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Mental Health Viewed From the *Social Determination of Health Approach*, the Differential Approach and the Population Approach

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Abstract

During 2008 and 2009, the District Department of Health conducted a reflection on the social determinants of health and indicators realize positive and negative results that have hitherto characterized the mental health level of the Capital District; this reflection revealed that it was necessary to promote mental health as a transformer shaft social realities of the population at the district level. Thus, programs, projects and policies on mental health should be understood, from that moment, as articulating elements of equitable and inclusive relationships, to improve conditions of emotional well-being, in order to influence better living conditions for populations; all framed in approaches to social determinants of health, differential approach and population approach. Therefore, this article aims to address the concepts of these three approaches to provide clarity about the same in the case of mental health.

Key words: Mental health; Mental health; Social determinants of health; Differential focus; Population

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INTRODUCTION

The nature of the concept of mental health and the approaches to which it relates, determine a contextual framework normative political and international, national and district wide, regarding the rights and conditions of life: education, housing, employment, social, economic and environment; Therefore, this article discusses the legislation and policies concerning the mental health of the various population groups, life cycles, ethnicity and gender, to conditions and situations such as poverty, disability (and rehabilitation), displacement and armed conflict, to perform a count in your evolution view through the rules that have been enacted in Colombia from 1960 to the present. Pretending, in addition to making an analysis of the application and development of the same, follow up on the progress made and the different perspectives from which has addressed this legislation; both at the national level, such as in Bogota specifically

1. MENTAL HEALTH VIEWED FROM THE *SOCIAL DETERMINATION OF HEALTH* APPROACH

The social determination of health corresponds to the developments of Latin American social medicine prior to the social determinants promulgated by the World Health Organization (WHO), a matter of interest in the last years; they have been used to point out significant differences. Such differences are summarized by Martínez (2008) in two statements. Firstly, the WHO's proposals do not provide substantial solutions since they have been planned only to reduce the damaging effects in the way of life of our societies. Secondly, they are not enough in approaching the historical-political dimension where societies originate, thus making epistemological innovation necessary in the study of health problems. That is to say, although they may modify the traditional view of risk factors, they could also be limited to "(...) a list of dissembled variables that do not allow impacting the root of problems" (Hernández, 2008, p.1); they gather

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evidence on the economic and health inequalities and highlight the role of social determinants, but they are not able to understand "(…) what Benach and Muntaner state as 'the causes of the causes'." (López, Escudero, & Carmona, 2009)

This approach constitutes the analytical-interpretative reference of the District's Mental Health Policy and thus it supports its situational analysis; the reason to choose this approach is grounded on proposals drafted at the District Health Secretariat (SDS in Spanish) and determines the explicit purposes for this Policy, since "(...) critical thinkers are not satisfied with finding measures that lessen the impacts of this way of life {of the current society} on the most disadvantaged members of society, but they also advocate for working in the construction of a better world for everyone." (Martínez, C. 2008, s.p.)

The theoretical Latin American perspective on the social determination of health, inherent to Critical Epidemiology, is explicit or implicit in many other SDS documents. Even the very District Policy on Mental Health designed in 2004 quotes aime Breilh -one of the main representatives of Latin American Collective Health- and its model of social determination of health. For Breilh, understanding the health-disease processes must go through an analysis of objective matters of social materiality which determine health, as well as work with the topic of social subjectivity and the subject-object relation, as the key to strengthen the subject of the transforming initiative on these objective conditions (Breilh, 2003).

Consequently, it involves an ethical stance named by the author the "Ethics of Way of Life", intended to recover human ways of work, human rights protection and the search for ethnic equity, gender equity and equity related to other conditions that place human beings in a vulnerable situation. His ontological stance to health seeks to transcend the notion of epidemiological object as a factor, while stating -from a complex epistemological stance- that it takes sides for the social strengths that boost strategic interests to defend life, with a maximum hope for integral and universal health (Breilh, 2003). From the Latin American view of social determination of health, it is understood that the process of living turns into destructiveness or protection, depending on the social relations operating in a series of domains -the general domain of society as a whole; the particular domain of its human groups; and the singular domain of people in their everyday life. (Breilh, 1989, 2003)

As analytical categories in the health-disease processes from this current, the proposal is to analyze health situations of inequity, ways of life[1], gender, ethnic group, exposition[2], the destructive-deteriorating processes[3], the protective-beneficial processes[4], the epidemiological profile[5], social reproduction[6] and reproductive processes, the generation processes[7], the critical processes of exposition[8], and core-epidemics, giving methodological priority to the triangulation of qualitative and quantitative methods for the analysis, and the concomitant transforming social initiative (Breilh, 1989, 2003, p.39, 40).

