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INVISIBILITY OF SOCIAL VULNERABILITY AND SOCIAL RIGHTS TO A COMPREHENSIVE HEALTH CARE IN CHILE

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ABSTRACT

Objective: To estimate the magnitude of perception of invisibility of social vulnerability and its impact on the access to universal and specific services of the Comprehensive Childhood Protection System in Chile.

Method: Cross-sectional study in 50 vulnerable dyads, who were registered in a family health care center (Metropolitan Region, Chile; 2012). After the informed consent, mothers were interviewed using a structured questionnaire. A correspondence analysis model was applied.

Results: The invisibility of social vulnerability estimated for mothers (92.0%) and children (86.0%), and a better access was observed to universal services by children and to specific services by mothers.

Conclusion: The invisibility of vulnerability limits the opportunities of social protection for disadvantaged groups. Therefore, public policy does not correct social inequalities, which deserve attention by the public health managers in Chile.

DESCRIPTORS: Social vulnerability. Public policy. Risk groups. Health inequalities. Comprehensive health care.

IN-VISIBILIDAD DE LA VULNERABILIDAD SOCIAL Y EL DERECHO AL CUIDADO DE SALUD INTEGRAL EN CHILE

RESUMEN

Objetivo: estimar la magnitud de la percepción de la in-visibilidad de la vulnerabilidad social y sus consecuencias en el acceso a servicios universales y específicos del Sistema de Protección Integral de la Infancia en Chile.

Método: estudio transversal en 50 díadas vulnerables, registradas en un centro de salud familiar (Región Metropolitana, Chile; 2012). Después de la firma de consentimiento informado, las madres fueran entrevistadas usando un cuestionario estructurado. Se aplicó un modelo de análisis de correspondencias.

Resultados: la in-visibilidad de la vulnerabilidad social fue estimada para madres (92.0%) y hijos (86.0%), observándose un mejor acceso a los servicios universales a los infantes y específicos a las madres.

Conclusión: la in-visibilidad de la vulnerabilidad limita las oportunidades de protección social a grupos desventajados. Como consecuencia, la política pública no corrige las desigualdades sociales, que merecen atención de los gestores de la salud pública chilena.

DESCRIPTORES: Vulnerabilidad social. Protección social en salud. Grupos de riesgo. Inequidad en salud. Atención integral de salud.

(IN)VISIBILIDADE DA VULNERABILIDADE SOCIAL E DO DIREITO AO CUIDADO INTEGRAL DA SAÚDE NO CHILE

RESUMO

Objetivo: estimar a magnitude da percepção da invisibilidade da vulnerabilidade social e suas consequências no acesso aos serviços universais e específicos do Sistema de Proteção Integral à Infância no Chile.

Método: estudo transversal em 50 díades vulneráveis, registrados em um centro de saúde familiar (Região Metropolitana, Chile; 2012). Depois do consentimento informado, as mães foram entrevistadas usando um questionário estruturado. Um modelo de análise de correspondência foi aplicado.

Resultados: a invisibilidade da vulnerabilidade social foi estimada para mães (92.0%) e filhos (86.0%), observando-se um melhor acesso aos serviços universais pelas crianças e aos específicos pelas mães.

Conclusão: a invisibilidade da vulnerabilidade limita as oportunidades de proteção social a grupos em desvantagem. Consequentemente, a política pública não corrige as desigualdades sociais, que merecem a atenção dos gestores da saúde pública chilena.

DESCRITORES: Vulnerabilidade social. Política social. Grupos de risco. Desigualdades em saúde. Assistência integral à saúde.

