals, etc.).

For all these (and much more) to happen, channels of communication must be developed, maintained, and kept open for efficient and effective operations, e.g. communication channels between hospitals on one hand, and district health centres, pharmacy shops and local dispensaries on the other, must be kept open. Similarly, it is very imperative that communication channels between the Health Ministry and other operators of health activities be kept open all the time. Studies have, unfortunately, shown

otherwise¹. Why?

1. Helping hand from the West

This situation of lack of communication channels and its ensuing lack of information structures must have formed part of the reference points of the World Health Report of 1987 by WHO Director General where it was stated:

"...Today, information structure and infrastructure to support decision makers in health activities is weak..."

In a meeting of the G7 (Group of Seven top industrialised nations), experts wondered if the world's poorest countries can develop, support and sustain global information highway, considering their poor economies. "...There's a problem in there..." they contended. But South Africa's Deputy

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President Thabo Mbeki, the only African invited to the event, urged the seven not to exclude developing countries from the plan which is expected to revolutionise communications, embracing the use of computers, telephones and televisions to link consumers with services and each other across the world^{3,6}. Similarly, World Bank Vice-President Jean-Francois Rischard said telecommunications and information technology could enable less advanced countries to make a big leap forward by helping them to streamline public services (especially Health Services) and expand education opportunities. In apparent sympathy for the position(s) of the developing world, satellite company Teledesic Corp said it would give away some of its telecommunications capacity to help developing countries. Russell Daggatt, the company's president, told Reuters that the offer meant several regions and countries would have free access to some of the fastest communications available for health or education purposes.

But is this what the developing countries really need?

Suppose the G7 countries agree to pull developing countries along, can developing countries actually afford and support these infrastructures? Do their organisational structures support the types of information arrangements found in western countries? Mbeki said:

"...Three quarters of white people in the South African City of Durban had a telephone but only 2 per cent of blacks had one. More than half of humanity in developing countries had never made a telephone call...."

He added:

"...The reality is that there is more telephone lines in Manhattan, New York, than in sub-Saharan Africa...."

Preliminarily, these assertions would seem to suggest that the models for information gathering and dissemination in these countries, and perhaps western world are presently not available in developing countries, and perhaps can not be supported (totally) by their poor economies and the organisational structures. If this premise holds, there is therefore a (compelling) need in developing countries to understand the cybernetics of their information structures to illuminate their problems. This cybernetics would provide a language sufficiently rich and perceptive to make it possible to discuss the problems objectively.

2. Assessment of health and communications services in some developing countries

Access to health and communication services are unequal across these countries; even within each country, these facilities tend to be highly unequal across administrative districts and between rural and urban areas. For instance, according to World Bank Report in 1993, among 23 States in Nigeria, the prevalence of health facilities ranged from 1 per 200 people in Lagos State (in the South-West) to 1 per 129,000 in Benue State (in the Middle-Belt) similarly 75 per cent of the country's public and private health facilities are concentrated in urban areas; serving only 30% of the population, the remaining being in the rural areas. For communications, there are only limited telephone lines even in the urban areas; in the rural areas communication is mainly by postage which take on the average 10-14 days within the country. Alternatively, important (urgent) messages are sent through personal/official drivers who at times have to drive long distances. In Angola, the supply of hospital beds ranged from 3.9 per 10,000 people in the province of Malage, to 41.6 per 10,000 in Lunda Norte. In Togo or Uganda, only 1 in 5 married women can obtain family planning advice at health centres or pharmacies within walking distance. Conversely, close to 50 per cent of urban women can obtain such services from health centres

in Zimbabwe. In Botswana similar access is 85 per cent in rural areas, and 95 per cent in rural areas, and in Mauritius, access is 99 percent¹⁰.

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Periscoping the Nigerian experience recently, the Coordinator of African Environment of Economic Peace Mission, Mr. Sam Obianigwe⁸ wrote: "...we identified two major limiting factors as the cause of the greater percentage of failure of the

initiative rather than the anticipated success. The first problem is the *communication gap between the urban and rural functions* in Nigeria. This is parallel followed by the distance between the rural population concentration and the Bamako Initiative Centre...." (author's italics).

This indicates that communications particularly across frontiers (i.e. between the various levels of operators) need to be examined closely, e.g. between Central government, state governments and the local or provincial governments; between decision makers in their urban offices and the implementers of the health programs in the rural areas; between international donors of drugs and the local clinics and community health centres in the rural areas, etc.

