American Journal of Public Health Research, 2017, Vol. 5, No. 6, 174-180
Available online at http://pubs.sciepub.com/ajphr/5/6/2

DOI:10.12691/ajphr-5-6-2

Co-responsibility and Intercultural in Public Health

Cortés Ascencio Sandra Yazmín[1], Jesús Carlos Ruvalcaba Ledezma[2,*], Avila Domínguez Rosangela[3], Torres Guevara Rosa Silvana[3], Calderón Rodríguez Nelly Patricia[3], Pérez Torres Lucia Vanessa[3], Barragán López Norma[3], Cobián Díaz Mariela Lizbeth[4], Reynoso Vázquez Josefina[5]

[1]Departamento de Ciencias Biológicas y Ambientales. Licenciatura en Promoción y Educación para la Salud [UNADM-SEP], Universidad Abierta y a Distancia de México-Secretaría de Educación Pública
[2]Área académica de Medicina, Departamento de Salud Pública. Maestría en Salud Pública [ICSa-UAEH]
[3]Estudiantes de la Maestría en Salud Pública [ICSa-UAEH] Instituto de Ciencias de la Salud-Universidad Autónoma del Estado de Hidalgo, México
[4]Cirujano Dentista, [U de G] Universidad de Guadalajara, Jalisco, México
[5]Área Académica de Farmacia y Departamento de Salud Pública [ICSa-UAEH]
*Corresponding author: dcspjcarlos@gmail.com

Abstract The low impact of promising and promoted in Mexican territory, national policy requires responsibility between citizens and government truly committed, both for the common good, the needs of both parties should merge not under requirements of a few, or political interests, the poor design strategies established only in theory, not correspond to the operational part that requires our population, this derivative of planning on the desktop without knowing the socio-environmental context. **Aim:** Promote the dissemination of the theory of co-responsibility and intercultural public health, educational strategies. **Methodology:** Systematic review and critical analysis that seeks to analyze the state of the art regarding co-responsibility, education and multiculturalism. **Results:** The approach to vulnerable communities, to detect the real needs of these, also this analysis reflects how people live and act according to their culture and conditions that warrant an exercise of co-responsibility where they look positively change the cultural influence from the development and implementation of the theory of responsibility in public health, considering valuable multiculturalism in designing strategies designed according to the real needs of the community, this individually and / or collectively and even nationally. **Conclusion.** The theory of co-responsibility and intercultural applied to the socio-environmental context and real needs set is a necessity, it must be a commitment to community and authorities to achieve the common good, if a change is generated in attention then the quality of health services is doomed to failure.

Keywords: *co-responsibility and multiculturalism, citizen-government, education for the common good*

Cite This Article: Cortés Ascencio Sandra Yazmín, Jesús Carlos Ruvalcaba Ledezma, Avila Domínguez Rosangela, Torres Guevara Rosa Silvana, Calderón Rodríguez Nelly Patricia, Pérez Torres Lucia Vanessa, Barragán López Norma, Cobián Díaz Mariela Lizbeth, and Reynoso Vázquez Josefina, "Co-responsibility and Intercultural in Public Health." *American Journal of Public Health Research*, vol. 5, no. 6 (2017): 174-180. doi: 10.12691/ajphr-5-6-2.

1. Introduction

The participation of the community in the preservation or improvement of their state of health implies a constant exercise of co-responsibility and consideration of the impact on the cultural exchange, that is to say, that both the population and the authorities assume a commitment to reestablish the social welfare in health [1].

Sometimes the government promotes services or proposals to mitigate damages to public health, but the community does not participate as much as would be expected; hence, to study the factors that determine co-responsibility would result in multiple benefits not only for the immediate users, but also for those who provide health services and even for the State, as far as economic investment is concerned. The challenge is to explore in depth the "cut-off point" of the effectiveness of programs generated by the government and the use of health services by users, which will make it possible to demonstrate the transcendent application of a theoretical model designed from of a methodology that proposes to make citizen-government co-responsibility in health services effective [1].

