

Health Policy in Bogota (2004-2008): An Analysis of the Experience with Primary Health Care

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Abstract

This study summarizes the health policy and the Primary Health Care strategies developed by the Bogota municipal government from 2004-2008. The experiences and outcomes during this time period indicate that, despite the market-oriented health policy that exists in Colombia, it was beneficial to implement health policies and strategies at the local level so as to guarantee the right to health and equitable access to health care. National level restrictions, however, impose constraints on the potential implementation of such policies and strategies. This suggests that in order to achieve effective and sustainable changes at the local level, it is necessary to promote substantial reforms within national health care policy.

Key terms: Comprehensive Primary Health Care, equal health rights, local government, Colombia.

Introduction

Primary Health Care (PHC) has been considered an effective strategy to improve population health and reduce health inequalities as it acts on the social determinants of health. PHC's contributions to health and health equity occur through the reduction in barriers to access and use of services, the development of coordinated and sustained re-

sponses to health needs, the implementation of health sector and intersectoral programs, and promotion of social and community empowerment, mobilization, and participation.¹

The Pan-American Health Organization (PAHO) has repeatedly underscored its concern over the relationship between health, equity, and development, noting the lack of equity in current health systems. During the 25th anniversary of the Declaration of Alma-Ata, PAHO's vice-director proposed to redefine PHC as "comprehensive health care for everybody, by everybody," adding that PHC is currently "a necessity, not only with regard to health, but also for the future of those countries that aspire to remain nations, sovereign states in a world that is every day more unjust."²

However, starting with the 1993 Law 100, policies in Colombia have not favored PHC. Given the pro-market orientation of this law and its subsequent revisions, PHC in its full expression received neither political nor technical support from the national government and the economic sectors linked to health-related businesses.

This document presents the context, design, implementation, and results of the Primary Health Care experience in Bogota from 2004 to 2008. During this period Bogota implemented a health policy designed to guarantee health rights and equity.

In preparing this study, evidence and information was collected from both published and unpublished sources, presentations at both district and national meetings, and from statistical reports, interviews and working documents of the Bogota Municipal Health Department (*Secretaría Distrital de Salud de Bogota, SDS*). These materials were reviewed and systematized so as to produce a narrative summary.

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Received: February 3, 2008

Accepted: March 15, 2008

Health Challenges and Opportunities for Change in Bogota

Until 2003, the social, public, and health policies of Bogota had not been effective in meeting the needs of the population. Evidence for this could be found in statistics showing high levels of social inequality, a large burden of preventable disease, and limited access to health and other social service programs for the socially and economically disadvantaged.^{3,4} In 2003 52.3% of Bogota's inhabitants (3,586,875 people) were poor and 13.7% were unemployed; it was the remainder of the population, those who had relatively good incomes, who enjoyed higher standards of living. The adoption of Law 100 in 1993 created a Social Security Health System (*Sistema General de Seguridad Social en Salud, SGSSS*) which generated new limitations and exclusions in the health system. As a result, the Social Security Health System was poorly suited to ensure equity in the use of health services.

As a consequence of these problems Bogota suffered from an infant mortality rate of 15.1 per 1000 live-births; a maternal mortality rate of 61.7 per 100,000 live-births, and comparatively high rates of pneumonia-related mortality (20.2 per 100,000 in children less than 5) and acute diarrheal mortality (5.2 per 100,000 < 5 year olds). At the same time chronic diseases increasingly appeared among the leading causes of death in all areas of the city, even the poorest.⁵ The poor, living in an unhealthy environment and exposed to unfavorable socio-economic conditions, are more vulnerable to disease.⁴ Yet, compared to the rich, they had less access to social and health services.⁶ Consequently, they died earlier and more frequently than the rich from diseases such as pneumonia, cervical cancer, eclampsia, and violence. In Ciudad Bolivar, one of poorest parts of the city, the 2002 mortality rate for children under the age of 5 was 250.9/100,000; in Teusaquillo, a middle class locality, the rate was 166.08/100.000. Although the middle-class had lower death rates and a higher life expectancy,⁴ members of this group felt increasingly concerned about their own economic stability, security, and access to health care services.

The 1993 health insurance law had a profound

impact on the access to and use of services. It did not provide universal coverage, and there were disparities in benefits. The private insurance companies created barriers to care—geographic, economic, and organizational—in order to increase their profits. According to data provided by the Quality of Life Survey,^{3,6} Bogota had the largest enrollment in the Social Security Health System. But within the city, levels of enrollment were inversely related to poverty rates. Enrollment did not guarantee access to service when needed. Furthermore, at least one million poor people were ineligible to receive subsidized insurance and could not enroll in the Social Security Health System. The wealthier affiliates used the system 1.5 times more frequently than the poorer ones. Only 73.9% of all affiliates used health care services when having a “minor” health condition. When faced with a severe health problem only 58.2% of the poorest 10th of the population used the service, compared to 84.3% of the wealthiest 10th.

The insurance program was focused on individual, curative care with an eye towards containing costs. This made the provision of timely, comprehensive, coordinated, and ongoing care difficult. It also hindered joint efforts to work with the community and other social sectors. The preliminary steps to create a more integrated model of care—based on the principles of PHC—were either done away with or minimized during the implementation of the 1993 Law 100. Although more services were made available, the logic of the market dictated that most providers were located in the northern part of the city; this created serious access barriers for people living in southern Bogota where socio-economic conditions were worse. Moreover, one-fourth of users rated the service as average or poor.⁴

The Social Security Health System was characterized by the high overhead associated with insurance; a tendency to increasingly transfer financial risks from the insurers to the health care providers; and a focus by management on cost control, competition, and economic profitability. These factors not only prevented the development of a management and service model that would promote prevention as well as comprehensive, continuous care (patient-oriented, family-oriented, and community-

oriented), but also threatened the mission of public institutions and their financial sustainability.

Quite apart from the problems generated by health insurance, financial intermediaries, and managed care, there was a need for new strategies and policies that would emphasize equal and comprehensive care, improvement in local government, and a democratic decentralization of the system. The new municipal government undertook a strategy designed to ensure health rights and equity. While national policies reflected the hegemony of neo-liberal policies, the municipal government felt that, given the local political context, it was possible to bring about progressive and innovative improvements through the Municipal Health Department.

Under these conditions, PHC would have to be a local effort implemented within the national health system. It should create a new model for equal and comprehensive care and influence insurers to buy into this new model. Both changes would be presented as ways of highlighting the restrictions and contradictions of the hegemonic national health system. They would thus clarify the spirit and content of any future structural changes that would be needed to change the Social Security Health System's principles and guarantee the transition to a system that was both equitable and guaranteed health rights.

Bogota's new health policy and the role of PHC

This new vision of public health policy was developed in close collaboration with the objectives, values, principles, and interventions of the Bogota Economic, Social, and Public Works Development Plan for 2004-2008.⁷

The values and principles of the Development Plan gave content to the health program's policies, strategies, and programs, and to the relationship of the Health Department with other City authorities. This was particularly true for those values and principles related to human rights, solidarity, and equity, and the means of realizing these values (comprehensive social interventions, citizen participation, accountability, etc). These principles and values would inform a unified program to improve the health of all the City's citizens.

The Plan's objectives were to be implemented in

three coordinated axes: social, urban-regional, and reconciliation. The key social policies included: comprehensive social security and protection provided through the guarantee of economic, social, and cultural rights with emphasis on children and gender equality; the right to food; equity in access to social, cultural, and recreational services; and creation of job and income-generating opportunities.

Health policies played a role in all three axes. Certain elements were key for health planning to move beyond a narrowly specialized vision, the traditional approach of public health. These elements were the promotion within the Plan of joint development programs between different government institutions and members of the cabinet; the development of district and local level coordination; collaboration and citizen participation; and the allocation of fiscal resources both at the district and local level in a way that was equitable and transparent.

