



Can primary health care strengthen the right to adequate food in Latin America?*

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ABSTRACT

Forty years ago, the Declaration of Alma-Ata emphasized health as a human right, introduced primary health care (PHC) as a strategy to attain an acceptable level of health for all, and included the issue of food and nutrition as an integral part of PHC. The right to adequate food (HRtAF) is closely related to the right to health, since it is essential to ensure dignified living conditions that promote health. The historical peculiarities and the political and economic position of Latin America constitute barriers for the full realization of human rights, and especially social rights. In this sense, the present article aims to explore the modes by which PHC services can leverage the HRtAF in Latin America. In addition, the article describes measures that exemplify how countries can strengthen HRtAF through PHC. Finally, the text seeks to recover the emancipatory potential of PHC through a vision of human rights enforcement beyond the right to health. The overview shows that PHC has the capacity to fulfill human rights that are interdependent on health in the Latin American context.

Keywords

Primary health care; food and nutrition security; human rights.

In Latin American countries, health system reforms since the 1990s have been strongly influenced by the Declaration of Alma-Ata (1). This document enshrined health as a fundamental human right and singled out primary health care (PHC) as a way of attaining an acceptable standard of health for all, based on social justice

(2). In Latin America, this was followed by the challenge of implementing PHC models supported by human rights, social participation, community empowerment, and intersectoral coordination (1).

The human right to adequate food (HRtAF) and the right to health are closely interrelated, as they constitute basic conditions for human welfare and dignity (3). In addition, a violation of the HRtAF may have consequences for social and mental well-being and jeopardize nutritional status (4). Accordingly, the Declaration of Alma-Ata included food and nutrition as core elements of primary health care (2). Addressing food

and health as rights is a strategy that has proven successful in health promotion, involving the responsibility of governments for monitoring and implementing these rights, social participation, prioritization of those most vulnerable, and nondiscrimination (3).

When considering the potential of PHC to safeguard the rights to food and health in Latin America, special attention must be paid to certain singularities. Several Latin American countries were ruled by dictatorships from 1960 to 1980, which created obstacles to the development of health systems in the region (1). In these countries, implementation of

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PHC coincided with the restoration of democratic rule, which made room for strengthening rights and social participation in public health (1).

In addition to the historical similarities and social inequalities that characterize the region, another common denominator in Latin America is its historical dependence on and subordination to the world's financial centers. Even under democratic governments, political mediation that prioritizes the macroeconomic agenda of hegemonic foreign nations jeopardizes safeguards for human rights in Latin America, including the HRtAF and the right to health (5).

Considering the relationship between these two human rights, the objective of this paper is to reflect on and explore the possibilities of PHC as a means of fulfilling the HRtAF. As a secondary objective, we propose an overview of what can be done, but not necessarily what should be done, since this article aims to be instigating and not prescriptive.

RESTORING THE PATH TOWARD THE HUMAN RIGHT TO ADEQUATE FOOD

Food is enshrined as a right in the Universal Declaration of Human Rights (6). In this document, food is included as one of the necessary elements to achieve health and well-being. The International Covenant on Economic, Social and Cultural Rights (ICESCR) also recognizes the right to be free from hunger (7). Most Latin American countries have ratified the ICESCR—and ratification means a legal commitment to enforce these rights. It is worth noting that Cuba has signed the covenant but has not ratified it.

States parties that have ratified the ICESCR must send periodic reports to the Economic and Social Council (ECOSOC), one of the six principal organs of the United Nations (UN), on the measures they have taken to implement it. ECOSOC, through its Committee on Economic, Social and Cultural Rights, composed of 18 independent auditors, publishes a “list of issues” to be addressed by the parties. To conclude the cycle, ECOSOC publishes concluding observations on the identified issues.

