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MODEL AR_ COMMUNITY HEALTH APPROACH BASED ON EDUCATION, THINKING, LANGUAGE AND SYMBOLISM

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— Abstract—

Talk about community health leads us to consider its structure and above all to the realities facing to make it possible as a mode of intervention of health systems. Social sciences provide theoretical-methodological elements of interest that allow support plans and programmes of intervention in health, as well as analyzing the scenarios upon which will perform their actions, waiting for success in promoting and prevention of health of populations. The Avila-Reyes model, is presented as a model inclusive of social elements that allow to visualize, analyze and consider social determinants of health that facilitate or not the development of cognitive processes that favour human health, from the individual to the collective. We analyze the symbolic interactionism, as positive a social approach to support the educational work within the field of health; even more so in countries with diverse geographical, social, cultural and development.

Keywords

Community health, symbolic interactionism, AR model.

It is necessary to start this document describing what we know as Primary Health Care (PHC) that can be defined from different perspectives and is considered an essential part of a health system. This importance is that it is the user's first contact with these services.

In this way we can understand the PHC as the essential health care accessible to all individuals and families in the community through means acceptable to them, with their participation and costs accessible to the community and the country. It is also the core of a country's health system and forms part of the overall socio-economic development of the community (WHO, 2016). The above is not a simple and uncomplicated scenario, but quite the opposite. Being the nucleus of the health system and being the user's first contact with health services, achieving this becomes a multifactorial, complex, dynamic and variant process.

It is multifactorial, because it cannot be represented by a simple linear equation like U + CS = HCS (user + care search = healthcare services). U, at all times will be determined by culture, religion, customs, education, gender, economic status, age, employment status, among others. Each and every one of these variables, which we will call determinant factors (DF), will be constructing the individual and structuring their perceptions and attitudes, cognitive elements that, to a certain extent, determine their practices. Here, CS is determined by the sum of all variables involved in the construction of the individual: $CS = \sum DF_{1-\alpha}$

Therefore, the attention of health services will be determined by CS + ($\Sigma DF_{1-\alpha}$), and the user U, will in turn, influenced by the size of n and charged consistent proportional measure it ; therefore $HCS = (U * 100 / n) + (\Sigma DF_{1-\alpha})$.

The role of PHC is in the set of health care processes for both the individual and the collective. This thinking is considered by the WHO-UNICEF by Alma Ata (1978), where essential care, based on practical, scientifically grounded and socially acceptable methods and technology, was defined as a PHC and made available to individuals and families-The community, through its full participation, and at a cost that the community and the country can support in each and every one of the stages of its development, with a spirit of self-responsibility and self-determination.

Given the complexity of processes, the breadth of the concept and the nature of human populations, it is necessary to adapt to each region, country, community, from the essential principles of health care, as well as from the essential principles of respect for diversity and human rights, without ignoring the level of socio-economic development of peoples.

Specifically, its variability corresponds to considering that community health is an area of public health that has the goal of prevention, promotion

and education around the health of a population, working together health professionals and the community (Romero et al, 1979). In this regard, the areas of action proposed by the Ottawa Charter are: building healthy public policies, creating health-enhancing environments, developing personal skills, reinforcing community action, and reorienting health services (Secretaría de Salud, 2016).

In this way, community health guidelines are elaborated from various disciplinary approaches and cover aspects related to promotion and prevention, in relation to community psychology, sexual and reproductive health, health education and nutrition.

Based on the above, the following integral model is presented, including and directed to the strengthening of community health; Based on the importance of symbolic interactionism (Blumer, 1982) when considering that people act on objects and other people in their world from the meanings or symbols they represent.

Also, it is important to mention the contributions of Piaget (1983) and Vygotsky (1934) on the evolutionary development of human beings, specifically their contributions on thought and language, essential elements within the educational processes and complementary to the total understanding of symbolic interactionism in the understanding that the main contribution of the model lies in the strengthening of education as a basic element of community health.

AR MODEL

The Ávila-Reyes Model, hereinafter referred to as the AR Model, considers the determinants of community health, emphasizing that the participation of the population is crucial for the resolution of the health needs of its own community and the promoters are people trained health community to be a source of solving their own problems, organizing and strengthening its own development, becoming empowered.

As mentioned above, this model is based on education, specifically in its non-formal, continuous teaching-learning process, through which skills and abilities are developed, as well as in the servers, which allows them to perform better in their usual tasks and in the community itself.