A health sector policy for 2004-2008 named "Health for a Good Life" (*Salud para una Vida Digna*) was developed by the Bogota Municipal Health Department. The policy was created through a process of consultation and debate with the Social Security Health System, the community, and the city's political forces. The overarching goal was to *make progress in guaranteeing the right to health in order to overcome inequalities in health outcomes and access to health services.*⁸ The values and principles that coordinated this health policy were: health as a fundamental human right, equity, solidarity, autonomy, and acknowledgement of differences. The general objective proposed for the Development Plan was:

*To promote universal, comprehensive health care through progressive incorporation of the population with special emphasis on poor and vulnerable populations. To carry out intersectoral interventions and actions that contribute to the improvement of living conditions, capacities, and opportunities so that individuals and families can create healthy communities and habitats. To strengthen public health in the urban-regional sector.*⁷

The Bogota Municipal Health Department adopted two basic, interrelated strategies in order to

achieve these public health objectives: 1) a strategy to improve health and wellbeing; 2) the promotion of PHC.⁸

Primary Health Care Approach

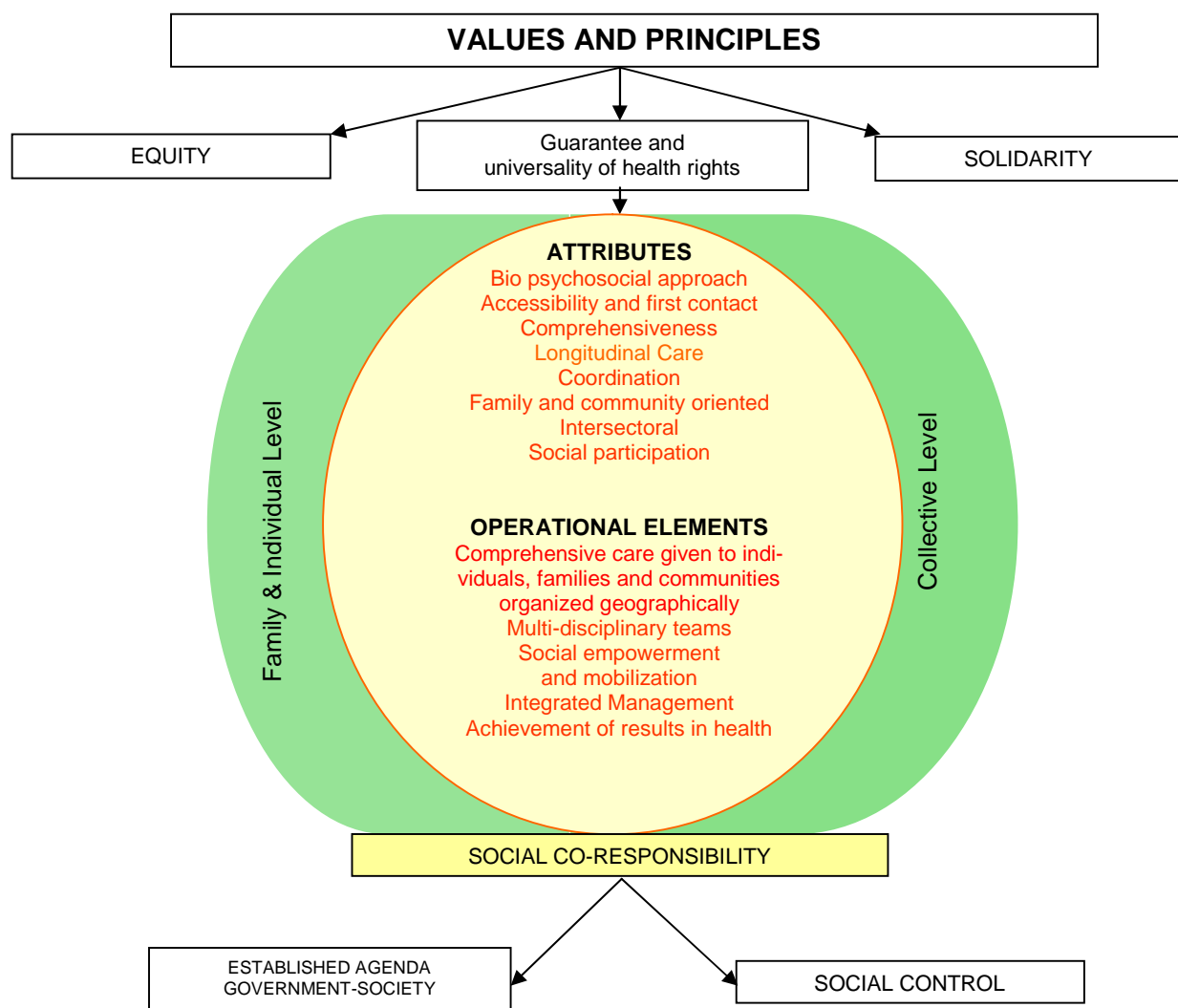
PHC was implemented through a program called Comprehensive Primary Health Care (CPHC, *Atención Primaria Integral de Salud*, see Figure 1). CPHC was established on four theoretical, conceptual, and normative principles.^{8,11} First was the Alma-Ata Declaration¹²; second were two components of the International Covenant on Economic, Social, and Cultural Rights: Article 12 and General Comment #14 from the Committee on Economic, Social, and Cultural Rights; third was the conceptual and scientific work developed in different contexts by Barbara Starfield^{14,15}; and

fourth was a public health approach known as the “The Health and Wellbeing Promotion Method.”¹⁷

The Alma-Ata Declaration emphasizes values, principles, and strategies such as the right to health, equity, a family and community orientation, comprehensiveness of care, disease prevention, autonomy, individual and community participation, and intersectoral health action. With this Declaration PHC not only became linked to the right to health, but was also validated by United Nations.¹³ The UN drew up norms and minimum requirements which would compel nations to guarantee the right to health.

The Health and Wellbeing Promotion Method was designed as way of making health a right and promoting equity. It also served to reinforce the *comprehensive* nature of PHC. In this method PHC

Figure 1: Comprehensive Primary Health Care (CPHC)



is seen as one of several ways in which wellbeing and health can be promoted through basic health services.^{11,17}

In Colombia PHC had come to mean the provision of only the most basic, rudimentary medical care. Since the 1993 Law 100, and its reforms, PHC's potential as a catalyst for change was neutralized. Consequently, PHC had to be reborn on new conceptual and scientific bases that could defend its relevance and foster improvement in the quality of its implementation.¹⁵

In addition to the above mentioned sources, discussion and analysis of the PHC experiences in countries like Brazil, Costa Rica, and Chile was undertaken. From these experiences we borrowed the family and community-oriented approach and the organization of medical care into geographically defined areas where comprehensive health care teams would meet the needs of the population and act as the entry portal to the health care system. This approach was biopsychosocial, multidisciplinary, and focused on health results. It would allow for an easy deployment of PHC into areas where it did not exist. It would also aid in the transformation of the physical and organizational structure, as well as the processes and practices of the city's traditional primary care units.³²

In 2006, some additional operational elements from the Revitalized PHC strategy^{19,20} were incorporated in the original PHC approach; this was done without undermining the comprehensiveness of the system.^{11,31} This renewal of PHC was promoted by the PAHO/WHO during the celebration of the 25th anniversary of the Alma-Ata Declaration² and at the Montevideo Meeting.³⁰ It was subject to extensive debate in the city and country at the National PHC Meeting in 2005.²¹ The following were the main elements of the renewed PHC that were approved:²⁴

1. The reorganization of institutions based on an appropriate *assessment of community needs*, particularly the needs of vulnerable populations.
2. The organization of PHC operations by territory, giving priority to the poorest areas.
3. Actions carried out in the places of *daily* community life and their surroundings: family,

neighborhoods, schools, parks, workplaces.

4. Organization of *collective responses* to the needs from a comprehensive social management approach. This would be promoted by and with the participation of other social institutions, such as education, social integration, housing, and environment.
5. The promotion of *social participation* as a right, and the creation of conditions allowing for autonomous social organization and mobilization.