The participation of people in health care, coupled with the participation of the authorities, make co-responsibility, a transcendent space of mutual participation and accessibility in which the community is integrated into the concern for its own state of health, and the participation of both parts becomes evident 1. Under the experience in fieldwork carried out in the Sierra Sur of Oaxaca, the theory of co-responsibility and interculturality in public health arises, where some of its fundamental principles are:

Authorities and society in mutual commitment for health. "Congruent programs for favorable results"

In Mexico, government programs designed to promote healthy lifestyles, offer quality health care and limit health

damage have not shown the desired effectiveness, since active community participation is not observed, hence the importance of co-responsibility that considers interculturality in the exercise of public health care is the mutual commitment and equitable participation citizen-government [1], since it is the citizenship who gave the government the authority that now carries, therefore has acquired the obligation to respond for "the use it has made of it and the results it has obtained" [2]. At the same time it is a civic commitment of the citizens to "receive public services, evaluate the quality of them and ..." carry out the debate, the deliberation and the solution of public problems, "[3] that is, to make full use of their rights for the common welfare.

The programs and policies contain, in essence, the noble purpose of giving attention and solution to the Public Health problems currently facing our country, and it is the State that provides the infrastructure, human and financial resources to carry them out, in reality, the policies implemented are not contextualized geographically, socially and culturally, so when evaluating the achievements, they may well be written down but not reflected in the well-being of the target population. Incompatibility between the scenario and the organization, coupled with the "inability to convert good models into practical achievements, the use of non-participatory methods in the design of services and the lack of a comprehensive and integrative approach in their conception. A common problem is the inconsistency of health policies and the practical application, derived from a null communication exercise that considers culture for decision making. Many politicians prefer social investments promoted by large newspaper headlines, for example, a hospital with ultimate technology or a center for transplant surgery, to the detriment of advocacy and prevention actions whose impacts would not be noticed within their government, but affect significantly larger or even vulnerable and unprotected segments of the population."[2].

The role of the population in the care of their own health is indisputable [2]. "The initial purpose of the Primary Health Care (PHC) strategy was that the people of the world by the year 2000 reached a level of health that allowed them to develop an economically productive social life. Two of its basic principles were to achieve accessibility and universal coverage in health and commitment, participation and self-sustainability of individuals and communities ... For these postulates to become reality, policies, resources and wills of citizens and governments must converge." [4].

It is important to point out that when strategies for public health policies are to achieve their goal in the Mexican population, education strategies must be given more prominence. For many years, the government represented by the health services has been responsible for providing information to its users, forgetting that informing is not educating and this is clear proof of the same health personnel, that although is the sector of the population is better informed on this issue, it does not adopt a healthy lifestyle as it intends to promote, hence , if we want these strategies to be successful before formulating them we must answer three questions: ¿what socio-cultural environment prevails? ¿To whom are they addressed? and ¿who will apply them? [5].

If we ask who is addressed the messages and practices of health education we must consider the geographical characteristics in which the population has developed, their origin and changes over time, their language, their sense of belonging, their identity, customs, religion and culture, to know their worldview, to do it we must be among them, to live in the locality, to live with the different age groups, to ask, to investigate, to listen, to never see them as minorities who, over time, will have to adapt and educate themselves for their benefit, through these considerations can be applied dialectical constructivism [5] and thus educate the community peers, that is why the approach to who will implement educational strategies, issues the answer that it is the same population who will, led by the health personnel, who must be a team of professionals, knowledgeable and respectful of the community cosmovision, sensitive to the problem in health characteristic of the locality, of high human quality, promoting the health and the development of competences, through an intercultural environment to be evaluated efficiently [1,6].

