Primary health care and Latin American territories marked by violence*

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ABSTRACT

The present article aims at discussing the singularities of primary health care (PHC) in contexts where violence, strongly supported by guns, is routinely, chronically, and systemically present, and to gauge the capacity of PHC as empowerment channel for communities where armed violence is an expressive vulnerability. Based on the Declaration of Alma-Ata and on the PHC principles described by Barbara Starfield and focusing on community participation and social determinants of health, the discussion sets out from the realities observed in Latin America and the commitment to access and universal coverage set forth in the third Sustainable Development Goal. The qualitative and quantitative characterization of armed violence and its consequences must be qualified using an intersectoral approach with heavy community participation in search of coherent and significant responses. The protection and safety of health care workers must be ensured to guarantee the continuous provision of health care services in contexts of violence.

Keywords Primary health care; violence; social participation; health services accessibility.

Latin America is an extremely diverse territory, both geographically and culturally. However, its countries share marked social inequality and high levels of income concentration in the hands of an extremely small group, as well as public policies that are often insufficient or yield only intermittent results, thus hindering attempts at changing the situation (1). Poverty and scarcity of resources affects a large part of the population, producing and reproducing processes of serious social exclusion, such as access barriers to decent housing, sanitation, water and electrical power, food security (with dietary quality and variety), and health and education services (2, 3).

With increasingly rapid growth, megacities are highly representative of these problems. At the same time, rural settings, despite their unique characteristics, are not free from the dynamics or the consequences of inequality (4).

In addition to the fragility caused by significant social vulnerabilities, the presence of armed groups whose economies are based on illegal activities means that residents of many neighborhoods and even entire regions experience daily contact with armed violence. Depending on their characteristics, such groups are referred to as "gangs", "guerrillas", "factions", "maras", or "militias". In such settings, violence is exercised both actively and reactively as a way of controlling bodies, spaces, and practices, and violent acts are committed both by members of the aforementioned groups and by state actors, which are also part of this complex scenario (4). Widespread circulation of firearms in a territory facilitates their use as a means of intimidation, defense, or direct aggression, increasing population exposure to the risk of intentional or accidental injuries and death (2). Violence is also responsible for forced displacements, family separation, and restricted mobility for residents of affected areas (3, 5). In such contexts, access to health and education services may be hindered or prevented altogether, either directly (i.e., blocked roads or unsafe travel to facilities) (3, 6, 7), or indirectly (difficulty assigning professionals to these areas, or shortened working hours) (8).

To varying degrees, this is a reality in several regions of Brazil, Colombia,
El Salvador, Honduras, Mexico, and Peru, among other countries. Oftentimes, the media’s presentation of this reality is linked to reductionist responses that tend to increase human rights violations (9).

There is no consensus on the nomenclature used to describe this situation: some authors use the term “unconventional violence” to describe the “phenomenon of organized and unorganized violence in the hands of different actors, criminal and state, which gives rise to humanitarian consequences similar to those of an armed conflict” (3, page 6). This definition has been used by agencies of the United Nations system and by some nongovernmental organizations to discuss the issue from different angles, although it is not yet used in health-related debates. The International Committee of the Red Cross uses the term “other situations of violence” to refer to similar scenarios with well-defined circumstances (3). Other terms used—both within and beyond academia—include the more generic “armed violence” and “urban violence”. These will be used throughout this text to refer to settings where violence is strongly supported by the widespread use of firearms; is routinely, chronically, and systemically present; and has significant implications for the quality of life, mobility, and physical and mental integrity of residents.

This article discusses the singularities of primary health care (PHC) in contexts of armed violence and seeks to gauge the power of PHC as an empowerment channel for communities where such violence is an expressive vulnerability. Based on the Declaration of Alma-Ata (10) and on the PHC principles described by Barbara Starfield (11), and focusing on community participation and the social determinants of health, the discussion takes as its starting point the realities observed in various Latin American countries and the commitment set forth in Sustainable Development Goal 3, to “ensure healthy lives and promote wellbeing for all at all ages” (12). It should be noted that this paper will not address significant cross-cutting gender issues in depth, although they are an important dimension of the phenomenon of violence (13).

SINGULARITIES OF PHC IN THE CONTEXT OF ARMED VIOLENCE

PHC work is predicated on a comprehensive, longitudinal (person-focused rather than disease-focused care over time [14]) and participatory approach to the context of care. Thus, it is coherent that it should take into account the singularities of the territory, population, history, and relationships in each setting, so as to construct meaningful narratives of care, taking into account the voices and knowledge of all those present (14, 15).

As one of the cross-cutting elements of PHC, violence is a multidimensional phenomenon with complex causes and determinants. Understanding it is no easy task: violence is part of the social determinants of health and one of the elements that determine population access to care facilities. Extended reflection on the reality of affected communities is required, taking particular care not to overlook their potential vitality and resilience. An even more challenging task is to actually provide health care in territories marked by armed violence, where personal, community, and institutional relations are permeated by the consequences of violence.