Implementation of the Strategy

Based on this philosophical and conceptual model, implementation of the strategy began in Stratas 1 and 2, the poorest social sectors of the City. Three regions were targeted. First were those areas with limited access to the traditional primary health care centers; here teams would begin creating the basic infrastructure for comprehensive care. Second were areas with relatively better access to traditional primary health care services; these services would be renovated in accordance with the best practices of CPHC. Third were the areas of everyday life and community activities, such as the family, neighborhoods, schools, parks, and workplaces.

Since CPHC was the strategic model for transforming health care delivery, care had to be provided with an emphasis on the family and community, on the coordination of medical care and health-related activities with other social services, on intersectoral action, and on community participation. Management of the system needed to adequately reflect the characteristics and goals of the service; this included coordination across sectors and networks, clinical management, resource management (physical, human, and financial), planning and programming based on specific needs, and monitoring and evaluation of both activities and results. As time went by, implementation of the CPHC strategy was carried out through the following elements: an overall operations plan, changes to provision of health services, intersectoral health-related actions, community participation, and management.

Operations Planning

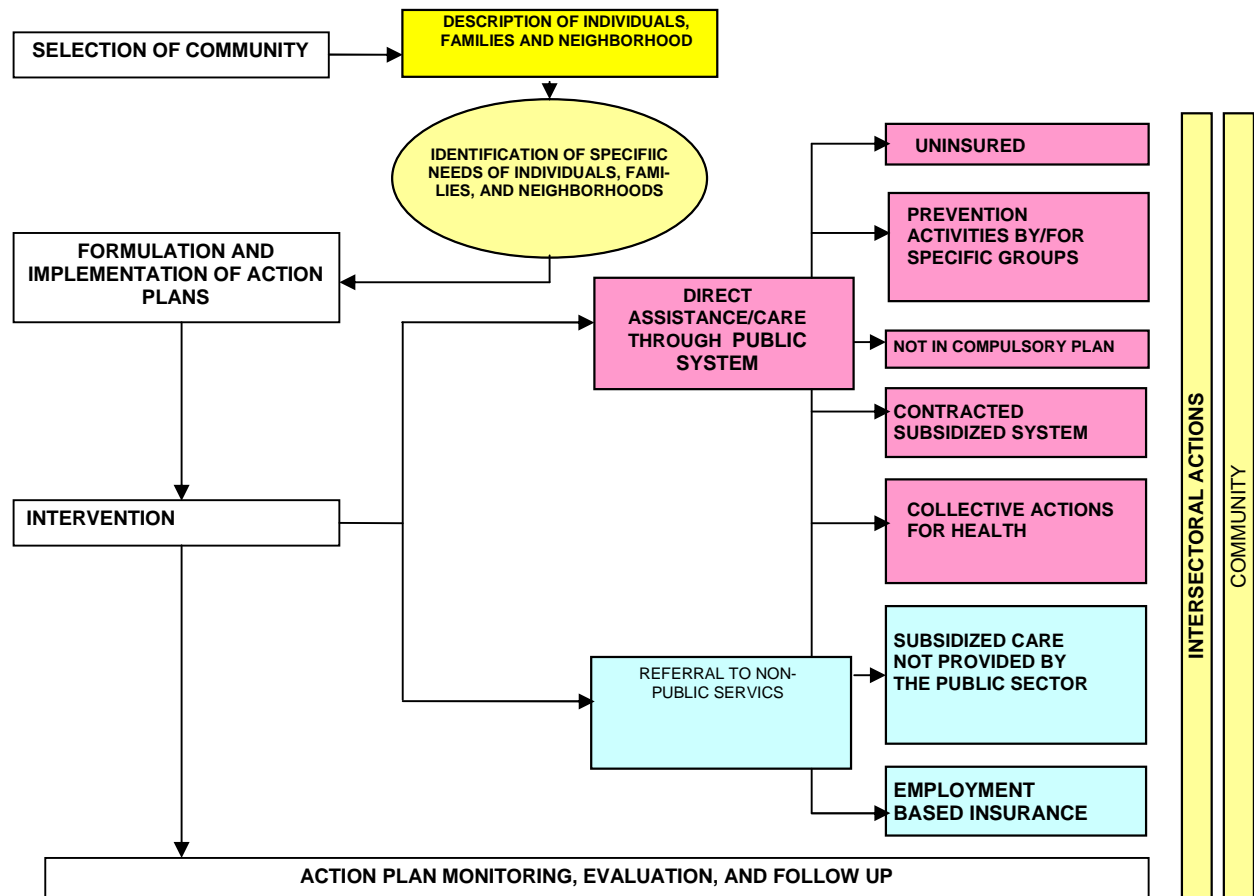
Following the approval of resolution 119 by the Bogota City Council,²³ the Bogota Municipal Health Department initiated the *Health at Home* Program (*Salud a su Hogar, SASH*) as part of CPHC. *Health at Home* was implemented in the following steps: (Figure 2)

1. Prioritization based on local health and living conditions.
2. Social and community mobilization.
3. Organization of family medicine and community health care teams.
4. Analysis of the health conditions of individuals, families, and social environments.
5. Enrollment of families into the medical care teams.
6. Development, approval, and implementation of comprehensive action plans.
7. Monitoring and evaluation of the results of the action plans.

The starting point for this program was a process of social mobilization and consensus building regarding which areas were to be prioritized for the *Health at Home* program. This was done using the results of local health diagnoses made with local social participation. Based on these diagnoses, the city was divided into zones based on health and living conditions, allowing the identification of micro-territories which were prioritized for the program. Simultaneously, family and community care teams were organized and trained. These teams were made up of—at a minimum—a generalist physician, a nurse, a nurse's aide, an environmental technician, and three health promoters. Each team was responsible for 800 families to whom they provided primary care. In addition, the teams surveyed the families to identify and analyze their health conditions, prioritize needs, and develop both health sector and intersectoral plans.²⁴

Health at Home incorporated both outreach and intramural activities. The outreach programs were

Figure 2: Implementation of *Health at Home*



based on interdisciplinary teams created by the Basic Care Plan (*Plan de Asistencia Básica*). They included health and vaccination teams/brigades, environmental technicians, health promoters, and other social services personnel. The program acted in micro-territories without health care services and served to coordinate collective and individual activities. Intramural activities are developed with *Health at Home* teams in cooperation with traditional health care personnel. Health care teams cared for the people identified by outreach teams working in the micro-territories. The teams included generalist physicians and nurses, with support from psychologists, nutritionists, physiotherapists, obstetrician/gynecologists, pediatricians, and other professional personnel as needed

The health care teams used a life cycle approach to designing health interventions for families and individuals. These interventions were supported by other parts of the social service network. This new, collaborative approach improved access to services, facilitated follow-up, created relationships between families, communities, and service providers, and created the possibility of acting on other social determinants of health.

Care provided in the *Health at Home* program was based on an individual's status within the Social Security System. *Health at Home* provides service to persons enrolled in the Subsidized Social Security System (*Régimen Subsidiado*) and to the uninsured poor who are covered by the contract between an insurer or the district health office and a public hospital. Individuals enrolled in the Subsidized or Employment-based Social Security Systems and who did not have a service contract with the public sector are sent to their insurer to receive the required health care. In this way *Health at Home* helps to identify local needs for health care services, to stimulate the demand for health care services, to resolve access problems, and to monitor medical care usage, regardless of who is paying for it. Monitoring was based on the findings of the initial community surveys. These had been administered to both individuals and their families and included a series of visits, referral to other social service institutions, individual and family accompaniment, community and family meetings, evaluation of adherence to health promotion/disease prevention pro-

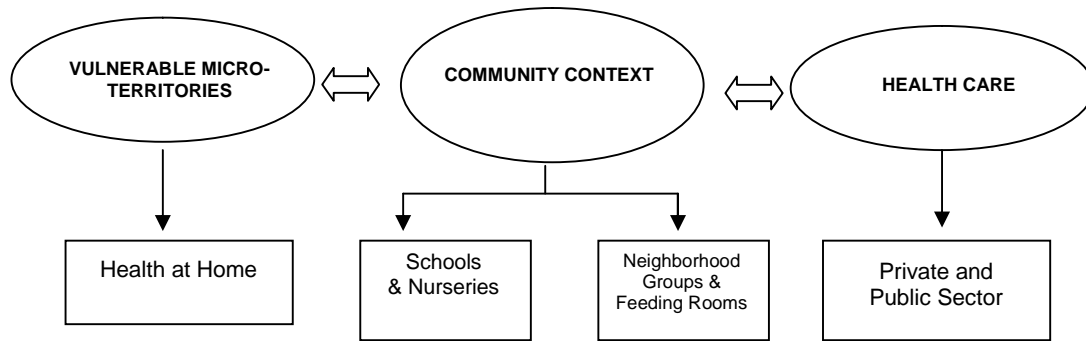
grams, comprehensive care and education, monitoring of special cases, and development of the micro-territory.

