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Commentary

From Community-Based Policy Development to People-Centred Primary Care: Community-Oriented Primary Care Across Knowledge Systems

Comment on "Routes of Well-Being, Spiritual Harmony and Recovery in Mental Health: The Community as a Policy-Maker"

Christine Leyns[1,2,3*]

Abstract

This commentary examines a community-based mental health policy developed through participatory engagement with Indigenous and local communities in Colombia from the perspective of people-centred primary healthcare. While the original study successfully integrates community priorities, cultural identity, and the social determinants of mental health into policy development, its implementation would benefit from a stronger link with primary healthcare through a community-oriented primary care (COPC) approach. Four key conditions are proposed: reflective and culturally humble healthcare professionals, transdisciplinary collaboration between biomedical and traditional knowledge systems, integrated health information systems incorporating social determinants of health, and formal partnerships between healthcare centres and their communities. The commentary also emphasizes the importance of health professional education in promoting equity, reflective practice, and population health competencies. Finally, it argues that Indigenous concepts of health should inform an intercultural dialogue alongside concepts including planetary health and social capital (SC) to enrich a general understanding of health.

Keywords: Community Health Planning, Community Participation, Primary Healthcare, Traditional Medicine, Latin America, Equity

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Background

The article by Agudelo-Hernández and Giraldo-Álvarez[1] resonates strongly with the principles of people-centred healthcare, which emphasize that health should be organised around the needs, preferences, and capabilities of individuals and communities rather than institutions or diseases.[2] Contrary to traditional policy development, the methodology of this article[1] puts people and their needs central by involving people in the community to identify their own needs and resources. The involvement of other sectors like education is instrumental to understand the social determinants that shape health and more specific mental health. By including historically marginalized populations, like Indigenous populations, the authors recognise the equity dimension in health, where more effort is needed for those with more needs.[3]

Participants consistently identified employment, education, housing, family support, recreation, and cultural identity as integral components of mental health. The proposed mental health pathway therefore reflects a comprehensive understanding of health. This pathway based on community-generated input was translated into official local policy, helping to bridge the gap between community participation and policy development. An important question remains on how to implement this policy pathway into practice.

Community-Oriented Primary Care

A missing link in the development of this plan that may hamper implementation is the unclear role of primary healthcare. A general policy plan on the municipal level in Riohacha, Colombia, will on itself unlikely be responsive to local needs and can even reinforce the inverse care law, whereby socially disadvantaged people receive less, and lower-quality healthcare despite having greater need.[4] Although it is highly relevant to involve social workers, the educational sector, the penal system, and the media in the development of the mental health pathway, it is unclear how primary healthcare providers and the organisation of primary care were accounted for.

As a reaction on healthcare that was merely limited to

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hospitals, curative care and selective public health programs, primary healthcare was redefined on an international conference in Alma Ata in 1978 as holistic healthcare for individuals, families and communities, including prevention and health promotion, over the life course and as close as possible to where people live and work. Primary healthcare is since the Alma Ata declaration of 1978 globally recognised, in line with people-centred care, as: (1) integrated health services to meet people's health needs throughout their lives; (2) addressing the broader determinants of health through multisectoral policy and action; (3) empowering individuals, families and communities to take charge of their own health.[5] A model to understand the practical implementation of the vision of Alma Ata in primary healthcare at the health service level is community-oriented primary care (COPC). This model integrates community diagnosis, epidemiology, and community participation to address the root causes of collective health problems.[6]

To implement the proposed mental health pathway, which strongly focuses on the inclusion of traditional medicine and the needs of Indigenous populations, at the health service level through a COPC model, there are at least four essential preconditions. First, a reflective attitude of biomedical and traditional healthcare providers about their own context, values and prejudices and how this impact the provision of inclusive and respectful care to all, independent of their sociocultural background; Second, a transdisciplinary collaboration between biomedical and traditional healthcare providers, wherein they can share knowledge to construct new knowledge in a respectful way; third, a health information system that supports collective health and health equity analysis by presenting health needs stratified for social deprivation, ethnicity, and community circumstances; and fourth, a monitoring committee linked to each primary healthcare service with healthcare providers, social care providers and representatives of the socio-cultural groups, communities, schools, and labour organizations present in that territory.

