

**PRIMARY HEALTH CARE IN THE AMERICAS:
CONCEPTUAL FRAMEWORK, EXPERIENCES,
CHALLENGES AND PERSPECTIVES**

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EXECUTIVE SUMMARY

Practitioners, educators, and researchers continue to search for innovative strategies and solutions to address priority areas that are relevant to societal and community needs. In this document for practitioners, researchers, and educators, we present a review of literature reflecting the models of care used for practice, research and education in the Region of the Americas.

We begin the review with a broad, inclusive notion of health. In this sense, health is considered more than the absence of disease. Further, we recognize that over-arching determinants of preventable illness and death are often the result of poverty, unemployment, and lack of participatory development, not biological/physiological determinants (Gottschalk, 1999). Moreover, policies devoid of the values embedded in society as well as consideration of the impact of social and economic policies (McKnight, 1995) can negatively affect health status on an individual and community level.

To gain an understanding of the sociopolitical and economic realities as well as the goals of a community and society, providers of health care services must familiarize themselves with the concepts that relate to growth, development, and sustainability (Gottschalk, 1999). How these concepts are defined and operationalized are critical factors for providers attempting to meet the health needs of communities and particularly members considered vulnerable. Specifically, providers need to incorporate a broad understanding of the interconnectedness of these concepts into their daily practice.

We present a Primary Health Care (PHC) Model that can be used as a philosophy and a strategy to promote health and to prevent diseases, through comprehensive health care, that is collaboratively and cooperatively provided by community members and multiple, health relevant disciplines. Additionally, the literature is reviewed to discuss and to examine the types of health care providers, the mode of service delivery, the location of services, types of health care programs, and health concerns/issues. We also discuss measurement criteria issues, evaluation methods, and implications, challenges, and perspectives. This document will be useful as a guide for practitioners, educators, and researchers who are interested in health issues and are involved in decision-making and policy development for institutions and programs providing health care services. Many practitioners, educators, and researchers assume that their practice-base is theoretical. We hope to challenge that idea with the suggestion that the PHC perspective is a useful way to organize disparate literature, take stock, and determine a preferred future.

PRESENTATION

Reforms of the health sectors in the Region of the Americas have often focused on the model of care in the search for new ways of meeting the needs and improving the health of the population. The need to evaluate these new models and their implementation challenges the health system to make more explicit the conceptual framework used in the approaches being considered. Many public health leaders view a model of care based upon a primary health care framework to be the best option for addressing the critical health issues being faced around the world.

A primary health care model is a useful approach to health care that focuses on the promotion of health and the prevention of disease, through comprehensive care that is collaboratively and cooperatively provided by community people and health relevant disciplines. As an interactive model, primary health care encourages individuals and communities to be more involved in decisions about their health and its management. At the same time, primary health care is able to accommodate discipline specific perspectives – medicine, nursing, midwifery, public health- as well as the models that focus on age groups or health problems.

The document, *Primary Health Care in the Americas: Conceptual Framework, Experiences, Challenges and Perspectives*, is intended to contribute to the ongoing discussions on designing, implementing and evaluating new models of care in the context of health sector reform. Based upon an extensive review of published literature from around the world, the authors present information on four components or aspects of care that are often considered in adopting a new model of care. These include provider, location of services, types of programs and health concerns or issues. They discuss methodological and measurements issues and propose implications for future work.

More than 400 articles published since 1990, including more than half from the LILACS database, were reviewed in the preparation of the document. A major difficulty encountered was obtaining full text articles from the Latin American sources. An impressive body of literature exists on these various aspects of the model of care. The research findings should be used more consistently to make decisions regarding practice, education, policy, and to guide future research.

1. INTRODUCTION

The new millennium brings an opportunity to evaluate models of care that are used for health care service delivery, education, and research. In the Pan American Health Organization (PAHO) Region, practitioners, educators, and researchers continue to search for innovative strategies and solutions to address a myriad of priority areas and issues that are relevant to societal and community needs. Although the countries and territories in the Americas are immensely diverse and many different cultures traversed (i.e., race, ethnicity, socio-economic status, disability status, political and religious affiliations), commonalities do exist among people and their health care concerns. According to the 1996 Report of the World Health Organization (WHO) Ad Hoc Committee on Health Research, the world community faces four critical health issues:

1. Infectious diseases, malnutrition, and poor maternal and child health will continue to account for a significant portion of unnecessary deaths and illness (particularly in countries with fewer economic resources), despite the health advances and public education during the past century.
2. Inequitable and inefficient health care delivery systems prevent access to health care for many individuals.
3. Epidemics of non-communicable diseases, injuries, and violence such as cardiovascular diseases, neuro-psychiatric conditions, cancer, diabetes, and chronic respiratory infections are affecting greater numbers of people.
4. A growing number of drug-resistant microbes are creating new health emergencies and a resurgence of diseases (e.g., tuberculosis, malaria, and pneumococcal disease) that were once considered to be under control.

For practitioners, educators, and researchers, the provision of health care services to address the above four areas of concern requires careful consideration of the model of care being utilized. Models of health care provide the foundation for constructing effective policies and strategies aimed at improving population health within the PAHO Region. Developing frameworks for health care services requires an understanding of both the critical health issues, and the determinants of population health (Tarlov, 1999). Determinants of health status can be categorized into five broad areas:

1. biology/physiology,
2. health care services,
3. personal health behaviors,
4. the interrelationship of individuals within their social emotional and physical environments, and,

5. social/societal influences.

While each of the above areas has been examined discretely to determine their effect on health status, consideration of the dynamic interactions among and between these factors on health status for individuals or communities remains a challenge. Examining the inter-relationships between determinants of health and critical health issues requires the explicit use of models to conceptualize and guide practice, teaching, or research. Models of care directly influence health care research and the health care services that people receive. Moreover, the framing of the care or the research questions will determine whether the processes and outcomes are *equitable, accessible, acceptable, or available*. *Participation levels* and *cultural relevancy* are also determined by the model's philosophical assumptions. Thus, understanding a particular model of health care is a crucial component in health care practice, education, and research. The use of a model illustrates the factors that determine health status and establish critical pathways to address health care concerns.

In preparing this document, we recognize that every segment is integral to the entire document. However, we have structured the paper so that each section can be reviewed individually, if the reader prefers to do so. The table of contents is a useful means for readers to locate topics, supporting references, and appendix documents. Further, we have included an appendix by Dr. Mamede as a stand along example of how a country specific examination of models of care might be organized. We hope that readers of this document use it to reflect on means for improving multidisciplinary and participatory activities to advance health care in the PAHO Region.

2. BACKGROUND

The 1999–2002 Pan American Health Organization's Strategic and Programmatic Orientations identified five Strategic and Programmatic Orientations to guide health planning and programmatic actions to address health concerns across all levels, local, regional, and national in the PAHO Region (See Appendix A). The strategies include:

1. health and human development;
2. health promotion and protection;
3. environmental protection and development;
4. health systems and services development, and
5. disease prevention and control.

The five strategic areas are useful guides for formulating new directions and objectives to be addressed in models of care in the Americas.

The health and human development strategies support the necessity of defining conceptual aspects related to inequities in health care (PAHO, 1999). Moreover, instruments need to be developed and refined for measurement and surveillance at the regional and national level to document and evaluate inequities in health. Studies examining the health profiles of neglected population groups must be conducted to design health interventions addressing the social inequities, and disparities in health status and health care services. Training for health care providers across all levels must be upgraded to enable them to analyze the health situation and living conditions of various population sectors and the prevailing social inequities—particularly those pertaining to health. Models of care need to address the formation of local, national, subregional, and regional intersectoral networks to assist in policy-making and the preparation of plans, projects, and programs aimed at bridging the gaps in health.

Health promotion and protection is a powerful strategy to address community and individual health concerns (PAHO, 1999). While health is a primary component of human development, health promotion must involve a much broader scope of action than that customarily handled by health systems and services. Additionally, health promotion and protection can be a useful focal point for countries to adopt and implement paradigms aimed at affecting the determinants of health in general. Moreover, the factors that are fundamental to a population's health relate to 1) their living conditions; 2) their opportunities to fulfill basic needs; 3) the quality of their environment; 4) the culture to which they belong; and 5) their knowledge, attitudes, and practices with regard to health and the political health structure foot health services delivery.

The environmental protection and development strategy is critical due to the potential adverse effects of environmental factors on the health of a community (PAHO, 1999). By including environmental factors as a component in models of care, programs and projects will

address the effects of the environment on the health of community members, particularly children, aimed at identifying and eliminating or minimizing due to its greater susceptibility. This strategy also supports the promotion and implementation of environmental care activities within the context of Health for All, along with active participation among community members in identifying their own needs and in finding solutions. The health systems and services development strategy supports the development and dissemination of methodologies and tools to strengthen capacities for analysis, policy-making, and the implementation and evaluation of sectoral reform programs, along with systematic and ongoing transfer of information to share experiences on a local and national level (PAHO, 1999). These strategies are best implemented by use of health care models that support a reorientation of health services to satisfy health promotion, health protection, and disease prevention criteria. These criteria emphasize improvement in the quality and comprehensiveness of specific interventions and strengthen the operational and problem-solving capability of the services at different levels of care.

The final strategy, disease prevention and control, is useful to address regional challenges and reduce and control disease (PAHO, 1999). This strategy also encourages community participation and changes in the behavior of individuals to insure success. For example, national capacities will be strengthened in order to control, reduce, or eradicate specific diseases. This can be achieved through regional and national partnerships for prevention and setting priorities regarding intentional and unintentional injuries, including the prevention of violence from a public health perspective. Additionally, providing support for countries in developing policies, models, and working partnerships among health care workers, laboratories, and treatment facilities will prevent diseases (e.g., helping cervical cancer control programs to understand women's attitudes and needs; evaluating demonstration projects; and planning their judicious, result-based expansion).

Limitations in health care resources require an examination of methods that are most effective for promoting healthy lifestyles to communities. A review of the literature on existing models of care examines practice as a way to integrate research and education, identify effective models, describe the crucial elements and areas that need to be addressed, and generate questions for future research, education, and practice. This review will be useful for health authorities at different levels and responsibilities for services, including educators, providers, and policy makers to analyze current models of care and determine future directions. The critical analysis of literature covers the following areas:

1. The primary health care model of care in the Americas;
2. Specific components of care (types of providers, mode of service delivery, location of services, types of programs, and health concerns/issues);
3. The challenges and implications associated with models of care;
4. Models of care used by practitioners/educators/researchers; and,
5. Systematic and strategic approaches to understanding models of care.

The review supported the PHC model as a framework to mobilize communities and health care providers to move forward with health sector reform on a local, regional, and national level.

Health sector reform recognizes that all members of a community with highly diverse interests are directly concerned with health and health care. Such processes require a gradual and transparent approach to development that fosters the understanding of those involved directly in the provision of care, as well as the recipients of care. Moreover, implementation requires intergovernmental association and cooperation and the participation of the private sector, non-governmental organizations, and individuals involved in health and health care. Overall, PHC models must be implemented that are comprehensive, embrace health promotion and disease prevention services, and extend health services to all with efficient use of increasingly scarce resources.

In order to shift the focus of health delivery systems from acute, curative medicine to the inclusion of health protection and health promotion, the health care system must decentralize some of the decision-making processes to regional and community levels (Green, 1994). Health professions training programs must increasingly think globally, but assume a greater role in the promotion of health within their own communities. Additionally, health care providers must engage a broader range of disciplines, such as dentistry, medicine, nursing and non-medical groups (e.g., community health workers) in partnerships and coalitions for health research and health care activities.

3. MODELS OF CARE

3.1 MODELS OF CARE FOR HEALTH CARE PRACTICE, EDUCATION, AND RESEARCH

Theories and models of care are an integral part of healthcare practice, education, and research (Alderson, 1998). The choice of models, albeit often unacknowledged, shapes the way practitioners, educators, and researchers *collect, analyze, interpret, and disseminate* information. To be effective, we must deconstruct our ways of “knowing” and understanding the influence of the values and philosophies forming the foundation of our practice, teaching, and research. As we increasingly work with culturally diverse groups, knowledge must be constructed in a manner that accurately reflects the nature of diversities and the consequences on responses to health (Im & Meleis, 1999).

While theories in health care may range from explicit hypotheses to models or frameworks that are expressly used to guide one’s practice or research (Alderson, 1998), conventional approaches to knowledge development in health care practice, research, and education are grounded in positivist theories (Oliver, 1998). Over the past century, the medical model has been the implicit, default model of care.

3.1.1 *Medical Model*

The conventional medical model uses a logical positivism philosophy, or empiricism, to verify cause and affect relationships for all human experiences (Wilson-Thomas, 1995). With this approach, the goal is to describe, predict, and control human responses. For example, practitioners and researchers use this approach to locate the “problem” within the individual and orient health care toward amelioration of disease rather than health. If “observable” physiological findings are identified, then a prescribed course of action is undertaken.

The medical model places the health-care professional as the expert responsible for curing disease and dysfunction and “helping” people to achieve “health and normalcy” (Oliver, 1998). The professional role is legitimized and professionals are authorized to label people as deficient and in need of care. Provision of care (interventions) within the medical model focus on remediation of personal health behaviors or curing biological factors (i.e., physical or mental abnormality or impairment) to restore health status; where prevailing research methods include controlled trials, random statistical samples, and structured questionnaires. Because the medical model focuses primarily on individual impairments and diseases, health is usually implicitly conceptualized as the absence of disease (Peters, 1998). Consequently, a limited perspective often fails to explain many of the social and environmental factors that account for today’s health concerns and inequities around the globe (Parsons, 1999). The traditional biomedical model does not consider the values embedded in society, nor one’s social position—a reflection of socioeconomic status and poverty—as an over-arching determinant of health status.

Practitioners and researchers often consider health care rooted in positivist philosophy as value-free, reducible and isolatable; yet, personal histories and experiences are not validated, and dialogue and sharing appear to be irrelevant in the process (Wilson-Thomas, 1995).

Research and practice rooted in traditional, empiricist methods that have separated the mind, body, and external environment are intrinsically problematic. *First*, traditional approaches to knowledge development that depend on assumptions of homogeneity, normality, and statistical reliability, rather than coherent reflections of diverse human experiences, have limitations in generating comprehensive models of care (Hall, Stevens, & Meleis, 1994). The knowledge gained from traditional research produces a limited understanding about the inter-relationships between people, their environment, their health and their relationship with their health care provider. *Secondly*, obtaining balanced power relationships is difficult when research and practice is based on logical positivist philosophy. *Lastly*, a reductionist approach toward research and practice can perpetuate the underlying assumptions that one has about gender, race, ethnicity, disability, and class. Such an approach inhibits gaining an understanding of critical external factors that may impact one's health status.