The educational strategies are based on the communication process, which is determined by the culture we acquire, that is where we find the term Interculturality, defined as: "the process of communication and interaction between people and groups where one cultural group is not allowed to stand above the other, favoring at all times the integration and coexistence between cultures "[7], is not limited to the rural/urban area, which is either an example of its application [8], nor is it a controversial concept that only repeats itself because it is fashionable, is rather a proposal for dialogue and negotiation in which the health professional shows respect and acceptance of the cultural identity of the people who, rather than giving a service, wants to generate positive change in favor of their individual health that will have collective transcendence if educational processes are developed respectful of the multicultural diversity in which we live [2].

"Interculturality must be understood as a political, social, epistemic and ethical project aimed at structural and socio-historical transformation, based on the construction among all of a radically different society. A transformation and construction that do not remain in the statement, the speech or the pure imagination; on the contrary, they require action at every social, political, educational and human level" [9].

Interculturality in health emerges as a process of approach between medical systems [10]. It generates a culture of shared solidarity, mutual support and close collaboration. This is what has also been experienced in the very center where this experience has been developed. An experience that condenses the capacity of a human group, an educational community when embarking on a common project and shared since its inception. Not designed by others, nor imposed "from above," but a process of change arising from one's own desire and need before a challenge to be faced: how to educate a society like the present before the urgency of an educational reform ?. A slow and progressive strategy of change, but in a common and shared direction [11].

A participatory character of the community involvement: among the participants in the research is created as a situation of active interaction, dialogue and negotiation.

And not only for the participation of the different sectors, but also to take into account that all the people involved are seen as equals, since they do not seek the "truth", but to know the perspective of the others. It is a type of evaluative research that seeks to serve the social groups and communities. Obviously, participation in the evaluative research process requires preparation and follow-up [11].

The authors note that the implementation of co-responsibility and interculturality represents a challenge that consists in exploring the effectiveness of the programs generated by the government and the use of the health services by the users with a theoretical model (with a new methodology) to make citizen - government co-responsibility for health services [1], immersed in specific cultural environments, for which it must be taken into account if the projects and programs that are created are specific to the needs of the particular population to the contrary there will be no real interest and quality in the delivery of the health service in that population. At the same time, an important point to generate co-responsibility necessarily has to be participation of the community and authorities or government where the main idea is the integration of the community and generate a common good that is the state of health resulting in accessibility, which would later probably lead to integration in public health.

On the other hand, public policies and programs seek to improve the health system in the world and that the population has universal access, equity, quality and justice in financing. Mexico is in a prolonged, uneven and complex epidemiological transition with respect to: patterns of disease, disability, death, infections, malnutrition, non-communicable diseases, mental disorders among others [12]. These topics become a priority in research and in search of evidence to create regional programs adapted to the real needs of each population [1]. Congruent programs should be created interculturally to obtain favorable results where co-responsibility is taken as a preventive factor, if the duality of citizenship and government is achieved, by seeking to reduce the risk to population health, which in turn will favor in the cost and effectiveness of public health programs. This requires a social and cultural revaluation [13] considering: specific characteristics of the population, public policies on health, design strategies taking into account culture, habits, customs to allow to acquire healthy behaviors on a permanent basis and in turn individual health care for that transcends the collective.

The problem lies in the decisive point where the implementation of a program is not effective for a community because it does not generate change or impact and there is no agreement with what the government implements and the needs of the community, since there is no dialogue that provides the sociocultural knowledge of what the community really needs. It is thus that the result of the problematic associated with the true reality that afflicts a community affects the result of an applied program. For change to occur, community health practices and public health programs need to be reoriented through a mutual commitment between government and community that results in a commitment to national social health.

Nowadays, education as an engine of development and as a construction of one's own health, using specific health strategies with a socio-constructivist approach, seeks to be a triggering mechanism for learning and generating healthy behaviors, based on the didactic critique of what has been learned and the daily to bring about permanent behavior changes in the community through workshops, visual messages, play activities in order to generate habits and skills in search of solutions; a teaching - learning process [14].