In addition, the UN has issued a general comment detailing the obligations of States parties regarding the HRtAF (8). The first obligation is to respect this

right, i.e., the State party itself must not violate the HRtAF. The obligation to protect involves measures by the State party to ensure that third parties, such as enterprises or individuals, will not violate the HRtAF. The obligation to fulfill is divided into two obligations: to facilitate and to provide. A State party facilitates the HRtAF when it strengthens access and utilization of resources and means to ensure the livelihood of its people; when no other means are available, the State must provide the HRtAF directly.

THE RIGHT TO HEALTH

The right to health is also enshrined in both the Universal Declaration of Human Rights (6) and the ICESCR, which recognizes “the right of everyone the enjoyment of the highest attainable standard of physical and mental health” (Article 12).

In UN General Comment No. 14, this right is described as covering individual biological aspects, socioeconomic preconditions, and the resources available in each State party (9). The right to health is framed as the right to the enjoyment of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health. Four interrelated and essential elements for its realization are introduced: availability, accessibility, acceptability, and quality.

Availability is fulfilled when public health and health care facilities, goods, and services are available in sufficient quantity within the State party. Accessibility, in turn, consists of four dimensions. The first concerns non-discrimination of any kind in access to existing resources. The second is physical accessibility, especially for the most vulnerable and marginalized populations. The third is economic accessibility, i.e., affordability: when payment for health services is required, it must be affordable for all. The fourth dimension is accessibility of information, i.e., the right to access health information. The element of acceptability is fulfilled when health services are ethical and culturally appropriate. This includes respect and special attention to minorities, citizens' needs at different stages of the life course, and sensitivity to gender issues. Finally, quality implies that, as well as being culturally appropriate, health services must be scientifically evidence-based and must have qualified

health professionals and the necessary medical equipment (9).

ADDRESSING THE HUMAN RIGHT TO ADEQUATE FOOD IN PRIMARY HEALTH CARE

According to the Declaration of Alma-Ata, PHC is the first level of contact of individuals, families, and communities with the health system. It should provide care based on practical, scientifically sound and socially acceptable methods and technologies to ensure health promotion and disease prevention and control (2).

However, PHC implementation is not uniform everywhere; it is pervaded by local singularities. In South America, for example, two organizational models of PHC predominate: one is characterized by fragmented, market-oriented care, while the other is dominated by public intervention and territorialization (10). Considering the position of PHC in health systems and the principles proposed in the Declaration of Alma-Ata, this paper reflects on how PHC can respect, protect, and fulfill the HRtAF. Some practical measures that exemplify ways to fulfill the HRtAF are summarized in Figure 1.

Obligation to respect

A State party's obligation to respect the HRtAF is all-pervading, and this includes PHC. Regarding availability, if health services to meet food-related demands—for instance, guidance on food quality, the health effects of foods, and the best ways to prepare them—are insufficient to meet the needs of the population, then this constitutes a failure to respect the HRtAF. Latin American countries have advanced to different degrees in terms of achieving sufficient service. In the United Nations' assessment, major problems in this regard remain (for example in Mexico, Colombia, Peru, Ecuador, and Guatemala) and it has been suggested that priority be given to the allocation of resources to vulnerable populations. This information has been present in the concluding observations of the most recent periodic reports issued by ECOSOC for each of these countries: Mexico (2018); Colombia (2017); Peru (2012); Ecuador (2012); and Guatemala (2014) (11).

The mere existence of health services does not ensure all aspects of

FIGURE 1. Summary of measures to strengthen the human right to adequate food in primary health care settings.