In May 2006, a proposal was made to create a new type of unit called the "Primary Health Care Center" (*Centros de Atención Primaria en Salud*). These units would be placed in those public sector institutions located in the prioritized zones. They would provide basic sanitary care to the members, particularly those poor individuals who were not affiliated to the Social Security Health System.²⁴ In The Primary Health Care Centers were created along two different models: some were located within pre-existing traditional structures such as the Primary Care Units, Basic Care Units, and Immediate Care Units. However, in areas with no preexisting health infrastructure, the Primary Health Care Centers were located in community centers; this was done with the consent of the community. The priorities of the Primary Health Care Centers were:

- Health promotion and disease prevention; screening for diseases, disabilities, vision problems, hearing problems, and cervical cancer; monitoring of pediatric growth and development; vaccination.
- Education in sexual and reproductive health.
- Prevention of psychoactive substance abuse.
- Prenatal care and risk assessment.
- Creation of an acute respiratory disease (ARD) room in order to prevent hospitalization and provide timely care to children with ARD.
- Breastfeeding Room.
- Collection of samples for the clinical lab
- Provision of medicines for public health programs.

Working collaboratively, the basic care teams for the vulnerable populations, the public health management teams, and the Primary Health Care Centers have become the basis for the "Primary Health Care Infrastructure." (Figure 3) This structure coordinates the ensemble of institutions, programs, and resources, including those of the private sector, in order to improve the health of individuals and communities.³¹ With their different positions, the health care teams and Primary Health Care Center teams serve as point of first contact not only for health care but also for social services at all levels.

Figure 3: Primary Health Care Infrastructure



The public health sector has been primarily responsible for the implementation of this strategy at the district level. Very few agreements have been worked out with private insurers for specific programs or even with other social institutions. The community and service users also play an important role in the identification, resolution, and monitoring of group needs.

One of the management approaches adopted for implementing this strategy is called Integrated District-Level Social Management (*Gestión Social Integral del Territorio*), one element of which is Comprehensive Social Action (Figure 4). This approach coordinates clinical and public health actions with other social and community sectors. This integration takes place at two different levels: a macro level, which is the district and community level, and a micro level, i.e. within the micro-territories. At these levels, primary, secondary, and tertiary prevention activities, as well as advocacy activities within other sectors, and management activities with different parts of the Social Security Health System are all integrated.

Comprehensive Social Action encompasses the coordination and cooperation of all health-related activities carried out by institutions, government agencies, and communities within a specific territory. The process involves the community survey made by *Health at Home*, the health analysis created with broad participation, and the creation, execution, follow-up, and evaluation of comprehensive action plans. A number of communities have been provided with multi-specialty support in order to foster social participation in these activities. This support has involved information systems, training

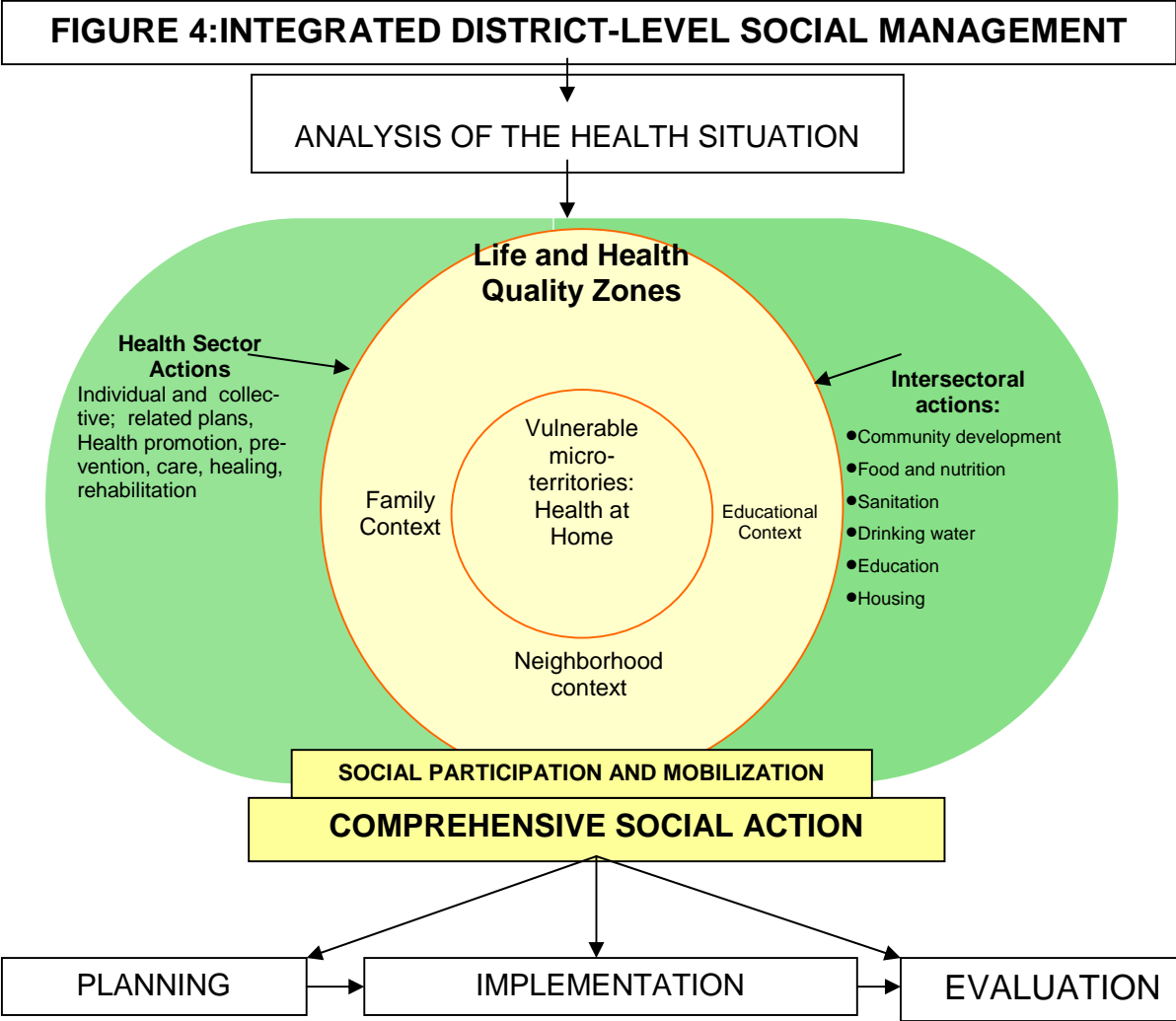
activities, inter-disciplinary work, and communications.²²

While the CPHC program has worked within the traditional public health structure, it has also developed its own innovative programs. Among these are interdisciplinary programs to control acute respiratory diseases (ARD), one of the principal causes of infant mortality in Bogota. Each sector placed ARD rooms in primary care centers. The goal was to develop comprehensive programs of education, prevention, treatment, and early rehabilitation. The ARD rooms were designed to lessen barriers to medical care and reduce unnecessary hospitalizations and readmissions. Research has been conducted looking at environmental exposures and vulnerability. Joint plans have been made to carry out comprehensive programs, community-wide educational campaigns, community vigilance, and the promotion of national and international technical cooperation.