For the foundation of community strategies is used constructivism being this a psychological and philosophical position where individuals build much of what they learn and understand, in turn generates that the participants are active, build knowledge, values, perception of self and others [2].

Dialectical constructivism is the knowledge that is constructed from the interactions of individuals in their environment through exogenous and endogenous constructivism; the exogenous constructivism is the reconstruction of the external world this reflects the reality and allows to determine how they perceive structures of knowledge in each area. While endogenous constructivism, are the mental structures that come from previous ones and the knowledge is developed by virtue of the cognitive activity of the abstraction and allows to explore the way in which they progress from initial levels to higher grades [2,5,15]. Constructivism maintains that it is constructed as it is known through certain cognitive structures of our tangible reality, our experience derives our knowledge [15].

Learning is internalized when practices that generate impact on the person are carried out. This is where health projects should be guided in the search for the welfare of the community, through workshops or activities that they can make a daily reality, constant awareness, so that the practices in health are of impact in the community and in turn give the responsibility. The education of health personnel as well as government and community entities is essential if the programs or projects that are believed to have viability and impact in each population without them are very likely to generate no beneficial changes in the communities.

"Co-responsibility and interculturality in the field of health must become the axis of public health, however the community's conscience still does not exceed the expectations of the government and much less of workers in the field of health"

2. Discussion

The application of health programs with strategies in the prevention of many diseases, or to improve the style and quality of life, have been in the air due to the poor application of the community, since many users are responsible for making only temporary changes and not definitive that would generate a greater impact on their individual health, and therefore on population health [1].

The commitment that comes from medical care must match the claimant's commitment to the care of his health. The government today has shown favorable and ambitious changes in the health system, however implementation is impoverished and retrograde whenever the population does not apply the pertinent care to improve collective health in all its spheres.

One of the limitations of the users corresponds to education, access and high demand to the health service, while a limitation that involves the government, is precisely the destination of financial resources, which affects in large proportion zones which should be further covered by the presence of determinants and conditioning factors leading to "poor health".

Understanding that access to health is a current need for the Mexican population has led to the extension of health programs and changes in public policies, since efficiency and effectiveness will be determined in high percentage by the user. The generation of programs applicable to the community according to their needs should be assessed by delimiting the zones congruently. Low education or no education, language, demand to health services with their respective human resources and adequate infrastructure, as well as access to them, have generated a stagnation of health, or the preventive model in our country [5].

It is important that people become aware of the present, study the past and value the future, as there are very interesting sociodemographic changes in our country due to the epidemiological transition of our population pyramid, which has an impact not only on the social, but at the government level, implying higher costs but greater benefits. It is incredible to note that our population dies, mostly, for preventable causes and that programs associated with prevention and those that seek true public health are limited by simple changes in human behavior. The human being at present, is forced to the greater study of public health, to change the concept that we have regarding individual and collective health, as well as social welfare, that implies congruent quality and life style.

The collective consciousness will make sense once the community understands the human synergy that must exist in the population and health binomial. Therefore, let us understand that health is a co-responsibility that involves great changes of consciousness and obviously in the application of these. Population health will benefit greatly despite the cultural, social and demographic conditions that each area has.