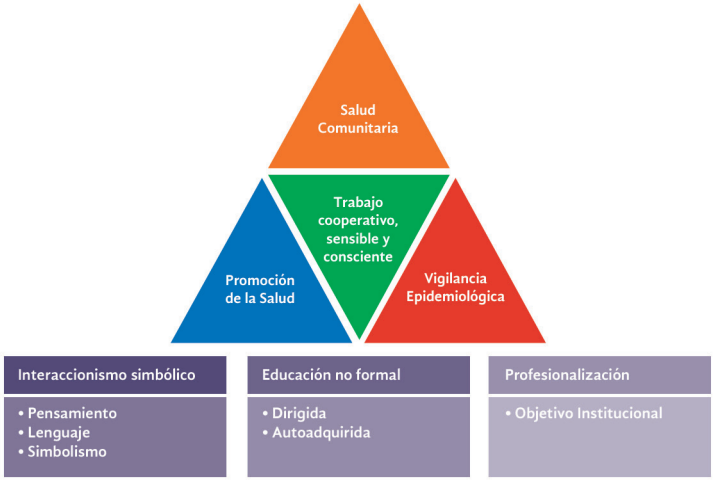
The AR model takes as strategic binomial to the epidemiological surveillance and the promotion of health, favoring through symbolic interactionism, the adoption of healthy practices. We can explain it by considering that the theory of symbolic interactionism is based on principles such as: 1) human beings are endowed with the capacity for thought; 2) this capacity is modeled by social interaction; 3) in this interaction people learn the meanings and symbols that enable them to think; And (4) the ability to

modify or alter meanings based on the interpretation of the situation (Rose, 1962, Blumer, 1969, Manis and Metzel, 1978). In this paper, we consider symbolic interactionism as an element in favor of self-learning, which is a form of learning in which each person becomes their own teacher and acquires knowledge of self-interest (DRAE, 2014).

It is then that we recognize the potential of the aforementioned for the promotion of health, which is constituted as part of a political and social process, encompassing not only the actions to strengthen the abilities and capacities of individuals, but also, is aimed at changing the social, environmental and economic conditions of communities, with the objective of reducing or eradicating their negative impact on public and individual health.

On the other hand, epidemiological surveillance is a continuous and systematic process of collecting, analyzing and interpreting data on diseases or damages subject to mandatory notification in the country, to know its trend and evolution, to identify the geographical regions and the most populous groups aware of the current health status of the population, identify early outbreaks or epidemics for timely intervention and control, and finally, to evaluate the results of prevention and control measures carried out by the health sector (DGE, 2016). This is how we will be considering epidemiological surveillance as a systematized source of information that will continuously reach the various social actors involved in community health processes.

Figure 1. Model AR_ approach to community health based on education, thought, language and symbolism..



It is for this reason that the present AR model considers as a schematic and structural form the triangle, in which vertex is community health and the base , education, with its respective variants-self-education and training acquired or directed. The latter is an institutional objective, that is, the institutional responsibility to direct the processes, the optimization of resources and the impact on the health of the community (Figure 1).

The development of the general process, ie the dynamics of the AR model, is based on 1) individual growth awareness; 2) the awareness of being ethical and 3) the "defense" in the understanding that it is necessary to have sustained knowledge, updated and in accordance with the prevailing reality, to solve problems.

AR MODEL DYNAMICS

In Latin America, one of the main goals pursued by public policies has been the coverage of public services, without having determined prior quality or user satisfaction. This, together with the current globalized socioeconomic changes, has generated wide social gaps that accentuate the lack of economic and social equity. Without a doubt, one of the horizontal axes that guarantee the development of communities is education, but has been underserved in this region.

It is precisely because of the above that when talking about health, we are obliged to talk about educational deficiencies and it is in the PHC that the first consequences of educational deficiencies are presented, both in the general population and in health services.

The AR model considers education, thought, language and symbolism as the articulating elements that guarantee the processes for the achievement of community health, an assertion that we can make from the moment of analyzing the contributions of Blumer, Piaget and Vygotsky for the understanding of the cognitive processes that detonate in man his growth and development.

As we can see in figure 1, the bases of community health are health promotion and epidemiological surveillance and the social actors involved, community and health servers, are required to be immersed in continuous educational processes, training, self-education. That is, the learning favored by symbolic interactionism.