<p>ASSUMPTIONS (cross-cutting in relation to the “respect, protect, and fulfill” framework)</p> <ul style="list-style-type: none"> • Create a legal framework to recognize the human right to adequate food and to health, prioritizing the constitutional enshrinement of these rights. • Establish policies and plans of action to fulfill the human right to adequate food and to health. • Create budgetary provisions to ensure the implementation of policies and plans of action. 		
<p>RESPECT</p> <ul style="list-style-type: none"> • Expand the supply of PHC services with capacity to meet food-and nutrition-related demands. • Prioritize the availability and accessibility of PHC services to vulnerable populations. • Eliminate fee-for-service payment in PHC. • Implement scientifically sound programs and interventions. • Ensure that all groups have access to these programs and interventions. • Train currently active health professionals and educate new health professionals on respect for food-related cultural, religious, and ethical practices, mores, and values. • Allocate resources to increase the availability and access to PHC services and train and educate providers with a view to respecting the human right to adequate food. 	<p>PROTECT</p> <ul style="list-style-type: none"> • Create/strengthen food and nutritional surveillance systems. • Include food insecurity assessment tools that monitor access, availability, quality, and acceptability of food. • Prioritize mechanisms that can identify violations of the human right to adequate food in vulnerable populations. • Promote intersectoral coordination, especially with social work. • Create/strengthen agencies to defend citizens’ rights. • Establish partnerships with sectors of civil society that are active in the defense of human rights. • Create mechanisms to enforce the human right to adequate food. • Ensure that health professionals allocate working time to food and nutritional surveillance activities and other activities seeking to identify violations of the human right to adequate food. • Train currently active health professionals and educate new health professionals to identify situations in which the human right to adequate food is being violated. • Allocate resources for training and continuing education aimed at protecting the human right to adequate food. 	<p>FULLFILL</p> <ul style="list-style-type: none"> • Prioritize critical and emancipatory educational approaches toward food. • Include discussions on social issues, poverty, and rights when addressing food-related problems. • Create strategies to overcome cultural, social, and linguistic barriers between health care providers and users. • Promote actions aimed at dialog between health care providers and users. • Have physical spaces and material conditions available to carry out educational activities. • Provide educational materials for PHC facilities. • Ensure that health professionals allocate working time to planning educational activities. • Provide qualified professionals (such as dietitians) to address food-related issues at PHC facilities. • Train currently active health professionals and educate new health professionals to promote the human right to adequate food. • Allocate resources for implementation of educational activities and for training and continuing professional education aimed at protecting the human right to adequate food.

Regarding acceptability, PHC services respect the HRtAF when they do not violate food-related cultural, religious, and ethical practices, mores, and values. This may seem obvious and, indeed, it is covered by the codes of conduct of health care providers. However, in the management of child malnutrition in Buenos Aires, for example, there have been reports of health professionals imposing a biomedical viewpoint being that disregards mothers’ cultural conceptions about disease and forces certain behaviors (13). Thus, it remains a challenge to ban practices that disrespect human rights and further strengthen the emancipatory and empowering potential of PHC.

Regarding quality, scientific evidence is a key dimension. In 2005, Brazil initiated an iron supplementation program for pregnant women, delivered via PHC, based on scientific evidence and recommendations from the World Health Organization (WHO). However, its implementation faced hurdles at the local level due to low coverage and unequal distribution of supplements among women (14). When the health services do not promote evidence-based care for all, low quality constitutes a failure to respect the HRtAF. The same happens when the health services employ practices already known to be scientifically unsound, i.e., recommending the introduction of complementary feeding through teas and juices for children under age 6 months.

Obligation to protect

PHC has great potential to protect the HRtAF, especially by identifying third-party violations of this right. The role of PHC in this case is to generate information in the territory where it operates.

From the standpoints of accessibility and availability, PHC protects the HRtAF when it has mechanisms to detect food insecurity and employs them without discrimination. Just as PHC can, through health surveillance mechanisms, monitor infectious diseases or violence against children and adolescents, it can monitor the state of fulfillment of the HRtAF through dietary and nutritional surveillance. Since 1977, Cuba, for instance, has had a nutritional surveillance system to generate information on nutritional status and access to adequate food by the population (15).

PHC can also identify dietary neglect in institutional settings (e.g., daycare

accessibility. The economic component is particularly important. From the user side, payment of fees at the point of care in PHC facilities results in lower service utilization and jeopardizes food security, financial stability, and female participation in health-related decision-making (12), i.e., myriad human rights violations.