- Public health education is a major challenge today in Mexico. The educational strategies in health have been directed to the improvement of the health conditions from the point of view methodological and application. The design of strategies reinforce public health, as long as the population optimizes both human resources and infrastructure in the community health ambit [5].
- The expectations are broad after seeking improvement in the quality of health, so it broadly links the population's perception of health. The reality in which public health develops in Mexico has been changed multiple times by the demand of health services in addition to the imperative need of users for quality care. The population itself is an important target for generating community welfare with an impact on population health throughout the country. Educational strategies give health promotion a new approach, qualitatively superior to the traditional one of public health, and in this it involves governments, social organizations and individuals, in the social construction of health [2].
- In order to generate innovative educational strategies, it is necessary to take into account that the behaviors of individuals are generated under the influence of many interrelated situations that are inevitable, and demand, to live giving immediate answers, with their body and their environment. These responses are necessarily modulated by motivation and knowledge.
- This gives the pattern to innovate in the way in which information is provided making people take action, since content appropriation is not sufficient, to change behaviors; individuals have to be involved in action, this implies a permanent revaluation, with readaptation and recreation of what is appropriate to other particular situations, guiding human activity for the desired ends, within the framework of the elementary technical-scientific principles of the Health. In addition, it is necessary to achieve a sense of belonging, because the changes of the behaviors are preserved, when people believe that these, are resulting from their own inner disposition and make sense for them. Conversely, the product of impositions made from the outside, will be little practiced.
- Therefore it is essential to generate strategies in education that lead individuals to have a greater appreciation of the risks that lead them to become aware that they can avoid them and according to this take new behaviors that later become protective habits for health .
- In what concludes the activities of health promotion imply the creation of educational strategies that allow the optimal psychological and psychophysiological development. These initiatives involve individuals in the process of achieving positive mental health, improving quality of life, and reducing the difference in health expectancy between countries and groups. It is an enabling process that is done with and for people [3].

Constructivism, the application of strategies by the same population, brings users' awareness to the care of their health, since they involve values, their own knowledge, as well as the development of skills and abilities to achieve healthy coexistence and in case to request, attention in case of any urgency.

A focus on reality in Public Health is merely adaptive. The individual and collective perspective determine the actions that will generate significant changes in the population.

The participation of the community is free, so "activism" in public health will always benefit from the diverse ideas that generate a reconstruction and therefore evolution in population health. Continuing education in

the area of health becomes the current axis to generate innovation in knowledge within community health. Knowledge must be developed according to the curiosity of the researcher, in this case of the population itself, which thanks to this have led us to generate new attitudes regarding education for public health. The transformation of health strategies for public health education are demanded by the government, since they generate important transitions that involve habits and customs of each region studied.

The impact of reformed ideas must generate a definitive change in self-care, reflecting a biopsychosocial well-being and harmonization between education and health.

Winslow's public health is the science and art of preventing disease, prolonging life, promoting health and physical and mental efficiency, through the organized effort of the community for: environmental sanitation, control of communicable diseases , the education of individuals in the principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of diseases, the development of social mechanisms that ensure all people a level of adequate life for the conservation of health, organizing these benefits in such a way that each individual is in a position to enjoy his natural right to health and longevity [16].

For a long time it has been thought that this is not related to the government, which is why a new term is incorporated: co-responsibility, which makes reference to the health care of the population, there is a need for active participation by part of the government and by the community, the first to create strategies that are applicable and the second to actively participate in these strategies.

Although this is very important to achieve a reduction in the presentation of the disease, there is a gap between the existence of programs and participation by the population. The question is why if the programs exist the population does not participate?

This is because some of the strategies being used are not applicable to all, are not understood, or are not given the importance they actually have because they do not understand its usefulness. The “Families in Action” program is an initiative of the National Government of Colombia and the Multilateral Banking to provide a nutrition subsidy to families with children under 7 years of age, and provide a school subsidy to children between 7 and 17 years old who belong to the poorest families. It aims to reduce the lack of attendance and desertion of primary and secondary school students, supplement the income of families with children under seven years of age in extreme poverty to increase spending on food, increase health care for children under seven years, improve child care practices in aspects such as health, nutrition, early stimulation and prevention of domestic violence [17]. And although its purpose is good, it does not cover the real need of the population, the majority of the population in Colombia is poor, since there is a Gini index (where 0 is total equality and 1, absolute inequality) of 0.539, and in 2014 of 0.538 [18]. However, the majority live with a minimum salary of $ 689,454 Colombian pesos, which almost does not even meet the basic needs and those who have work, because those who do not, suffer a more precarious situation , in which if they receive this subsidy they will not use it to go to the doctor, or to send their children to school, they are going to use it to make the market, or to pay the rent that at the moment are things of higher priority. The programs are not explained to the community, this same program Families in Action tells the mother head of household that they have children under 5 who will receive the subsidy if they take the children to the control of growth and development and effectively they do because they need to receive the money, but during the control they do not pay attention to the observations made by the health team. When it would be appropriate for the health secretary to hire the appropriate staff to address vulnerable populations and through community diagnoses educate mothers primarily on the benefits of bringing children under 5 years of age to their growth controls and development, so that they become aware of why they should do so and also transmit this to other mothers of families.