Despite the technological excellence and sophisticated medical care that has been advanced by using the medical model, its usefulness is becoming increasingly limited in the current health care delivery system. Several issues suggest a need to move beyond the medical model and to use existing theories and models that develop and employ models of care sufficient to achieve PHC criteria.

When health is narrowly defined within the medical model, differences in cultural attitudes and values regarding definitions of "health" are often ignored. Moreover, the use of diagnoses creates patient dependency on the expertise of the health care professional to treat the "problem" that has been socially and scientifically constructed. Increasingly, this power inequity is viewed as a mechanism of control and oppression for disenfranchised groups. With a restricted view of health, clients are seen as passive recipients of medical care, rather than active participants working collaboratively and cooperatively with multiple health relevant disciplines. Skyrocketing medical care costs, decreasing access to health care and increasing disparities in health care status among groups of people (women, aging adults, racial/ethnic minorities, disabled people, and children) also suggest a need to create new models of care. Ideally, useful models of care delineate the subjectivity and social construction of reality, sociopolitical and economic influences on health care research and practice, and the prevalence of discrimination against marginalized groups (Im & Meleis, 1999). Models that capture the complexities of multiple determinants of health status and the diversity and sociopolitical and historical contexts inherent among persons are more likely to achieve the desired connections between factors which influence our understanding of health.

Philosophies and models of health care are increasingly used to address the sociopolitical, cultural, and economic forces that may impact one's health and to address power imbalances experienced by disenfranchised groups and individuals. These philosophies and models are posing important questions for health care and health care research. The use of more comprehensive models that incorporate a focus on promoting health and disease prevention will allow practitioners to identify critical issues that are important to an individual and avoid overlooking or minimizing the impact of societal attitudes and values on the dynamic state of health. A Primary Health Care (PHC) model is a useful approach to health-care that focuses on the promotion of health and the prevention of disease, through comprehensive care that is collaboratively and cooperatively provided by community people and multiple health relevant disciplines.

3.1.2 Primary Health Care Model

As an interactive model, PHC encourages individuals and communities to be knowledgeable in health matters and to have an opportunity to participate in their health care management. Moreover, PHC addresses self-care practices for physical and mental aspects of community health as well as community social and environmental conditions. A basic goal of PHC is to ensure that essential health care is available to everyone in the community. Implementation of PHC emphasizes several concepts:

- *Provision of accessible and affordable essential health services for all segments of a community;*
- *Maximization of individual and community involvement in the planning and operation of health care services to ensure that services are appropriate and acceptable to participants;*
- *Emphasis on services that are preventive and promotive as well as curative;*
- *Use of appropriate technology funded by local resources and supported by government structures;*
- *Integration of health development within the overall social and economic development of the community;*
- *Provision of culturally acceptable, applicable, and equitable health services and programs;*
- *Focus on health concerns that are identified and prioritized by community members so that essential services are available; and,*
- *Use of strategies that maximize self-learning, self-determination, self-care, and self-reliance, on the part of the people.*

In this document, a PHC perspective was used to organize the review of literature on models of care in the Americas. The disparate literature on PHC can be considered by using Figure 1 as a map for developing an action plan. In other words, we often have insufficient resources to take on a comprehensive PHC study, but we can situate the work being undertaken within a larger context or perspective. We define PHC as a participatory approach to healthcare delivery that encourages a partnership between community residents and health professionals to achieve a mutual goal of improved health (McElmurry, 1999). This approach is consistent with the WHO tradition that was initiated in 1978 and with the current agenda. In the Americas, the nursing community defines PHC (McElmurry & Brumbaugh-Keeney, 1998) as presented in the 1978 WHO document. However, the definition of primary care is used within the public health model of primary, secondary, and tertiary levels of care. Primary care is oriented to the care and prevention of illness among individuals and families. In the U.S., primary care is perceived as the entrance to secondary and tertiary levels of care (Marion, 1998). While differences exist between the “worldviews” enmeshed in different perspectives, they are not mutually exclusive and can be incorporated in the WHO’s current strategic directions as captured in the following:

1. To reduce excess mortality of poor and marginalized populations.
2. To effectively respond to leading risk factors.
2. To strengthen sustainable health systems.
3. To place health at the center of the broader development agenda (WHO, 2000).

4. METHODOLOGY

Literature was retrieved from 1990 through 2000 for the following languages in the PAHO Region: English, Spanish and Portuguese. The databases searched included the MEDLINE and CINAHL databases of the US National Library of Medicine and the LILACS database for South America and the Caribbean Region. To develop the search strategy used with the National Library of Medicine for identifying models of care in the Americas, we used a Primary Health Care definition that focused on the following service areas:

1. Types of services provided (health promotion, health education, and health care interventions = 21,882 abstracts);
2. Type of provider (midwife, nurse, physician, rural health motivator, community health aides, and community health worker = 43,152 abstracts);
3. Mode of service delivery (midwifery, nursing, and medicine = 81,715 abstracts);
4. Measurement criteria and issues (affordability, accessibility, availability, applicability, acceptability, equitability = 24,477 abstracts); and,
5. Methodological issues (qualitative, quantitative, evaluation, or methodology = 188,022 abstracts).

To capture the concepts included in *models of care*, the following search terms were used:

Community Health Planning or Health Planning Organization or Health Planning Administration or Community Health Services or Community Networks or Consumer Participation or Delivery of Health Care or Developing Countries or Family Health or Health Services Accessibility or Health Care Delivery or Health Care Model or Health Care Sector or Health Planning or Health Planning Guidelines or Health Policy or Health Priorities or Health Resource Allocation or Health Care Models or Primary Health Care or Public Health Practice or Voluntary Health Agencies or Voluntary Health Administration (1990-2001 = 59,105 abstracts)

To narrow the search further, *models of care* terms were crossed with *types of service* provided with a Primary Health Care (PHC) perspective:

- Models of care by type of service = 4,192 abstracts;
- Models of care by type of service by *type of provider* = 283 abstracts;
- Models of care by type of service by *mode of service delivery* = 357 abstracts;
- Models of care by type of service by *measurement criteria and issues* = 132 abstracts; and,

- Models of care by type of service by *methodological issues* = 473 abstracts.

The equivalent strategy and key words used to retrieve literature from MEDLINE and CINAHL were used for the LILACS search. LILACS is a component of the Latin American and Caribbean Center on Health Sciences (BIREME) abstract library. It is a cooperative database that covers literature related to the health sciences since 1982. Research articles were obtained from LILACS in English, Spanish, and Portuguese. Some of the articles have the title in Portuguese and English or in Spanish and English, however the majority of them do not have abstracts in English. The access to this database from the US is achieved by accessing the web page < www.bireme.br >

The first search to identify models of care in the Americas, using Primary Health Care as a term resulted in 17,134 citations from the aforementioned database. Use of the services provided search definition resulted in the next display:

1. Types of services provided (health promotion, health education, and health care interventions = 1,989 abstracts);
2. Type of provider (midwife, nurse, physician, rural health motivator, community health aides, and community health worker = 9,610 abstracts);
3. Mode of service delivery (midwifery, nursing, and medicine = 1,797 abstracts);
4. Measurement criteria and issues (affordability, accessibility, availability, applicability, acceptability, equitability = 1,685 abstracts); and,
5. Methodological issues (qualitative, quantitative, evaluation, or methodology = 2,053 abstracts).

To further narrow the search, *models of care* was crossed with *types of service* provided and concepts associated with a Primary Health Care (PHC) perspective. A total of 147 articles were retrieved:

- Models of care by type of service = 32 abstracts;
- Models of care by type of service by *type of provider* = 10 abstracts;
- Models of care by type of service by *mode of service delivery* = 63 abstracts;
- Models of care by type of service by *measurement criteria and issues* = 15 abstracts; and,
- Models of care by type of service by *methodological issues* = 27 abstracts.

The LILACS abstracts were read (147), and the articles that meet the search criteria were incorporated for final analysis. It was difficult to reach the complete document selected from LILACS since the articles cannot be downloaded automatically as full text from the Internet. Many libraries in the US do not have an agreement with LILACS, and so in some cases,

document retrieval took approximately a month, while in other instances the documents were unobtainable.

Thus, the more limited number of references above became the database included in the review of literature from the LILACS. Overall, several questions emerged from a review of the composite literature. The English, Spanish and Portuguese language abstracts for this database were read with attention to the following types of questions:

1. Who are the different types of providers?
2. What are the various modes and levels of service delivery?
3. Where are the services provided, such as, health promotion, education, treatment, and prevention services?
4. What are the environmental health risk factors?
5. What are the socioeconomic risk factors?
6. What are the behavioral risk factors (physical fitness, nutrition, sexual practices, alcohol and drug use, safety practices)?
7. Are services accessible, affordable, acceptable, applicable, and available?
8. What are the biological risk factors (genetic conditions, age, race/ethnicity, gender-specific conditions)?
9. How do health providers in the America's Region view PHC?
10. How can we improve access to full text documents for the health workers in Latin America and Caribbean Region?
11. How can we improve access to LILACS for English speakers in the US who need to obtain information about the Latin America and Caribbean Region?
12. How can the curriculum of health professionals be oriented to PHC?
13. Why is it that in some countries the experience of working with community health workers is an important and successful component of the health care system while other countries do not have this experience?

5. HEALTH STATUS IN THE AMERICAS

5.1 HEALTH STATUS

In general, health status across the lifespan of individuals in the Americas has improved over the past decade as a result of enhanced social, political, environmental, cultural and technical factors (PAHO, 1998). Moreover, the expansion of health care systems from an emphasis on treatment of diseases to a focus on health promotion through health education, disease prevention, and supportive socio-environmental conditions is improving health status.

Despite improvements in health care status and health care services, the characteristics and speed of the improvements have not been the same across countries or in all population groups within any one country (PAHO, 1998). Infant mortality in the Americas has declined steadily (PAHO, 1998). While the risk of dying in adulthood (45-64 year old group) across countries is relatively stable for males between 1980 and 1994, the mortality pattern for women shows a long-term downward trend that is systematically higher in lower-income country groups, which suggests gender inequality. Specifically, adult males in the Americas seem to have achieved greater access to preventive, curative, or palliative care services, whereas, access for adult women may still be influenced by their economic level. However, the risk of dying due to external causes across the Americas is higher for males 45-64 years of age compared to females. In particular, men have a greater risk of dying from external causes in Colombia, Chile, El Salvador, Mexico, and Nicaragua.

Over the past century, improvements in industrialization, affluence, housing, hygiene and nutrition, clinical care, and disease prevention initiatives have enhanced child and adolescent health status in many countries (Gracey, 1998). We have learned the elements that reduce risk for children and adolescents: parental caring and connectedness; parental expectations for school and parent availability all outweigh family structure; ethnicity and, income (Blum, 1998).

In the U.S., mortality rates, overall, are decreasing and many morbidity rates have declined (Blum, 1998). In the PAHO Region, although the prevalence of low weight-for-age and low weight-for-height has declined for children (PAHO, 1998), low height-for-age resulting from periods of inadequate nutrition continues to be seen in approximately 50% of preschool and school-age children in some countries. Conversely, obesity has rapidly increased in the Region, particularly among lower socioeconomic groups, urban communities, and women.

5.1.1 Communicable diseases

Communicable diseases vary across countries. Currently, poliomyelitis has been nearly eradicated, the spread of measles is under control, and progress has been made in slowing the spread of Chagas' disease (PAHO, 1998). However, after an absence of almost 100 years, cholera returned to the PAHO Region in 1991. Moreover, dengue and other vector-borne diseases are still occurring at epidemic rates in many countries throughout the Hemisphere. Tuberculosis has also re-emerged, along with antibiotic resistant diseases. Lastly,

approximately, half of the 1.6 million AIDS cases reported worldwide, since the beginning of the epidemic, are in the Americas.

5.1.2 *Non-communicable diseases.*

Deaths from chronic and degenerative diseases are increasingly outnumbering deaths from infectious and parasitic diseases in the Region. The ratio was estimated to increase from 5:1 in 1985 to 10:1 by the year 2000 (PAHO, 2000). Deaths from nutritional deficiencies and anemia have decreased among individuals under the age of 25, but have increased in varying degrees among people over the age of 25 in almost all of the countries in the Region. Additionally, the total number of deaths due to malignant neoplasms has been rising at a much faster rate than the overall population growth, resulting in higher specific mortality rates in the general population. Specifically, this increase is noted beginning at 25 or 30 years of age and is greatest among women. These findings are due in part to the decline of deaths at earlier ages due to avoidable causes. Because people are living longer, they are exposed to risk factors leading to malignant neoplasms for a longer length of time, and therefore, more deaths at later ages are occurring. The most common sites for malignant neoplasms for men are the lungs, digestive system (primarily esophagus and stomach), and the prostate. In developed countries, lung cancer is the leading cause of death, while neoplasms of the digestive system are more common in developing countries. For women, the leading causes of death are malignant neoplasms of the digestive system (primarily colon and rectal), breast cancer, and cancer of the uterus. Breast cancer is more common in developed countries and cancer of the uterus is more common in less developed countries.

Deaths related to diabetes mellitus also increased across the Region, especially among the population over 25 years of age, and in the English-speaking Caribbean, Andean Area (see Appendix A, Brazil, and Mexico (PAHO, 1998). The lowest increases were in the Southern Cone and North America. Additionally, the Southern Cone and North America saw a decrease in ischemic heart disease, which is a trend seen across many developed countries around the world. However, in Mexico and other subregions, mortality related to ischemic heart disease increased. This trend is reversed for pulmonary circulation and other forms of heart disease that increased in the Southern Cone and North America, but decreased in other subregions.

In North America, cerebrovascular disease has decreased as a cause of death, and the number of deaths has remained the same from 1980 to 1994 in other subregions (PAHO, 1998). However, cirrhosis has increased across four subregions, Central America and the Latin Caribbean, the Andean Area, Brazil, and Mexico. Additionally, mortality related to cirrhosis in all the subregions is approximately three times greater for men compared to women.

Mortality associated with bronchitis, emphysema, and asthma declined across many of the Regions, except in North America and the Southern Cone where rates are unchanged between 1980 and 1994 for population groups under the age of 35. However, the over-35 age group experienced a significant increase. Morbidity related to psychiatric disabilities has also increased in almost all of the countries in the Region. Moreover, mortality related to smoking and alcoholism has increased in the Region.

5.2 HEALTH RISKS

The major factors associated with morbidity and mortality in the Americas varies across regions and countries. Social, political, economic, and environmental factors, along with behavioral risk factors, are a large component of health risks (Green & Kreuter, 1991). With a decrease in mortality and morbidity rates in the Americas, a greater interest in preventing diseases related to lifestyle and social environment has emerged.

