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Family Medicine, Primary Care and Violence: training and action in Latin America

Medicina Familiar, Atención Primaria y Violencia: formación y acción en Iberoamérica

Medicina de Família, Atenção Primaria e Violência: formação e ação em Iberoamerica

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Abstract

Objective: To identify the perception of family and community doctors - as well as other professionals in 20 countries that make up the Ibero-American Confederation of Family Medicine (CIMF) - on the most prevalent forms of violence in their country and in the communities they attend. Also, to identify the perception about their own motivation and ability, as well as that of family physicians from their countries, to address violence and contribute to the culture of peace. **Methods:** Cross-sectional, exploratory study, descriptive and quantitative approach, carried out in the 20 member countries of CIMF, between the months of September 2017 to March 2018. A survey was designed based on a literature review of the study phenomenon, discussion and validation with different family medicine professionals considered to be experts in the subject. It was disseminated with the support of the different scientific societies of Family Medicine that make up the 20 countries of the CIMF, reaching 242 responses. **Results:** More than 92% of professionals consider that they lack sufficient training to deal with violence in their daily work and only 24% consider that they have received sufficient training in the Culture of Peace. On the other hand, the perception of prevalence of the different types of violence from the personal, family and community point of view in the region is alarming. **Conclusions:** It is necessary to integrate in the training of family doctors and primary care professionals, as well as in the undergraduate curricula of Medicine, contents related to the approach to violence and the contribution to the culture of peace to overcome violence. The knowledge gap on these issues is visible by family doctors and other professionals who work in Primary Care. On the other hand, the potential benefit of having these professionals acting in this serious and prevalent health problem is remarkable, especially considering their frequent and longitudinal contact with people, families and communities who have been victims of violence.

Keywords: Training; Family Medicine; Primary Care; Violence; Culture of Peace

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Resumen

Objetivo: Identificar la percepción de médicos de familia y comunidad, así como de otros profesionales de Atención Primaria, en los 20 países que conforman la Confederación Iberoamericana de Medicina de Familia (CIMF), sobre las formas de violencia más prevalentes en su país y en las comunidades que asisten. Además, identificar la percepción sobre sus propias capacitación y motivación, además aquellas de los médicos de familia en sus países, para abordar la violencia y contribuir a la cultura de la paz. **Métodos:** Estudio exploratorio, corte-transversal, de carácter descriptivo y enfoque cuantitativo, realizado en los 20 países miembros de CIMF, entre los meses de septiembre de 2017 a marzo de 2018. Se construyó un instrumento tipo encuesta, a partir de revisión bibliográfica del fenómeno de estudio, discusión y validación con diferentes profesionales de la medicina familiar considerados expertos en el tema. Se divulgó con el apoyo de las diferentes sociedades científicas de Medicina Familiar que componen los 20 países de CIMF, alcanzando 242 respuestas. **Resultados:** Más del 92% de profesionales consideran carecer de formación suficiente para abordar la violencia en su cotidianidad laboral y solo 24% considera haber recibido formación suficiente en la Cultura de Paz. Por otro lado, es alarmante en la región la percepción de prevalencia de los diversos tipos de violencia desde el punto de vista personal, familiar y comunitario. **Conclusiones:** Es necesario integrar en la formación de los médicos familiares y profesionales de la Atención Primaria, asimismo en los currículos de pregrado de Medicina, contenidos relacionados con el abordaje de la violencia y la contribución a la cultura de paz para superar la violencia. Es visible la brecha de conocimiento en estos temas por parte de los médicos de familia y demás profesionales que actúan en la Atención Primaria. Por otro lado, es notable el potencial beneficio de tener esos profesionales actuando en esto grave problema de salud por su elevada prevalencia y especialmente considerando su contacto frecuente y longitudinal con las personas, familias y comunidades quienes han sido víctimas de violencia.