Since government-created programs must be based on the true needs of the population, innovative strategies should be sought that will lead people to take ownership of their health status, that they know the importance of taking care to prevent disease in order to get better quality of life and to participate actively and consciously.

In conclusion, the best way to apply co-responsibility is for the government to detect the true needs of its population and to provide education for development. Generating behavioral changes in people to prevent disease development or complications is often difficult because each who acts according to their way of thinking (which is influenced by multiple factors: culture [19], family education, personal beliefs), because of this the importance of using the appropriate strategies in each population.

For which it is essential to know the difference between teaching and educating since they are words that, although they can be known as similar are not, they have different meanings, but they complement each other. Teaching is related to instructing, illustrating, illuminating, indicating, exposing something so that it is known, while educating on its part means driving, guiding, directing towards an ideal [20].

"Sit", "keep silent and listen", "they will make a copy and momorize dates and names". Who does not remember those famous phrases of the professors, my contemporaries and previous ones will understand and remember without needing of greater detail to which I am referring. The traditional model of education in Mexico that has remained for so long is what I mean, obeyed the supposed rules of a pattern: the teacher in front of the group made a speech in which the students lacked of initiative strategies, self-thinking and opinion based on experimental, search and inquiry foundations that will foment the close inquiry of responses to everything around us.

Over time, various national strategies and policies have presumed in their objectives to be competent and promising, however, the reality under which the Mexican territory lives is another. The transcendence of the existence of man, the environment in which he has developed and the millions of circumstances that have taken place, have set the guidelines for the individual to achieve his adaptation to the world around him. But it seems that despite current modernity, certain scenarios

remain impassive, man has been self-condemned to repeat his story over and over, that is, he has not learned from it. The Role of the community (the individuals immersed in a society) and the authorities (the government), should make fusion for the common good; it would be appropriate to consider co-responsibility as a value of society to actively participate in the promotion of services, proposals and the realization of accurate diagnoses that seek innovation in policies and programs that cease to be social experiments [1].

The epidemiological transition has led to the mutation of morbidity and mortality of infectious diseases by chronic diseases. However, it should be mentioned that, in addition to the policies and their lack of coordination with social security institutions, individuals have also failed to land on its reality. We live surrounded by pathological food, health, visual, auditory, ecological and educational environments of which, unfortunately, we have become suitable actors and the best vulnerable targets on welfare issues.

Now, it would seem that the reader could get lost in my lines, ¿what was first, the egg or the hen?, and is that the same, I wonder right now. Education, as a way of measuring the degree of development of a country, indicates the situation of its population, the teaching-learning process in Mexico is still the traditional model that asks the students to witness monologues of a supposed leader, nowadays our children and young people do not want to think, they only obey orders that are imposed on them and they are annoyed by the fact that they are forced to have someone demand more of what they can give, or rather the fact that no one ever told them they could achieve , "Involving health professionals as actors-generators of a pedagogical relationship with their consultants, oriented towards the learning of an attitude of self-care and preventive health, based on human development" [4].