5.2.1 *Socio-economic and environmental factors*

Socio-economic and environmental factors play a pivotal role in health status (Fernandez, Tate, Bonet, Canizares, Mas, & Yassi, 2000). For example, inadequate financial resources can constrain people from obtaining necessary health care services; and, health insurance programs may impose requirements and restrictions that limit access to needed services. PAHO uses a variety of indicators to measure socio-economic status (SES) including: Gross National Product (GNP) per capita, annual GNP growth rate, percentage of population in poverty, and the highest 20% to lowest 20% income ratio. As Gross Domestic Product (GDP) per capita falls, accessibility, coverage, and availability of medical care decrease (PAHO, 1999). All of these variables are also dependent on a population's geographic location. PAHO also tracks literacy rate, percentage population with drinking water supply services, percentage of population with sewage and excreta disposal services, and the ratio of different types of health care providers compared to the population

Living conditions in the Americas have generally seen a gradual improvement among basic SES indicators (PAHO, 1998). Access to safe water increased from 60% in 1980 to 75% in 1995; and, sanitation coverage rose from 43% to 68%; and, vaccination coverage increased from 47% to 88% between 1984 and 1996. Moreover, adult literacy increased from 72% to 92% between 1970 and 1995. Despite these improvements, between 1990 and 1994, countries with the lowest GNP rate consist of Cuba, Haiti, Puerto Rico, Trinidad, French Guyana, Tobago, Nicaragua, and Bahamas; and, the percentage of population living in poverty is highest in Bolivia, Haiti, Honduras, Ecuador, Guatemala, Peru, Panama, and Brazil. Men and women are at greatest risk of low literacy rates if they live in Brazil, St. Lucia, El Salvador, Honduras, Nicaragua, Guatemala, and Haiti. Women living in Bolivia also have extremely low literacy rates. Lastly, the ratio of physicians, professional nurses, and dentists per 10,000 population rose from 13.7 to 18.2, from 23.7 to 34.7, and from 3.3 to 5.3, respectively, between 1980 and 1995 (PAHO, 1998).

Environmental factors also may determine whether health-care services and health-related information are accessible, affordable, acceptable, or available. For example, a study by Dellasega, Brown, and White (1995) found that older adults living in rural areas were concerned about the accessibility of health promotion activities, such as cholesterol screening, along with being able to have the results of screening explained and dietary interventions taught in an accessible format. Thus, health care programs need to consider and incorporate factors that affect access and acceptability to community members.

The environment is a critical determinant in the level of risk for violence and the amount of opportunities to engage in healthy behaviors. While some countries still face basic health care issues associated with poverty, environmental degradation, and deteriorating living

conditions, other nations are experiencing health issues related to aging populations, rapid urbanization, and unhealthy lifestyles (PAHO, 1998).

Children around the world experience a vast array of social pressures and health risks (Gracey, 1998). In the PAHO Region, children's experiences include the following: 1) those who are living in wealthy, industrialized countries; 2) those living in rapidly industrialized countries that are experiencing rapid changes in their health care systems (Gracey, 1998; Bossert, Larranaga, Ruiz Peir, 2000); 3) minority groups including recently arrived immigrants in otherwise affluent and healthy societies; 4) previously traditional people in rapid transition to urbanized, Western lifestyles; and, 5) many millions living in grinding poverty in overcrowded, unhygienic conditions where child mortality is high, often due to malnutrition and infections (Gracey, 1998).

Health care delivery systems are constantly changing and have significant implications for access to health services and health information. Currently, many health care systems worldwide are consolidating services, while available resources and funding for health care and health-related programs are increasingly limited. Increased time pressures are especially problematic for people with disabilities who have needs that require extra time for examinations, tests, procedures, and health teaching (Heller & Marks, in press).

Despite the improvements in health status among children in the PAHO Region, the gains are being offset by obesity, smoking, alcohol and drug abuse and social disruption, mental disease and high rates of violence, including homicide and suicide. Moreover, these 'new morbidities' are magnified among minorities and in populations undergoing rapid social change, as well as those experiencing social pressures, such as unemployment and family dysfunction.

Deaths related to accidents and violence have essentially remained the same for the PAHO Region (PAHO, 1998). However, some countries have experienced a marked increase in the number of deaths due to homicide, while accidental deaths are decreasing. The U.N. Population Fund (September 20, 2000) report states that discrimination and violence against women "remain firmly rooted in cultures around the world," stopping women from reaching their full potential. Globally, girls and women are still routinely denied access to education and health care, including control over their reproductive activity, equal pay, and legal rights. At least one in three women has been beaten, coerced into sex, or abused in some way. Studies over the past decade suggest that women with intellectual disabilities are four to ten times more likely than other women to be targets of sexual assault and other violence (Sobsey, 2000); and, greater than 75 percent of mentally disabled women are victims of sexual abuse.

5.2.2 Behavioral risk factors

Behavioral risk factors can consist of inadequate exercise, poor nutritional habits, cigarette smoking, drug and alcohol abuse, unsafe sexual practices, or living in a psychological state of helplessness, without options for major life choices and decisions. Tobacco use is the leading preventable cause of death in the Americas, killing an estimated 625,000 people every year (430,000 in the US, 150,000 in Latin America and the Caribbean, and 45,000 in Canada) (PAHO, 2000). According to available data in North America and Latin America, between

1996 and 1999 tobacco prevalence in the population ranged from a high of approximately 40% in Argentina and Chile, to a low of 22% in Colombia. In some urban areas, more than half of the young people smoke. In Latin America, more people already die of non-communicable diseases, many of which are caused by tobacco, than of communicable diseases, maternal and perinatal conditions and nutritional deficiencies.

The trend toward non-communicable diseases is expected to continue. Tobacco use, which kills through chronic diseases such as heart disease, cancer, and lung disease, has contributed to a regional shift in causes of death from infectious to non-communicable diseases (PAHO, 2000). Behavior can directly influence health and it can have an indirect affect on health by influencing environmental factors. Health behaviors also can maintain or enhance health status and quality of life, control or remove deleterious risk factors, and prevent the onset of chronic conditions.

Non-communicable diseases are responsible for approximately two-thirds of all deaths in Latin America and in the Caribbean (PAHO, 1998). Additionally, deaths from chronic and degenerative diseases were projected to outnumber deaths from infectious and parasitic diseases by a ratio of 10:1 by the year 2000. In order to control or remove harmful risk factors, personal choice or social and environmental changes may be required. Health promotion strategies are primarily concerned with creating behavior change through modification of lifestyles and living conditions to increase well-being. Lifestyle changes can be facilitated by a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices. However, the influence of lifestyle and living conditions on the state of well-being reportedly varies among different socioeconomic levels (WHO, 1988). For example, while personal lifestyles may dramatically affect the development of a state of well-being among the affluent, social and environmental conditions may be larger determinants of well-being among the less affluent.

5.2.3 *Biological risk factors*

Risk factors related to biological factors can include genetic predisposition, age and gender. Although health promotion activities are directed toward factors that are changeable, consideration must be given to the biological risk factors that are not changeable (Green & Kreuter, 1991). Biological risk factors include genetic predisposition, age, gender, race or ethnicity, and climate. While many of these factors do not lend themselves to direct intervention, they must be taken into account when identifying high-risk population groups. Biological risk factors play a role in several leading causes of mortality, including heart disease, cancer, stroke, diabetes, and cirrhosis.

6. COMPONENTS OF CARE

The following components of health care are reviewed in this section: types of providers, modes of service delivery, location of services, and types of programs. In the PAHO Region, a variety of health care providers deliver primary health care services. Although many disciplines provide health care services, the discussions in the literature center on community health workers, nurses, and physicians. Thus, for the purpose of this paper, the review is limited to these specific providers.

Along with the various types of providers, the different modes of service delivery are discussed here. Service delivery modes consist of medical care, nursing care, health education, health promotion, and health protection services. Locations of health care services are also delineated. For example, Services may be delivered in churches, clinics, schools, workplaces, prisons, homeless shelters, nursing homes, and community recreational centers. Types of health care programs may also vary depending on location of services and types of providers. The following review of literature describes the myriad of health-related programs that have been implemented in the Americas Region.

6.1 PROVIDERS

Dramatic changes in the health care system have occurred over the past century. Because of the increasing complexity of health-related concerns and health care delivery systems, *interdisciplinary approaches* are critical for designing and implementing services across a variety of settings. Additionally, current trends in health care delivery are moving us toward a system with *less compulsory* and *more arbitrary standards and services* delivered by quasi-official and voluntary bodies (Halperin, 1998), including a variety of health delivery providers (e.g., community health aides/workers, midwives, nurses, physicians, rural health motivators). These standards are developed in response to specific needs that are driven by sociopolitical and economic agendas (Silva & Gomes, 1998). As new standards are developed in an age of increasing technology and rapid information exchange, issues related to the rights of access must be balanced with protection from unsafe, ineffective, and poor quality services and products. Additionally, standards must incorporate flexibility to enable consumers to choose their level of protection. In order to develop participatory services and programs, health care professionals must embrace the value of multidisciplinary and interdisciplinary approaches for individuals and communities.

Despite the increasing emphasis on interdisciplinary approaches, professionals and academicians still resist teamwork and knowledge sharing across disciplines (Najera & Perez, 1999). These obstacles often stem from the persistent over-valuing of specific experiences of particular disciplines. Professional training needs to shift educational programs from a compartmentalized model of care to a model of comprehensive care that includes a variety of care providers with a range of skills that are situation-specific and equally valued. For example, depending on the health care issues, certain health care providers may be most appropriate (e.g., community health aides/advisors, community health motivators/volunteers, nurses, midwives, nurse practitioners, physicians, etc.). This section reviews research related to specific types of providers.

6.1.1 Community Health Workers/Aides/Activists, Community Health Motivators/Volunteers

Community health workers (CHW) is just one of many terms used throughout the world to describe an indigenous outreach health worker who is trusted and respected in his or her community (Rodney, Clasen, Goldman, Markert, & Deane, 1998). They are also known as community health aides or advisors, lay health advisors, community health motivators, community health advocates, community health volunteers, or ethnic minority link workers. In general, CHWs are local lay community members who interface directly with residents in the community as “health activists” to convey a variety of health messages that promote health (Bental & Paran, 1990) and to improve access to and utilization of health and human services (Baker, et al., 1997). CHWs are often indigenous to the community and work with community members who are underserved and may share their ethnic racial background (Love, Gardner, & Legion, 1997). As frontline health care professionals, CHWs are increasingly viewed as health agents with key roles in the primary health care model as the CHW programs are designed to build on the strength of existing community relationships to improve health (Baker, et al., 1997). The role that CHWs play in breaking down social and cultural barriers between the formal health care system and the client community is a pivotal factor in access to health care services for community members (Tomas Sancho, Kennedy, & Colomer Revuelta, 1998). CHW volunteers often have the ability to administer more personalized services to community members and can bridge the gap between community residents and the health agency (Dick & Schoeman, 1996).

CHWs also have different activities and settings across the Americas Region (Lopez, 1999). In developed countries, activities for CHWs are developed in response to a lack of responsiveness within the formal health care system to facilitate health promotion and illness prevention (Tomas Sancho, Kennedy, & Colomer Revuelta, 1998). In developing countries, the primary goal of CHW activities is to implement primary health care services in areas with limited professional resources. CHWs also provide services for a variety of community members in settings ranging from urban areas (Parker, Schulz, Israel, & Hollis, 1998; Schulz, Israel, Becker, & Hollis, 1997; Solla, Medina, & Dantas, 1996)), rural areas (Earp, 1997; Berner, 1992; Robinson & Larsen, 1990), schools (Berkley-Patton, Fawcett, Paine-Andrews, & Johns, 1997; Olvera, Rodriguez, Perez, Eibenschutz, & Villalba, 2000; Velasquez, 1993)), churches (Simpson & King, 1999), and migrant camps (Booker, Robinson, Kay, Najera, & Stewart, 1997).

Many CHWs are adult women volunteers (Peru, 1996; Lange, Aguiló, & Barros, 1994). Love, Gardner & Legion (1997) reported the majority of CHWs in eight Bay Area counties in California are women (66%), of color (77%), with a high school degree or less (58%). However, depending on the target population, newer models of care are training different groups of people to work as CHWs, such as, adolescents (Berkley-Patton, Fawcett, Paine-Andrews, & Johns, 1997; Garfield, 1996), older adults (Earp, et al., 1997), church members, mothers (Johnson, Howell, & Molloy, 1993; Gutierrez & Paredes, 2000), and members of racial/ethnic minorities (Jackson & Parks, 1997). While the location of services and goals may vary across the Region, the processes that are fundamental to CHWs performance are similar. These factors include recruitment, training (Gutierrez & Gavilano, 2000), monitoring, ongoing support, and evaluation.

Health care activities

Lay health workers have essentially three primary functions: 1) to serve as mediators between community members and health agencies, 2) to establish a social network, and 3) to offer a range of services from emergency care to health protection and social support (Berner, 1992; Brownstein, Cheal, Ackermann, Bassford, & Campos-Outcalt, 1992). Specifically, CHWs are trained to participate in a variety of health education programs including *smoking cessation* (Lacey, Tukes, Manfredi, Warnecke, (1991), *cardiovascular health education* (Bental & Paran, 1990), *providing vaccinations* (Solorzano Moguel & Alvarez Cuevas, 1991), *violence prevention education* (Davies, Harris, Roberts, Mannion, McCosker, & Anderson, 1997; Anderson, Harris, McCosker, 1997), *cancer screening and education* (Navarro, Senn, McNicholas, Kaplan, Roppe, & Campo, 1998; Earp, et al., 1997; Navarro, Senn, Kaplan, McNicholas, Campo, & Roppe, 1995), *enhancing self-care and advocacy skills for women* (McElmurry, Swider, Grimes, Dan, Irvin, & Lourenco, 1987), and *surveillance and treatment activities for tropical or communicable diseases* (Cairncross, Braide, & Bugri, 1996; Ruebush, Zeissig, Koplun, Klein, & Godoy, 1994; Engelkes, 1992; Solorzano Moguel & Alvarez Cuevas, 1991). One study in California reported that the major foci of the CHW's activities were AIDS and maternal child health (Love, Gardner & Legion, 1997). Community Health Aides (CHAs) have a vital role in improving access to preventive health services (Sox, 1999). For example, women CHAs were trained to collect specimens for Pap and sexually transmitted disease testing and perform breast examinations to increase access to women's health services for Alaskan natives.