Changes to the service delivery model

A new service delivery policy was implemented in September of 2000. Its main objective was to strengthen the management and financial structure of public sector institutions. In some cases, areas were merged. Networks were developed to optimize efficiency and profitability.²⁶ The introduction of CPHC required changes not only in priorities of the networks and the management of public sector institutions, but also in the content of all service provision policies.

The restrictions put in place by the 1993 Law 100 required all individual health services to be offered through Social Security insurance companies and providers. However the CPHC program started



to change the way uninsured or insurance-subsidized persons received care. Through their contract with the public sector, a needs assessment was carried out, families were enrolled into local health teams and health care was provided either directly or by referral to other providers. The CPHC Program responded to the demands of marginalized communities by reopening health care centers that had been closed in the process of merging the public services areas; by opening new health care facilities; by renovating existing facilities, hiring new professionals, technicians, auxiliaries, and health promoters; and by introducing home visits. As demand increased, some public hospitals allowed appointments to be made directly from the field as soon as a need had been identified within a family. Mechanisms were set up to allow sick patients to bypass waiting lists, and health teams were

organized to deal with the increased demand. Several care centers increased their working hours, opening at night and on the weekends. Others set up mobile medical units which reached isolated parts of the city. In rural areas, a “Health Route on the Byways” (*Ruta de Salud Interveredal*) was established using telemedicine equipment. Most public hospitals created call centers for telephone appointments. In these ways the CPHC program has improved poor people’s use of and access to health care services.

With the implementation of this strategy, Comprehensive Primary Care networks were introduced as the coordinating mechanism for all stakeholders involved in the delivery of personal health services at whatever level of complexity. The networks included stakeholders involved in protecting collective health. The goal was to develop comprehensive

solutions to the health needs of the population, based on relationships of trust, solidarity, support, and cooperation. In order to better integrate the different plans and benefits and to insure the comprehensiveness of any intervention, public health actions were coordinated with those of the comprehensive primary care networks. This was done by promoting social co-responsibility and participation, by demanding that the right to health be enforced, and by requiring intersectoral actions when elaborating and applying all public health policies.

Intersectoral Action and Community Participation

The concept of *transectoral action* has been used in the CPHC Program as a way of improving wellbeing and health. It is defined as the coordination of the work performed by different units and institutions in the social services field through creative responses to challenges arising from the health and social conditions of the population.⁵ It can be considered as a special case of intersectoral action as applied to health.²⁷ Through this, the CPHC program has attempted, along with the redesign of management processes in public health, to impact on the social and environmental conditions that are directly related to health. This is accomplished by coordinating the actions of the health sector with those of other parts of the social service and community networks. This model serves as a starting point for the development of public policies and strategies for intervention and management that possess a comprehensive quality. Examples of these are the infant and adolescent policy,⁸ the “A Bogota Free of Hunger” campaign, the environmental and social housing policy,⁷ the Comprehensive Social Action program, and the involvement of programs in the settings of daily life.

Comprehensive Social Action was implemented first in priority communities. These are defined by their degree of social vulnerability and the community’s exposure to factors harmful to health and quality of life. These assessments were based on data provided by different government institutions. At least 35 zones were identified as priority areas for intervention. This form of intersectoral action coordinates different government players and processes, both from the private sector and from civil

society, and at different levels of intervention: local, micro-territories, schools, and households. The groups work on closely related issues and problems, such as health, food, nutrition, education, housing, environment. They draw on the distinct competencies of different disciplines and governmental actors.

In coordination with public health, CPHC works in the settings of daily life to realize programs of health promotion, prevention, clinical care, and rehabilitation. These intersectoral actions occur primarily in the family, school, and community setting. They have strengthened networks for maternal and child health, for the disabled, and for health care quality improvement. They have also strengthened local environmental committees and youth councils.

The Family Context

In the family context, CPHC works through the *Health at Home* Program. *Health at Home* studies housing conditions, the health of individuals and families, and the environmental conditions of the micro-territories. Using this analysis of health conditions, intervention and monitoring activities are carried out in mental health, pregnancy, disability, infant health, healthy housing, and public health surveillance.

From 2004 to 2007, *Health at Home* worked actively with other social service programs involved in health. An example of this was the Housing Subsidy program. In this program diverse institutions worked collaboratively to “*improve housing and living conditions*” for the most vulnerable families in Bogota. Programs were established to promote basic health conditions mainly by upgrading bathrooms, kitchens, and basic sanitary infrastructure. Healthy Families identified approximately 80,000 families who met eligibility standards for the subsidy and would benefit from the program. In 2006, 466 families in 20 *Health at Home* areas received subsidies. In 2007, an additional 1000 families are estimated to have received subsidies in 21 *Health at Home* areas of the town of Usme.

As part of the agreement setting up the Housing Subsidy program, each institution agreed to contribute human and financial resources. The Health Department, for example, provided technical assistance in basic environmental sanitation; the Housing De-

partment coordinated the development of procedures for the payment of the housing subsidy; the Community Housing Fund provided technical assistance to establish the improvements needed for each housing unit; and Metrovivienda provided the economic resources for payment of the subsidy. Finally, local City Halls provided economic resources for technical support and for the identification and verification of the actual housing conditions of potential beneficiaries. Within the *Health at Home* areas, the housing subsidy impacted some of the most important social determinants of acute respiratory infections, nutritional deprivation, diarrhea, and other health conditions.

Healthy Home teams also worked with the “OIR Ciudadanía” (Listen to the Citizens) program. This program operates in those areas with the least developed public infrastructure. It provides technical training and assistance to individuals and families living in conditions of extreme poverty and vulnerability. By providing them with information and referral it brought them into the social services network. Through community empowerment and the efforts of the *Health at Home* teams, great strides made in improving wellbeing and health in populations that live in micro-territories.

Educational Context

CPHC works with the “*Healthy at School*” (*Salud al Colegio*) program.²⁹ *Healthy at School* identifies students’ needs and verifies their enrollment in the Social Security Health Program. It develops educational programs, collaborates and assists in teaching activities, diagnoses cognitive problems, refers to the health care team and other social services, monitors nutritional and micronutrient status, screens for domestic violence and abuse, and develops programs to prevent the exploitation of children. These activities bring together parents, teachers, students, and other social sectors. This program arose from an agreement between the Education and Health Departments in which the schools committed to act as promoters of wellbeing.

Healthy at School seeks to improve school retention and learning as well as to decrease barriers to school attendance. Working from a human

rights perspective, the program seeks to incorporate the educational community into the process of community and individual development. Using an intersectoral approach, *Healthy at School* has developed interventions for the following problems: adolescent pregnancy, domestic and sexual violence, comprehensive care for the disabled, identification and monitoring of students with evidence of growth deficiency and other forms of malnutrition, prevention of school accidents, occupational health of the teaching and administrative staff, and the creation of primary care centers within the schools. These programs represent an important tool to adequately respond to the daily concerns of the community. They seek to improve the capacity of the educational community to identify, refer, and monitor those common circumstances that may impede the ability of children and adolescents to learn and develop.

Community Context

CPHC works in collaboration with the *Health at Home* program, the customer service offices of the public hospitals, the public health teams, and community organizations to identify needs, promote community organization and mobilization, encourage the social management and monitoring of community epidemiological conditions, organize vaccination campaigns, celebrate the Day of the Child and World AIDS Day, give training within the community, support community kitchens and breastfeeding, perform nutritional monitoring, and provide oral health.

Innovative intersectoral community programs included the organization of health and wellbeing meetings designed to strengthen the social fabric. These meetings set up community support groups for those adults, adolescents, or children who might need assistance. Opportunities were created for community members to see themselves as subjects in their daily interaction with their neighbors. The groups were formed around people at a common stage in the life cycle or sharing a common interest or condition. The goal is to encourage the emergence of collective or community proposals addressing specific local social needs and problems that, in one way or another, affect the social deter-

minants of health and wellbeing among the population.