The above mentioned preconditions seem hard to achieve without the support of educational institutions that form human resources for health.[7] A reflective attitude, for example, is not constructed overnight and the lack of it is related to the disproportionate care law, whereby socially disadvantaged people,[4] and minorities, regardless of income and insurance coverage, are more likely to receive lower-quality healthcare. A systematic review showed that patients from a lower socio-economic background received significantly less positive socio emotional engagement and a more directive and a less participatory consulting style by their care providers.[8] Various measures in professional health education can promote this reflective attitude like proactively including students from non-traditional backgrounds, like socially deprived or Indigenous households, in medical education. They are not only more aware of the impact of social determinants on health, but they can also increase the empathy or their fellow students through intersocial or intercultural friendships.[9] Empathy and person-centred attitudes often decline during medical training but can be sustained through among others communication skills and structured reflective practice.[10] Within a supportive learning environment students can learn to recognize and mitigate explicit and implicit biases toward historically marginalized populations. Moreover, people-centred care requires equitable rather than equal treatment, allocating greater empathy, time, and resources to individuals or communities with greater needs. To prepare healthcare professionals for people-centred care and the COPC model it is necessary to integrate population health, health equity, leadership, and interprofessional collaboration into clinical practice.[7,9]

The mental health pathway recommends the integration of the approach of Indigenous communities with the Western approach. This means integrating traditional medicine with so called biomedical medicine, wherein like mentioned in the article by Agudelo-Hernández and Giraldo-Álvarez,[1] reimbursement of both services will be necessary beside the need for knowledge exchange as discussed later.

To guarantee that the health pathway benefits people proportionate to their needs an integrated health information system that includes social determinants of health is paramount. The need for a stratified data analysis was seen during the COVID-19 pandemic, where pre-existing racial and socioeconomic inequalities exacerbated health outcomes in the UK as much as in Ecuador, where a close to four times higher excess mortality was seen in the Indigenous populations.[11] This illustrates the importance of analysing the people behind the numbers. Who are most affected? Are there population groups left behind? What are the determinants of this higher mortality or disease burden? The leave no one behind principle is at the heart of the 2030 Agenda for Sustainable Development. It states that progress can no longer be measured in averages but to benefit all people. This principle is essential to the people-centred care approach.[9]

The last essential prerequisite for COPC is a formal collaboration between the primary care or community health services and community leaders or representatives. Probably this is the most challenging factor for which healthcare providers lack formal preparedness. Social scientists can play a central role in the dialogue between health professionals and the populations.[11]

Sharing Knowledge and Power

A major strength of the study lies in its recognition that mental health is socially and culturally constructed. Instead of imposing a biomedical definition, the authors allow participants to define mental health according to their lived experiences. For Indigenous communities, mental health extends beyond the absence of illness to encompass harmony among the individual, family, community, territory, and spirituality. Such findings reinforce the argument that effective health systems must be responsive to local values and knowledge systems rather than relying exclusively on standardized biomedical frameworks.

Sharing knowledge systems in a horizontal dialogue has the potential to enrich general knowledge and learn from one another. The mere recognition of another knowledge system as a parallel reality holds the risk of polarisation between

our and their system. Therefore it seems important to reflect upon the emphasis this article puts on "spiritual harmony" as a concept specific for the knowledge system of Indigenous communities. Spiritual harmony is a concept primarily used by Indigenous peoples in Colombia, particularly within the Indigenous and Intercultural Health System, to describe health as a state of balance between individuals, the territory, nature, ancestors, and spiritual beings. Disruptions to this balance are understood as manifestations of illness or disequilibrium and are restored through traditional healing practices, rituals, and the guidance of Indigenous spiritual authorities.[1]

This Colombian "Indigenous" concept is similar to the South African concept "Ubuntu," the balance of a person with others and their environment and the Andean concept "El buen vivir" (to live good), being complementary and living together in solidarity without excessively competing with one another and with the natural environment.[11] But are these concepts really limited to Indigenous knowledge systems?