The classified analytical domains proposed are the following:

- General Dimension: reflects the social logic of reproduction principles.
- Particular Dimension: involves the analysis of ways of life and lifestyles.
- Singular Dimension: represented in the genotypic and phenotypic expression of health-disease in individuals (Breilh, 1989, 2003; Breilh, Granda, Campaña, & Betancourt, 1987; Breilh, Granda, Campaña, Yépez, Páez, & Costales, 1990).

The existence of a dialectic movement is assumed among such dimensions; it tends to be a subsumption from the general to the singular and from the singular to the particular (Breilh, 2003). The epidemiological profile category is essential since all the health spheres -which are reduced from other perspectives- relate there, namely, directly observable health, which corresponds to people's signs and symptoms; current health, a wider vision that also includes generative or determinant relations, including those part of the ways of life of social classes; and real health or full reality of health, which covers the two aforementioned spheres and includes relations of macro or general determination that belong to a structural level (Breilh, 2003).

A matter worth highlighting, which differentiates the diverse versions of social determination of health and disease, refers to how the relations among the different levels of causality are understood. While in the Anglo-Saxon school, and particularly for the WHO, acknowledging the existence of different levels of social reality is performed based on some linearity, which implies a similar degree in terms of causal hierarchy, the

[1] Total historical reality that belongs to a specific social group as it is experienced in the group's praxis in every aspect that identifies its members. The epistemes of each social group are part of their way of life.

[2] Understood as the contact point of life conditions and concrete involvement of people.

[3] Those that cause deterioration or spoil quality of life.

[4] Those that contribute favorably to developing and improving life.

[5] Assumed as a multi-dimensional system of contradictions among protective conditions and deteriorating conditions of health.

[6] Movement of production and consumption that occurs in the productive base, contributing to the configuration of ways of conscience, organization and relation that contribute to perpetuate social praxis and society as a whole.

7 Actions of individual or particular creation inherent to self-control, with a potential to transform social praxis and society as a whole.

[8] Delimited based on the study of society's general movement, with the relations of ways of life of sub-groups and lifestyles of people, who all together comprise the study of determination.

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reading of society acknowledges a key role in the way social production and reproduction organizes, which implies not only canceling other causality matters, but placing them at lower levels in a hierarchy (District Health Secretariat of Bogota – Guillermo Fergusson Group Corporation, 2008).

For these authors, critical epidemiology must be the method of analysis for the health-disease process conceived from the Latin American vision of social determination of health; but not only as a renewed discourse, but as a set of innovative practices and technologies that replace the arsenal of hegemonic views, starting from the critical analysis of those currently used in the light of such models (Breilh, 2003). They specifically propose, for example, redefining the epidemiological information systems and other information systems of health in the light of the new categories presented and using a strong component of social involvement, not only in case detection, but specially in the components of design, analysis and sanitary decision-making (Breilh, 2003).

For this current, a new health information system, as well as its components, must comply with some basic features that define it as "an instrument of knowledge, consciousness and social power", namely, the contextuality[9], human directionality[10], the epidemiological impact, and the integral quality of information and processes (Breilh, 2003). In particular and in order to keep coherence with the theoretical model of social determination of health, the information system must transcend the indicators of final results (risks, disease, death and execution of activities or resources), by incorporating indicators related to protection and deterioration processes, and corresponding to the different levels of health-disease determination (Breilh, 2003).

2. MENTAL HEALTH FROM THE DIFFERENTIAL AND POPULATION APPROACHES

[9] It corresponds to the insertion degree of contents, processes and forecasts of the information system in the collective needs of the human conglomerate involved as subject and object of information. Consequently, it must creatively meet the social, ethnic and gender needs inherent to the social conglomerate. The proposed contextuality indicators are: the matrix of critical processes, the integration of information systems into plans and activities of human security development, the cultural and organizational strengthening of the collective.

[10] Including information related and suitable to the activities of social solidarity in the collective; ways of seeking for gender, social and ethnic equity; information that contributes to the collective identity of each conglomerate and sharing identity jointly among the different conglomerates; in an information system that becomes a milestone of self-reliance and negotiation capacity of the collective and its stakeholders to face their interlocutors from the State and groups of power.

In line with the proposals above, the SDS has insisted on a differential approach that highlights the particular aspects determined by the life cycle, gender, diverse conditions and situations, as well as the reciprocal determination between people and their environment. The differential approach provides comprehensive responses to particular features and vulnerabilities; acknowledges, restores and guarantees the Rights of the traditionally most vulnerable populations and positive actions to reduce discrimination and transform social and cultural conditions structurally.