CPHC developed new organizational methods in order to encourage community participation and foster community management and representation in the planning and decision-making processes. One of these is the Management Center. Management Centers identify local needs and present them to the government. The government then makes policy proposals that coordinate collaborative actions at the local level. They meet with the health teams and discuss possibilities for local development. They elaborate action plans and serve as a monitoring group for the various family and community projects.

In a similar way the CPHC has promoted the involvement of communities in local government and local decision-making. Through the Basic Care/Assistance Plan, lines of communication have been opened up between communities and territorial authorities. Participation of hospital representatives in the local Government Councils and local Social Policy Councils is yet another channel by which community needs are communicated to higher governmental levels. This communication directs political attention to locally identified problems and assists in creating intersectoral responses.

Organization and Management

An information system was developed which incorporated information from the household survey and community assessments into software called "Online PHC" (*APS en Línea*). The primary objective of the information system was to integrate field work data collected by different institutions and actors for purposes of strategic planning and the fostering of social control and participation. Data for the survey and the assessment were collected by health promoters and sanitary technicians respectively. The information system allows for analysis of health conditions, the definition and implementation of action plans, their monitoring and evaluation, as well as the auditing required by the Bogota Municipal Health Department. The system had been completely installed in local hospitals by June of 2007, and it is currently operating in

Bogota's towns with a total of 64 teams and 101 active users.

Organizational guidelines have been established for the relationship between health service financiers and health service providers. These guidelines outline audit procedures following CPHC principles. However, appropriate financial incentives have not yet been developed in the payment schedules used by the District Financial Fund and the insurance companies.

The managerial, technical, and financial autonomy of the public health system, as well as its neo-liberal labor policies, have created a human relations environment that has been in conflict with the spirit of CPHC. These policies have led to high levels of staff turnover due to the use of temporary contracts, lack of adequate incentives, and meager wages. Although some professional development activities have been carried out, a coherent educational policy with a CPHC orientation is clearly missing. Pre-graduate and graduate health education in Colombia has been marked by the biomedical and paternalistic spirit of the 1993 Law 100.

Auditing by the Municipal Health Department has played an important role in the design, implementation, and monitoring of CPHC and, to a lesser extent, in the monitoring and control of activities and duties of providers and insurers. This auditing has also been quite important for assuring the financial resources for the system, avoiding duplication of efforts. Yet it has limitations with regard to criteria used for equitable resource allocation in accordance with health needs and also in the development of the relationship between insurers and private health care providers.

Activities and Results

Between September 2004 and December 2006,³⁴ 280 territories were established by the *Health at Home* teams in the poorer and more vulnerable areas of the city. A total of 260,077 families (850,953 people) were surveyed and enrolled into the health teams. As of September 2007, this number has increased to 1,163,307 individuals, covering 36.84% of the population of Strata 1 and 2 (Table 1).

By December 2006, 71.67% of identified pregnancies received prenatal care. Pap screening had reached 34.69%. Growth and developmental monitoring were done on 52.35% and 49.67% of children under 12 months and aged 1 to 4 years respectively. In addition, these programs underwent substantial improvement. A total of 89,562 educational activities were carried out for families with children aged less than 5 years. These covered the prevention, early detection, and control of acute respiratory and diarrheal diseases. 855 children were treated in ARD rooms and then monitored by the *Health at Home* teams in order to prevent complications and readmissions. Some 300 community leaders were trained in the prevention of prevalent pediatric conditions. 42,117 patients were diagnosed with hypertensive and 12,267 with diabetes. All of these persons have been informed of their diagnosis, instructed in the promotion of healthy nutrition habits, and referred to prevention and control programs. Another 12,138 individuals were identified as having some form of disability. 5,900 cases of malnutrition were identified and referred to nutritional rehabilitation centers and soup kitchens working under the Bogota Free of Hunger Program. They also have received health instruction and follow-up (Table 2).

During 2004-2006 the homes of 8,537 families were renovated. 9,752 families were educated on home improvement, basic sanitation, and risk prevention at home.

Through December 2006, 67 community meetings were held in the different *Health at Home* territories. Fifty territorial social action plans were elaborated, and several organizations were created in different city localities.

Health Outcomes

The short time that has elapsed since the implementation of the CPHC program makes it premature to judge its impact. In addition, there are difficulties in analyzing the information at the level of the communities reached by *Health at Home*. But there are some short-term achievements that have lived up to the expectations of Bogota's social policies.

Rates for infant mortality, post neonatal mortality, pneumonia and ADD (Acute Diarrheal Diseases) in infants under 5 years in Bogota began to drop after the strategy was implemented. Between the years 2004 and 2006 these rates have dropped 12.61%, 12.93%, 45.20% and 67.10% as observed in Graphs 1-4 on the next page.

As part of the current study, an analysis is being performed comparing the standardized mortality

Table 1: Individuals enrolled by the Health at Home Program, Strata 1 & 2, Bogota	
Population Zones 1 & 2 - Bogota 2007	3,156,387
Total surveyed (Sep 2007)	1,163,307
Percentage enrolled, Zones 1 & 2	36.84%
Non-pregnant women (December, 2006)	9,573
Pre-natal Control Assistance Coverage	71.67%
Women of childbearing age (December, 2006)	340,547
Percentage of women receiving cervical cancer screening	34.69%
Children less than 12 months (December, 2006)	18,899
Vaccination coverage for infants under 12 months	76.71%
Children aged 1 to 4 years (December 2005)	70,673
Vaccination coverage of children aged 1 to 4 years	76.66%
Children aged 1-4 years receiving Growth & Development Screening	52.35%
Infants less than 1 year receiving Growth & Development Screening	49.67%

TABLE 2 - HEALTH AT HOME ACTIVITIES THROUGH 2006	
Monitoring Visits to pregnant women	15,803
Percentage of pregnant women enrolled	100%
Monitoring Visits to women of childbearing age	82,377
Percentage of all women of childbearing age receiving visits	24%
Monitoring visits to infants under 12 months	18,624
Percentage of all infants under 12 months receiving monitoring	99%
Monitoring visits to children aged 1 to 4 years	41,679
Percentage of all enrolled children aged from 1 to 4 receiving monitoring	59%
Children assisted in ARD rooms	855
Percentage of enrolled children hospitalized secondary to ARD	22%
Monitoring visits to hypertensive individuals	21,144
Percentage of enrolled hypertensive individuals receiving visits	50%
Monitoring visits to diabetic individuals	5,606
Percentage of enrolled diabetic individuals receiving visits	46%
Monitoring visits to individuals with TB or Leprosy	178
Percentage of enrolled individuals with TB or leprosy receiving visits	100%
Monitoring visits to individuals with malnutrition problems	3,401
Percentage of enrolled individuals with malnutrition problems receiving visits	58%
Monitoring visits to adults over 75 years	8,594
Monitoring visits to individuals with disabilities	4,326
Percentage of enrolled individuals with disabilities receiving visits	36%
Monitoring visits to individuals who reported suicide attempts	145
Percentage of enrolled individuals who reported suicide attempts receiving visits	69%
Monitoring visits related to psychosocial risk	2,073
Monitoring visits for housing problems related to healthy housing.	39,635