Community Health Workers Impact in Primary Health Care activities

Research suggests that services provided by lay health activists can improve the efficiency of health promotion programs to increase public awareness of health risks related to diseases (e.g., cardiovascular disease, cancer screening, TB prevention, emergency care). Because a fundamental tenet within CHWs training focuses on improving access to essential primary health care services of community members, they are often effective in getting people to engage in health promoting behaviors and activities that prevent illness. Additionally, use of CHWs can significantly increase the use of the available public health care services (Christensen & Karlqvist, 1990). This in turn reduces the overall cost of health care services within a community. Despite the positive benefits that front-line community workers have in influencing health status, successful implementation of CHW programs remains challenging (Robinson & Larsen, 1990). Reports have suggested that high turnover rates, absenteeism, poor quality of work, and low morale among workers in CHW programs is associated with weak organizational and managerial capacity within the government health systems. To address these issues, studies have shown that good supervision, in service training and adequate logistic support are necessary components in maintaining CHWs' skills and participation (Ashwell & Freeman. 1995).

6.1.2 Nurses, Midwives, and Nurse Practitioners

Nurses throughout the PAHO Region have a vital role in community activities, and have been instrumental forces behind the development of many types of community-based model programs to address community health concerns (see Table 1). Additionally, nurses have a long

Table 1. Model Programs Developed by Nurses

- The Cool Kids Coalition (Corryrino, Walsh, Boyle, & Anselmo, 2000)
- Experiencia de enfermería en la atención materno infantil (Campos, Jaimovich, Campos, 1999)
- The Arkansas AHEC model of community-oriented primary care (Hartwig & Landis, 1999)
- The Expanded Care for Healthy Outcomes (ECHO) Project: addressing the spiritual care needs of homeless men in recovery (Brush & McGee, 1999)
- The McGill Model and Local Community Service Centers: A Fetching Combination (Malo, Cote, Giguere, & O'Reilly 1998)
- Shuler Nurse Practitioner Practice Model (Shuler & Huebscher, 1998)
- Put Prevention into Practice (Grey, 1998)
- Partners in collaboration: The Homan Square Project (Hollinger-Smith, 1998)
- The 60 and Better Program: A Primary Health Care Program for the Aged (Nay, 1997)
- Health Care Delivery in Faith Communities: The Parish Nurse Model (Weis, Matheus, & Schank, 1997)
- The Comox Valley Nursing Centre (Attridge, et al., 1997)
- Selfcare nursing as a contribution to quality improvement in health: A Latin American experience (Lange, & Jaimovich, 1997)
- A Comprehensive School-based Clinic: University and Community Partnership (McClowry, et al., 1996)
- A community- based primary health care program for integration of research, practice, and education (McElmurry, Swider, & Norr, 1991)

history of forming partnerships with a variety of health care providers and with community groups in response to health care educational needs expressed by community members. For example, nurses assembled a multidisciplinary task force in response to several women who presented with post-partum depression in order to educate health care professionals to identify women experiencing depression (Straub, et al., 1998).

Nurses in the PAHO Region continue Florence Nightingale's tradition of integrating scholarly work with political activism (Rafael, 1997). Just as Nightingale became well versed in major areas of public policy and lobbied extensively to create policies that integrated factors in the biophysical environment with social and economic factors, nurses today assume leadership roles to advocate for critical issues affecting specific communities. One such nursing leader (who also is disabled) in the Disability Community is Marca Bristo. A highly respected leader in the Disability Rights Movement, Bristo has directed a leading Center for Independent Living, since it was established in 1980. Its mission includes service, advocacy and promotion of social change for people with disabilities. The Center brought disability to the forefront in Chicago and nationally. Because nurses are often informally sought out for education and health care information, they have a critical role in promoting health behaviors by acting as health educators and change agents outside, as well as within, their professional roles (Tessaro, 1997). Oftentimes, nurses have to step outside normal roles and bureaucratic expectations to achieve resolution of the issues that people are bringing to them from the community. Nurses also are

instrumental in providing training and supervision of community health aides (Berner, 1992) and other paraprofessionals who provide direct care services.

Health care activities

Services provided by nurses occur in a variety of community settings including the following: schools (McClowry, et al., 1996), churches (Weis, Matheus, & Schank, 1997), correctional facilities (Miller, 1999), home care (Keating, 1995;Bandeira, 1997)), rural and urban areas (Dumas, 1992; Cufino Svitone, Garfield, Vasconcelos, & Araujo Craveiro, 2000), and physician office-based practices (Hill & Becker, 1995). Nurses are also committed to providing services to a variety of population groups. For example, nurses in the Region work with low income women (Kozlowski & Zotti, 1994), immigrants and refugees (DeSantis, 1997), prisoners (Miller, 1999), children (Corrarino, Walsh, Boyle, & Anselmo, 2000), people who are homeless (Brush & McGee, 1999), older adults (White & Nezey, 1996), women with chemical addictions (Dumas, 1992), workplaces (Parrish, 1995; Wassel, 1995), & adult day care (Dunham-Taylor, Oldaker, DeCapua, Manley, Oprian, & Wrestler, 1993).

Specific topics covered by nurse-developed programs include the following: education in specific content areas, such as cardiovascular health promotion (Hill & Becker, 1995), assessment, screening and treatment for various conditions, including mental health issues (Straub, et al., 1998) and cancer screening (Ansell, Lacey, Whitman, Chen, & Phillips, 1994), scald burn prevention education for parents (Corrarino, Walsh, Boyle, & Anselmo, 2000), individualized health promotion services (Malo, Cote, Giguere, & O'Reilly, 1998), empowerment strategies and promotion of equity and access for older adults (Weis, Matheus, & Schank, 1997; Nay, 1997), maternal, child health (Hollinger-Smith, 1998), and lead screening (Block, Szekely, & Escobar, 1996).

Nurses impact in Primary Health Care activities

Research documenting the clinical- and cost-effectiveness of community-based nursing services is limited. While anecdotal evidence suggests nurses do contribute to improvements in health status and to reducing health care costs, nurse leaders in key community positions will require more support for addressing effectiveness (Dunham-Taylor, Oldaker, DeCapua, Manley, Oprian, & Wrestler 1993). Additionally, more research-based demonstration projects need to be conducted in communities to document the clinical effectiveness of nurse-run health promotion and prevention programs. If more nurses were able to bill and/or be directly reimbursed for their services, this picture might change as most effectiveness studies are tied to costs rather than the social value of their services.

Community health nurses are in a strategic position in the PAHO Region to maintain, promote, and protect the health of populations both now and in the future (Kuss, Proulx-Girouard, Lovitt, Katz, & Kennelly, 1997). As the health care environment increasing emphasizes the protection and promotion of health, access to health services, and prevention of illness, public health nurses given their training and historical roots are paramount in the changing focus to primary prevention. Nurses also have the breadth of knowledge to interface with many different levels of service delivery professionals and to translate this information to community members, to build community capacity for health promotion, and to facilitate

community participation by enhancing community health services and coordinating public policy to achieve core public health responsibilities of assessment, policy, and assurance (Kang, 1995).

6.1.3 Physicians

In the PAHO Region, physicians have focused on curing and restoring health to individuals who experience specific disease states. Much of the extant literature reviewed demonstrates that the primary goal for physicians to change the individual by replacing disease or impairment with “health” or “normality” (Gill, 2001). Additionally, the “key problem” in many of the studies in the physician-based primary health care literature was seen as a physical or functional impairment. The interface between the environment and the individual was for the most part neglected in these studies. Moreover, incorporation of the cultural, political, social, and economic factors into the analysis of the “problem” was virtually absent.

Health care activities

An important conclusion cited in a meeting between the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) in 1994 was: “Optimal medical practice is responsive to individuals and communities, being person-centered, health oriented, and community based the systems of medical practice and public health should be closely linked” (WHO, 1994). While this conclusion supports the use of a primary health care model, unfortunately, compared with the depth of literature for nurses and CHWs, a paucity of literature exists relating to models of care for primary health care activities among physicians.

Much of the literature about health care services provided by physicians centers on teaching them more effective ways to provide office-based health promotion counseling for their patients. For example, studies review counseling activities for nutrition (Ockene, Hebert, Ockene, Merriam, Hurley, & Saperia, 1996), smoking, drug abuse, obesity, contraception, breast self examination, cholesterol checks, diet, exercise, hormonal replacement, Papanicolaou smears, and glaucoma checks (Davies, 1991). Studies also examined factors associated with preventing low birth weight babies (Stewart & Nimrod, 1993), accidents in children (Carter & Jones, 1993), sports-related injuries (Rouzier, 1995), cancer (Frame & Werth, 1993), and preventive care measures for patients with diabetes (Streja & Rabkin, 1999).

The studies also addressed treatment issues for patients in providing health promotion and prevention services. For example, research studies examined the patient-physician interaction (Walsh & PcPhee, 1992) and the impact of physician cooperation with a community-based prevention and health promotion program for older adults (Bula, Alessi, Aronow, Yubas, Gold, Nisenbaum, Beck, & Rubenstein, 1995). In sum, the literature review found that, on a community level, physicians are involved with activities that omit attention to the social realities that often have a much greater impact than the presenting physical or psychological concerns. Consequently, this contributes to health care services from physicians that are internalized as oppressive, rather than helpful.

6.1.4 Partnerships: Health Professionals and Community Coalitions

Interdisciplinary and multidisciplinary work creates an opportunity to develop partnerships with other health professionals (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Dos Santos, 1997). As we shift from a compartmentalized model of care to a model of comprehensive care, health professionals must maximize their relationships with providers across disciplines in the health care system and embrace partnership relationships with clients and their communities (Goulart, 1997; Stockins & Pantoja, 1997). Partnership relationships can transform the *professional* and the *client roles*. As professionals relinquish their positions of authority to partner with clients, clients / families / communities shift from being passive recipients of care to becoming active participants in maintaining health and preventing disease (McElmurry, Tyska, & Parker, 1999). Additionally, partnerships build capacity among individuals and communities (Kang, 1995); and, are particularly beneficial for communities that have been under-represented and/or minority populations (Courtney, Ballard, Fauver, Gariota, & Holland, 1996). For example, Lough (1999) described an academic-community partnership between a college of nursing and a neighborhood grade school and parish. This partnership actually achieved two goals. First, the provision of needed health care services improved health status and increased access to health promotion services. Secondly, similar to other academic community health centers (Beauchesne & Meservey, 1999), nursing students are given an opportunity to provide services using a community-based primary care model.

The formation of multiple partnerships within communities fosters community empowerment and mutual accountability (Labonte, 1999; Eisen, 1994). Moreover, including “out-of-the-mainstream” groups as partners, such as youths (Harper & Carver, 1999), farmers (Ehlers & Palermo, 1999), religious groups (Simpson & King, 1999), and minority populations (Levine, et al., 1992) can result in informative health service programs, along with a unique opportunity to build community coalitions as change agents. Within a community, coalitions encourage broad community involvement and “ownership” in the planning and implementation of needed health promotion and health education services (Levine, et al., 1992; Armbruster & Gale, & Brady, 1999). For example, a coalition of consumer organizations, health care providers, and activists in Rhode Island directed their activities toward improving maternal and infant health (Aaronson, 1991). With multiple inputs from people with varied areas of expertise, the Rhode Island coalition achieved important legislative initiatives to improve maternal and infant health, such as, health insurance for uninsured pregnant women and promotion of midwifery services. Thus, the power of coalitions can enhance perceived ownership, which in turn can result in greater community participation and interest in health promotion and protection activities.

6.2 LOCATION OF SERVICES

The acute, inpatient-oriented illness model of health care is being replaced with a health protection, health-promotion, and primary health care model (Shortell, Gillies, & Devers, 1995). As the location of health care services moves into the community (e.g., worksite, schools, churches, healthcare sites), questions emerge concerning the dimensions of health education/health promotion programs and policies (Mullen, et al., 1995). Research about program needs, feasibility, efficacy, and effectiveness also must be undertaken.

Although care is shifting to a primary health care model, models outside of the formal health care arena exist. For example, “informal care” is one strategy that is being used to empower minority communities with respect to health care and health promotion and is a significant force in health maintenance, health promotion, and disease prevention (Chen, 1999). Informal care is defined as the practice of alleviating physiological and psychological distress through others (e.g. traditional healers, family members, self, etc.) using measures that do not require a physician's prescription or intervention (e.g. lifestyle modifications) (Werner, 1994). These actions are usually outside of formal, institutionally based care mechanisms (e.g. homes and communities) (Nigenda, Lockett, Manca, & Rodriguez, 1997; Seravalle & Book, 1996). In the U.S., at least one-third of the population is estimated to engage in unconventional medical practices, and approximately one-half of racial/ethnic populations use informal care. Use of informal care is advantageous because it is often more culturally compatible, relatively low in cost, and flexible.

Community-based programs located where people frequently congregate can play a valuable role in health promotion activities. For example, health promotion and health protection programs can be implemented in churches, schools, nursing homes, worksites, Centers for Independent Living for persons with disabilities (CILs), firehouses, supermarkets, military systems, housing projects, barbershops and beauty salons, and other community settings. For the purpose of this paper, however, only churches, schools, and work-site programs will be discussed in-depth.

6.2.1 Church-Based Health Programs

Churches are increasingly used as sites for health promotion and health protection activities. A partnership between religious groups and health providers enables incorporation of the culture of the community into health promotion efforts to reach vulnerable populations (Simpson & King, 1999). A church-based model focuses on using the faith community to influence the behavior and lifestyle of persons within an organized public health model, which provides a new model of ministry (Cook, 1997).

Church-based health programs offer an innovative response to achieve health policy as well as address the changing health needs and altering social and economic trends of a community (van Loon, 1998). Nurses are often the key providers in many of the faith-based community programs. These programs have the ability to foster community participation in health and promote health from a holistic perspective, within the supported social and culturally specific context of a faith community. Religious leaders may also play an instrumental role in initiating health promoting and protecting messages (Anonymous, 1993). Research has shown that the religious community is more willing to accept health messages, when the church-based programs stress ways to improve the quality of life in keeping with the messages conveyed by the church, rather than framing health issues in mortality statistics (Sanders, 1997).

A variety of health messages have been promoted in church-based programs. For example, program aims have included the following: reduction of breast, cervical, and diet related cancers in women (Castro, et al., 1995); smoking cessation (Anonymous, 1993); nutrition-related programs (Demark-Wahnefried, Hoben, Hars, Jennings, Miller, & McClelland, 1999);

cardiovascular risk reduction programs (Oexmann, 2000); and, stroke prevention (Okwumabua, Martin, Clayton-Davis, & Pearson, 1997).

Health promotion programs in churches have targeted different groups of people. For example, population groups have included: people living in rural areas (Simpson & King, 1999; Demark-Wahnefried, Hoben, Hars, Jennings, Miller, & McClelland, 1999); Latino/Hispanic women (Castro, et al., 1995); and, African-American men and women (Okwumabua, Martin, Clayton-Davis, & Pearson, 1997; Thomas, Quinn, Billingsley, & Caldwell, 1994). Research is limited concerning the interconnections among public health, health education, and faith-based communities (Chatters, Levin, & Ellison, 1998). However, researchers and practitioners are increasingly interested in theoretical issues and frameworks explaining the relationships between religious involvement and health. Additionally, research studies are increasingly exploring the associations between religious involvement and health attitudes, beliefs, and behaviors. Lastly, future efforts need to evaluate health education programs in faith communities and examine the contributions of religious institutions to the development of health policy.

