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Primary Health Care, Comprehensive Social Management and Participation

Nelson Ardón Centeno[a],*; Andrés Cubillos Novella[a]

[a]Graduate Programs in Health Administration, Pontificia Universidad Javeriana, Cundinamarca, Colombia.
*Corresponding author.

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Abstract

For many, the implementation of strategies of Primary Health Care (PHC) based on interdisciplinary approaches, constitutes a condition of possibility for undertaking mental health reform proposals for the Americas region. This view of the emphasis that makes the APS in social and state responsibility to uphold the rights of social citizenship, necessary to ensure the complex processes of reform. There are numerous experiences of implementing actions primary mental health care in Latin America, many linked with focused on community mental health programs. This paper makes an analysis of these successful experiences of implementing actions primary mental health care through community experiences that have determined that they are characterized: they had the presence of at least one mental health officer; was no explicit support from national and provincial authorities; was recognized as the focus of psychosocial problems geographic area and a population group; it had specific allocation of human and material resources; had managed to organize a multidisciplinary team; subsisted program where assisted community was well defined; there was a sense of identity and recognition had its problems and claim areas.

Key words: Primary health care; Participation; Social management; Mental health; Community mental health; Health

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The Primary Health Care (PHC) strategy relies on the International Conference Alma - Ata hosted by the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the UNICEF, sponsored by the former USSR, using the motto *Health for All by year 2000*. It was received and conceived as follows:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and 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. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

However, throughout the years, pursuant to the particular circumstances of countries and regions, its implementation adopted different methods, some even changed it completely. The PAHO/WHO (2007) classified these methods in four approaches based on their focus: *Selective PHC: limited set of activities of health services for the poor Primary Health Care: a health care level of a Health Syste Extended PHC Alma Ata: a strategy to organize health care systems and society for health promotion. Health and Human Rights Approach: a philosophy crossing the health and social sectors.*

Such analysis, the epidemiological changes, the significance of social determinants and the challenges of complying with the Millennium Goals led to a PHC renewal and the making of the Position Paper validated in more than 20 Latin American Countries. In the Declaration of Montevideo, the participating countries committed to integrate the PHC principles into the health systems, supporting their organization, management and financing to contribute together with other sectors to "(…)

comprehensive and equitable human development", as well as other challenges (PAHO/WHO, 2005)

In this respect, it is necessary to highlight that a system led by the PHC Strategy adheres to sustainable human development, the struggle against poverty, education and social, political and human rights development, the protection of the environment and resources (PHC, 2005).

It implies clean, integrated and continuous care, considering the diversity and needs in promotion and prevention (privileged phases of comprehensive protection), early diagnosis, recovery, rehabilitation, palliative care and support to self-care, based on the family and the community; furthermore, active individual and community participation mechanisms, intersector actions, strengthening of networks and associations of national and international cooperation.

It seeks to make easier social inclusion and equity in health matters, remove (institutional, geographic, ethnic, gender, cultural or economic) access barriers, and design concrete programs for the vulnerable population.

As far as mental health is concerned, the WHO proposed including it as a PHC component in 1990; such proposal was reiterated in the Declaration of Caracas (PAHO/WHO, 1990) and in the Declaration of Brasilia (PAHO/WHO, 2005). The grounds for incorporation are held by the WHO and the Word Organization of Family Doctors (WHO/WONCA, 2008), namely, the amount of mental illness load, the links between physical health and mental health, the gap to access treatments for mental disorders and the fact that "*mental PHC improves access, fosters respect for human rights, reduces stigmatization and discrimination as much as possible, is affordable and efficient in terms of the costs, generates good sanitary results."*

These organizations state ten principles to achieve this inclusion, including their incorporation to Policies and Plans, appropriate training of PHC workers, availability of support from professional mental-health specialists, access to medications, collaboration from other sectors, organizations and communities, *advocacy* to modify attitudes and behaviors, setting limits for PHC tasks, the fact they should be practicable, the needs of human and economic resources.