Palabras clave: Formación; Medicina Familiar; Atención Primaria; Violencia; Cultura de Paz

Resumo

Objetivo: Identificar a percepção de médicos de família e comunidade, bem como outros profissionais, em 20 países que compõem a Confederação Ibero-americana de Medicina de Família (CIMF), sobre as formas mais prevalentes de violência em seu país e nas comunidades que atendem. Além disso, identificar a percepção sobre suas próprias motivação e capacitação, além daquelas dos médicos de família de seus países para abordar a violência e contribuir para a cultura da paz. **Métodos:** Estudo corte-transversal, exploratório, de abordagem descritiva e quantitativa, realizado nos 20 países membros da CIMF entre os meses de setembro 2017 a março de 2018. A pesquisa foi projetada com base em uma revisão da literatura sobre o fenômeno de estudo. Um questionário foi elaborado e validado com diferentes profissionais de medicina de família considerados especialistas no assunto e posteriormente disseminado com o apoio das diferentes sociedades científicas de Medicina de Família que compõem os 20 países do CIMF, alcançando 242 respostas. **Resultados:** Mais de 92% dos profissionais consideram que não possuem treinamento suficiente para lidar com a violência em seu cotidiano de trabalho e apenas 24% consideram que receberam treinamento suficiente na Cultura de Paz. Por outro lado, a percepção da prevalência, na região, dos diferentes tipos de violência, do ponto de vista pessoal, familiar e comunitário é alarmante. **Conclusões:** É necessário integrar na formação de médicos de família e os profissionais de cuidados primários, bem como nos currículos de graduação de Medicina, conteúdos relacionados com a abordagem à violência e a contribuição para a cultura da paz para a superação da mesma. A lacuna de conhecimento sobre essas questões é visível pelos médicos de família e outros profissionais que trabalham na Atenção Primára. Por outro lado, é notável, o benefício potencial de ter esses profissionais atuando nesse grave e prevalente problema de saúde, especialmente considerando seu contato frequente e longitudinal com pessoas, famílias e comunidades vítimas de violência.

Palavras-chave: Formação; Medicina de Família; Atenção Primária; Violência; Cultura da Paz

Introduction

[..] We often talk about how a "culture of violence" can take root. In many societies, violence is so widespread that it thwarts the hopes of economic and social development. We cannot allow this situation to continue. .... It is possible to prevent it, as well as completely reorient the cultures in which it prevails. ... Governments, communities and individuals can change the situation.

We owe our children, the most vulnerable citizens of any society, a life without violence or fear. To guarantee it, we must be tireless in our efforts to achieve peace, justice and prosperity not only for countries, but also for communities and members of the same family. We must face the roots of violence. Only then will we transform the legacy of the last century of burdensome ballast into instructive experience.

Nelson Mandela

(World Report on Violence and Health, 2002)

Primary Care [PC] is a fundamental strategy to improve health with criteria of Equity and Social Justice. Several authors, such as Barbara Starfield,[1] have pointed out the great impact that investment in PC has on equity. A health system based on PC requires a solid legal, institutional and organizational framework, adequate human capital, as well as sustainable economic and technological resources to guarantee an adequate response to the health needs of the population, orientation towards quality, responsibility, social justice, sustainability, participation and intersectoriality.

After 40 years of Alma Ata and its goal of "Health for All in the Year 2000", we are still very far from reaching that goal. Health goods and services continue to be unattainable for many, especially those who need them most. This inequality, if we look for example the order of the countries according to the indicator Gini[2] as in many Ibero-American countries there are communities immersed in poverty and with restricted access to public services, with few social-labor opportunities and therefore, low levels of quality of lifetime.[3] Many of these people are in Latin America and the world, settled in the peripheries of large cities, living in a situation of exclusion, in precarious conditions, virtually unassisted, silent victims of oblivion and the greed of corrupt power groups, or hostages of criminal organizations. This environment constitutes a favorable environment for the appearance and maintenance of serious social and health problems, including violence.

This violence, with all its manifestations, must be understood as a tacit consequence of the enormous social inequality and as one of the most serious social and health problems in the world. Many studies indicate that violence is more common in societies with greater inequality and income inequality and with fewer possibilities of social development.

These societies will hardly have an atmosphere of peace, especially if the citizens and, specifically, the 1st level health professional, assume a passive role, maintaining ourselves as mute witnesses to injustice, if we keep silent about inequity, and we end up fostering that violence.[4]

Social inequality, violence and disease: an inseparable triade

In 1996, the 49th World Health Assembly, declared violence as a growing public health problem that brings serious short and long-term health consequences for individuals, families, communities and, in addition, results in harmful to health services.

The Assembly itself urged Member States to urgently consider the problem of violence within their own borders and to establish public health activities to address it, setting goals, including: (a) Raise awareness about the problem of violence in the world, and make it clear that violence can be prevented and (b) that public health has the fundamental task of addressing its causes and consequences.[5]

Each year, more than 1.6 million people die and many more suffer non-fatal injuries as a result of self-inflicted, interpersonal or collective violence. Violence is one of the main causes of death in the population between 15 and 44 years of age. In 2012, almost half a million people died from intentional homicides and more than a third of these (36%) took place in the Americas.