6.2.2 School-based Health Services and Health Education

School-based health clinics in the US have grown from a few programs in the early 1970s to more than 600 in the 1990s (Klein & Cox, 1995). Implementation of comprehensive school health education and integrated school health services based on an assessment of community needs and resources can improve access to health care for millions of underserved school-aged children (Anonymous, 1994). Greater attention to health promotion and protection services provides an optimal setting for improving health for all children and adolescents by focusing on health behaviors in school settings (Brindis, 1993). See Table 2 for examples of school-based clinics.

Table 2. School-based Clinics

- Mariner Project: A coordinated school health pilot program (Valois & Hoyle, (2000).
- School-Based/School-Linked Health Centers' (Willis, 2000).
- A comprehensive school-based clinic: university and community partnership (McClowry, 1996)
- A collaborative effort for sex education in rural school settings (Faulk & Mancuso, 1998)

A variety of contextual factors may facilitate or impede the provision of school health services. For example, schools whose students experienced more health risks were generally *more likely* to provide related services than schools whose students experienced fewer risks (Billy, Grady, Wenzlow, Brener, Collins, & Kann, 2000). Schools within states that had strong state policies and requirements for health-related programs and services were also associated with *greater* school-based provision of services. Additionally, schools were *less likely* to provide services on site when communities had readily available and accessible health care services. Lastly, more affluent communities were *more likely* to provide school health services than less affluent communities. Similarly, public schools were *more likely* to provide school health services than private schools. Public schools may have more access to public dollars, which could account for the greater likelihood of providing school health services.

The inclusion of a multidisciplinary approach (e.g., school nurses, nutritionists, exercise physiologists, social workers, occupational therapists, and pediatricians) in the continuum of health care delivery promotes effective, timely, accessible, cost-effective services for children (Gaffrey & Bergren, 1998). Moreover, the success of school-based programs requires collaborative linkages across many levels of systems and individuals. Collaboration can increase points of access for children, by mobilizing community resources among local leaders, parents, and statewide health systems (Willis, 2000). While the development of collaborative networks for comprehensive school health programs remains largely untapped, common dimensions of collaboration have been identified (Gottlieb, 1999). These dimensions include:

1. Having interpersonal and organizational interactions;
2. Awareness and understanding of comprehensive school health programs;
3. Understanding organizational priorities and reward systems;
4. Identifying political forces;
5. Having resources available, and
6. Sharing resources.

Research supports the suggestion that many elements are critical to the success of a school-based health program:

1. Administrative support/buy-in;
2. Coordination of the school-based health promotion team;
3. Program liaison/facilitator; and
4. Staff wellness coordinator (Valois & Hoyle, 2000).

Implementation of a comprehensive school health education program requires that teachers feel comfortable and prepared to teach specific health topics. On-going training and reinforcement for teachers can increase the teachers' feelings of preparedness, which in turn can have a significant effect on the students (Hausman & Ruzek, 1995).

School-based health care services in the US are often delivered by APNs (Advanced Practice Nurses) (Walker, Baker, & Chiverton, 1998; Faulk & Mancuso, 1998). A primary focus of school-based services is the provision of primary health care and psychosocial counseling to children and adolescents in schools (Klein & Cox, 1995). Additional services often include health promotion, screening, and anticipatory guidance (Walker, Baker, & Chiverton, 1998). Use of an integrated approach to school-based health care services and health education can provide programs to reduce tobacco use (Mackie & Oickle, 1995) and provide sex education to reduce the incidence of teen pregnancy and sexually transmitted diseases (Faulk & Mancuso, 1998).

The availability of school-based health care services can be expanded by institutional partnerships and capitalizing on each other's strengths (McClowry, et al., 1996). More research needs to be conducted to document the most cost-effective and cost-efficient manner, and determining the needed staff and resources (Brindis, 1993).

PAHO is developing a document that includes an overview of the current status, difficulties, and constraints of school health services in the Americas Region in 2002. Issues of availability, coverage, inconsistent quality, design, content of care, coordination between the school health services and the local network of services, financing, management, and the scarcity of trained personnel designated for the management and provision of care in the school setting are addressed. Experiences from Chile, Cuba, Jamaica, Ecuador Peru, and the U.S. are also discussed. (To obtain more information about "Status of School Health Services in the Americas Region 2002" document, contact Dr. R. Rojas, PAHO, HSP/HSEO).

6.2.3 Work-Site Programs

Work-site health promotion programs frequently implement health promotion and protection strategies to reduce obesity and the prevalence of cigarette smoking (Jeffery, et al., 1993). Work-site programs have traditionally focused on individually oriented wellness programs (provided at the worksite and aimed primarily at changing employees' health behavior) (Stokols, Pelletier, & Fielding, 1996). However, current programs are emphasizing the joint impact of the physical and social environment at work, job-person fit, and work policies on employee well-being.

6.3 TYPES OF PROGRAMS

Health care interventions are typically directed across three areas: individual, family, or community interventions. To manage new causes of morbidity and mortality, traditional health services must move beyond the individual level and subsume greater focus on health protection and health promotion (Guldan, 1996). Because most common health problems amenable to prevention have strong environmental, cultural, lifestyle, and behavioral components, community-wide or population approaches are imperative in most health promotion and prevention strategies (Luepker, 1994). Individuals, communities, and countries make choices about whether or not to consume alcohol and drive, smoke cigarettes, exercise, or have their children immunized. While all of these involve personal choices, they also involve societal or cultural barriers and enticements, access, and availability, monetary and opportunity costs, laws, and other community-wide factors (Luepker, 1994). Although some prevention issues respond to traditional clinical approaches, many do not. Thus, a coordinated community approach to support the preventive efforts of the health care system and develop a healthy environment and health literate population is required.

6.3.1 Family Models

A new model of health proposed by Mendoza & Fuentes-Afflick (1999) is the family-community health promotion model. This model attempts to account for the paradox that Latino children do not seem to have a consistent association between poverty and poor health.

While a majority of Latino children in the US live in poverty, many poor Latino children have unexpectedly good health outcomes. The family-community health promotion model emphasizes the family-community milieu of the child. Instead of focusing on traditional models of health, the family-community model expands the outcome measures from physical health to functional health status, while incorporating the contributions of cultural factors to functional health outcomes.

6.3.2 Community Models

Currently, the focus of health promotion is shifting from the individual level to organizations, communities, and broader social policy areas (McKinlay, 1993; McKinlay, 1992). Community-based health promotion and protection services emphasize community participation, along with empowerment of community members to address inequities and increase control over their health (Guldan, 1996).

Community-based educational programs are often conducted to promote healthy lifestyles (Reger, Wootan, & Booth-Butterfield, S. 2000). For example, the "1% Or Less" message used public relations and community-based educational activities in supermarkets, schools, worksites, and other community settings to encourage community members to switch from high-fat (whole or 2%) to low-fat (1% or fat-free) milk. The Canadian Heart Health Initiative-Ontario Project (CHHIOP) used an ecological approach to health promotion within which public health agencies are seen to play a central role in implementing community-based heart health promotion activities (Taylor, Elliott, & Riley, 1998; Lothrop, 1999).

Community coalitions are a popular tool for promoting community-based solutions to health problems, such as alcohol, tobacco, and other drug abuse (Butterfoss, Goodman, & Wandersman, 1996). Member satisfaction and participation are critical components in community coalitions that are providing health promotion and protection programs. Moreover, community leadership, shared decision-making, linkages with other organizations, and a positive organizational climate are factors that predict satisfaction, participation, and planning.

6.3.3 Health Care Programs

The extent and type of services depend on the location of the services. While there is a wide variety of health promotion and health protection programs in the Region, for the purpose of this paper the programs examined were categorized as follows: asthma treatment, cardiovascular health, exercise and physical activity, weight reduction, eye care, dental treatment, injury prevention, maternal child health, mental health, reproductive health/women's health, sexually transmitted diseases, substance abuse programs, and unwanted pregnancy.

Schools and community programs have tremendous opportunity to help children and adolescents adopt lifelong, physical activity patterns (Anonymous, 1997). Key components of school and community programs for encouraging physical activity include: 1) policies that promote enjoyable physical activity and social environments; 2) physical education curricula and instruction; 3) health education curricula and instruction; 4) extracurricular physical

activity programs that meet the needs and interests of students; 5) involvement of parents and guardians in physical activity instruction and programs for young people; 6) personnel training; 7) health services for children and adolescents; 8) developmentally appropriate community sports and recreation programs that are attractive to young people; and, 9) regular evaluation of physical activity instruction, programs, and facilities.

Many of the asthma and injury prevention programs are developed for children and adolescents. For example, substandard housing and lack of resources often result in asthma triggers for many low-income urban children with asthma (Krieger, Song, Takaro, & Stout, 2000). Health educators, outreach workers, medical providers, health care insurers, housing agencies, and elected officials have developed various programs to address issues related to asthma and asthma triggers (Fisher, 1994; Diaz Vazquez, Alonso Bernardo, Garcia Munoz, del Ejido Mayo, Sordo Espina & Alonso, 1997; Kohler, 1993).

Behavior and environment have been found to be key determinants of both unintentional and intentional injuries in childhood and adolescence (Grossman & Rivara, 1992). Injury prevention programs have focused on *violence* (Borzekowski & Poussaint, 2000; Wallack, 1999; Gabriel, Hopson, Haskins, & Powell, 1996); *childhood unintentional injury* (Bass, Christoffel, Widome, Boyle, Scheidt, Stanwick, & Roberts, 1993); and, *use of bike helmets* (Wesson, Spence, Hu, & Parkin, 2000; Parkin, Hu, Spence, Kranz, Shortt, & Wesson, 1995). Many health programs have addressed *substance abuse prevention and treatment*.

Programs have been developed for *children and adolescents* (Biglan, Ary, Smolkowski, Duncan, Black 2000; Abernathy, 1994), *minority populations* (Plested, Smitham, Jumper-Thurman, Oetting, & Edwards, 1999), and *adult men and women* (Fisher, Glasgow, & Terborg, 1990). Programs also targeted specific drugs including *alcohol* (Giesbrecht & Rankin, 2000) and *tobacco use* (Edwards & MacMillan, 1990). Additionally, health promotion and protection programs have focused on *mental health issues* (Dalgard, Sorensen, Sandanger, & Brevik, 1996), oral health (Pack, 1998; Gift, Drury, Nowjack-Raymer, & Selwitz, 1996), *eye health* (Sperandio, 1999), and *skin care* among adults and youths (Junkin, 2000; Miller, Geller, Wood, Lew, & Koh, 1999).

A plethora of programs have been developed for hypertension (Kong, 1997), cardiovascular disease (Gyarfas, 1992), diabetes (Engelgau et al., 1998), sexually transmitted diseases and unintended pregnancies (van Dam & Holmes, 2000; Santelli, DiClemente, Miller, & Kirby, 1999), along with exercise promotion (King, 1998), maternal child health (Mora & Nestel, 2000; Stewart & Nimrod, 1993), nutrition (Arenas-Monreal, Paulo-Maya, & Lopez-Gonzalez, 1999; Usinger-Lexquereux, 1994; Stevens, 1994), agricultural health (Schenker, 1996), tropical health (Leontsini, Gil, Kendall, & Clark, 1993) and worksite health (Gelfand, Parzuchowski, Rivero-Perry, & Shernoff, 2000).

6.4 HEALTH CONCERNS/ISSUES

Health inequities among population groups continue to grow throughout the PAHO Region. Health professionals and communities must develop innovative health promotion and health protection strategies that are culturally relevant to at-risk groups (see Table 3 for examples) to enhance access and improve the health status. Some strategies may include the

creation of alternative health care delivery models and the use of lay community outreach workers to bridge cultural issues (Gwyther, 1998).

6.4.1 Primary Health Care

Traditional health care for older adults and persons with disabilities has focused on illness diagnosis and management (Swenson, 1992). As individuals, women especially, are living longer and living better, the emphasis needs to shift to include primary health care for elderly people (Paier & Bowdish, 1995; Swenson, 1992). Although primary health care includes health promotion and health protection activities, older adults and persons with disabilities, unfortunately, are often not included in health promotion programs (Callahan, 2000; Resnick, 2000; Rimmer, 1999). Moreover, delivery of primary health care to people with disabilities is often compromised due to the provider's lack of knowledge concerning disability issues and barriers to accessing health care services (Lennox & Kerr, 1997; Perez, Oliver-Vasquez, Andino, & Vega, 1999). Researchers also are just beginning to explore the conditions promoting optimum health among older persons and persons with disabilities.

Table 3. At-Risk Groups

- Children and adolescents
- Immigrants
- Migrant farm workers
- Older adults
- People living in poverty
- People with disabilities
- Prisoners
- Racial/ethnic minorities
- Undocumented immigrants
- Women

Despite the evidence that health-promoting activities can maintain or enhance health status, control or remove deleterious risk factors, and prevent chronic conditions, older adults and persons with disabilities have only recently been included in health promotion activities. Nonetheless, anecdotal evidence and limited research suggests that older adults and persons with disabilities are interested and willing to participate in health promotion programs (Durham, Beresford, Diehr, Grembowski, Hecht, & Patrick, 1991). However, Resnick (1998) found that older adults demonstrated a decrease in cancer screening behaviors, aerobic exercise, and compliance with a low cholesterol diet. The most common reasons identified by participants for not having these tests were advanced age, not being instructed by their primary health care provider, and no interest in pursuing abnormal findings. Participants stated that they had lived a sufficient period of time, and were no longer interested in disease prevention and prolongation of life.

6.4.2 Access and Equity

Access issues prevent people from receiving necessary screenings (e.g., cancer screenings) and health promotion and protection services (Masood, 1997). Globally, girls and women are still routinely denied access to education and health care, including control over their reproductive activity, equal pay, and legal rights. In order to access services and learn how to interface with these services, women must be given culturally appropriate health information regarding the availability of such services. Moreover, gynecological and reproductive services, such as mammograms, health education for sexual/reproductive knowledge, STD counseling/treatment, and prenatal care for women with intellectual disabilities are often limited or not offered (Kopac, Fritz, & Holt, 1996).

The consolidation of services in the Americas impinges on the resources that we have available to provide care. This is especially problematic for at-risk groups who need more time in order to attain desired changes in health status outcome. The lack of time limits the ability to realize maximal health goals.

While health promotion services and health information is a critical ingredient for health status, decision makers must actively address access barriers such as the lack of adequate preparation of health care providers, lack of health insurance coverage, transportation problems, and geographic unavailability of health services. In addition, harsh social and economic environments, communication barriers, poverty, marginalization, abuse, and lack of support also may reduce access to health screenings and promotion activities (Messias, Hall, & Meleis, 1996).

