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Review Article

Community Health in the Covid-19 era

Garcia Lirios C*

Department Economy, University of Sonora, Mexico

***Corresponding Author:** Garcia Lirios C, Department Economy, University of Sonora, Mexico.

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Abstract

Objective Confirm the exploratory factorial structure of an explanatory model of the conformation of community health networks before risk events.

Method Two non-experimental, cross-sectional and correlational studies were carried out with non-probabilistic selections of 107 students for the first job and 101 users of community health services for the second research, considering the professional practices and the social service of the first ones, as well as Access to services by the second group.

Results In the first study, the instrument was validated and in the second, the three dimensions reported in the consulted literature were confirmed.

Conclusion The design of the research limits the findings to the scenarios and the study samples, suggesting the extension of the work to other contexts for the contribution of empirical support to the proposed model.

Keywords: Governance; health; model; intervention; network

Introduction

Gross mode, community health has been understood as a variant of public health, which historically has been defined from a biomedical paradigm of attention to diseases, epidemics or pandemics focused on prevention, although users of health services they understand that such prevention consists of the demand of their needs and the expeditious attention. Community health, for the purposes of this paper, refers to a management system in which civil society is excluded, although the new post-bureaucratic institutionalism increasingly meets the demands social. In this ne or institutionalist management and administration scheme, community health acquires dimensions ranging from institutional stewardship to civil self-management, but in both models one or the other actor is excluded from the health agenda, decision-making, strategies and the actions of prevention or social attention. Unlike management and self-management systems, community health that is built with the help of political and social actors not only generates a cooperative or solidarity dynamic but also an evaluation of the quality of its processes and products, considering objectives, tasks and common goals [1].

However, public health, when conceived as the result of a system of state management or civil self-management, focused its basic premises on the determinants of governmental action or collective action without assuming the integrality of co-management. In this way, the theoretical frameworks that explain public health administration focus their interest on the bureaucratic dynamic that supposes the vertical synchrony between leaders and talents without assuming that communication and motivation are the result of a climate of empathy and trust, or are linked to commitments and habitus that distinguish health professionals from other unions [2].

In the same way, the approaches that explain the community dynamics of self-management of health highlight the importance of coexistence relationships, the sense of community, the attachment to the place or the local identity without assuming that the evaluation of their processes would generate a greater commitment and responsibility for events and problems that can be prevented with the help of specialists in the field and not only of regional or daily customs and uses [3].

In both cases, state management and civil self-management, the absence of a comparative and integrative theory is evident in the research or intervention models, which do not suggest an evaluation of the changes before and after the implementation of strategies, or, the absence of factors that suppose the construction of an integral system and that necessarily transit through mediation, conciliation or arbitration. Well, the new institutionalism oriented towards governance supposes the emergence of organized social actors that agglutinate social demands and establish a dialogue with the authorities, obtaining financing or penetrating in the decision making or prevention actions, but excluding sectors that do not they have the required level of information processing to raise their demands and establish their intervention strategies [4].

In this sense, the proposals of self-government: self-management and self-administration of health services, focusing on alternative medicine do not exclude specialists and health professionals, but they do emphasize the importance of respecting their uses and customs as part of their identity. Local which is necessary to defend against other cultures or systems that question their community health methods [5].

However, deaths due to water-borne diseases of infringed groups such as infants are not only the responsibility of state management, but are also the responsibility of civil self-management, since they assume an identity of resistance that entails risk behaviors, which charge the life of one billion infants every year, even when each family without access to drinking water destines about 20% of their income, the increase in deaths intensifies in areas peripheral to the cities. In this way, community health is in a crisis of co-management, the main response strategy to hydro-transmitted diseases. This situation lies in the exclusion of one or the other actor in prevention, although the absence of a theoretical and conceptual framework around co-management is a flaw in the legal framework and intervention proposals [6].

Precisely, the importance of building a theory of community health from the vision of co-management lies in the establishment of a common agenda to guide political and social actors towards co-responsibility, although in principle it is necessary to overcome the exclusion of one or the other in the state management or civil self-management, as well as its inclusion in the premises that explain the differences and similarities of the health systems, guiding the recognition of the strategies and the overcoming of the deficiencies no longer only by the incompetence but by the exclusion of one or the other actor [7].

This is how the objective of this paper is to establish the axes and discussion topics that inhibit the construction of a common agenda on community health between governments and citizens, as well as recommendations for overcoming state management and community self-management. The project is part of the discipline of Social Work, an area of documentary studies, but includes concepts of health psychology, community sociology and solidarity economy [8].