The World Health Organization (WHO) defines violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (2, p. 1165). Regarding the typology of violence, WHO explicitly recognizes the categories “interpersonal violence”, “self-directed violence”, and “collective violence”, the latter practiced by organized groups (including nation-states) to achieve political, economic, or social goals.

One obstacle to identifying the problem of violence as a systemic phenomenon is reliance on categorizations and practices that prioritize the individual scope of each violent event. This hinders the search for answers more pertinent to the observed reality. The term “collective violence” does not fit the scenario of armed violence referred to in this article, since the lack of legal or political legitimacy for perpetrators of violence such as gangs or factions precludes their recognition from the standpoint of “organization”. Furthermore, official recognition of systematic acts of violence by certain actors, such as militias, has social and ideological implications, and such events may be disregarded by the authorities.

Likewise, the manner in which the situation is captured by health indicators makes it difficult to get beyond the individual dimension of violence. When taking a broader view of health policies, the characterization and typology of interpersonal or self-directed violence proposed by WHO is often used, supported by traditional epidemiological indicators such as homicide rates and the incidence of gunshot wounds. The use of these markers does not help distinguish between isolated acts of interpersonal violence and violence as a chronic practice of control, heavy-handed application of the law, or expression of power struggles. The complexity of collecting data to document and typify instances of physical violence, threats, and homicides means this issue is addressed in a fragmented manner, through specific efforts to address, for example, gender violence and sexual violence. Data on events considered to be “criminal”, and thus collected by law enforcement agencies, or even the debate on availability of firearms, for instance, are not widely discussed with health stakeholders. The need to formulate this issue as an element of public policy—the response to which also includes strengthening PHC, as envisaged in the Declaration of Alma-Ata—is jeopardized by the adoption of segmented, department-specific policies.

The article by Dahlberg and Krug (2) is mandatory reading on the subject of incorporating data on violence, its typology, and its characterization into public health policies. It provides an excellent analysis, although it does not focus on the specific PHC resources for analyzing the problem and developing responses. In 1994, Minayo (16) was already stressing the difficulty of describing violence in Brazil from a qualitative and quantitative standpoint.

In addition to the complexity of understanding the context of armed violence, another challenge is to go beyond the microdimensional space of clinical care for victims of violence and ensuring that the capture of each violent event by health providers follows a brief cycle, beginning with receipt of the patient’s complaint and ending with reporting the violent event, either in medical records or by sending the relevant information to be included in databases. Situation analyses and consequent structural, amplified responses to the dynamics of
violence require efforts for local interpretation of the information produced in these individual patient encounters. In addition, the bureaucratic process faced by those who have experienced a violent event removes the human perspective from health care and makes it difficult to coordinate the person-centered care that is so important to PHC (17).

Discussions in group and community spaces are a good way of understanding the impact of violence on territories, although a high degree of trust between the population and health professionals is required before experiences and impressions can be shared (7). There is no question that PHC is the best level of care for community participation in the design and implementation of health activities. Thus, it is of utmost importance for the population to speak as a peer in terms of identifying demands and understanding the context in which PHC activities will be carried out (15). Community engagement in spaces and practices can be a key element for the daily experience of violence to be openly considered, characterized, and integrated into health care, and for PHC interventions in each territory to be not only context-appropriate, but also transformative (18).

Given this transformative dimension, it bears stressing that the continuous presence of PHC in a territory over the long term and the bonds this creates, as well as the role of PHC as a gateway to the health system, means that primary care has great potential to offer a sustainable path toward health care in all settings, but especially in the most fragile ones. Macro-level policy safeguards that ensure equitable access to care, as well as the very personal and human security of seeing familiar faces when receiving care, makes PHC a path toward citizen empowerment for populations chronically affected by social exclusion and deprived of their rights.

In addition to the challenges of understanding the phenomenon of armed violence and integrating this context into their practice, providers face personal challenges working in these territories: exposure to violence-related hazards cannot be completely avoided and the protections afforded to health professionals as impartial care providers are not always respected by the actors involved (state-affiliated or others). One key aspect for preserving this impartiality is the importance of ensuring the confidentiality of information produced in PHC contexts, since the legal safeguards covering such information are fragile and not always respected.

Machado and Daher (8) and Polaro et al. (7) discuss, among other issues, the impact of urban violence on the work and well-being of PHC providers. The experience of psychologically impactful situations, attacks, threats, and coercion while working is an unfortunate reality that must be appropriately monitored and addressed.

To ensure people’s access to health care, it is imperative to move beyond practices and interventions and ensure that services are resilient within their settings. PHC venues should consider the safety of providers while simultaneously avoiding barriers between the population and health workers. Furthermore, the working hours of PHC facilities must strike a balance between minimizing the risk to providers’ safety and meeting the needs of the population. Long-term construction of this balance is necessary—and requires broad social mobilization and the support of the authorities—in order for PHC to develop efficiently and, indeed, to expand population access to care (3, 5).