INTRODUCTION

Social vulnerability is an inequality indicator associated with insecurity, exclusion, uncertainty, lack of protection, susceptibility to health damage, and unequal access to health care. It is a state to which social determinants of the overall context converge, being a substrate for health problems.[1-5] Deteriorating health is main consequence of adverse social conditions accumulated during life, as high-level risk and physical and psychological damage are generated compared to population groups who do not present the social vulnerability condition.[1,5] Health vulnerability is understood as the deprotection that people face due to lack of personal, family, social, and financial resources.[5-6] In these scenarios, primary health care (PHC) requires relevance as a capital of vulnerable groups, due to the territorial distribution and universal accessibility of public health centers, being a strategy that allows to prevent and mitigate health risks.[5,7]

In countries with high rates of inequality, as in the case of Chile, compensatory policies have been implemented for social protection of people exposed to social inequalities and vulnerability.[5,8-9] The concept of inequality covers a broad spectrum of differences and disparities in the circumstances in which people live.[10] The effectiveness of these policies depends, among others, on perception and detection of vulnerability by health professionals in the health care system, as well as integrated and synergic management capacity of public institutions in transferring the services to vulnerable people and groups.[5,8-9,11] In the social protection policy, it was defined in the objective of process integration that institutions and their work teams are responsible for managing implementation, financing, and regulation of services.[5,12] This is a condition that has required ability for contextualized responses and new forms of institutional organization.[5,12] Collaboration between health services and local government institutions is considered to be the best way of obtain effectiveness and efficiency of health resources for poor people, as it has been based on collaboration between institutions and work integration between disciplines.[11-12]

Previous reports showed disparities between professionals' perceptions about social vulnerability of pregnant women (8.6%) and data obtained from the Social Protection Records (91.4%).[13] At the same time, poor women are perceived by themselves as invisible, hopeless, and socially excluded, and such perception affects their possibilities of self-determination, autonomy, and enjoyment of the welfare rights.[14] Reports of socioeconomically disadvantaged women show that they have unequal access to the health care provided by the network of health institutions and social protection.[1,15-16] The literature on social policies warns that there is an inability to make visible the social vulnerability, which is accompanied by a weakening in the coverage of social services to the citizens.[8]

In present study, the question was related to the visibility and opportunity situations of access to the services by dyads (mothers and infants), in conditions of extreme vulnerability and psychosocial risk, who were treated in a family health center of an urban community in the Metropolitan Region of Santiago, Chile. The aim of this study was to estimate the magnitude of perception of invisibility of social vulnerability and its consequences in the access to the universal and specific services of the Comprehensive Childhood Protection System, Chile Grows With You (*Chile Crece Contigo*, ChCC). Programs for universal social transfers, which are conditioned and focused on socially vulnerable children, are the fundamental axis of public policies directed to mitigate the inequality effect and reduce children vulnerability.[17-19] There is a growing debate

focused on the need to generate knowledge about the effectiveness of the social protection policy to reduce social vulnerability, especially in the opportunities for access to their services.[6,18]

METHOD

A descriptive cross-sectional study (non-experimental design) was conducted in a family health center of an urban community in Chile (Metropolitan Region of Santiago of Chile; 2012). Mothers and infants in extreme social vulnerability condition (<4,213 points) participated in the study. The inclusion criteria were as follows: history of prenatal control in women during pregnancy in the public health network, with percentile 5 in the social vulnerability stratification scale as measured by the Social Protection Record (SPR) scale, and their infant children, with health control only in the family health center of an urban community. During that period, 287 pregnant women were admitted to the obstetric control center. They met the inclusion criteria (71) or were not considered (21) for the following reasons: address change, non-acceptance to participate in the study, were not found at home, or the address and contact data were incorrect. Therefore, 50 mothers and their children were the final universe.

Variables on the women and their infants were studied regarding visibility of social vulnerability as recorded by professionals who conducted the health controls and biosociodemographic aspects (age, marital status, education, history of their biomedical, obstetric and psychosocial condition as identified during the prenatal control and after delivery). In children, biomedical birth parameters and history of the biomedical and psychosocial conditions were identified during child health control. This information was obtained from the clinical records and institutional databases of the health center. Information on the opportunity for access to universal services for mothers (15) and their children (7) during the child health control was obtained from secondary sources. Information on access to specific services was also obtained. The primary data were obtained by the investigators through a standard face-to-face interview, which was performed at home or in the health center. When mothers did not recall the information on the services received from the ChCC system, they were checked in the secondary data sources mentioned above. The study objectives were explained to the mothers, and anonymity and confidentiality were assured according to the criteria established by the Scientific Ethics Committee (School of Nursing, *Universidad Andrés Bello*, L1/CECENF/87). The mothers signed the informed consent form voluntarily.