The true learning that generates healthy behaviors of all kinds, alludes to the real needs of real populations, the individual should build after what he lives, he observes and is lacking, perfecting with it his abilities and knowledge, interacting with his surroundings when breaking with that passive scheme that has been implanted mentally and unconsciously. Learning is an action of self-reflection, of thought and culture, as mentioned in its publication Cortés and Ruvalcaba, 2011 [5]; "If I do it, I learn it" [14], reflecting lifestyles that demand positive behavioral changes.

At present it seems that we live under the same template, for although we enjoy the bizarre superiority of having instruments, technology and knowledge of the various scientific areas and empirical cultures, our societies allow, with all their advances and multiple and infinite wealth, which, from my crude opinion, would consider as the spheres of the poor human factor. The first one represents the governments of developing countries, with poor distribution of goods and services in countries such as ours, with money in the air and captured at the hands of individualistic political interests. The second, education, which without stopping scientific or technological advances, prevents higher and rising thinking is able to thrive. It is worth mentioning the opposition of some political authorities that block valuable public health campaigns.

The threat to public health continues to have its red focus in rural areas and unfortunately the most affected are vulnerable populations in the face of biases with secondary interests. My purpose is not to make a devastating criticism of the context, if not to highlight the generality of the flaws with which we continue to run into the XXI century. Health must be defended by the actions of the government and organized society [1] in the case of Mexico, such actions are still in an apparent state of hibernation of multiple causes.

The failures of the Mexican health system, on the other hand, should not be considered as a complete failure, but should be taken as wasted opportunities from which valuable reforms could be extracted to release the unfinished agendas mentioned in their publication by Cortés and Ruvalcaba, (2011) [1]. This allows us to act as an area of opportunity to truly work in a model that generates the option of achieving the common benefit and not fall into verbalism as the term universalization of health services, that is, it is initially required to integrate the system of Mexican health and subsequently with a change in form and substance to establish the reforms to the health system, where individual attention is achieved in an integral way in regards to their health problems, since the popular insurance does not fully cover the care in health and from there you cannot talk about the universalization of health services, moreover, we would have to speak of Integration of the Mexican health system.

3. Conclusions

For equitable health co-responsibility, together with government-generated policies, successful educational strategies should be formulated, such as dialectical constructivism based on the concept of interculturality, which will enable health professionals to find matches that will facilitate communication of messages and practices that motivate the action of the population towards the adoption of healthy lifestyles, which will improve the individual quality of life and at the same time, it will be these same educated subjects who will promote health among their community peers.

Co-responsibility is a commitment of both the community and the authorities to restore the common welfare, that is, without participation of the two parties will not generate a change in the care and quality of health services.

The relationship between poverty and disease is an indelible framework between the health authority and the population, the incompatibility between health proposals and the reality of its inhabitants continues to generate conflicts of great impact; know our background to deduce our current situation, should be a strategy fully inclusive, employer of an accessible language that ensures information for all.

Health must be defended by the actions of government and organized society, in the case of Mexico, such actions are still in an apparent state of hibernation of multiple causes.

Acknowledgements

The authors are deeply grateful to **PROMEP** for the support for the publication of this article, since it represents a stimulus to generate knowledge and its transference with a scientific character.

The authors declare that there is no conflict of interest for the publication of this article.

References

[1] Cortes Ascencio, S. Y., Ruvalcaba Ledezma, J. C. La Corresponsabilidad en Salud Pública. *Revista Viva Salud, Gaceta Informativa del Instituto Nacional de Salud Pública*, 2011; 3(1): 40-43.

[2] Rojas, A., De la Cruz, E. La promoción de la Salud y la formación del docente en la Universidad Pedagógica Experimental Libertador . Instituto Pedagógico de Miranda José Manuel Siso Martínez The promotion of health and the training of teachers , in the University Pedagogical Exper. *Revista de Investigación.* 2012; 36 (76): 11-34.