Theory of Community Health networks

The theoretical frameworks that explain community health are: 1) theory of the new institutionalism, 2) theory of the establishment of the agenda and 3) theory of the remote-controlled society.

Community health, from the three approaches, is based on a system of management, self-management and co-management oriented to prevention rather than to the care of diseases, accidents, epidemics or pandemics, but each approach distinguishes between the degree of trust, commitment, entrepreneurship, innovation and satisfaction of each subsystem. Indeed, the differences between leaders and citizens reflected the levels of prevention and facing a health problem in the community order. Each approach has explained the process of asymmetry in decision making and the strategies that result in the evaluation of performance or self-care according to the actor or user of health services [9].

In this way, the new institutionalism seeks dialogue with the users of health services when adjusting their strategies in the care or prevention of common diseases and accidents, but it demarcates the authorities of the community agenda in terms of uses and customs, or, traditions of alternative medicine or ancestral procedures. The new institutionalism is an effort to reconcile state interests in the prevention of epidemics that, if located in the periphery of cities, do not inhibit their dynamics, establishing sanitary fences, but

essentially a propaganda of self-responsibility in which state institutions are unmarked of risk behaviors and are ready for attention according to their possibilities and capacities [10].

It is about the establishment of an agenda centered on the stewardship of the State as the main axis of public health, although in the case of community health, this rectory is symbolized by health service institutions. Unlike the new institutionalism that highlights the importance of addressing social demands, the establishment of the agenda involves the emergence of diseases that the State links to local or federal electoral processes. Indeed, the politicization of community health is not only the intensive diffusion of investments in infrastructure, training of professionals or quality of care, but is essentially observed in the absence of prevention campaigns that would nullify the importance of health policies and they would demarcate the responsibility in the individual to open the discussion about the construction of a system of co-management between authorities and users, but that the State prefers to establish an agenda that serves its proselytizing interests and frames health in its omnipresent rectory of which society is dependent [11].

In this logic of stewardship, citizens self - victimize in order to demand needs related to subsidies and compensation from the State in terms of food and donation campaigns. In this phase, the new institutionalism fits in with the establishment of an agenda focused on the supply of health services, but linked to the upcoming elections. In this electoral contest scenario and agenda focused on the diseases of the most unprotected sectors will emerge the effects of the remote-controlled society on public health in general and community health in particular. If the media intensify the dissemination of topics focused on the needs of the civil society that has been violated and if this process intensifies on the eve of local or federal elections, then we are witnessing a context in which health is attributed to the corruption of the government in turn and the urgency of a total and absolute change in the political, social and community linked to diseases associated with poverty [12].

This is how the remote-controlled society in matters of health and elections involves the processing of an agenda centered on common diseases and attributed to the management of the ruling party. In such a scenario, community health no longer only consists of local customs and uses, it depends not only on the investment of the State but, in addition to the interference of the media in the dissemination of diseases, the prevention of epidemics, the demand for needs and the propaganda of rulers or candidates. In short, the new institutionalism, the establishment of an agenda and the remote-controlled society consist of an emotional processing of information that: 1) determines the diseases most commonly linked to poverty, such as the hydro-transmitted diseases in the public agenda; 2) affects the social demands of health care rather than prevention; 3) build a propaganda alluding to the rectory of the State consisting of the construction of hospitals, supply of medicines, expedited medical attention, affiliation to vulnerable sectors, granting of food or support, each and every one associated with the performance of the governing party, or , in the expectation of a change of government dedicated to public and community health in an electoral context [13].

Therefore, community health models focus their attention on the care of diseases by proposing to contain the spread of an epidemic or reduction to its minimum expression and effect. It is an instrument of state management that is increasingly determined by the strategies and electoral propaganda of governments in turn or parties and aspiring candidates to govern the demarcation where a society dependent on the subsidies or remission of the State prevails [14].

Models of community health networks

The models that explain community health are: 1) exponential function model, 2) prey-predator model, 3) disease propagation model.

In principle, the exponential function model would allow the anticipation of scenarios of high contagion and health risks in a violated group. Based on these data, the Social Worker of a basic health institution would promote through images the scenario of health deterioration due to the lack of hygiene and daily personal hygiene among the students. Model determinists because, the factors that integrate them and the relationships that determine them can be controlled by the researcher. In contrast, stochastic models such as logistics do not suppose a control of the factors that integrate it [15].