Crude and refined databases were configured for processing and statistical analysis of the data. Critical analysis of the data was based on the SPSS (v. 20.0) computer program. Data were analyzed from position and dispersion descriptive statistics according to the variable nature. A correspondence analysis model was applied with regard to delivery of social services, and intending to form homogeneous groups from a set of relevant variables.

RESULTS

The invisibility of social vulnerability affected both pregnant women (92.0%) and their children (86.0%) in the access to the health control center. Visibility of psychosocial risk was greater because the health professionals used a standardized screening questionnaire (mothers: 34.0%; infants: 30.0%), which further increased its detection when the investigators reviewed the screening results and clinical records (Table 1).

Table 1 - Invisibility of vulnerability and visibility of psychosocial risk in 50 vulnerable dyads, according to the status of female household leadership, 2012

	Female household leadership					
	With		**Without**		**Total**	
	22		**28**		**50**	
	n	**%**	**n**	**%**	**n**	**%**
By perception of the health professional who enters the pregnant women.	20	90.9	26	92.9	46	92.0
By perception of the health professional who enters the infants.	20	90.9	23	82.1	43	86.0
Visibility of the psychosocial risk						
Mothers with psychosocial risk by application of psychosocial guideline.	6	27.3	11	39.3	17	34.0
Infants with psychosocial risk by application of psychosocial guideline.	5	22.7	10	35.7	15	30.0

	Female household leadership					
	With		Without		Total	
	22		28		50	
	n	%	n	%	n	%
Mothers with psychosocial risk by screening and clinical records.	13	59.1	12	42.9	25	50.0
Infants with psychosocial risk by screening and the clinical records.	16	72.7	20	71.4	36	72.0

As a consequence, invisibility of psychosocial risk also existed in mothers and infants, with a greater proportion in mothers who were household heads, relative to women who did not have that condition (Table 1). The children's situation is similar to that of mothers. In addition, only 52.2% of women reported having received information about the public policy for comprehensive protection of children, but none about the social protection network.

Table 2 - Biosociodemographic and obstetric profile of 46 pregnant women with in-visible social vulnerability, according to the condition of female household leadership, 2012

		Female household leadership					
		With		Without		Total	
		20		26		46	
	Categories	n	%	n	%	n	%
Profile of pregnant women							
	< 20	-	-	4	15.4	4	8.7
Age (years)	20-34	14	70.0	21	80.8	35	76.1
	≥ 35	6	30.0	1	3.8	7	15.2
	Single	11	55.0	8	30.8	19	41.3
Marital status	Married/Cohabitant	8	40.0	18	69.2	26	56.5
	Separated/Widow	1	5.0	-	-	1	2.2
Education (years)	< 12	3	15.0	11	42.3	14	30.4
Work activity	Yes	15	75.0	7	26.9	22	47.8
With social security	Yes	8	53.3	5	71.4	13	59.1
Progenitor at home	Yes	10	50.0	19	73.1	29	63.0
Obstetric history							
Access to the prenatal control	≤ 20 weeks	18	90.0	24	92.3	42	91.3
Planned pregnancy	No	13	65.0	17	65.4	30	65.2
With biomedical risk	Yes	-	-	4	15.4	4	8.7

Regarding dyads' profile, one in two pregnant women were household heads, and this condition showed more adverse biopsychosocial determinants, compared to the group without this condition. Differences were observed between groups regarding age when the women became pregnant, education, and paid work activity (Table 2). They did not have the presence of the father in one of every two families with female household leadership. From the perspective of the reproductive health care, the women were admitted to the center before the first 20 gestation weeks (91.3%), facilitating compliance with delivery of ChCC services in the prenatal period. It is noteworthy to mention that pregnancy was not planned in two out of three (65.2%) women, and this situation represents problems in their access to the fertility control services.