Statistics reveal that **almost half** of all homicides occur in countries where 11% of the world population lives, which, not coincidentally, concentrates the poorest population from the socio-economic point of view.[6] The average homicide rate in the world is 6.2 per 100,000 inhabitants, however, in South Africa and Central

America, rates were up to four times higher (30 and 26 victims per 100,000 inhabitants, respectively). In contrast, rates up to five times lower than the world average, occur in East Asia, southern Europe and Western Europe in 2012.[6]

The greatest causes of violence are deeply related to the social, cultural and economic issues, constituting a public health problem, given the social value of the phenomenon and the forms of social mobilization that it triggers. Multiple family, community, cultural and other external factors interact to create an environment that favors the emergence of violence.[5]

It is a problem that lacks a systemic approach in most countries, because the interventions arise from the Cartesian care paradigm, of reductionist nature, which leads to linear thinking whose solutions go through a simple cause-effect relationship. This paradigm prevents thinking and proposing structural solutions that look at this phenomenon from its complexity.

In contrast, for some authors, interventions designed from education, job opportunities and support for families are long-term strategies that show more solid and broad results than punctual care reactions.

In the field of health, in addition to the accompaniment of health professionals in the processes of rehabilitation and socio-labor inclusion, we must consider that the consequences of violence are immediate and acute, but also long-lasting and chronic. Research has shown that the more severe the abuse, the greater the repercussions on physical and mental health. It is also known that the negative consequences for health derived from violence can persist long after the abuse has ceased.[5]

The "collective violence", that is, the one derived from wars, terrorism, uprisings, ethnic, religious or similar conflicts, gang fights and mafia extortions, and in general all aggression and extortion carried out by an organized collective against other groups, civilians or military, is undoubtedly an important cause of mortality and serious alterations and sequelae in health. The high frequency of psychological consequences suffered by combatants and the civilian population in armed conflicts or similar has been widely documented.[5]

How to confront and overcome violence?

As a complex problem, facing violence demands more than punctual actions.

It requires understanding its matrixes, its roots and, in addition, it requires proactive actions that help to have another attitude, another way of answering, that does not respond more violently to violent situations. That is, we need another social-scientific paradigm. *"This nascent paradigm forces us to make progressive journeys: we have to move from the part to the whole, from the simple to the complex, from the local to the global, from the national to the planetary, from the planetary to the cosmic ... Now, either we take care of Humanity and Planet Earth, or we will not have any future.*[7]

In this context, it is worth bringing to consciousness the idea of the Culture of Peace and other central issues to overcome violence and that, synthetically, are listed here.

The relationship between violence and the culture of peace is established by understanding that repression and punishment of violent acts are not sufficient for a transformation of the individual (author of violence) and society. The one who practiced violence is not violence itself: he must be held accountable

for his actions, but he must also have access to the means to overcome that condition.[8] Many violent behaviors are learned socially and are not natural expressions of humanity, nor are they associated with a certain gender or social group.

The vision of the Culture of Peace through the promotion of a healthy and meaningful human life is the most effective way to prevent violence. The Culture of Peace presents a concrete alternative to replace the action that generates violence by an action that generates peace.

Another point that should be highlighted in the context of the paradigm shift and facing violence is the development of Spirituality. Spiritual health care has been considered an emerging field worldwide in the last three decades. Multiple disciplines have been conducting research and contributions to build a body of knowledge and practices consistent with science, this has been mainly contributed by palliative medicine, psychology, psychiatry, geriatrics, nursing and, more recently, family medicine.

Spirituality is related to the Culture of Peace, once peace is considered a source of spirituality and, in turn, it would also be linked with other associated sources such as hope, strength, love, connection, well-being and social support.[9] As Krishnamurti says: "World peace rests on inner peace". In this sense, a crucial aspect is the spiritual self-care of the person who cares, the health professional in all his subjectivity.

Another aspect that should guide actions to face violence has to do with the Ethics of Care.