In the case of community health, both deterministic and stoic models are essential to establish an intervention centered on the individual, the family, the institution and the environment. In the first case, the determination of random factors is prone in individual and isolated cases, the random stochastic model is fundamental for the anticipation of infections in groups and communities. In the case of the logistic model, the Social Work professional would generate an inventory from which potential victims of dermatological contamination would have to adopt preventive lifestyles by reducing their contact with groups at risk of contagion. In this way, the logarithmic results would allow decisions to be made against or in favor of the separation of infected groups and groups at risk, as well as the reprogramming of their activities inside or outside the classroom [16].

The transmission networks go beyond a random interaction as assumed by the logistic model. Therefore, the inclusion of aleatory interactions same factors is necessary to anticipate feasible, pessimistic or optimistic scenario. As the s disease is potential hoisted by the propagation through the asymmetries between infected and victim, social work school emerges as a response to the spread of equity and reducing asymmetries to a minimum. For its part, the press role model to integrate -predator likely scenarios contamination exponential effects of this pollution on groups most at risk and in care for low - risk groups. In this way, the model would allow to anticipate probable scenarios of a new dermatological contamination that would be confronted with a systematic and intensive diffusion of collaborative strategies around the care of the environment for the avoidance of a new outbreak [17].

The model predator-press to involves the interaction of random factors where possible relationships established networks propagation from social work are essential to promote free lifestyles risk and styles of self-based on the possible contagion a potential victim may acquire whether a specific context. If the propagation networks warns dynamic to the potential of an epidemic, graphs explains the formation of a spread of disease from random and indeterminate factors. In this sense, both theoretical and conceptual frameworks allow establishing areas of opportunity according to the diffusing capacities of Social Work in scenarios susceptible to contagion and the spread of an epidemic [18].

Finally, the disease propagation model, more adjusted to the requirements of cooperation and solidarity for the governance of dermatological health, includes not only the groups harmed by the disease, but also the future interaction scenarios in which new outbreaks in other groups and the recontact of the first cases would generate a scenario of high risk, but with enough information to reduce its exponential and logistical effects [19].

Unlike the exponential, logistic and prey-predator models, the contagion factor or contact pattern is the determinant of a spread of contagion or proliferation of an epidemic. Precisely, from this factor the intervention of the Social Work acquires a greater relevance since, if the propagation is established through a school interaction, then the prevention is fundamental between the Social Worker that contributes in the schools and the Social Worker who visits the home scenarios of relatives and friends prone to contagion. In summary, the models of public health in general and community health in particular assume that the relationship between governors and the governed is disconnected with prevention and self-care strategies, risk behaviors and life styles free of illnesses or accidents. They also assume that personal health is separated from occupational health, which is determined by access to the public health service [20].

In such a scenario, the models differentiate the State from the co-responsibility that implies the promotion of healthy life styles, free of risks, illnesses and accidents, as well as a propensity to the future that implies considering health as a common asset in institutions. State and civil organizations [21].

Community Health Studies

Community health emerges when the effects of climate change on local climates increase. In that sense, they underlie the epidemic because the potential heat is increased in areas with low human development; health, education and employment, but these epidemics spread n in other economic sectors by the dynamics of contagion. In this sense, the classic environmental public health models acquire relevance with respect to the contagion of diseases; the models latter ideal to establish intervention models; prevention, treatment and

adherence, but according to the locality in the promotion of self-care [22].

Social Work studies of community health show that prevention is a low cost factor with respect to the treatment of a disease acquired by a contamination. In this sense, an integral model for the study of a contamination outbreak supposes strategies of intervention from the Social Work in institutions of basic education. The propagation model has been identified as the most complete, although the integration of other models explain in more detail the problems of contagion and future scenarios treatment, recontact and prevention such as prevention strategies and promotion of lifestyles d and self-care [23].

Social Work has gone from models of charity, charity and altruism to models of diagnosis, intervention, participation, management and co-responsibility according to health policies and targeted programs. In that sense, the models used allow the work of dermatological health promotion and the dissemination of innovations aimed at the prevention of diseases in the groups that are harmed. In the case of an epidemic, the Social Work intervention stands out for its capacity to spread contagion, promotion of healthy lifestyles free of contamination and self-care strategies. These are devices in which the social worker generates information that counteracts beliefs about the spread of diseases such as parasites [24].

However, the contributions of exponential function models, logistic, predator-prey and disease propagation can contribute to build an intervention focused on multiple factors, with emphasis on the pattern of infection and adherence to treatment, but especially the propensity to prevention through the influence of risk-free groups and self-care lifestyles. In this sense, community social work, focused on the profile of leaders and their influence on groups, is fundamental for the task of health promotion and self-care, but above all in the dissemination of risk-free values and standards [25].