Regarding 25 women with invisible vulnerability and psychosocial risk, as detected by screening and records in the clinical file, depressive symptoms (64.3%) and insufficient family support (50%) were the most frequently mentioned determinants. The latter condition increased in women who were household heads, where two out of three of them reported this type of determinant. One in every four women mentioned having experienced domestic violence.

About 43 infants whose vulnerability was invisible, the birth parameters were very similar in both groups. Attention was called by the high proportion of neonates (two of three) and low proportion of women who indicated encouragement to maternal attachment during labor (Table 3). The health control was updated in nine of ten infants at

the time of the interview and most mothers (86.0%) reported a breastfeeding duration over six months. About half of the mothers were main children caregivers (44.2%). Rates of underdevelopment (11.6%) and psychomotor retardation risk (9.3%) were calculated for infants (Table 3).

Table 3 - Profile of 43 infants with invisible vulnerability according to mother household leadership status, 2012

Background		Feminine household leadership					
		With 20		Without 23		Total 43	
	Categories	n.	%	n.	%	n.	%
Neonates							
Weight (grams)	2500 a 2999	4	20.0	4	17.4	8	18.6
	≥ 3000	16	80.0	19	82.6	35	81.4
Sex	Male	8	38.1	8	34.7	16	37.2
	Female	12	61.9	15	65.2	27	62.8
Gestational age	< 37 weeks	2	10.0	1	4.3	3	7.0
Attachment reinforcement at delivery	Yes	9	45.4	12	52.2	21	48.8
Biomedical risk	Yes	6	30.0	4	17.4	10	23.3
Infants							
Updated health control	Yes	18	90.0	21	91.3	39	90.7
Mother is the primary caregiver	Yes	11	57.0	8	34.8	19	44.2
Duration of breastfeeding	< 6 months	4	20.0	2	8.7	6	14.0
Psychomotor development	At risk	0	0.0	4	17.4	4	9.3
	Delayed	1	5.0	2	8.7	3	7.0
Underdevelopment history	Yes	3	15.0	2	8.7	5	11.6

As detected by screening and access to revising the clinical records, the main problems of the family environment in infants with invisible vulnerability and psychosocial risk were as follows: history of mental health problems in the family group (female household heads: 100%; total: 91.7%) and use of addictive substances (20 and 16.7%, respectively), were found in infants with invisible vulnerability and psychosocial risk.

Table 4 - Universal and specific services received by 46 mothers with invisible vulnerability, 2012

Condition	Coverage of services	
	Universal	Specific
With invisible vulnerability.	69.6%	78.4%
With invisible vulnerability in 24 women who received information about *Chile Crece Contigo*.	68.9%	84.1%
With psychosocial risk by screening.	66.2%	63.0%
With psychosocial risk by screening and review of clinical records.	69.4%	75.7%
Women as household heads.		
With invisible vulnerability.	66.7%	83.2%
With invisible vulnerability of woman who received information about *Chile Crece Contigo*.	70.3%	87.2%
With psychosocial risk by screening.	60.0%	71.4%
With psychosocial risk by screening and review of clinical records.	69.0%	90.1%

In this invisibility context, establishing the consequences for mothers and children in terms of their access to the universal and specific services, as established by the ChCC, was important. Tables 4 and 5 show a better access to universal than to specific services by both mothers and infants. In addition, coverage of universal services for infants was more effective than for mothers, but coverage of specific services for mothers was more effective than for infants (Tables 4 and 5).

Table 5 - Universal and specific services received by 43 infants with invisible vulnerability, 2012

Condition	Coverage of services	
	Universal	Specific
With invisible vulnerability.	91.0%	56.5%
With psychosocial risk by screening.	96.4%	54.5%
With psychosocial risk by screening and review of clinical records.	92.9%	47.1%
With history of developmental delay.	95.7%	25.0%
Infants from household-head mothers with invisible social vulnerability.		
With invisible vulnerability.	91.1%	70.3%
With psychosocial risk by screening.	100.0%	57.1%
With psychosocial risk by screening and review of clinical records.	95.2%	35.0%
With a history of developmental delay.	100.0%	42.3%

In the model of multiple correspondence analysis, the mother and infant variables were analyzed separately in two dimensions: dimension 1) biosociodemographic background and psychosocial risk history; and dimension 2) access to the ChCC services. In both cases, a high concentration of points was observed in the central area between both axes, revealing little dependence between the categories of both dimensions in the case of both mothers and infants. In short, the graph with all points of the categories provided little explanation on the behavior of the biosociodemographic and psychosocial history, regarding the services transferred to mothers and their children by the social protection system.