3. Channels (and types) of communications between the various bodies involved in health delivery

The study looked at the organisational structures of the Health Care Delivery System in Botswana, Fiji and Nigeria; the structures in Botswana and Fiji were very similar in that there are only two tiers of implementers (the Central government and the Provincial governments). In Nigeria, there are 3 tiers – the Federal, the State and the Local governments. In all these cases, however, there were, so to say, evidences of channels or avenues of communications (meetings, memos, official visits to local communities, etc.). But without any attempt to discredit the performance(s) of the systems, it could be said that these channels of communication between the various organs, laterally and vertically, exist only on paper; in reality these channels are either for purposes of window – dressing and/or cosmetic displays; where they function at all, it could be said that they have been reduced to channels of For-Your-Information-Only (FYIO) messages, especially where they function vertically (e.g. between the Federal Ministry of Health and the Teaching Hospitals).

A fairly recent example of this situation is exemplified in the doctors' strike at Teaching Hospitals all over Nigeria over:

"The Federal Ministry of Health's failure to honor the agreements reached between it and officials of Nigerian Association of Resident Doctors"⁴ and over "The Minister of Health's unguarded and inflammatory media pronouncements' which undermined the credibility of the said agreements"⁵.

The FYIO tagging is further strengthened by the *ad-hoc* nature of meetings between the various organisations, which are mostly at the instance and/or convenience of the respective bodies at upper levels – timetables for meetings are very hardly adhered to and agendas are always drawn by "superior" bodies.

A reasonable deduction from these situations is that no matter what communication systems (physical or procedural) are donated to these developing countries there is very little contribution these donations can make to the efficiency/effectiveness of the Health Care Delivery if the appropriate channels are not available and the communication channels in these countries are not wide open.

There is no doubting the fact that western communication systems would be very valuable in Health Care Delivery Systems in developing countries; but these benefits have to

be viewed against impediments: that would work against their success.

1. Poor economies

Evidences abound all around us to testify to the poor economies of developing countries. In Fiji; over 30 per cent of the population live below poverty line¹¹. In Botswana⁹ and Nigeria¹⁰ the corresponding figures are 28 and 21 respectively. Other countries are just as bad as these are, if not worse. In countries where there are not enough food, shelter, (good) roads, (drinkable) water, etc, where children mortality is very high, where life-expectancy is low, and where medical facilities are grossly inadequate, it will not stand to good reasoning to make western technologies their priorities, in the name of development. As opined ear-

lier, even if these technologies are donated free to these countries, their economies and manpower will still not be able to cope with the maintenance, not to talk of the necessary infrastructures to support them.

2. Technical know-how

Western countries develop their technologies themselves and there are therefore no problems of understanding their workings. However, when these tools are brought to developing countries, there arises the problem of know-how i.e. usage, maintenance, repairs, upgrading, and replacement in times of obsolescence. Where there are initial aids to take care of these problems, the fact still remains that these aids can not be on forever. There are evidences of western donors withdrawing their aids from developing countries because of the global economic recession, or because of change of policies, or at times, because of ideological differences or political (re)alignments.

3. Organisational structures

The sociological and/or cultural structure of developing countries may have encouraged organisational structures that border on hierarchical arrangements that manifest in superior - subordinate concepts. In some cultures in the developing world, juniors or subordinates do not talk back to their seniors or superiors, even when the junior knows that what the senior has just said is false (not true). This cultural phenomenon is carried even unto official matters, where true information offered by the subordinate can be "declared" false or unsuitable; conversely an information by the senior can be forced down the system, true or otherwise. This is at variance with situations in the west where there is some latitude in dual examination of information gathering and dissemination. Situations of this nature cannot be

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Table 1. Advocated Channels of Communication