A final (and perhaps even greater) challenge for PHC in settings of armed violence is to respond to the demands for care that arise from the community and from individuals, since many of the consequences of violence have relatively subtle clinical manifestations, such as high blood pressure or panic attacks. One must also consider the secondary victims of violence: those who did not suffer the actual event but were impacted through their direct social network, such as the relatives of murdered or disappeared persons. Here, too, a broad understanding of the context, shared monitoring of adverse events (such as deaths, kidnappings, and shootings), careful and attentive listening in clinical settings, and multidisciplinary work can help to respond more effectively, playing an adjuvant role in combination with the biomedical response. The multidisciplinary nature of PHC as set forth in the Declaration of Alma-Ata—as well as its proximity to patients’ everyday reality—means that it can play an important role in integrating the dimension of violence in a way that does not limit the provision of individual care nor the local collective response, both of which correspond to the planned work of each health service in all dimensions of care.

CONCLUSION

PHC is not meant to be a universal solution to the issues that affect society, nor should it be regarded as such. The adoption of intersectoral policies, the establishment of robust and effective health systems, as well as political commitment to equitable access and popular involvement in the formulation of responses to people’s demands are essential to ensure that no single intervention has to bear the weight of transforming disparities and excluding realities of the kind seen in much of the Americas.

Nevertheless, it must be recognized that, because of its comprehensive, multidisciplinary, participatory, and longitudinal nature, PHC is an extremely powerful way to implement processes of coordination, citizenship, and care. PHC’s unique role in recognizing and validating a community’s narrative of the experience of violence should be valued—both objectively, in terms of characterizing reality, and from the standpoint of individual clinical experiences. Finally, it is necessary to explore the opportunities for horizontally constructing community-supported sustainable responses guaranteed by the continuity of care and the continued presence of PHC teams in settings affected by armed violence.

The limited space of this article cannot address all the questions surrounding PHC in settings of armed violence: how to approach this reality from a broad, intersectoral viewpoint; how to increase population access to health services; and how to ensure the involvement of communities in transforming their situation without detriment to the protection and safety of health professionals. However, it is hoped that the points raised here may help highlight the relevance of this discussion and trigger new and necessary reflections.

Conflicts of interest. None declared.

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A atenção primária à saúde e territórios latino-americanos marcados pela violência

O artigo busca discutir singularidades do trabalho da atenção primária à saúde (APS) em contextos onde a violência, apoia fortemente pelo uso de armas de fogo, tem expressão rotineira, crônica e sistêmica, e dimensionar a potência da APS enquanto canal de empoderamento da comunidade onde a violência armada é uma vulnerabilidade expressiva. Com base na Declaração de Alma-Ata e nos princípios da APS emanados por Barbara Starfield, e com enfoque na participação comunitária e na perspectiva de determinantes sociais da saúde, a discussão tem como ponto de partida realidades observadas em países da América Latina e os compromissos voltados ao acesso e cobertura universal à saúde previstos no terceiro dos Objetivos de Desenvolvimento Sustentável. É necessário qualificar a caracterização quantitativa e qualitativa da violência armada e de suas consequências, a partir de uma abordagem intersectorial com ampla participação comunitária na busca por respostas coerentes e significativas. Também é preciso garantir a proteção e a segurança dos profissionais para que a presença dos serviços de saúde nos espaços seja contínua.

Palavras-chave
A atenção primária à saúde; violência; participação social; acesso aos serviços de saúde.

RESUMO

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RESUMEN

La atención primaria de salud y los territorios latinoamericanos marcados por la violencia

En el artículo se trata de abordar los aspectos singulares del trabajo de atención primaria de salud (APS) en los entornos donde la violencia, con el sólido apoyo del uso de armas de fuego, tiene una expresión habitual, crónica y generalizada, y de determinar la posibilidad que ofrece la APS de servir de canal de empoderamiento de la comunidad, donde la violencia armada representa una vulnerabilidad manifiesta. Con base en la Declaración de Alma-Ata y en los principios de la APS descritos por Bárbara Starfield, y con un enfoque en la participación comunitaria y en la perspectiva de los determinantes sociales de la salud, el debate tiene como punto de partida las realidades observadas en los países de América Latina y los compromisos orientados hacia el acceso universal a la salud y la cobertura universal de salud previstos en el tercero de los Objetivos de Desarrollo Sostenible. La caracterización cualitativa y cuantitativa de la violencia armada y de sus consecuencias debe hacerse a partir de un enfoque intersectorial con amplia participación comunitaria en la búsqueda de respuestas coherentes y significativas. También es preciso garantizar la protección y la seguridad de los profesionales para poder prestar servicios de salud de una manera continua en estos entornos.

Palabras clave
Atención primaria de salud; violencia; participación social; accesibilidad a los servicios de salud.