However, most of the efforts have not accomplished the desired results so far, partly due to gaps in training and administrative support that hinder care at levels of low-complexity and articulation among the different system levels; similarly, it is due to other type of limitations that must be solved because a comprehensive approach on PHC (Santacruz, C. de, 2011) assumes that:

> It is not about structuring a particular PHC strategy in mental health, but about linking mental health to the PHC strategy.
>
> As stated by the WHO (1990), the introduction of a mental health component in PHC implies (at least) two areas of action:
>
> Psychosocial knowledge to'(…) improve the operation of general health services; contribute to the general socio-economic development; contribute to the quality of life, foster mental and emotional health.
>
> Prevention, diagnosis, treatment and rehabilitation of mental and neurological disorders.
>
> PHC is not exclusively in the low-complexity level, although it is privileged; it requires adaptation and participation from all levels. Moreover, emphasis on the low-complexity level and promotional and preventive tasks generates an increase of demand in the other levels, as well as, the need for them to develop advisory and accompaniment tasks.
>
> Promotion and prevention are not understandable either, since -not denying its great significance- the PHC also implies actions of screening, diagnosis, treatment, rehabilitation and social inclusion.
>
> The PHC transcends the health sector because it adheres to the goals of development and quality of life and the transformation of social determinants. It can then join the global capital and rights perspective.
>
> Participation is a sine qua non condition of PHC.

Part of Urrego's (2010) text related to PHC is hereby transcribed to specify the aforementioned; it states that:

> For many, the implementation of PHC strategies based on cross-disciplinary approaches constitutes a possibility condition to be able to execute the mental health reforms proposed for the Americas Region. This stance is based on the PHC emphasis on the social and state responsibility of enforcing the social citizenship rights needed to guarantee complex reform processes (Solitario; Garbus; Stolkiner, s.f). There are numerous experiences of PHC implementation in mental health in Latin America, many of which are linked to programs focused on community mental health (González, 1992).

An analysis of such successful experiences of PHC implementation in mental health by means of community experiences have determined their main features, namely, there was at least one mental health employee present; there was explicit support by the national and provincial authorities; there was a geographic area and a population group acknowledged as center of psychosocial problems; appropriate human resources and materials had been specifically assigned; a multi-disciplinary work team had been arranged; the program survived where the cared community was well delimited; there was a feeling of identity and acknowledgment of their problems and areas of vindication; a preliminary study of the community was carried out in all cases, but none was systematized or published, and thus it was not used for the purposes of planning and decision-making processes performed by the relevant rulers; the program designed in this way required official resources from other government sectors, a circumstance that made it difficult to identify potential sources of cooperation, having very few exceptions; the model included cooperation from other alternative

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models of mental health management (Ministry of Social Protection, 2005; González, 1992).

In Honduras, for example, the model mixed the mental health care service provision with community work; the experiences of Ciudad Sandino in Nicaragua and Carundú in Panama showed that it is possible to cover the community needs using a type of PHC model by means of the day hospital and a mental health center.

Both models link patients to the family and social support network they belong to, so that they are able to live in the community, obviously reducing the demand of hospital services (Ministry of Social Protection, 2005; González, 1992).

In Cuba, since the Cuban system started structuring in the 60s, psychiatry had a community approach. In 1995, mental-health community centers were defined in the Havana Charter as a basic element of psychiatry in the community, and its interrelation to the secondary level would be performed by means of "community outreach", pursuant to the concept introduced by the Ministry of Public Health for these purposes (Cervantes & Oliva, 2004).

Upon evaluating the impact of Cuban community outreach during the 5-year period from 1999 to 2003, a trend was observed towards the reduction of hospital entries due to mental health disorders, having less hospital beds occupied less long-stay patients and less infirmary staff for institutional care (Cervantes Oliva, 2004).