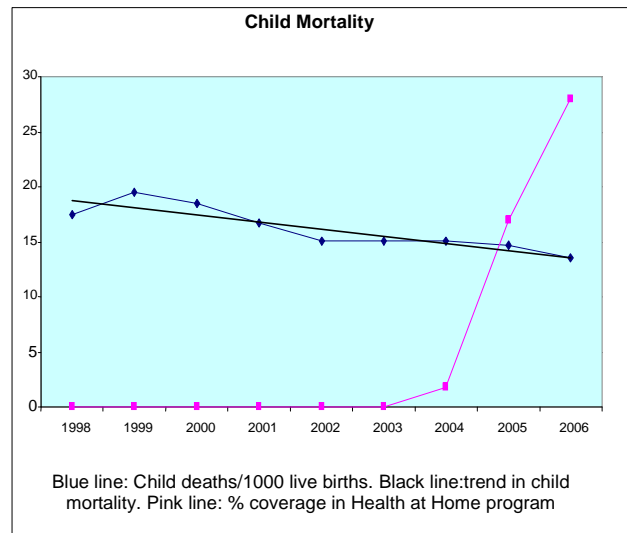
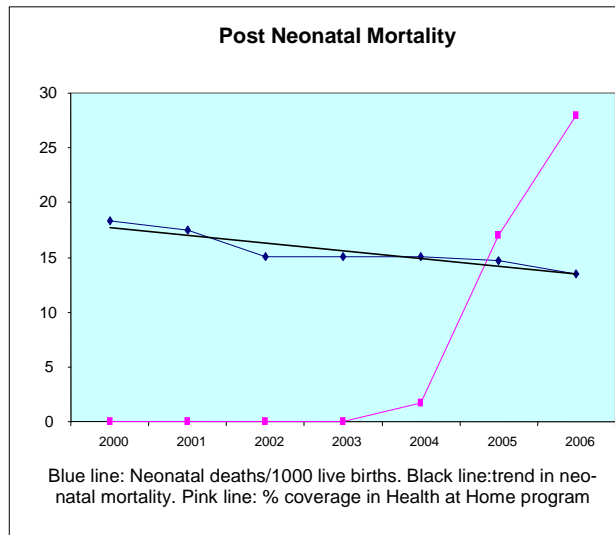
rates among localities grouped according to their degree of coverage by the new strategy.³ Localities are divided into low, medium, and high coverage areas. Preliminary findings suggest that localities with highest coverage have lower mortality rates for the majority of variables (infant, post-neonatal, and pneumonia-related mortality in children < 5 years) with the exception of mortality related to ADD in children under 5 years (Table 3).

This study³³ will also consider health equity. Analysis of the three groups of localities indicates

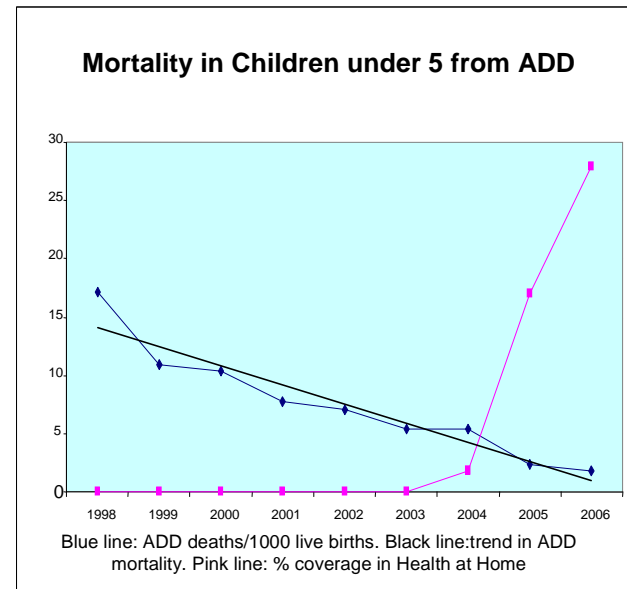
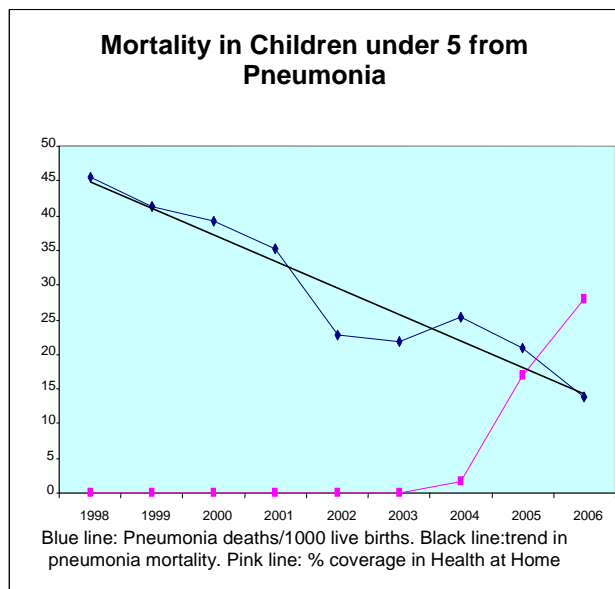
that disparities in child and post-neonatal mortality related to socio-economical status tend to decrease in the towns of high strategy coverage. The opposite is the case for towns with low coverage, where the disparities tend to increase (Graphs 5, 6).

The same tendency is seen in pneumonia-related mortality in children under 5 years. Disparities decreased more in the localities with higher coverage. This appears to be contrary to the case of ADD mortality where the proportion of decline is greater in

Graphs 1&2: Infant and Child Mortality Trends



Graphs 3 & 4: Deaths from Pneumonia and ADD in children under 5



localities with low strategy development (Graphs 7, 8).

However, as shown in the case study (see Case Study), several of the challenges faced by CPHC with respect to the improvement of performance, financial sustainability, community participation, and intersectoral action, among others, were not solved adequately.

Conclusions

This experience demonstrates that even in adverse contexts such as the one in Colombia, gov-

ernments committed to health rights and equity can make positive responses to the needs of the population and, in particular, to those living in underprivileged socioeconomic conditions. The health policy and the CPHC strategy developed in Bogota appears to have contributed to the comprehensiveness and coordination of individual and collective actions in the public sector, making better use of resources, and improving health conditions and health equity. However, these policies did not involve the entire health system, were not carried out

TABLE 3: MORTALITY RATES STRATIFIED BY LEVEL OF COVERAGE IN HEALTH AT HOME PROGRAM

	Rate per 1000 LB 2000	Rate per 1000 LB 2001	Rate per 1000 LB 2002	Rate per 1000 LB 2003	Rate per 1000 LB 2004	Rate per 1000 LB 2005	Rate per 1000 LB 2006
Infant Mortality							
LOW COVERAGE	18.69	17.82	16.10	16.34	16.49	16.23	13.55
MIDIUM COVERAGE	20.78	18.03	14.32	14.98	15.78	15.45	13.91
HIGH COVERAGE	15.95	14.37	13.63	12.63	13.67	12.60	12.50
RATE DIFFERENCE	2.74	3.45	2.46	3.71	2.83	3.63	1.05
RATE RATIO	1.17	1.24	1.18	1.29	1.21	1.29	1.08
Post neonatal Mortality							
LOW COVERAGE	6.86	6.54	5.74	6.05	6.40	5.66	4.98
MEDIUM COVERAGE	7.05	7.38	5.47	6.48	6.41	6.66	5.54
HIGH COVERAGE	5.80	5.10	5.33	4.27	4.47	4.21	4.43
RATE DIFFERENCE	1.06	1.44	0.41	1.78	1.93	1.45	0.55
RATE RATIO	1.18	1.28	1.08	1.42	1.43	1.35	1.12
Pneumonia Related Mortality in < 5 years							
LOW COVERAGE	4.18	3.30	2.11	2.01	2.73	1.91	1.55
MEDIUM COVERAGE	3.84	3.53	2.32	2.44	2.70	2.32	1.78
HIGH COVERAGE	2.71	2.83	1.87	1.78	1.63	1.83	0.84
RATE DIFFERENCE	1.47	0.47	0.24	0.24	1.10	0.08	0.71
RATE RATIO	1.54	1.16	1.13	1.13	1.67	1.04	1.85
ADD related Mortality in < 5 years							
LOW COVERAGE	1.03	0.79	0.54	0.48	0.54	0.27	0.15
MEDIUM COVERAGE	0.87	0.52	1.08	0.57	0.71	0.31	0.23
HIGH COVERAGE	0.77	0.74	0.37	0.55	0.34	0.09	0.18
RATE DIFFERENCE	0.26	0.05	0.17	-0.07	0.20	0.18	-0.03
RATE RATIO	1.34	1.07	1.45	0.88	1.57	3.08	0.84

in large areas of the city, and did not reach the required dimensions.