DISCUSSION

Evidence indicates the relationship between adverse social determinants with higher maternal stress and depression levels during pregnancy and postpartum. Consequently, it also indicates higher incidence of prematurity and higher rates of child development delay, which affects the behavior and trajectories of individuals forever.[20] The history of unplanned pregnancies (66.0%) represents a family planning that was not treated in vulnerable women. The literature indicates that women with unplanned pregnancy have higher levels of depression, unsafe abortion, domestic violence, less healthy practices during pregnancy and delivery, as well as higher frequency of low birth weight, neglect in child care, abuse, and increased drug addiction. In these cases, it is considered that early admission of women to the health control service, especially household head women, is a factor of protection against health disparities and inequalities, as it offers better access to the universal and specific services. However, our results showed that provision of these services was not 100%.[21-22]

As for the situation of poor household head women, it was noted that they have access to the informal labor market, with lower wages and without social security, wich makes them more vulnerable and dependent on the family support networks and public financial and social security.[26] It was also highlighted that children who live in households headed by women are the most vulnerable members in the society. They also have more economic and health disadvantages and, therefore, their development depends partly on the impact of social welfare policies.[27]

Explanations for the best performance of the provision of universal services, especially for children, rely on the conscious family health culture, relative to prenatal and child health control, and the wealth of experience-knowledge and skills of nurses, relative to the compliance with program goals.[28-29]

In the public policy for child protection, attention is focused on vulnerable children to repair the equity gaps to which they are exposed since their birth. The implications of low provision of specific services for vulnerable children, is translated into unprotection and insecurity that limits their opportunities for maturation of the neurosensory system, especially in children included in a psychosocial risk environment and/or in those with evidence of development delay. In this study, data on the access to specific services show the incapacity of institutional response, and therefore a debt relative to the effective support by the State for equity of the most vulnerable children so that they have a dignified and secure life since their birth. This increases the institutionalized reproduction of inequality, and marginalization until adult life.[30-32]

It has been repeated that this situation can be overcome if the reductionist view the "biomedical" approach is supplemented. From this view, people's options have no space, because they are

subject to the expectations and prescriptions of others. This situation can be also overcome if the quality of information on social protection policies delivered to the target population is improved, so that they take the initiative and control in the access to the services.[30,32] In this study, best provision of specific services was observed (82.5% and 83.3%, respectively) when the ChCC system and its services were explained to the women.

The magnitude of invisibility of social vulnerability observed in the present study and its consequences for the right to comprehensive health care, reinforces the need to consider the concepts of social vulnerability and exclusion, as well as to understand the value of interdisciplinary work in the nursing practices.[23,33-35] Formalizing the construction of meaningful learning and skills in recognition of complex social phenomena is urgent, as they are essential for a humanized, comprehensive, and quality care that can reduce health disparities and inequalities. The previous attitudes will allow nursing professionals to progress in the understanding, empathy, and sensitivity, going beyond a health control, as they promote interaction among caregivers and making visible the vulnerability and reasons to act with a conscious relevance.[2,11,36-37] In order to increase the certainty of compliance with the public policy, integrating the concept that users in social disadvantage are subjects with unrestricted right to universal access to the services of the social protection system is necessary, especially at the primary level of health care.[29,31]

CONCLUSION

An elevated magnitude of invisibility of social vulnerability was found in mothers and children attended in the public primary healthcare system, showing the system inability to make itself visible. As a consequence, mothers and infants with extreme social vulnerability had partial access to the services from the public policy of social protection. It is of vital importance that the persons responsible for the public policy, especially nurses, promote the opportunities provided by the State to reduce the health inequalities and disparities among vulnerable children and women.

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