Similarly, it is important to keep in mind that the mental health programs that failed are characterized by lack of resources, lack of a structural-operational organization working as support and lack of political willingness of the ruler to make government policies matching the population needs for mental health (Ministry of Social Protection, 2005; González, 1992).

Normally in these experiences, program monitoring is performed implicitly as a routine activity, but without formal evaluation of the situation, which has allowed analyzing cost-benefit. In some cases monitoring and supervision were merely expert meetings to revise the goals; the relations among projects of the community mental-health program, the psychiatric hospital and the general health services varied widely from strong collaboration to marked disagreement. In most cases, the solution of the most evident social problems faced was given priority, taking into account the opinion of the community (Ministry of Social Protection, 2005; González, 1992).

Prevention and promotion activities bloomed in all the experiences, working at schools, mother clubs and community groups, such as the mutual support groups, anonymous alcoholics; the practical nature of training was a supporting factor, as well as the fact that they were carried out at places of service provision, thus allowing update of the entire health staff (Ministry of Social Protection, 2005; González, 1992). Apart from few exceptions, the mental health programs linked to PHC are not usually derived from a national policy, and that is why their success and sustainability depend on people and incidental support from a ruler concerned with this topic, but without a strategic view (Ministry of Social Protection, 2005; González, 1992).

The introduction of the concept of social determinants of health in the revitalization of this strategy supported by the PAHO and the WHO is equally relevant; in addition, comprehensive PHC concepts have been readdressed, thus recovering the postulates of universality and human rights fulfillment (Solitario R; Garbus P; Stolkiner A, s.f)

The cross-disciplinary nature of PHC acknowledges the historicity of PHC and therefore the relative nature of disciplinary knowledge, enabling a non-linear and non-unilateral approach, contributing to a complex view (Solitario; Garbus; Stolkiner, s.f).

In addition to the cross-disciplinary approach, the redesigned PHC defends a series of values, principles and elements that must be essential for any health system based on it.

Table 1
Values, Principles and Elements

Values	Principles	Elements
Right to health at the highest possible level. Solidarity. Equality.	Respond to the population needs. Searching for quality. Responsibility and accountability of governments. Social Justice. Sustainability. Participation. Intersectoriality.	Universal access and coverage. Comprehensive and integrated care. Emphasis on promotion and prevention. Appropriate Care. Family and community counseling. Mechanisms of active participation. Optimum organization and management. Pro-equality policies and programs. First contact. Appropriate human resources Intersector actions.

Note. Source: Solitario R; Garbus P; Stolkiner A, s.f.

Primary Health Care, Comprehensive Social Management and Participation. Currently, pursuant to Law 1438 from 2011, the PHC strategy is based on the integration and interdependence of the health services, the intersector / cross-sector action for health and social, community and citizen participation, and it is defined as follows:

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> the intersector coordination strategy that allows comprehensive and integrated care from public health, the promotion of health, the prevention of illness, the diagnosis, treatment, rehabilitation of the patient at all levels of complexity in order to guarantee a higher level of user wellbeing.

The District Health Secretariat, in turn, has achieved significant progress in conceiving the PHC from a collective dimension of health, highlighting the comprehensive feature of care (with individual and collective services), with an equity principle in line with the needs of people, in specific territories, with the participation of communities, based on an approach that promotes quality of life and health, based on contractual relations among users, insurance companies and public and private providers within the framework of the General Social Security System for Health (SGSSS in Spanish). Speaking of health, in addition to benefits for disorder care prioritizing effectively tested and standardized interventions, there is a proposal for it to be acknowledged as a public policy, thus:

> (…) its development implies including the matter in the public agenda, the participation of all social stakeholders and the encouragement of favorable opinions and social representations. In its most specific sense, the PHC approach implies guiding the actions of health promotion, primary, secondary and tertiary prevention, which considers care and rehabilitation, promoting the development of personal possibilities by strengthening human capital, thus leading to collective development and not only to the identification of problems and their solution(…).