However, the contribution of Social Work, an intern, multi and transdisciplinary dialogue with other areas and disciplines of knowledge is necessary to locate the efficiency, effectiveness and effectiveness of Social Work in the prevention of diseases and the attention to cases of contagion or potential propagation. Even as a health discipline, Social Work is called to establish areas of opportunity and collaborative networks based on professional training with negotiation, mediation, conciliation and arbitration competencies [26].

From the exponential, logistic models, predator-prey and spread of diseases can propose a comprehensive model that dependency relationships between infected groups, potential groups to infection, care groups, potential groups re-coinage and groups are specified that develop new styles of prevention and self-care. In this scenario, the intervention of social work would not only be for the promotion of health free of infection, but also the dissemination of lifestyles of self-care and cooperation in the prevention of disease. It is a collective health process in which the objective is the avoidance of a new outbreak, or the reduction to its minimum expression [27].

The formalization of mathematical models for the study of the governance of dermatological health in vulnerable groups involves a discussion about the scope and limits of the models in order to demonstrate their usefulness in decision-making, the establishment of programs of prevention and dissemination of self-care styles. Studies of community health show that, within the framework of co-management, educational training and professional training are consecutive phases of commitment and social responsibility with the problem rather than with the institution and with users of the public health service [28].

However, the limits of occupational community health in the adoption of models focused on the balance of external demands and organizational resources, lie in the self-management capacities rather than in the conciliation of interests between authorities and users. In this sense, the construction of a community health model involves the testing of local needs with respect to civil protection policies. From both models, it is possible to notice that community health depends on the stress and risks perceived by political and civil actors [29].

Public health, within the framework of the governance of local development, is indicated by the degree of resilience between civil and political actors regarding the establishment of funds that involve co-management, but which are determined by the policies of business promotion and health. Occupational in the prevention of diseases and accidents derived from risk activities. Although co-responsibility between political and civil actors is necessary to achieve community health, on a symbolic level, representations of youth

and representations of old age that define resilience and coping with epidemics prevail as an act of local identity more than as a construction of social needs and expectations [30].

This means that community health includes two dimensions related to governance and local traditions, norms and values. Although citizens build a representation of health based on the differences of generations and their capacities to respond to an epidemic, it is also true that these responses are agglomerated around the expectations of future governors. If public health and community health derive from the state institutionalist power of management and administration of the health service, then before the corruption represented by the authorities, civil society has built an influence that guides risky behaviors and resilient lifestyles. In such a framework of state management and civil self-management, community health is reduced to the interference of policies in daily life and civil evaluation in the performance of its officials [31].

It is an influence of self-management of community health supported socially by two types of beliefs related to abandonment and accompaniment. To the extent that patients or potential victims of epidemics build beliefs of loneliness, their expectations of treatment are limited to specialized and immediate attention, but if their beliefs revolve around accompaniment, then their expectations and quality of life will be determined by the support of family, friends or colleagues [31].

However, the essential factor for the study of community self-management lies in resistance rather than in empathy or commitment, as is the case of urban public health models. It is a shared management, but focused on cooperative and solidary civil society in the face of the tragedy caused by the loss of collective health due to an epidemic. If civil health self-management depends on its relations of influence rather than on its alliances with the state's institutional power, then health policies seem to distance themselves from strategies centered on the individual, such as self-care styles or free behaviors. Risks although responsibility in such a scenario would be the starting point to achieve community health, after having obtained the bi - being and subjective and collective quality of life required [32].

In a few words, studies of community health highlight the asymmetries between governors and the governed with respect to the prevention and care of public services, although the proximity of the state management system to local needs seems to demonstrate a social construction of diseases in function of the ages, as well as the uses and customs. Community health, as indicated by community resilience and the institutional stewardship disseminated in the media, implies an emotional process from which information is processed and applied to collective and governmental actions. Based on these affectivities, the performance of officials, care programs and prevention strategies are evaluated [33].

Method

A documentary work was carried out with an intentional selection of sources indexed to national repositories, considering the year of publication and the inclusion of concepts such as "community health", "care models" and "self-management studies". Additional research lines of identity are seen, an essential factor of the literature consulted.