Across the PAHO Region, we are failing to involve those most in need of health promotion. If *equity* in provision of health promotion is to be achieved, measures must be taken on a local and national level to ensure that underserved populations have access to services (Davis, McWhirter, & Gordon, 1996).

6.4.3 Priority Areas

PAHO (1999) delineates the following health concerns and issues as priority areas to address in health promotion and protection activities throughout the life cycle.

Family health and population, which attaches special importance to promoting and assessing growth and development at different ages; this includes programs for adolescent health, reproductive health, and health of the elderly.

Food and nutrition, with special attention to malnutrition, the fortification of food with micronutrients, breast-feeding, supplementary feeding, nutritional guidelines for the different age groups, and food security.

Healthy lifestyles and mental health, particularly preventing the use of tobacco, alcohol, and drugs; domestic violence; and child abuse, including social communication in health, as well as health education and community participation, an area that involves initiatives to promote healthy schools, healthy communities, and healthy environments.

7. METHODOLOGICAL AND MEASUREMENT ISSUES

As health promotion activities move from the individual level to the level of organizations and communities, measurement criteria need to change. Traditional quantitative methods that are appropriate at the level of individual behavior change require adaptation and refinement when sociopolitical change becomes the mechanism for health promotion (McKinlay, 1993; McKinlay, 1992). Health services researchers and health educators who are challenged to make methodological changes as they move beyond their initial training, experience, and focus, often find it useful to use well-designed and carefully conducted qualitative studies to complement quantitative approaches. Using techniques such as ethnographic interviews, participant observation, case studies, or focus group activities can fill gaps where quantitative techniques are sub-optimal or even inappropriate. Additionally, qualitative techniques can also support quantitative methods. The utility of qualitative techniques in process evaluation is now beyond dispute. The role of qualitative research in the evaluation of health promotion through planned sociopolitical change is essential (McKinlay, 1993; McKinlay, 1992).

7.1 PRIMARY HEALTH CARE MODEL

Employing holistic approaches to evaluate health care programs and services can ensure that key variables are measured (Jan, 1998). The use of conventional forms of economic evaluation, where value (or benefit) is seen in terms of either health consequences or individuals' utility, results in overlooking a number of aspects of health-related programs. Moreover, use of economic evaluation imposes limits on the capacity to inform public policy. In contrast, use of a Primary Health Care model (see Figure 1) to measure health promotion and health protection activities acknowledges that change in the broader socio-political environment can be a source of value. This is particularly relevant when evaluating indigenous health programs, where notions of "cultural appropriateness" have strong influence over the *effectiveness* and *acceptability* of such programs. Additionally, community and population health depends on a qualitatively different set of investigative methods, decision-making procedures, and assignment of responsibility for action than those applied in the health care systems (Green, 1994). Because no one evaluative approach is appropriate in all situations, a Primary Health Care model allows for a blending of methodologies ranging from qualitative to quantitative and non-experimental to true experimental.

Use of the Primary Health Care (PHC) model requires consideration of several methodological and measurement issues. A fundamental tenet of the PHC model is the use of participatory methods throughout the educational, practice, research process for the purpose of empowerment and emancipation (refer Figure 1).

7.2 TRANSFORMING ROLES

The PHC model creates a template for conducting participatory education, practice, and research activities. However, educators, clinicians, and researchers must first consider ways of working with "subjects/clients/patients" to transform the hierarchical relationship into a mutual partnership (Campos, Jaimovich, Campos, & Berger, 1998; Lange & Jaimovich, 1994). Six

principles of emancipatory research have been outlined by Stone & Priestley (1996). The first principle involves a shift from a positivist model that views “medical problems” as an individual pathology, to a model that incorporates the socio-political-environmental interplay between the individual and society (Stone & Priestley, 1996). Secondly, we must surrender objectivity – where the context is one of oppression. Third, we must be ready to identify the relevance of the treatment or research for the individual or the community. In other words, what’s in it for them? Fourth, a principle that must be considered is the reversal of social relationships. Researchers, educators, and practitioners are challenged to move beyond traditional approaches that treat people as “passive subjects” which can in turn effectively disempower them (Stone & Priestley, 1996). To produce relevant research results within a PHC framework, researchers must consider the social context of the research activity, social relations, and hierarchical structures throughout the research process. This requires recognition of the power structure within the researcher-researched relationship. Fifth, another concern is the collectivizing rather than individualizing experiences of a marginalized group. Researchers and educators must move beyond the “knowing of individual realities” and locate personal experiences within a human rights analysis. A sixth and final principle concerns the use of qualitative and quantitative methodologies. In order to identify sociopolitical issues that affect health, investigators must employ both qualitative and quantitative methodologies. Qualitative methods permit the personal narratives, whereas, identification of access barriers may be greatly enhanced by quantitative data.

Within the PHC framework, various methodologies may be used independently or simultaneously for the purpose of triangulating results or to add richness to the data. For, example, to examine access issues among rural, older adults, focus groups may be conducted along with a quantitative survey to collect socio-demographic data (e.g., health insurance coverage, age, race/ethnicity, disability status, sources of health care, perceived health status, and geographical accessibility of health care provider).

7.3 CRITERIA AREAS

Key criteria areas within the PHC model that need to be accounted for by researchers, educators, and practitioners include several issues. For example, issues include affordability, accessibility, availability, applicability, acceptability, and equitability. In practice, while each of the criteria can be discussed as discrete variables, they are all interrelated to each other.

In reviewing the literature concerning the core criteria areas in the PHC model, several measurement issues emerge. One issue concerns the operational and conceptual definitions of the criteria areas. As an example, various approaches have been used to define variables affecting access to health care (Puentes-Markides, 1992). Moreover, variables affecting access may be highly specific to each sub-population. For example, some people may indicate that ability to pay for services acts as a major determinant of access to health care, whereas others point to behavioral issues related to motivation, health seeking behavior or perception of illness as a deterrent to women in the low socioeconomic strata. Furthermore, others indicate that socio-cultural issues, such as values, education, religion or demographic variables related to age, influence access to health care. Other considerations affecting access issues concern geographical location (physical access), perceived poor quality of care and experiences of discrimination and stigmatization, fear of legal/social services, and punitive actions (Perry &

Gesler, 2000; Oliva, Rienks, & McDermid, 1999). Lastly, access issues may relate to the following: examination tables that are too high for transferring from a wheelchair; lack of accessible rest rooms; reading materials that are not visually accessible; health education that is not developmentally appropriate; lack of Braille signage in facility; lack of signage regarding the accessible entrances; or, programmatic barriers, such as, inflexible appointments that fail to accommodate transportation difficulties or a lack of staff to assist in the examination room (Marks, 2000).

As can be seen by the example above, various definitions exist concerning access, which in turn impacts other criteria areas, such as acceptability, cultural sensitivity, equity, social participation, and acceptability. Thus, researchers, practitioners, and educators must incorporate qualitative methods into their practice, teaching, and research to ascertain a clear understanding of the issues that may affect access or any of the other criteria areas.

Evaluation studies are generally limited to short-term follow-up studies in the health promotion and health protection literature. Frequently, monies are targeted toward demonstration projects, but the evaluation piece is often not funded. Consequently, more evidence is needed to document the effectiveness of health promotion programs. This lack of evidence poses several areas of concern. First, new models providing primary health care are often funded by foundations, and often embrace a mission oriented toward "action projects" versus "evolving the science." Additionally, work environments present additional competing values when professionals have difficulty implementing a particular model of care due to the values held by the employing organization.

While we need more evidence on one hand, this must be balanced with the values that we hold concerning social justice and equity. Nonetheless, in spite of the limited evidence-based data, we have enough evidence in the literature to suggest that we must transform our views of how we provide care. Health care, "the health care business" as we now know it, must stop. We must bring the "care" back into health care, and change the practice of treating patients/clients as commodities for the health care industry.

By embracing a Primary Health Care (PHC) model, evaluations can be improved by incorporating the social value aspect when evaluating the effectiveness of a model of care. For example, within a PHC framework, by including the political dynamics of a community, health promotion programs have a greater potential to recognize that assisting people to empower their communities is as important as assisting them to improve their health (Eng & Parker, 1994). Therefore the evaluation process would use a participatory action research approach to ensure that the methods would not contradict or interfere with the program's empowerment agenda. Moreover, a close and collaborative working relationship among evaluators and local service providers is an essential component of the evaluation method. Key community informants and program staff would define and operationalize the areas for evaluation. Lastly, the community would then "own" the data and decide how best to use the information to address the issues that they want to change or modify.

A PHC model also incorporates the primary health care criteria areas (see Figure 1) in the evaluation. Issues of access, equity, acceptability, availability of resources, and cultural values are central to all evaluation efforts. Additionally, evaluation methods include both qualitative

and quantitative components to assure accuracy of the findings using criteria from the PHC model (Cotton, Brazier, Hall, Lindsay, Marsh, Polnay, & Williams, 2000). Evidence suggests that using qualitative evaluation methods (e.g., focus groups, individual and family interviews, interviews of community members, and interviews with health care providers) can demonstrate improvements in health and social need (Lazenbatt, Orr, Bradley, & Mc Whirter, 1999; Phan, Rosenthal, & Diamond, 1999).

8. IMPLICATIONS, CHALLENGES, AND PERSPECTIVES

“Health For All” remains an elusive vision in the PAHO Region. We continue to strive toward healthier communities by reducing health disparities and gaining universal access to health care services. Health professionals emphasize multisectoral participation across disciplines, organizations, and community members to create “healthy communities.” But, questions remain—where are the outcomes? More importantly, why are health disparities a growing rate for marginalized groups?

Leadership in defining requisite action and securing necessary resources is required. This leadership must come from governments, health professionals, and most importantly, the individual members of the community. Strong national health programs must be created and embraced to achieve *equity* in *access* to personal health care (McBeath, 1991). More relevant to the goal of access and reduction of health disparities is *equitable* sharing in basic health determinants within communities (e.g., nutritious food, primary education, safe water, decent housing, secure employment, adequate income, and a non-violent community).

8.1 ALTERNATIVE APPROACHES TO CARE

In general, there is a paucity of literature that captures the voice of the people within their culture and communities. Future efforts need to incorporate a Primary Health Care (PHC) model, which embraces the values of participatory action research and PHC criteria. Primary care services are a crucial component to achieving the goals of “health for all” as we search for alternative ways of providing services that are affordable, accessible and appropriate. The services provided by a General Practitioner, whose role as the central health professional or “team leader” may satisfactorily provide first-contact medical services, is a problematic approach in terms of equity and access for people who have lower incomes. Studies that have examined nurse practitioners as the first contact in primary care demonstrate that they can function competently and safely among a similar clientele (North, 1991). Most important, clients report that nurse practitioners are both satisfactory and acceptable as health care providers.

Health care changes must also occur beyond the routine provider re-configuration. The literature is overflowing with evidence declaring a need to revolutionize primary care services. Within our use of a primary health care framework, primary care services can no longer act as a repository for dissemination of pharmaceuticals and diagnostic testing. Too often medications are the first line of treatment among primary care providers and health promotion and protection services take a much lower priority (North, 1991). Transitioning the primary care provider’s central focal point from medical interventions to health promotion and educational activities, user-participation and involvement in health services, along with empowerment and self-responsibility in health are more likely to be achieved. Moreover, expenses will decrease due to a reduction in use of pharmaceuticals and diagnostic tests. As we shift the main focus of primary care to health promotion and educative functions, we will want to consider providers that have training in the areas of health promotion and health education.

Because health status is directly affected by environmental conditions and by personal health-related behaviors, as a comprehensive approach to health care, primary care services need to educate individuals to adopt and maintain personal behaviors that prevent disease and promote health (Brown, 1991). Primary care providers should discourage health-damaging personal behaviors by individuals and facilitate people engaging in health-promoting behaviors. Primary care providers need to provide care within a physical and socio-environmental context where community action is a central tenet. Providing primary care services within a PHC framework requires social and community action to change environmental conditions as well as efforts to change individual behavior. People are given the opportunity to acquire skills to act on a community level to eliminate health hazards from their environment and to create a more health-promoting community.

Community approaches are essential. Because most common health problems amenable to prevention have strong environmental, cultural, lifestyle, and behavioral components, people, communities, and whole countries can make choices about whether or not to consume alcohol and drive, smoke cigarettes, exercise, or have their children immunized. (Luepker, 1994). While all of these behaviors involve personal choices, they also have external components. For example, societal and cultural barriers and enticements, access, availability, monetary and opportunity costs, laws, and other community-wide factors have a significant impact on one's personal choices and decision-making processes. Although some disease prevention issues respond to traditional clinical or health care approaches, many do not. Therefore, a coordinated community approach is required to support the health promotion and protection efforts, along with activities toward developing an accessible and healthy environment and an educated population.

8.2 BARRIERS TO CHANGE

Efforts at health promotion and health protection face numerous barriers:

- Cultural, physical and structural barriers to access health care persist (Stewart, 1990).
- Severe financial constraints owing to the general economic situation (Tillinghast & Tchernjanskii, 1996).
- Lack of acceptance of individual responsibility for health.
- Lack of role modeling by the medical community.
- Lack of critical appraisal of benefits and cost-effectiveness for health promotion and disease prevention interventions.
- Low priority for health care, and for prevention specifically.
- Failure to validate community voices or perspectives.

8.3 PRIORITIES FOR THE NEW CENTURY

Priorities for the next decade include:

- Providing epistemological, methodological, and historical/critical interdisciplinary training for health care professionals so that they can conceptualize their practice which will in turn enhance health care services (Najera & Perez, 1999, 74).
- Establishing resiliency-building interventions (Blum, 1998).
- Establishing broader multisectorial interdisciplinary teams (Blum, 1998).
- Incorporating factors associated with successful interventions, such as, strengthening families; strengthening educational involvement; expanding economic opportunities; and supporting youth development, not just problem reduction (Blum, 1998) and using life cycle, family cycle, and gender approaches.
- Building health promotion and health education as well as CHW's into the health care system to promote health for the population.
- Adopting strategies that are consistent with premises of the PHC model and health promotion: 1) *education*, 2) *comprehensive and personalized care*, 3) *consumer participation*, and, 4) *environmental strategies* (Stewart, 1990).
- Increasing the prevalence of health promotion and disease prevention services in communities, so that distribution and availability of the services are equitable and accessible to all community members (Olden & Clement, 2000).
- Shifting from health outcomes as ends in themselves to quality of life concerns as defined by individuals and communities (Green, 1994).
- Developing models of health care delivery that have a balance between medical care and health care, between public health and personal health services, and between curative and preventive care issues of *cost, access, and quality* (Wright, 1993).
- Disseminating scientific and technical information on health promotion and protection activities to the greatest number and variety of individuals in the PAHO Region who are working in health care services.
- Providing training for health care providers to become more actively involved in decisions about the use of public resources in disease prevention, health education and more rational and equitable use of advanced health care technology.
- Providing training for health care providers to become active advocates for children and human rights issues.
- Fostering international collaboration, training and exchange programs involving agencies at all levels, local, national and regional.