The population approach Guideline document (SDS, 2011) serves as a framework that integrates concepts and approaches prioritized in the District Policy of Mental Health, as shown below based on the quoted text, first transcribing the core definitions of the approach:

> The population approach is an analytical guide that reaches even the interventions and acknowledges the human and collective individual in their integrality. It focuses attention on people whose features are included in each stage of their life cycle-generation (childhood, youth, adulthood and old age), identity-diversity processes (ethnic group, sex, gender identity, sexual orientation, peasantry), the conditions and situations (practice of prostitution, forced displacement, homelessness situation, disability, deprivation of freedom, armed conflict -groups in reintegration-) and gender as a category across all areas; in the social, cultural, economic and political context of groups and individuals.
>
> Population is understood as an organic set of subjects who interact with one another and the environment seeking their biological and social reproduction.
>
> In turn, territory is seen as the historical and social product incorporated to the ecosystem, where symbolic and cultural changes, transforming activities and production and consumption practices that determine the construction of subjectivities originate. The results of the territory-population interrelation are evident in the populations through the inherent features that the territory sets on populations depending on their strengths and/or limitations, allowing whether to generate or not life conditions for people to contribute to their integral development processes and that of the communities, and they strengthen or limit the territories of groups. (SDS, 2011).

This approach -its principles being the acknowledgment of differences and diversities, equity, justice and social inclusion and interculturality- introduces relative categories linked to the life cycle and generation, the identity and diversity and the condition and/or situation, assuming a gender perspective.

The first category (life cycle-generation) divided into stages links the continuum of development including its (physical, cognoscitive, emotional and social) facts to the constant change and adaptation to the context, a context that distinguishes generations in terms of accrued cultural inheritance. The stages are:

- *Childhood and adolescence:* From pregnancy to 18 years old, review of the psychological, biological, cultural and social development of the individual. It comprises: early childhood, from 0 to 5 years old; intelligence, personality

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and social behavior are consolidated in this period, which is highly vulnerable, dependable and requires care and protection; and childhood, from 6 to 12, which includes socio-emotional development, greater independence to solve problems and make decisions, acknowledgment of own interests and those of others as well as some social problems.

- *Adolescence*, from 13 to 18 years old, characterized by individualization and identity processes that may be associated to criticisms against the family and society, difficulties to communicate with parents, search for expressive and social-participation means, as well as exploration of sexuality and relationships as a couple.
- *Youth,* the construction of identity and interaction with society and the particular territory is emphasized, embracing symbolic expression (clothes, practices, musical tastes, views), stating a stance towards reality and particular social demands.
- *Adulthood, includes young people* 27 to 44 years old and *mature* people 45 to 59 years old; this is a stage of transition and preparation for old age, with important changes in family and professional roles, decisions related to procreation, care of others, education, work and production, as well as political involvement.
- Old age starts at 60 and is determined by social, economic, environmental, nutritional and cultural conditions.

The second category (identity-diversity) matches -considering the particular in the universal- common factors in terms of values, traditions, believes... that give a sense of individual or collective belonging to the distinctive or the diversity. To this regard, they point out features of (Afro-descendant, Raizal, Indigenous, Rom-gippsy and Kumpania) ethnic groups, gender identity and sexual orientations (taking into account sex, intersex conditions or intersex, sexual orientation and gender identity), and peasantry (typical rural way of life).

The third category (condition and/or situation) seeks to underline constant differences without options for modification or those temporary and suitable for change. They include the following:

- Situation of displacement: Population in the greatest degree of vulnerability due to a serious, massive and systematic violation of their fundamental rights.
- Situation of homelessness: The fact that they are living in the street establishes for this group a particular reasoning and sociocultural dynamic.
- Situation of disability: Condition and situation derived from the interaction between a person's impairment and the possibilities or limitations of their environment for full and effective social involvement.

Other situations would be deprivation of freedom, the practice of prostitution, demobilization of armed conflict or social reintegration. Additionally, the gender perspective is underlined to highlight the disparities in the stories and places of men and women which translate into possibilities or limitations to performance and the assessment or lack of assessment of their skills, rights and duties.

> In this sense, the District Health Secretariat of Bogota has been building in the past years a health model focused on rights, a model included in the quality of life and health promotional strategy, set on the logic of explaining health inequalities based on the analysis of the social determinants of health; a strategy that proposes -as the sense of actions- the promotion, preservation and recovery of the autonomies of subjects and collectives, strengthening the role of the State as guarantor of rights and proposing a strategic action directed from social management of health, where cross-sectoriality in the State initiative and social participation are essential milestones. (SDS, 2011)

CONCLUSION

It is worth highlighting that, within the Quality of Life and Health Strategy, the concept of Life Cycle assumes features that must be emphasized, as described by Urrego (2010), including the evolutionary continuum of human life. Its development is due to biological, psychological and social experiences, where such experiences in each stage are going to make easier or undermine those of the next stage, evidencing the impacts of inequality on a person's lifetime and thus the social determination of health and disease. The incidence of the interaction on the contexts that set up the collective references of human development is also evident. The "primary role of family as immediate and founding scenario of the social relation of subjects with the social context" is acknowledged here.

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