What about the scientific "planetary health" approach which recognizes the interconnection between people, animals, plants, and their shared environment. The evidence base for the importance of planetary health is undeniably growing and the effect of ignoring the environment for far too long as an essential part of health is felt today more than ever.[12] Another broadly studied concept with a strong link to health is "social capital" (SC), which recognizes the interconnectedness between people as a resource. Cognitive SC refers to the perception of trust, reciprocity, norms, and values within a community, while structural SC refers to the quantity of relationships and membership in institutions that can bring individuals and groups together.[13] Both concepts emphasize the need to relate primary care to other disciplines like sociology, public health, and environmental engineering to start with. The current climate crisis, loss of biodiversity and pollution are complex contemporary examples of how the environment affects health and how people affect their environment. Primary care can be a great place to identify and prevent related health hazards and advocate for evidence-based solutions from an interdisciplinary team.[12] Is it possible that the west can learn from these "Indigenous" concepts focused on self-care and the relation people have with others and their environment? Is it time to listen to "Indigenous" knowledge and not set it aside as ideas only relevant for some population groups? How important is a balanced self, the relation with others and the environment for our mental health?

It can be good sometimes to take step back and look to how western medicine colonised clinical practice and health policy across the globe. Is this knowledge so ancient or well-established to be superior to all other knowledge on health? Antibiotics, for example, were only discovered less than a century ago (1928), while Kallawayas saved many lives with a plant extract that contained quinine during the construction of the Panama Canal (1905). Meanwhile, general population knowledge on the effect of local plants or food on health are being replaced by medication and food supplements.[9]

Concepts for well-being and health perceived as Indigenous seem to be mostly related to interconnectedness, possibly as a compensation for the loss of interconnectedness in more western cultures. An additional concept from the Colombian Indigenous populations is "spirituality." Although, this concept is less present in academic publications related to health topics, it was included as part of the Bio-psycho-social-spiritual model described in 1940 by a family physician from Geneva named Paul Tournier in his first book about medicine of the person.[14] This spiritual dimension was later defined by consensus in the biomedical literature as individuals' spiritual or religious beliefs, values, and practices that can impact their sense of purpose, meaning, connectedness, and coping mechanisms.[15] Spirituality is difficult to measure, making it hard to include in studies and to acquire evidence on its impact on health. Does this mean that spiritual harmony is only relevant to Indigenous populations?

An intercultural dialogue and a mutual learning between knowledge systems can strengthen a more integrated plan for all than traditional actions related to the "Indigenous" concept with "Indigenous" treatment strategies by "Indigenous" healthcare providers. Genuine intercultural care requires health professionals who possess cultural humility, flexible service models, and mechanisms that allow traditional and biomedical knowledge to coexist respectfully.

Conclusion

Agudelo-Hernández and Giraldo-Álvarez[1] demonstrate that community participation is not an optional element of health service delivery but a cornerstone of effective health governance. This commentary argues that translating participatory policies into improved health outcomes requires stronger integration with primary healthcare through a COPC approach. Successful implementation depends on reflective and culturally humble health professionals, equitable partnerships between biomedical and Indigenous knowledge systems, integrated health information systems, and sustained community engagement. More broadly, the study highlights the value of intercultural dialogue, showing that mutual learning between knowledge systems can strengthen people-centred, equitable, and sustainable primary healthcare for diverse populations.

Disclosure of artificial intelligence (AI) use

I used ChatGPT to help edit the paper.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that she has no conflicts of interest.

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