- Implementing community-wide or population approaches (Luepker, 1994).
- Promoting evaluation of both inputs, processes, as well as the short- and long-term outcomes of the health promotion strategies.
- Documenting, analyzing, and disseminating information on the national experiences in health promotion, noting the cost-effectiveness of these strategies compared to curative and rehabilitation activities in health.

8.4 EDUCATIONAL ISSUES

While community-based health promotion programs have been implemented over the past two decades, the shift in focus requires a reorientation of professional training. Additionally, social structures in communities must be reorganized (Guldan, 1996).

8.4.1. *Educational Barriers.*

Several barriers exist in relation to the training of health care professionals. The following is a listing of some of the major issues that need to be addressed.

- Physicians are expected to provide an expanding array of clinical preventive services and be responsible for the health and well-being of entire populations and communities (Pomrehn, Davis, Chen, & Barker, 2000). Although prevention principles are being taught in many contexts, most medical schools do not have adequate curriculum-tracking systems that allow them to track the delivery of education and training in disease prevention and health promotion.
- Many countries in the PAHO Region have an increased demand for nurses (Villa, et al., 1999).
- Most countries in the Region have a shortage of nursing personnel.

8.4.2 *Educational Needs*

The health care needs of people in the PAHO Region are not met by physician specialists (Okasha, 1995). Likewise, while nursing education has emphasized health education, along with health promotion and protection activities, this is beginning to shift in some countries and institutions where training is focusing more on diagnosis and medical treatment. Thus, while nurse practitioners might impact on primary care by enhancing peoples' self-responsibility for health through improving their competence and awareness (Campos, 2000; Casas & Lopez, 2000), current trends in training are minimizing these skills.

8.5 SUMMARY

The process of reviewing models of care in the Americas is a worthwhile endeavor for practitioners, researchers, and educators. While we often view models of care within a context that is restricted to discrete areas of practice, today's environment requires the use of models

that are transparent, dynamic, and comprehensive in order to capture the complexities of health. Additionally, ongoing dialogue between researchers, educators and practitioners must be fostered. We must identify ways to use the system to alleviate communication barriers to bridge discussions across the PAHO Region. The process of generating, testing, and practicing new ideas is an iterative process that requires an active exchange of ideas to move forward with new models of care.

8.5.1 Suggestions

- Develop cooperative links between MEDLINE and LILACS, so the literature in one database can be reached from the other.
- Develop full text access to documents in the LILACS to enhance its use and promote inclusion of additional publications in this database.
- Incorporate abstracts in English and Spanish for both the LILACS and MEDLINE databases.
- Incorporate PHC in the curricula for health professions students.
- Create a PHC database or virtual means where health workers, educators, researchers, students, and politicians can share experiences.
 - Use a common language to discuss PHC in the Americas Region.

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ANNEXES

ANNEX A: THE AMERICAS - 48 COUNTRIES AND TERRITORIES

- North America: Bermuda, Canada and the United States of America
- Latin America: the Andean Region, Brazil, Central America, the Latin Caribbean, Mexico and the Southern Cone.
- Central America: Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama.
- Latin Caribbean: Cuba, Dominican Republic, Haiti and Puerto Rico.
- Andean Region: Bolivia, Colombia, Ecuador, Peru and Venezuela.
- Southern Cone: Argentina, Chile, Paraguay and Uruguay.
- Non-Latin Caribbean: Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Cayman Islands, Turks and Caicos Islands, Virgin Islands (UK) , Virgin Islands (USA), Dominica, French Guyana, Grenada, Guadeloupe, Guyana, Jamaica, Martinique, Monserrat, Netherland Antilles, Saint Kitts and Nevis, Santa Lucia, San Vincent & the Grenadines, Surinam, Trinidad and Tobago.

ANNEX B: PAHO STRATEGIC AND PROGRAM ORIENTATIONS, 1999-2002

According to PAHO's (1999) Strategic and Programmatic Orientations, 1999–2002, a new culture of health promotion and protection must be jointly created with the countries. As health becomes a social value, individuals and communities, as well as public, non-governmental, and private institutions will be trained to assume responsibilities for preserving and continually improving their health and wellbeing. Additionally, PAHO (1999) recommends that technical cooperation be provided to address the following:

- Acknowledge the role of health promotion as a tool for empowerment;
- Promote the formulation of policies, plans, programs, standards, and tools for health promotion;
- Support cooperative and operations research through the network of WHO designated Collaborating Centers in the Regions of the Americas;
- Design and strengthen methodologies and models for the evaluation of health promotion programs and interventions;
- Develop environmental initiatives or healthy spaces in schools and municipalities;
- Consolidate networks of mayors, public health officials, and school health associations;
- Develop intersect oral work strategies;
- Mobilize technical, scientific, political, and financial resources in support of health promotion;
- Develop technical, political, and social support networks at all levels, including strategic alliances between the Pan American Health Organization and both the international community and the relevant organizations in the countries; and,
- Promote the use of social communication in health, especially through the mass media.

ANNEX C: PRIMARY HEALTH CARE IN BRAZIL

THE SANITARY REFORM IN BRAZIL

In Brazil, the sanitary reform process started in the mid 1970s. After the political opening and in a period when the transition to democracy had advanced, the “Brazilian Sanitary Movement” started to fill important positions in institutional health apparatuses in federal, state and municipal levels. The reforming project was supported by broad criticism of the prevalent model, based on the growth of the private sector at the expense of the public sector (the former being financed by the latter), which led to the bankruptcy, deterioration, inefficiency and crisis in the public health system. The Sanitary Reform Project was based on a conception of enlarged health care, which was related to general life conditions, such as housing, sanitation, diet, work conditions, education and leisure. In this sense, health care is defined as a citizen's right and, consequently, a State's obligation, that is, health care reaches beyond the treatment of diseases and is also extended to prevention and to the improvement of life conditions that generate illness. Thus, the proposed health care policies were: the creation of a Unified Health Care System, SUS, with the remarkable predominance of the public sector, the system's decentralization and the hierarchization of the health care units, the population's participation and control in the reorganization of services and, finally, the sector's financial readaptation.

In 1988, the universal right to health care and the creation of a decentralized, accessible and democratic Unified Health Care System were included in the Brazilian Constitution. Since then, and more actively in the 1990s, many efforts have been made throughout the country in order to conform to the new health care system.

Methodology

The reviewed literature dated 1990 to 2001. It was in Portuguese and was obtained from the LILACS database. The search strategy used the following key words: model X health X clinical. One hundred and eighty-seven articles were obtained, of which 50 were disconsidered due to the following reasons: repetitions, absence of abstracts, abstracts in Spanish, and no reference to the health care model existing in Brazil. In this way, the sample consists in 137 abstracts and through their repeated reading, there was an attempt to answer the following questions:

What health care models and levels of health care service provision are available to the population?

1. What are the types of health care service provision?
2. Who are the health providers?
3. Where are the services located?
4. What are the health programs?

5. What are the main interests and health care-related questions found in literature?
6. What are the challenges and implications associated with health care models in Brazil?
7. How can such models be used by professionals and researchers?

Results

Health care models and provision levels. Discussions in literature (chart 1) focus on themes related to the country's sanitary reform as an alternative political project to the privatization-inclined care model which, along its course, has followed a decentralization strategy that establishes the creation of regional health care centers and integral health care actions (2, 15, 22, 24, 65, 72, 77, 87, 88, 93, 96, 97, 105, 124).

A lot of criticism of the process of change in the care model is made when it is observed that the individual and curative medical model is maintained, since the principles on which the new proposal is based have not been concretized in practice (8, 12, 97, 99, 119).

Types of health care services provision. *In addition to medical care in accordance with the various specialties offered to the population, the types of health care services provision are as follows: (chart 2):*

Nursing care to pregnant women, school-age children, in intensive care units, breastfeeding, family planning, diabetic patients, the elderly, workers, in emergencies, etc. (6, 20, 37, 38, 43, 55, 62, 67, 90, 106, 109, 110)

- User embracement as a care strategy in health care services, (29).
- Psychological care by psychologists (in hospitals, public health services) (29, 92).
- Care to adolescents (46)
- Dental care (49, 82, 91, 131)
- Health education (especially for street boys and girls) (19)
- Oral Health (13)
 - Hospital emergency care (26)
 - Non-alopathic practices (121)

Chart 1

The various models and levels of services	References
<ul style="list-style-type: none"> • Individual and curative medical model • The health care system in the city of Manaus has been characterized as essential, clinical, individual and curative since the occupation of the Amazon Forest (8) • Family Health Program (2) • The principles of the Unified Health Care System (SUS) have not been concretized in the clinical practice (12) • Decentralization and administrative reform are fundamental elements for the characterization of the new care model: The Unified Health Care System (SUS) (24, 72, 97), • Decentralized information system to accelerate outpatient care (77) • Regionalization model (88) • The effective implementation of SUS must not be restricted to measures of a judicial, administrative or institutional nature (99) • Proposal for the characterization of the health care services network (119) • The area's general characterization and sanitary profile in order to propose the implementation of the new care model (3) • Presentation of instruments and of a legal basis for the municipalization of SUS (15) • Description/discussion on the care model (22, 65, 87, 105, 124) • Points out the importance of the health surveillance process and the fulfillment of the population's care needs in order to legitimize the change in the care model (96) • The analysis between concepts and practices from past decades with the organization of the Unified Health Care System forecasts improvements in health care (93) • Organization process of municipal/state conferences as a preparation phase for the National Health Conference (124) • Report on the workshops on health policies (135) • Concept of "municipalization-districtalization" in the light of the texts by the Pan-American Health Organization based on the strategy for the development of local health care systems (134) • The sanitary reform proposed through a care model centered on "organized provision" enables the recovery of the epidemiological focus for the control of health problems and imposes a constant updating of technical and scientific advancements (86) • Proposes the use of the risk focus in the planning and programming of health care actions (95) 	<p>2, 3, 8, 12, 15, 22, 24, 65, 72, 77, 86, 87, 88, 93, 95, 96, 97, 99, 105, 119, 123, 124, 134, 135</p>

Chart 2

Types of service provision	References
<ul style="list-style-type: none"> • Nursing care to pregnant women (61) • Nursing care to school-age children (38) • Nursing care in Intensive Care Units (20, 67) • Nursing care during breastfeeding (90) • Nursing based on the medical model • Non-allopathic practices (121) • User embracement as a care strategy favors accessibility to health services (47) • Clinical psychological care in public health care services (29) • Dental care (49, 82, 91, 131) • Health education for street boys and girls (19) • Nursing care to diabetic patients in the public and private networks- self-care promotion (43) • Oral health: requires more global actions in order to overcome the idea that it is a luxury article which is restricted to private institutions (13) • Nursing model: application of Roy's Theory (55) • Nursing care model for the elderly centered on King's Model (109) • Nursing care in the perspective of Liliana Felcher Daniel, the attempt to systematize care to pregnant women (62) • Proposes the use of the risk focus in the planning and programming of health care actions (95) • Nursing care model in ICU aiming at care humanization and at the participation of the involved actors in the whole process of caring (67) • Clinical and hospital psychology service (92) • Nursing care in worker's health (37) • Hospital emergency services (26) • Nursing care in the perspective of Dorothy Johnson (20) • Nursing care in emergencies: the construction of a theoretical mark (106) • A small number of assisted adolescents is observed and their care is directed to curative and individual assistance (46) • There is a disagreement between the theoretical assumptions concerning the new care model and what actually takes place in everyday practice, since in the concrete aspects of health care services, nursing actions are subordinate to the biomedical model, which is centered on the client's complaints, thus privileging medical and clinical actions, reinforcing emergency care and not detecting significant changes with regard to the integrality of health care actions (90) • Construction of a theoretical model to help in the systematization of nursing actions in health education for family planning programs (110) 	<p>13, 19, 20, 26, 29, 37, 38, 39, 43, 46, 47, 49, 55, 61, 62, 67, 82, 88, 90, 91, 92, 95, 99, 106, 109, 110, 121, 131</p>

Health care providers. Regarding the types of health care providers, various works analyzed the role of different health care agents, such as: doctors, nurses (20, 38, 39, 43, 55, 61, 62, 67, 70, 109, 110), dentists (131), psychologists (92) and community agents.

Concerning community agents, the articles point out the need for a more active, and conscious participation as well as a critical view of their work in their education. Some studies show that there is a disagreement between the theoretical assumptions concerning the SUS (Unified Health Care System) care model and that which is effectively found in the everyday care delivered to the population. They reveal that, in the concretion, of health care services, nursing actions are subordinate to the biomedical model, which focuses on the client's complaints, thus privileging clinical medical actions and not detecting significant changes concerning the integrality of health care actions (90).

Researchers have claimed that nurses may have somehow come to understand how to deal with clients (especially women); however, the determinations which are present in their everyday practice have prevented more concrete actions towards the transformation of such practice. (Chart 3).

Location of health care services. In addition to hospitals, health care provision takes place in the following locations: elementary and high schools, workplaces, health units, outpatient units, at home, companies and associations. (Chart 4).

Chart 3

Care components related to care models	
A -Types of providers	References
<ul style="list-style-type: none"> • Dentist (131) • Auxiliary personnel in the oral health programs (91) • Nurse (20, 38, 39, 43, 55, 61, 62, 67, 70, 109, 110) • Psychologist (92) • Community agents 	20, 38, 39, 43, 55, 61, 62, 67, 70, 91, 92, 109, 110, 131

Chart 4

Care Components:	
Location of services	References
<ul style="list-style-type: none"> • Schools (Elementary and High schools) (19) (91) • Workplace (Urban Cleaning Department) (120) • Health Centers (35) • Outpatient units/ hospitals / home (nursing care to the elderly) (109) • Hospital/ psychological care (92) • Outpatient and home care to pregnant women (61) • Companies (37) • Hospital (more complex care) (68) • Associations (52) • hospital/ Intensive Care Unit/ nursing care (20, 67) 	19, 20, 35, 37, 52 61, 67 68, 91, 92, 109, 120

Health care programs. *Chart 5 presents the works that identify the health care programs offered as follows: Family Health Program, Family Planning, Oral Health and Dental Care, Mental Health.*

The Family Health Program, as a strategy that makes the change in the care model viable, has been a focus of controversy for if such model is not shaped within a large political structure, it will present limitations in its practice and in the stratification of its clientele (2, 17, 20, 30, 112)

The community programs described in the analyzed literature are those targeted at indigenous populations (129), mentally ill patients and dental care (82).