All approaches and concepts presented so far reiterate social participation and organization and the set of institutional and community efforts and resources, requirements where all kinds of problems are identified during the policy's validation and agreement process; they range from the impossibility to assume mental health beyond its disorders (not including the obstacles that generally appear in mental-health care) to the topics related to the mechanisms and procedures to make them possible.

As far as participation is concerned, although evident proof is available through the presence of people from the community in diverse mechanisms and processes stated in the SGSSS (e. g. COPACOS, User Associations), statements of non-conformity and distrust are frequent due to "manipulation", as well as statements of ambivalence facing the achievement of a community contribution and its institutionalization. Also, an isolated and particular job of the different institutions is seen, as well as the need to match efforts concretely in relation to the objectives of guaranteeing rights and life of quality.

Rectifying those gaps may constitute the achievements of the Promotional Strategy for Quality of Life and Health and Comprehensive Social Management.

Urrego's (2010) text transcribed below states that in the methodological sphere, the processes to develop the Promotional Strategy for the Quality of Life and Health are (SDS and Guillermo Fergusson Corporation, 2008):

> Identifying social needs completely: identification of stakeholders and territories, initial approach to problems or needs of quality of life, problematization of reality, construction of narratives from the identification of action-generating topics, creation of social agendas.
>
> Construction of coherent social responses considering the complexity of social needs detected and the existing inequity: exercise actions[1], protection[2], recovery and restoration of autonomy[3].
>
> Public management based on the State's perspective as guarantor of rights: construction of spaces for social participation, territorial approach, cross-sector logic, promotion of social action and institutional guarantee.

The feasible mechanisms identified for strategic development are:

Training;
Research;
Monitoring and supervision;
Communication;
Access to social welfare services;
Assistance for institutional adjustment.

As far as *Comprehensive* Social Management (CSM) is concerned, it is understood as:

> a public management strategy that promotes from the systemic, critical and comprehensive reading the realities of the territory and the status of guarantee of rights, the construction of comprehensive responses based on the development of skills, cross-sectoriality, social and decision-making community participation and efficient management of resources. (…). (Secretariat of Social Integration, 2010)

Comprehensive Social Management (CSM) expresses the development of cross-sector action plans by territory, strengthening the resources and it comprises five components:

a) *Approach of population in territory*, seeks to acknowledge the possibilities and difficulties of their population, agree on actions and articulate resources, initiatives and commitments.

b) *Cross-sector work,* aims at building responses together (District Administration, private sector, academy, NGO, social stakeholders in general) that fit the needs to guarantee rights and quality of life.

c) *Participation,* autonomous citizen exercise to achieve a fair and democratic society by impacting decision-making processes related to quality of life.

d) *Development of skills,* acknowledging and fostering the possibilities and knowledge, as well as the conditions for appropriation, enforcement and demand of rights and liberties.

e) *Appropriate budget,* which gathers state and private

[1] That promote the emancipation of persons as individuals with rights.
[2] For example, actions of positive discrimination.
[3] Service offer, comprehensive intersector action by means of social networks.

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economic resources *to* support responses agreed in the territories.

The five key factors of CSM are:

a) Information, analysis and supervision that allow contrasting the baseline of life condition before and after the interventions.
b) Training of public and community agents, focused on rights and strengthening capacities and skills for participation and decision making leading to autonomy and community social self-management.
c) Provision of services is articulated among sectors, identification and reduction of barriers of access to comprehensive sector and cross-sector care and community empowerment.
d) Articulated and continuous care is at the greatest number possible of people identified in vulnerable situation and assessment the impact of social interventions.
e) Permanent call to more stakeholders seeking their commitment to the strategy. (National University and Secretariat of Social Integration, s.f.).

The CSM is, in brief:

> …a cross-sector effort, a budget, a territory, a development of skills and social participation that impacts the decision-making related to public resources, by means of managing strategic projects per populations and territories that can be bound to the development plan or other instances that provide national or international resources to solve difficulties (Castiblanco, s.f).

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