Health promotion within primary care has become an essential part of the practice of professionals working in health systems. It is an area in growth and development, whose limits are not yet defined and the theoretical-methodological support is still under construction. The promotion of health incorporates determinant social factors, which allow

people to control factors related not only to health, but to life itself; That is, it constitutes the basis of empowerment (Sarría and Villar, 2014).

The goal of health promotion specialists is to apply specific methods, skills and strategies to help people adopt healthy lifestyles, improve health services use, self-care and other healthy practices (Sarria and The Cross, 2014).

The AR model shows dynamism in each of its elements and in its entirety. That is, the general triangle can be dissolved into three specific triangles with its own dynamics and factorial interaction, and in one articulated by cooperative, sensitive and conscious work. At the same time, at the base, it can be explained through symbolic interactionism by its elements of thought, language and symbolism, as well as its direct influence on education and professionalization.

APPLICATION OF THE AR MODEL

First, when discussing the participation of epidemiological surveillance, we are considering a series of practices that allow the continuous monitoring of morbidity and mortality presented in communities. Although it is true that within a health system epidemiological surveillance is essential to anticipate needs and inform decision makers, it is also true that inter-institutional linkages have a strong impact on the prevention and control of health problems (Kuri, 2006).

This is where the importance of epidemiological surveillance within the AR model, based on all community health processes, is based on the updated information on the epidemiological profile of the communities. In this way, decisions can be made, not only in the area of public policies, but also in the execution of prevention tasks, specifically in the tasks related to the promotion of health.

In this way the promotion of health will take epidemiological references to direct actions consistent with the reality of the communities. Likewise, it is expected to have a sociocultural and demographic diagnosis that supports this information and allows planning and execution of health promotion programs related to the particular characteristics of the communities. All this is reflected as a potential for the development of prevention tasks in the field of public health.

Secondly, when talking about health promotion, we are referring to the mechanisms to provide people with the necessary means to improve their health and exercise greater control over themselves. The Otawa Charter (1986) specifies that in order to achieve the health, adequate physical, mental and social well-being of an individual or group, they must be able to

identify and fulfill their aspirations, meet their needs and change or adapt to the environment.

This conception makes it clear that health promotion does not exclusively concern the health sector, and also makes it clear that it needs various multi and interdisciplinary tools for the planning and implementation of its models, plans and programs aimed at community health.

It also makes clear that the training of health personnel requires this same multi-disciplinary and interdisciplinary scheme, resulting in the interaction of personnel trained in various areas, as well as the ongoing training of health personnel responsible for carrying out these processes of intervention in communities.

Finally, to recognize the strength of an educational base, based on the understanding of symbolic interactionism, is to affirm that cultural and social dimensions are intrinsic determinants of the learning process.

For this reason, we can focus on what Gonio and Llinares (1998) mention, although they apply it to the teaching of mathematics, it is also an analytical thought of cognitive processes. They mention that symbolic interactionism explains:

a. The complementarity between the analysis of the structure and the nature of the interactions, with the consideration of the structure of the educational contents.
b. And the balance between individual and collective approaches within the analysis of learning processes.

For its part, Sierpinska and Lerman (1986) mention that symbolic interactionism promotes a sociocultural vision on the sources and growth of knowledge, emphasizing the subjective construction of knowledge through interaction, assuming the basic assumption that cultural and social processes are part of the teaching-learning processes.

BY WAY OF SYNTHESIS

The complexity of the interactions between health and disease is clear, both in talking about individuals and in doing so for communities. This complexity requires comprehensive analysis and awareness of conditioning factors of diverse, geographical, cultural, political, economic, and cognitive origin, among many others. Thus, within health systems, and specifically, of community health, health promotion and disease prevention, a multi, inter and transdisciplinary work is required- Multi and interinstitutional and aware of diversity within populations.

In particular when talking about community health, one of the main challenges is to impact on the favorable determinants of health, to establish interactional synergies, to impact on the culture of peoples in the order of health care, to contribute to individual health education And collective, and of course, to achieve the positive impact of the actions of health systems, from the efficiency and effectiveness of their actions.

Thus, the AR model represents a contribution to the theoretical-methodological background in this field, through reflection on the scenarios and educational processes based on symbolic interactionism.

Finally, there are several studies that visualize symbolic interactionism as positive social approaches to a fundamental analysis within the health sphere and even more so in countries with geographic, social, cultural and developmental diversity (Parsons, 1982; Mummert, 1998; Castro, 2001).

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