South American countries that have adopted non-payment-dependent health coverage are closer to the comprehensive

approach proposed by the Declaration of Alma-Ata, considering elements such as the concept of PHC, the way in which services are organized, intersectoral coordination, and social participation (10). Chile, for instance, has expanded public investment in PHC since the 1990s, aiming at elimination of all user fees under the National Health Fund (1). Additionally, legal recognition of the right to health has been an important step toward advancing health coverage in Latin America (1).

centers, schools, long-term care facilities) and households. It is also worth stressing that tools designed to identify food insecurity can reveal different aspects of HRtAF violations. Thus, instruments such as psychometric scales for evaluating food insecurity, e.g., the US Household Food Security Survey Measure and its derivatives, are more useful than the simple measurement of biological outcomes such as malnutrition (4).

Hunger can feel shameful to those who experience it. In this sense, the element of acceptability should include confidentiality when reporting information about HRtAF violations to the relevant authorities. Responding to such cases demands intersectoral coordination, especially with social workers, to direct victims to existing programs (such as cash transfers). If violations persist, recourse can be had to agencies tasked with defending citizens' rights (such as the local prosecutor's or public advocate's office), especially in countries with an established legal framework for the HRtAF. In countries with less advanced legislative frameworks, partnerships with HRtAF advocacy organizations (e.g., the Food Information and Action Network, FIAN International, <https://www.fian.org/>) provide a route.

To ensure that HRtAF protection is feasible, it is important to highlight the importance of PHC having qualified human resources and appropriate structural conditions as components of quality service. PHC physicians must be trained to address the technical aspects of food security without embarrassing users (16). It is essential that providers allocate working time specifically for these tasks, so that they do not become an impractical addition to their daily workload.

Obligation to fulfill

With regard to the two components of fulfilling the HRtAF, PHC is a more suited to facilitation than provision, although historically it has sometimes taken on food distribution tasks in Latin America. The fulfillment of a human right depends on many areas and requires legislative, administrative, and financial support. It is the role of PHC to promote this right and strengthen the conditions for its ful-

fillment, especially by promoting knowledge about the subject.

Educational activities in PHC settings play a key role in facilitating fulfillment of the HRtAF. In particular, dietary and nutritional education can raise awareness about the right to food and about the problems of poverty, hunger, low-quality food, and the social and economic inequalities that generate these conditions. However, this education must provide for dialog between providers and users, always with a view to users' autonomy and empowerment (17).

Regarding availability and accessibility, PHC facilitates the HRtAF through activities to promote an adequate diet from a human rights perspective, both within health units and in locally accessible facilities, without any kind of discrimination. Community gardens at PHC facilities, for example, can reinforce community action, build skills, and recover traditional practices and habits (18). All of these outcomes are consistent with the HRtAF.

Regarding acceptability, activities should appreciate users' cultural and food preferences and be guided by ethical principles. Food-related cultural and religious differences can constitute barriers to dealing with dietary issues. The theoretical framework proposed by Santos (19) can be used to support actions to facilitate fulfillment of the HRtAF in PHC. The author proposes a multicultural conception of human rights, which recognizes the incompleteness of all cultures as a starting point for intercultural dialog and preventing the imposition of one culture over another (19). The case of Bolivian immigrants in the Brazilian municipality of São Paulo is an example. Spanish classes and courses in Bolivian culture targeted to Brazilian health care providers and the recruitment of Bolivian community health workers were proposed as ways of bringing immigrants closer to PHC services (20).