At the Federal or Central Government Level	At the State Government Level	At the Provincial or Local Government Level
<i>Exogenous Channels</i>	<i>Combination of Exogenous and Indigenous Channels</i>	<i>Indigenous Channels</i>
International Conferences Sponsored (foreign) Visits Computer related tools: email, internet, teleconferencing, etc. High-frequency telephones Telephones with International dialing facilities Fax facilities Regular cabinet meetings Advertisements	Regional conferences National conferences Seminars High frequency telephones Fax facilities Email National telephones State participating radio stations, Sets of television for rural areas Battery operated radio sets Regular meetings of State Cabinet Advertisements	Regional conferences Radio-phones Smaller sets of television Telephones at the headquarters and health clinics Visits by Health Workers and Health Visitors Religious meetings (e.g. Churches, Mosques, Temples) Posters Dramas Community Meetings Village or Chiefs o Announcers Social gatherings e.g. Mothers Clubs, Council of Elders etc.

rectified by any type of technology; perhaps, the only type of technology that can help is systems technology, i.e. procedural systems and methods that take cognisance of the sociological and cultural needs for gradual change of attitude in these countries.

4. Societal attitude

There were grave evidences of lack of willingness to share information with others; there was the (unfortunate) attitude of "keeping what you have to yourself". This sort of attitude does not help information gathering and/or dissemination. What developing countries need very badly is to cultivate the culture of information dissemination. If this does not form their bedrock, it is difficult to believe that sophisticated western communication tools and practices will solve their communication problems.

On top of this, in the South Pacific for instance, is the "*Malau fever*", which describes the easy the attitude of the people; here, life is generally taken easy, even official matters. So even with the best of communication tools, the human attitude is absolutely essential to utilise them efficiently and effectively.

Which way out?

It can not be denied that the introduction of electronic tools like e-mail, internet, cellular phones even ordinary phones, computers, etc., have helped in some ways to put information closer to the operators of Health Care Delivery System in developing countries; but these are only available at the very top of the system, and only to very few. They are perhaps useful mainly in policy functions.

For the time being, and perhaps in parallel with erogenous western channels of communication, developing

countries can revisit some other forms of communication they seemed to have abandoned or not paid much attention to again. These are described as "indigenous" channels of communication, which have formed important aspects of the people's culture and have enjoyed high credibility among the people; people had become familiar with these channels which were easy to control. They can be effectively employed for conveying health messages as some of them facilitate informal and interpersonal contacts. For more effective dissemination of health information and messages, particularly in the rural areas, these indigenous channels are advocated, not necessarily individually, but in some novel combinations as the situations require, as in Table 1.

The issue of TV in the rural areas is very desirable and may form a large portion of communication channels, especially battery - operated sets; the same thing goes for radios and radio phones. These indigenous channels of communication satisfy the concept of Primary Health Care which WHO¹² described as:

"Essential health care based on practical (and practicable) scientifically sound and socially acceptable methods of technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

These indigenous channels are potent media for educating the public on health issues; in addition, they are means by which culture is preserved⁷.

In conclusion, we would say that the poor economies, along with technical know-how, organisational structure and the social attitude of developing countries will not for

now, sustain the efficiency and effectiveness of western technologies for communications in health care delivery, particularly in the rural areas. And because the rural communities constitute about 70 percent of the population in developing countries, these exogenous channels of communication do not serve the generality of the people; rather they are mainly useful at the top of the system.

Health Care System will be accentuated if there are more programs for training and human resources development, if there are more drugs, if there are equipment like speed-boats, rugged vehicles, and perhaps helicopters. These successes will increase if government policies encourage provision of basic needs that would in turn encourage paramedics to stay in rural areas. There will also be greater success in the system if public enlightenment programs are mounted. Previous efforts at these have mostly been via organisational vehicles, which include educational institutions, health organisations, television, prints and radio. Much as these have proved useful to some extent, but their usefulness among the rural communities and the urban poor is limited, as much depends upon the economic power of the people. To reach the urban poor and the rural dwellers, it may be more successful to transmit health knowledge and public awareness through folk media, social organisations, home visits and instructions, dramas, and traditional songs, amongst others. This is particularly pertinent where the urban poor and the rural dwellers constitute about 70 per cent of the population.

Finally, organisational structures of the system may need to be modified in some situations for greater effectiveness. In his report, Obiangive⁸, the Coordinator of African Environment and Economic Peace Mission further submitted

"...Research revealed that the base of Bamako Initiative (a UNICEF and WHO program against AIDS) in Nigeria is the health centre attached to every local government secretarial instead of every community centre. By the original design of the initiative, it is

community-based and not local government complex-based. The local government is the central place for rural communities while the community central-place is the rallying point for rural dwellers..."

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Innovation comes from creative destruction.

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