Among the other programs for the population's health care, those aiming at adolescents' health (46, 104), oral health (13, 82, 131), mental health (7, 17, 113), school-age children's health (38) and pre-natal care (61, 62) are distinguished.

Major health-related issues and interests. The major health-related issues and interests focused on in the analyzed literature, according to Chart 6, are as follows:

- access to risk groups (children, pre-school- and school-age children) (98, 131)
- adolescents, especially street boys and girls (19)
- mental health / psychiatry (7, 9, 11, 66, 113)
- oral health (13)
- systematization of Nursing assistance to specific groups (26, 37, 38, 61).
- construction of theoretical models for nursing systematization (20, 31)
- alternative practices (121).

Chart 5

Types of programs	References
<ul style="list-style-type: none"> • Family Health Program (PSF) (2, 17, 30, 137) • Family Planning (110) • Oral Health (13, 91) • Dental Health associated to popular participation (82) • Mental Health (113) 	2, 13, 17, 30, 82, 91, 110, 113, 137
A- The family	References
<ul style="list-style-type: none"> • Family Doctor Program: When it is not shaped within a large political structure, it presents limitations in its practice and clientele (112) • Family Health Program: is in danger of becoming isolated by keeping its autonomy and not communicating with the system (30) • Family Health Program: in spite of consisting in a new proposal for a care model, it has not been able to change the logic of the assistance centered on the clinical model. Its way of delivering health care does not incorporate the principles of the Sanitary and Psychiatric Reform (20) • The team's influence on social networks is still very modest and the action dynamics is passive and individual (17) • Approaches based on listening, embracement and ties are rarely used, except for health community agents, who show greater continence and concern about people such as those with mental disorders (17) • The Family Health Program as a strategy that will make the change of the Care Model in the SUS context has been questioned once it can both serve to simplifying tendencies and to the encouragement of changes in order to generate more effective results in the Unified Health System - SUS (2) 	2, 17, 30 112
B- Community	References
<ul style="list-style-type: none"> • Family Health Program Model (mentally ill person) • Health care to the indigenous populations (129) • Association develops a structure of community participation (52) • Work with street boys and girls and the University (19) • Popular participation through associations and incorporating dental care (82) • In the community participation model, the community is the essential component in the decisions concerning the health sector and the work model in communication by means of multidisciplinary teams (56) 	19, 52, 56, 82, 129
C- Health care program	References
<ul style="list-style-type: none"> • Adolescents' Health (46, 104) • Oral Health Preventive Program at Charity Institutions (131) • Oral Health (13) • Dental Care (82) 	7, 13, 17, 38, 46, 61, 62, 82, 83, 104, 109, 113, 131

<ul style="list-style-type: none"> • Mental Health Program (7, 17, 113) • School-Age Children Health Program (38) • Pre-natal Program (61, 62) • Disabled People's Health Program (83) • Elderly People with Chronic Diseases (109) 	
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Chart 6

Interest and health-related issues	References
<ul style="list-style-type: none"> • Alternative practices (121) • Access to risk groups - pre- school- and school-age children (131) • Deinstitutionalization of psychiatric care (66) • Adolescents (street boys and girls aged 11 to 14 years) sexuality, drugs, hygiene (19) • Diabetic people (430) • Accessibility of children aged 5 to 9 years (school-age children's health) (98) • Problems in the implementation of mental health care policies in the basic network (9) • Access of risk groups: psychiatric patients (11) • The population's greater access to oral health (13) • To design a model for the use of the multi-colored media by the State and medical companies in order to enlarge awareness of the sanitary reform (94) • The transformation of the care model as an attempt to find a new logic in the relations in the field of psychiatry with users is an important alternative for the improvement of the situation of mental health care (7) • Elaboration of a theoretical mark in order to help in the systematization of nursing care in Intensive Care Units (20) • Systematization of nursing care to school-age children so as to facilitate the planning of nursing actions (38) • Construction of a theoretical model for the systematization of nursing care to pregnant women (61) • Characterizes the nursing personnel performing in the workers' health field (37) • Characterize the profile of the demand for hospital emergency services in order to adjust to the new care model (26) • Segregation and prejudice to psychiatric patients (113) • Inclusion of disabled people in the health care system (83) • Nursing work in the process of construction of the care model (31) 	<p>7, 9, 11, 13, 19, 20, 26, 31, 37, 48, 43, 61, 66, 83, 94, 98, 113, 121, 131</p>

SUS, as a Primary Health Care strategy, determines the use of other practices such as the non-allopathic. Research (121) aiming at understanding the culture involving non-allopathic practices in the public services of Belo Horizonte/Minas Gerais reveals that non-allopathic professionals experience dilemmas and conflicts during the rites leading from the western medical practice to their engagement in non-allopathic medicine. The data show that the Non-Allopathic Practice Program has not yet been established as a policy in the extent of that city's Municipal Health Secretariat, thus revealing the need for a more effective integration of such practices in the public services in order to demythicize prejudice and make such practices respected.

Challenges and implication associated with the health care model. The literature presents a series of difficulties in the implementation of the Primary Health Care Model through the Unified Health Care System - SUS- proposed by the Brazilian government (Chart 7).

Therefore, studies point out that the construction of SUS has brought challenges in the change of the care model, which must be based on the principle of integrality, that is, a new view of individual and collective health is required in order to revert the clinical hospital model (25, 42, 48, 59, 78, 100, 126, 128).

Regarding the challenges, the need for collective adherence to the new model and the professionals' motivation to change is emphasized (5).

Ensuring the population's access to services, particularly that of risk groups such as children, mentally ill people and adolescents, has been a great challenge (28, 68, 84).

In the same way, the emphasis on potential preventive, collective and educational health promotion actions needs to be implemented actions (46).

The practice of decentralization of health care services as well as breaking the dichotomy between the curative X the preventive approaches are long processes to be concretized (114, 116, 117).

Authors have pointed out that the change in the care model will not be concretized if it is dislocated from the development of health care professionals, since such qualification must be associated with the basic principles of the country's current health care system.

Chart 7

Challenges and implications associated with care models	References
<ul style="list-style-type: none"> • A new way of thinking and acting in health care resists to governmental changes when there is the collective adherence and persistence by technicians (5) • The University's responsibility to overcome inefficiency and low quality in health care services (133) • Improve nurses' education for the application of the Family Health Program model (10) • Public Health schools must define their teaching, research and technical cooperation programs based on the epidemiological and epistemological contexts of the health care services contexts (21) • The implications concerning justice, education and care in the nursing professional practice (36) • Medical education is inadequate for the model (23) • Decentralizations is not synonymous to municipalization (117) • Influence from actors (physician) in the conformation of the care system: based on professional autonomy, corporative interests and conflicts present in micro-institutional environments (76) • Establishment of directives for medical education according to the sanitary reforms (6, 115) • Ensure various forms of access (28) • Need to revert the present care model so as to emphasize preventive, collective and educational activities with greater effectiveness potential for the health promotion of adolescents (46) • The care model has shown limits in the offer of care services to children (aged 28 days to 5 years old) in more complex levels (68) • The teaching of mental health nursing is still directed to a predominantly hospital-centered care model with emphasis on pharmacotherapy (123) • Over time, University hospitals have produced and reproduced a hospital-centered technical care model aimed at the clinical treatment of individual patients (101) • Health planning and local programming (Pau de Lima / Salvador) have been partly incorporated, but have not been used as a means of work for most managers, which has shaped a partial implementation of health surveillance (136) • Understanding interdisciplinary in the view of positivism, which is predominant in the present mental health care system and precedes that which is based on dialectic materialism with the purpose to change mental health care through the participative action of all those involved in it (health care workers and the population) (114) • The implementation and development of primary care services have faced various deadlocks resulting from the difficulty in changing political principles, represented by those concepts in work operation techniques (35). • The construction of SUS has shown the need to re-direct health care practice and the formation of human resources including community agents (81) • Value health care workers (32) • Change disease profiles, break the dichotomy between curative and preventive actions (116) • Education of physicians is based on a specialized profile and on limited knowledge on the current health care system (34) 	<p>4, 5, 6, 10, 21, 23, 25, 27, 28, 32, 33, 34, 35, 36, 40, 41, 42, 45, 46, 48, 57, 59, 64, 68, 70, 73, 76 78, 81, 84, .100, 101 , 103, 114, 115, 116, 117, 123, 126, 127, 128, 130, 132, 133, 136</p>

Challenges and implications associated with care models	References
<ul style="list-style-type: none"> • The characteristics of a new care model requires the training and formation of human resources to be associated with the model's basic principles (33) • Reorganization of SUS care model (128) • Re-orientation of the care model by bringing new concepts, methods and management techniques, etc. (42) • Re-organization of psychiatric care (48) • Re-organization of mental health .(78) • Implications as to: the use of financial resources, the situation of hospitals and human resources policies (41) • Change in the care model, which must be based on the principle of integrality with a new view on individual and collective health so as to revert the hospital- and clinically centered model (100) • Reach beyond the limits imposed by the medical and scientific monopoly of health care actions in the public sector and the need to revalorize the universe of non-scientific health knowledge and practice that can present potential contribution to public health (130) • Nursing care based on nursing theories aligns with the predominant care model, which gives little contribution to the construction of SUS (70) • The reorganization of services has not been enough to obtain the expected results (45) • With the municipalization process, conflicts arise between institutional cultures and health care workers' cultures if encouragement and commitment mechanisms are not created (4) • Changes in the care model require changes in political and operative levels (25) • Process of reorganization of health services aiming at ensuring the universality of care, integrality and equity of actions with administrative decentralization and popular participation requires the construction of a new care model (84) • The proposal of a new care model in a context where economic neo-liberalism advances brings great difficulties in the fields of financing and institution-site ordering (64) • In order to propose a new health care model, the present model and its transformations must be reviewed and then it must be adapted to the institutional context (59) • The distribution of the services network requires the re-orientation of the emergency system, alteration of the clinical profile of outpatient units as well as changes in the investments in physical and human resources (27) • The municipalization of health care opposes the privatization logic of the services production apparatus, to the clinical paradigm and to the situation the country currently faces (126) • Management with the effective transparency of the decision-making process and accompanied by the change in the predominant care model • The health information municipalization system enables a diagnosis of the health care situation (40) • Overcoming resistance and attempts to separate special programs from the new care model (127) • Overcome the factors leading to poor performance. Management is privileged as a determinant factor in order to reach organizational objectives through planning, coordination, direction and control (57) 	

Challenges and implications associated with care models	References
<ul style="list-style-type: none"> The practice of doctors in public services is different from that of most other doctors (103) 	
How the models can be used (practice/educators/researchers)	References
<ul style="list-style-type: none"> Faculty-clinical practice integration strategy (1, 44, 51, 52, 56, 69,74, 85, 102, 107, 118,137) Municipalization provides greater autonomy for administrative and financial management (50) Integration of medical and nursing schools to the Family Health Programs (137) Contribution from epidemiology to the practice of health planning and reduce social inequities (125) Model brings the bases for the concretion of educational strategies by incorporating its ideology (respect to human dignity, favoring of man's welfare) (63) Forms of municipalization (71) Decrees establishing directives / norms for outpatient and hospital care in assisting mental health (16) Implementation of a technical care model of health policies in the defense of life (74) Brings management as a factor that can contribute to the improvement of health care services. Among the characteristics of management, in addition to the decision-maker, it needs to exert its information and autonomy role as well as to have a point of reference (58) Health program examined as a model for services organization (111) The fact that macro-structural theoretical models are not enough to explain the current tendencies of health care policies needs attention (122) The participative management model is distinguished as a technical care model for the defense of life (75) Presents the particularities of indigenous people as to epidemiology, culture and political organization and their influence on the sanitary profile and health programs and, particularly, the relationship between health teams and traditional medicine agents (129) The faculty-clinical practice association contributes to the transformation of health practices and implementation of the Unified Health System (132,89) Faculty-clinical practice integration in the construction of a model of an integral health care model for adolescents (104) The new care model presents a new market to doctors and consequently a new education model (79) It enables the analysis of the historical perspective of the transformation and of the care model (60) UNI Program - the association with the community, integration with medical and nursing schools and health services is a strategy for the improvement of the qualification of professionals for the new health care system (85) Exchange of experiences among districts and states (53) Program for faculty-clinical practice integration - particularizes the experience of nursing students in psychiatric nursing courses, which enables the re-orientation of professional qualification in the present transformation context (14) Document from PAHO "Formulation of Health Policies" represents a political actor in the methodological orientation of health planning (18) Models, such as the public health laboratory network, which was conceived decades ago in a regionalized and hierarchic fashion, must be kept (108) 	<p>1, 14, 16, 18, 39, 44, 50, 51, 52, 53, 56, 58, 60, 63, 65, 69 71, 74, 75, 79, 85, 89, 102, 104, 107, 108, 111, 118, 122, 125, 129, 132, 137</p>

Otherwise, in addition to the sector's inefficiency, the risk of its reversion becomes imminent (33).

On the way to the construction of the Unified Health Care System, the need for re-orientation of health care practices as well as of the education of human resources has been pointed out (81).

Studies reveal the urgent need to adapt professionals' education - doctors, nurses - as well as the training of community agents, etc.

Most of the Brazilian medical schools do not use health units as a practice field for their students; therefore such students remain in specialized hospital institutions, the structure of which is directed to the resolution of more complex problems.

Hence, the result is the inadequacy of the current clinical training model if it is assumed that the major quality of a doctor should be the capacity to resolve health problems within an enlarged perspective of the clinical practice in which it is expected that knowledge and practice should contemplate biological, subjective and social aspects (6, 33, 34, 76, 79, 115, 116).

In the same way, nursing teaching is also criticized, since in many fields, namely Mental Health, teaching is directed to a predominantly hospital-centered clinical model with emphasis on pharmacotherapy (70, 101, 114, 123).

The utilization of the model by professionals, educators and researchers. *The literature shows that in clinical practice, the Primary Health Care model enables:*

- greater autonomy in administrative and financial management (50, 58)
- reduction in social inequities (125)
- the development of care model for the defense of life (74, 75)
- the consideration of particularities of groups/cultures/organizations with specific sanitary profiles (125, 129, 137).
- the incorporation of traditional practices (63)
- the use of decrees and norms (16)
- participative management (75)

The faculty-clinical practice integration is an important strategy in the development of human resources in health care and, at the same time, for the implementation of the new care model. Various studies have shown that the faculty-clinical practice integration contributes to the transformation of health care practices and implementation of SUS (14, 89, 132).

In the same way, the new model presents a new market for health care professionals (particularly for doctors) and consequently requires a new education model (79).

To researchers, it is an excellent opportunity to make an analysis of the process of transformation of the health sector in Brazil according to a historical perspective.

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