For this purpose a documentary, cross-sectional and exploratory study was carried out with a non-probabilistic selection of sources indexed to national repositories such as Dialnet, Latindex , Publindex, Redalyc and Scielo , considering the year of publication from 2000 to 2019, as well as the inclusion of concepts such as: "community health", "governance" and "network". Based on the Delphi technique, which consists in comparing and integrating information, a content analysis and data agenda were carried out in a matrix. Based on this distinction, the objective of this paper is to discuss theoretical frameworks, models of care and studies related to community health.

A non-experimental, cross-sectional and correlational study was carried out with a non-probabilistic selection of 107 students, considering their participation in social service programs and community practices in central Mexico.

The inventory of collaborative networks (IRC-21) was used, which includes three dimensions related to trust networks, commitment

networks and support networks. It is an instrument made up of the Community Sense Scale (ESC-32) and the Social Capital Scale (ECS-24). It includes 21 assertions and questions about trust, commitment and support. Each item is answered with one of five options (see annex).

The confidentiality and anonymity of the answers of the respondents was guaranteed in writing, as well as the non-involvement of the results of the study with their academic status. The information was processed in the statistical analysis package for social sciences (SPSS version 24.0). The parameters of mean, standard deviation, kurtosis, asymmetry, reliability and factorial weight were estimated in order to be able to validate the instrument.

A second non-experimental, cross-sectional and correlational study with a non-probabilistic selection of 101 users of community health centers was carried out with the purpose of confirming the factorial structure, considering a factorial analysis of principal components with varimax rotation and the estimation of the parameters of fit and residual of the structural model.

Results

Table 1 shows the parameters used to demonstrate the validity of the instrument, which shows that they exceed the minimum standards required and essential to observe the normal distribution, internal consistency and the convergence of indicators in preponderant factors.

R	*M*	*S*	*K*	*A*	*F1*	*F2*	*F3*
r1	4,31	1,03	1,92	0,721	0,439		
r2	4,39	1,82	1,40	0,783	0,328		
r3	4,67	1,43	1,54	0,752	0,549		
r4	4,83	1,56	1,67	0,763	0,672		
r5	4,02	1,49	1,49	0,751	0,540		
r6	3,62	1,23	1,30	0,704	0,516		
r7	4,37	1,41	1,26	0,762	0,437		
r8	4,37	1,46	1,47	0,773	0,540		
r9	4,82	1,30	1,52	0,793		0,641	
r10	4,36	1,85	1,69	0,762		0,673	
r11	4,51	1,78	1,56	0,761		0,548	
r12	4,46	1,65	1,40	0,704		0,619	
r13	4,02	1,40	1,72	0,793		0,650	
r14	4,37	1,67	1,58	0,676		0,693	
r15	4,63	1,70	1,40	0,751		0,540	
r16	4,13	1,84	1,53	0,783		0,532	
r17	4,24	1,36	1,67	0,794			0,673
r18	4,31	1,42	1,57	0,706			0,549
r19	4,30	1,56	1,23	0,762			0,672
r20	4,65	1,94	1,43	0,793			0,504
r21	4,83	1,50	1,40	0,761			0,665
r22	4,31	1,32	1,31	0,752			0,540
r23	4,25	1,25	1,54	0,793			0,659
r24	4,60	1,57	1,58	0,754			0,497

R = Reactive, M = Mean, S = Standard Deviation, K = Kurtosis, A = Alpha excluded values item. Adecuation and Sphericity [$\chi 2 = 32$,45 (23df) p < 0,5; KMO = 0,549] F1 = Confidence (15% of the total variance explained, F2 = Commitment (11% of the total variance explained), F3 = Support (7% of the total variance explained).

Source: Elaborated with data study.

Table 1: Instrument descriptions.

Once the three factors that explained 33% of the total variance were established, we proceeded to estimate the relationship structures between the factors in order to observe their trajectories with respect to the indicators (see Table 2).

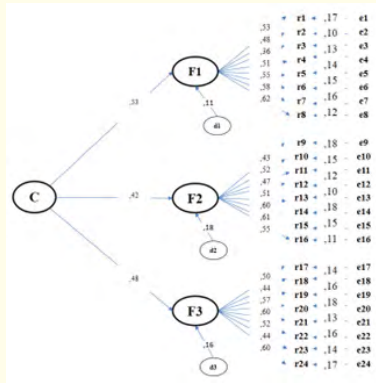
	M	***S***	***F1***	***F2***	***F3***	***F1***	***F2***	***F3***
F1	24,35	15,49	1,000	0,548***	0,542**	1,893	0,548	0,631
F2	25,47	14,37		1,000	0,549*		1,782	‘0,672
F3	29,57	14,32			1,000			1,843

M = Mean, S = Standar Deviation, F1 = Confidense, F2 = Commitment, F3 = Support. * p < ,01; ** p < ,001; *** p < , 0001.