Neither insurers nor an important number of providers could be engaged in the program. Coordination with the private sector was almost non-existent. Community and family counseling were clearly weak, probably due to deficiencies in labor policies and human resources training. Community participation was still organized by the rules of individual institutions and health market rational-

ity. Intersectoral action was not broadened and deepened as desired. And there were other problems. Together they suggest that the national political context prevented a much firmer and sustained development of the local health policy and the PHC approach which was adopted.

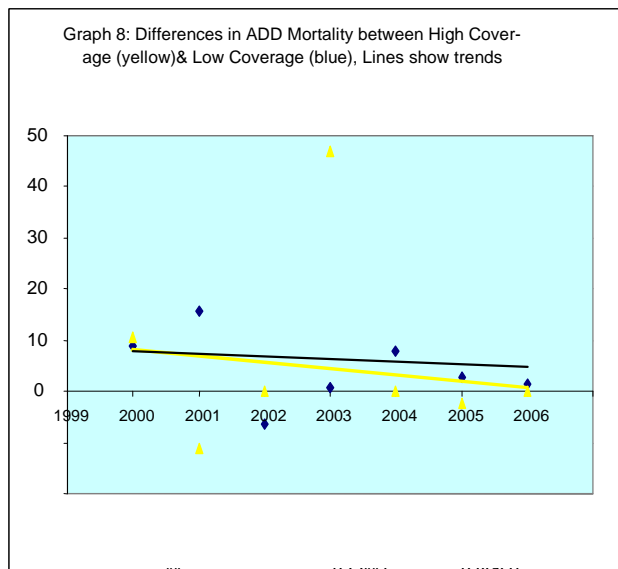
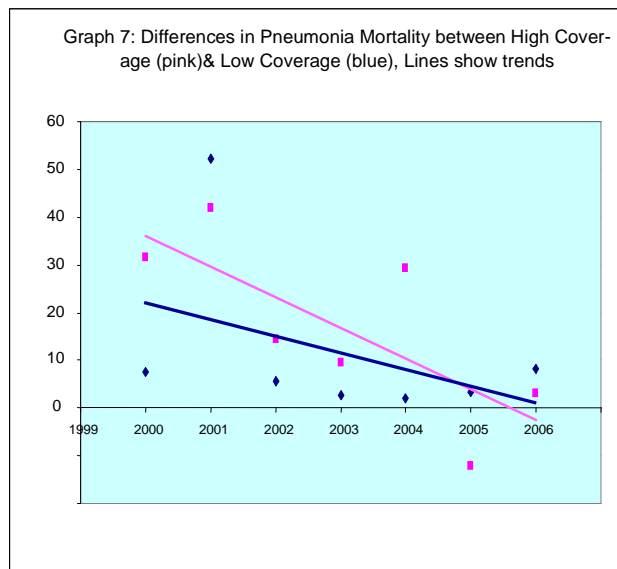
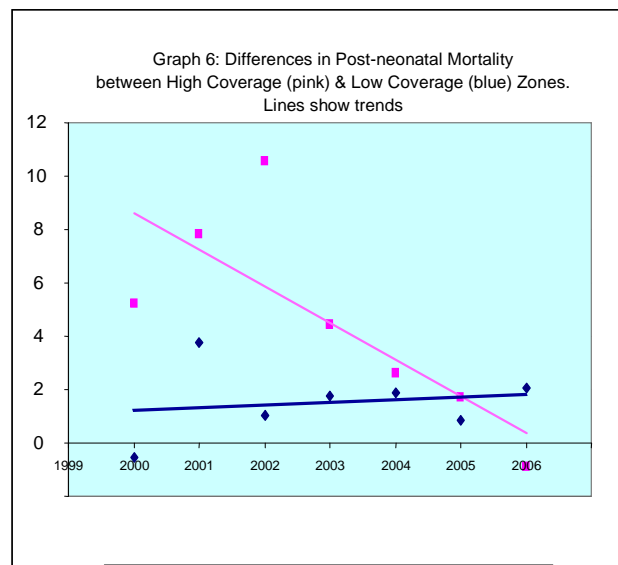
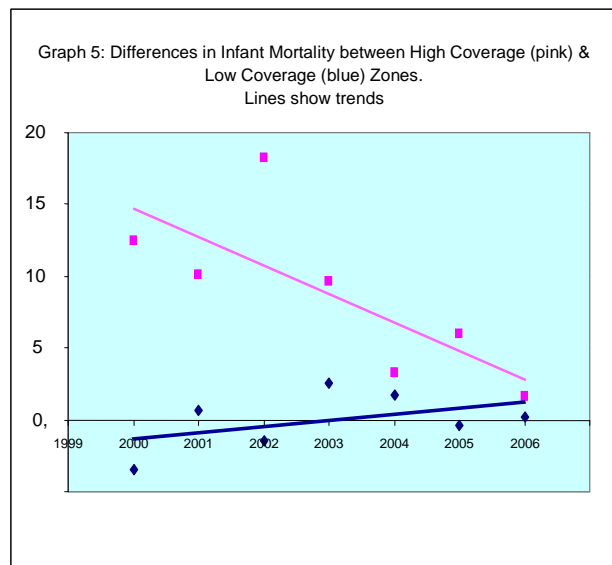
The results of this experience also suggest that in order to be consistent with the goal of guaranteeing health rights and equity, it is not possible to work within the current framework of the Social

Security System. A strategy to profoundly transform the system is needed. Under these circumstances, a combination of actions both from within and without the system must create the necessary force for such a radical transformation. The danger for alternative governments in Colombia is that they become administrators of the Social Security System and, in doing so, focus their energies on the needs of the system and its supporters.

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CASE STUDY: SUBA

Suba was one of the first towns in Bogota to implement the CPHC strategy. This reflected the local government's political willingness and economic support, as well as the determination of the community. The adoption of CPHC was facilitated by health sector leadership, particularly at the Suba Hospital. Suba is one of the largest towns in the District in terms of territory and population; there are 911,925 inhabitants, of which 34.1% live in households with incomes below the poverty line. During the last few decades, the town has experienced increasing demographic growth and rapid urbanization; land usage has quickly changed from predominantly agricultural to commercial and residential. Population growth is a consequence of forced displacement due to internal conflicts in the country.

In Suba, CPHC has achieved coverage of 70 micro-territories, 84,270 families, and 242,646 individuals in a short period of time. This corresponded to 100% of the poorest and most vulnerable areas. It has grown from five ambulatory care centers in 2004 to fourteen in 2007. The program has evolved into a primary care complex with seven new Primary Care Centers (PCC) and one mobile unit. The community has contributed to this infrastructure by donating three communal rooms to serve as PCC's (after some reconditioning). Another particular quality of this model is seen in the diversity and amount of human resources (a total of 331 people) involved in CPHC. While the involvement of traditional health care personnel is essential, other groups of people joined them, including social workers, environmental technicians, psychologists, anthropologists, and others. This reaffirms the emphasis given by the model to social and community issues, to prioritizing problems, and to the diversity and vulnerability of the population.

In spite of these advances, three studies were recently conducted under this research program which have revealed meaningful challenges in CPHC implementation. A quantitative-comparative study of the public institutions that managed the implementation of CPHC and of the private institutions that do not use it—conducted through surveys given to users, professionals, and managers of the strategy—has shown that there was a meaningful achievement in terms of comprehensiveness. Evaluations of family and community approach, coordination and access to both types of institutions were either average or poor.³⁵ The qualitative study reveals that community participation is still largely passive; it is used for the channeling of resources and legitimizing speeches, programs, plans, and institutional practices without aiming at nor achieving an adequate level of community mobilization and empowerment.³⁶

On the other hand, economic evaluation showed that even if the strategy is cost-effective, the conditions do not exist for the long-term sustainability of secondary care given that Social Security Health System recruiting and payment policies favor financial income related to curative services, which are decreased with the prevention actions of the CPHC strategy.³⁷

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