Promoting the right to adequate food from a human rights perspective can be a difficult task. The availability of qualified health care providers, continuing professional education, decent working conditions, and adequate provision of supplies promote the quality of HRtAF-facilitating actions. In Brazil, Family Health Support Centers (*Núcleos de Apoio à Saúde da*

Família, NASF) are an example of a strategy used to expand the scope of PHC and its problem-solving capacity. These centers are staffed by other professionals, including dietitians, in addition to the core family health team. Three years after the program was proposed, dietitians were the third most common class of provider in NASF teams (21), thus expanding opportunities to facilitate the fulfillment of HRtAF in PHC settings.

FINAL CONSIDERATIONS

This paper provides a reflection on how to increase the capacity of PHC to respond to the food problems experienced by the Latin American population. PHC is not only a venue for identifying HRtAF violations; it is also a space for action to promote human rights beyond the right to health, with a view to overcoming inequalities. The measures presented in Figure 1 do not exhaust all possibilities for such action, but they can serve to stimulate discussion in each country regarding the local configuration of PHC networks. Although policymakers are the target audience, these measures can also be used as a tool for advocacy, since rights are won through participation and social engagement.

This paper, 40 years after the Declaration of Alma-Ata, calls for PHC to rethink health practices from a human rights perspective, to recover the emancipatory potential of PHC in Latin America. PHC alone cannot solve the problems of this region, but its activities can be expanded to promote decent living conditions and, consequently, good health for the population.

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RESUMO

Como a atenção primária à saúde pode fortalecer a alimentação adequada enquanto direito na América Latina?

Há 40 anos, a Declaração de Alma-Ata reforçou a saúde como direito humano, apresentou a atenção primária à saúde (APS) como caminho para atingir um grau de saúde aceitável para todos e incorporou a questão alimentar e nutricional como parte integrante dos cuidados primários em saúde. O direito humano à alimentação adequada (DHAA) está intimamente relacionado com o direito à saúde, pois é requisito para a existência de condições de vida digna para promover a saúde. As particularidades históricas e a posição político-econômica da América Latina representam barreiras para a realização plena dos direitos humanos, e especialmente dos direitos sociais. Nesse sentido, o objetivo deste artigo é explorar os modos pelos quais os serviços de APS podem alavancar o DHAA na América Latina. Adicionalmente, são apresentadas medidas que exemplificam como os países podem fortalecer o DHAA a partir da APS. Finalmente, o texto se propõe a resgatar o potencial emancipatório da APS na América Latina vislumbrando sua atuação na realização de direitos humanos para além do direito à saúde. O panorama apresentado demonstra a capacidade de resposta da APS no sentido de efetivar direitos humanos interdependentes da saúde no contexto latino-americano.

Palavras-chave

Atenção primária à saúde; segurança alimentar e nutricional; direitos humanos.

¿Cómo puede la atención primaria de salud fortalecer la alimentación adecuada como derecho en América Latina?

RESUMEN

Hace 40 años, la Declaración de Alma-Ata reforzó la salud como derecho humano, presentó la atención primaria de salud (APS) como camino para alcanzar un grado de salud aceptable para todos e incorporó la alimentación y nutrición como parte de los cuidados primarios en salud. El derecho humano a la alimentación adecuada (DHAA) está íntimamente relacionado con el derecho a la salud, pues es un requisito indispensable para la existencia de condiciones dignas para promover la salud. Las particularidades históricas y la posición político-económica de América Latina representan barreras para la promoción plena de los derechos humanos, y especialmente de los derechos sociales. En este sentido, el objetivo de este artículo es explorar la manera como los servicios de APS pueden impulsar el DHAA en América Latina. Adicionalmente, se presentan medidas que ejemplifican cómo los países pueden fortalecer el DHAA a partir de la APS. Finalmente, el texto se propone rescatar el potencial emancipatorio de la APS en América Latina vislumbrando su actuación en la promoción de derechos humanos más allá del derecho a la salud. El panorama presentado demuestra la capacidad de respuesta de la APS para hacer efectivos los derechos humanos interdependientes de la salud en el contexto latinoamericano.

Palabras clave

Atención primaria de salud; seguridad alimentaria y nutricional; derechos humanos.