[3] Bang, C. Estrategias comunitarias en promoción de salud mental: Construyendo una trama conceptual para el abordaje de problemáticas psicosociales complejas, Valparaíso. 2014; 13 (2). Disponible en: http://www.scielo.cl/scielo.php?script=sci_arttext&pid=S0718-69242014000200011

[4] Lillo, V. Salud y Educación: dos vocaciones al servicio de los derechos humanos. *Revista Médica Clínica Condes*. 2014; 25 (2): 357-362.

[5] Cortés Ascencio S. Y, Ruvalcaba Ledezma J. C. Estrategias de Educación para la Salud Pública. *Gaceta Informativa del Instituto Nacional de Salud Pública,* 2011; 3(4): 34-37.

[6] Mariñez, F. La dimensión relacional del gobierno abierto y el liderazgo colaborativo. *Espiral, Estudios sobre Estado y Sociedad.* 2016 Ene/Abr; XXIII (65): 47-87.

[7] Trejo E. G. Comunicación intercultural y culturas indígenas en México. En busca de elementos para generar identidades compartidas en educación. En: Pech S. C., Rizo G. M. coordinadores. Interculturalidad: miradas críticas. Barcelona, España: *Instituto de la comunicación*; 2014. p. 87-97.

[8] Hasen, F. N. Interculturalidad en salud: competencias en prácticas de salud con población indígena. *Ciencia y Enfermería*. 2012; XVIII (3): 17-24.

[9] Barrios, S, Masalán M. P., Paz. M. Educación en salud: en la búsqueda de metodologías innovadoras. *Ciencia y Enfermería.* 2011; XVII (1) 57-69.

[10] Ramírez, S. Salud, globalización e interculturalidad: una mirada antropológica a la situación de los pueblos indígenas de Sudamérica. *Ciência & Saúde Colectiva.* 2014; 19 (10): 4061-4069.

[11] Achig, D. Interculturalidad y Cosmovisión Andina. *Revista Médica HJCA*. 2015 Mar 1; 7 (1): 88-92.

[12] Omran AR. The epidemiologic transition: a theory of the epidemiology of population change. *Milbank Mem Fund Q* 1971; 49: 509-38.

[13] Espejo, JC. Educación, interculturalidad y ciudadanía. Educar em *Revista, Editora UFPR*. Curitiba, Brasil. 2012; (43): 239-254.

[14] Zarzar Charur C. *Habilidades para la Docencia*, Editorial Patria, 1996.

[15] Dale H. Shunk. *Constructivismo. Teorías del aprendizaje.* 2DA EDICION ED. Pearson prentice hall. pp. 208.

[16] Figueroa, S. (2016). *Introducción a la Salud Pública.* [online] Available at: https://saludpublicayepi.files.wordpress.com/2012/06/documento-3er-parcial-compilacion-4-documentos.pdf [Accessed 8 Aug. 2016].

[17] Anon, (2016). *Programa Familias en acción*. [online] Available at: http://siteresources.worldbank.org/SAFETYNETSANDTRANSFERS/Resources/281945-1131468287118/1876750-1140107387177/ColombiaCCT.pdf [Accessed 8 Aug. 2016].

[18] PEÑA, A. (2015). Si una persona recibe más de $211.807 mensuales ya supera la pobreza - Indicadores - El Tiempo. [online] *El Tiempo.* Available at: http://www.eltiempo.com/economia/indicadores/pobreza-y-desigualdad-en-colombia/15457376 [Accessed 8 Aug. 2016].

[19] Diéz, E.J. Investigación-acción: el cambio cultural con la implicación de los participantes. Revista electrónica universitaria de formación del profesorado. 2013 Oct 10; 16 (3): 115-138.

[20] Catholic.net. (2016). Enseñar, educar y formar: pasos para el proceso educativo. [online] Available at: http://es.catholic.net/op/articulos/43159/cat/29/ensenar-educar-y-formar-pasos-para-el-proceso-educativo.html [Accessed 8 Aug. 2016].