Source: Elaborated with data study.

Table 2: Correlations and Covariations.

The structure of relations reveals values close to unity that suggest the dependence between factors and the incipient emergence of a second order factor common to the three first order factors. In order to observe the trajectories among the factors to be able to show the construct of community health networks, we proceeded to estimate a model of structural equations of trajectories and reflective relationships (see Figure 1).



F1 = Confidence, F2 = Commitment, F3 = Support: R = Reactive, d = Disturbance, e = Error: ← relations between disturbance or error and factor or indicator; → relations between factors and indicators.

Figure 1: Structural equation modelling.

The structure of trajectories of relationships between the factors evidences the emergence of a second-order factor that the literature identifies as community health networks and that the adjustment and residual parameters [$\chi^2 = 23, 12$ (21df) p > 0,5; GFI = 0,990; GFI = 0,997; RMSEA = 0,007] suggest that it is considered as the non-rejection of the null hypothesis relative to significant differences between the theoretical relations with respect to the findings of the studies.

Discussion

The contribution of this work to the state of the question lies in the discussion around community health, but the intentional selection of information sources and processing technique limit the debate to a local rather than regional or multilateral context. It is recommended to extend the search for information in international repositories such as Copernicus, EBSCO, Scopus and WoS in order to refiner processing through text mining.

Well, the contribution of the discussion centered on an agenda related to the governing State, as well as resilient citizenship, is a) the emergence of civil defenselessness before the institutionalist power of the health service and b) the advent of conflicts between authorities and users for the exclusion of one or the other in the state management and civil self-management [34]. In such a scheme is that it will be relevant to contrast the theoretical premises and models of community health as an instrument of state power and community influence, both focused more on care than prevention, which involves the construction of a co-management.

The sociopolitical identity as a determining factor in state management, civil self-management and co-management seems to obviate the fact that community health is exempt from the effects of climate change on public health: availability of resources, environmental contingencies, natural disasters, ecological catastrophes and atmospheric crises [35]. In the same way, the sociopolitical identity as a capacity for negotiation, conciliation and shared responsibility is sufficient to face the risks and threats of the environment in the face of the capacities of state institutions and organizations.

In the same sense resilience is only a result of sociopolitical identity and also sufficient to establish a local agenda about local problems and endogenous opportunities without assuming that it is more a symptom of despair before the impossibility of agreement between the political and civil actors [36]. In all three approaches, the sociopolitical identity has explained the asymmetries between governments and citizens, but does not integrate state management with community self-management in situations of environmental crisis, scarcity of resources and shortages of public services. In addition, they seem to ignore that socio-political emotions are sufficient to explain and guide collective action directed towards self-government, self-defense and self-management in matters of community health and local development.

In contrast, the present discussion highlights the exclusion of the actors around the systems of state management or civil self-management. From this differentiation it will be possible to anticipate scenarios of cooperation and solidarity in the prevention of diseases and accidents that may extend to the eradication of problems such as epidemics or pandemics without forgetting that the effects of climate change are emerging. Therefore, it is necessary to include in the discussion on community health the theoretical, conceptual and empirical frameworks related to the effects of climate change on environmental public health and community health with emphasis on occupational health, the main indicator of quality of life, subjective well-being and representation of health.

Conclusion

The aim of the present work was to confirm the factorial structure that exploratory studies had established and conceptualized as public health networks to explain the order and process in which three factors related to trust, commitment and support converge in a situation contingent of risks.

Therefore, the contribution of this work to the state of the matter lies in the establishment of a model for the study of the phenomenon, considering the validity of an instrument that was corroborated in a subsequent investigation and whose parameters seem to indicate that it fits the relationships established theoretical.

However, in the process of falsifying the theory of community health networks, it is essential to contrast the model in other different and similar scenarios in order to construct a meta-analysis of assumptions, instruments and parameters in order to establish retrospective and prospectively the conditions in which the phenomenon affects public health.

A line of research that has been developed from theories, models and established variables has been that of community health networks that explain the cognitive responses of public service user sectors in the face of contingencies such as shortage of resources, stockout, unsanitary conditions and shortages of medicines or treatments of diseases and accidents, mainly in the occupational field.

The construction of public policies guided by community health networks involves the construction of a public agenda in which the axes and topics of discussion are distinguished and focus on the factors established in this study.

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