The care with the other, although it is an archetypal attitude of the human being, was displaced to give place to egocentrism. Recovering care, in its historical concept, means promoting social relations of reciprocity, co-responsibility and mutual support. For this, an affective education of individuals or citizens is necessary. The education of the affectivity does not only lead to a better self-esteem but to a greater commitment with the others and with the society.[10]

Study problem

The approach to violence is necessarily a cross-cutting issue and Family Physicians, as well as all Primary Care professionals, can and must contribute to its solution, through their own health actions, as well as being able to invest in participation of the community and citizen, and in the search and implementation of solutions to the problem together with governments, and health and education managers.

In the meantime, in training and in professional practice to address violence, we know that we have gaps to overcome here manifest in the following hypothesis that this study tried to explore:

Hypothesis

- Although violence is one of the biggest public health problems in the world, from a theoretical and practical point of view, the approach to violence is not a relevant part of the training programs of the MFyC and other Health Professionals. of Primary Care.
- Health services in the field of Primary Care and Family Medicine are not adequately prepared to identify and adequately care for individuals, families and communities that suffer violence.

General purpose

- Identify the perception of family and community doctors, as well as other primary care professionals from 20 countries of the Ibero-American Confederation of Family Medicine Network (CIMF), about the situation of violence in the countries and places where they work, and on training in the approach to violence and, also, its understanding of the culture of peace.

Specific objectives

- To explore what has been the training of family doctors and health professionals in terms of the approach to violence in undergraduate and postgraduate studies.
- Identify the practices of family doctors and health professionals, who participate in the study, in the approach to violence in their daily clinical practice.
- To know the perception about the situation of violence in the countries and places where family doctors and health professionals of the first level of care that participate in the study work.
- To explore the feelings and perspectives of family doctors and health professionals of the first level of attention to address violence.
- Know the perception of family doctors and health professionals of the first level of care in relation to the Culture of Peace.

Methodology

This is an exploratory, cross-sectional study of a descriptive nature and quantitative approach, carried out in the 20 Latin American and Ibero-American countries, members of CIMF, between the months of September 2017 to March 2018. The target audience of the study consisted of family doctors and residents of family medicine, as well as other primary care professionals.

Methods

A previous bibliographical study was carried out to elaborate a questionnaire that identified the formation and the role of the Family Doctors and other Primary Care professionals in the promotion of the Culture of Peace and the perceptions about the situation of violence in their countries and place of work, and also on the approach to this phenomenon from their point of view. The Instrument was prepared, reviewed and validated in its content by representatives of the associations of Family Medicine constituting CIMF, considered experts in the subject. The questionnaire was self-administered, anonymous and in an online format. It was sent to each scientific society in each country for dissemination. It was also placed on the Facebook page of CIMF.

Results

1) Profile of respondents

The population that participated in the survey added a total of 243 professionals. The profiles and occupations of the participants are varied, being almost all (93%) family doctors or residents of Family Medicine. The provenance of the 243 records informs that the survey participants are from 19 of the 20 countries that make up the CIMF. A respondent from the United States was included (Table 1). A total of professionals from 97 cities distributed in these 20 countries have participated in the Survey.

Table 1. CIMF Survey - Participants in the project: "Formation and Role of the Family Doctors and other Primary Care professionals in the approach to the phenomenon of violence and in the promotion of the Culture of Peace".

Country	Number of participants
Argentina	22
Bolivia	10
Brazil	25
Chile	20
Colombia	25
Costa Rica	20
Cuba	2
Ecuador	6
Salvador	2
Spain	25
United States	1
Mexico	20
Nicaragua	1
Panamá	10
Paraguay	12
Peru	8
Puerto Rico	7
Dominican Republic	5
Uruguay	8
Venezuela	14
Total	243

Source: Survey of the authors.

If the information is organized according to the conformation by Subregions, Table 2 is taken into account; it is observed that, in percentage terms, the origin (%) of the participants is proportional to the population (%) of each region.

Table 2. Respondents for CIMF Regions - Percentage Participation, Accumulated Population and Percentage.

Subregion	Respondents - Participation Percentage	Accumulated Population by Region	Population Percentage by region
Southern Cone	35.9%	280,243,774 Inhabitants	43.5%
Mesoamerican	27.7%	167,991,115 Inhabitants	26.1%
Andean	26.0%	139,563,236 Inhabitants	21.6%
Iberian	10.4%	57,030,280 Inhabitants	8.8%
Total	100%	644,828,405 Inhabitants	100%

Source: Survey of the authors.

The sex distribution among the respondents was 69% of women and 31% of men.

In terms of ages, the results of the variable were organized by age groups with the following categories, 20-40 years - 41.9%; 40-60 years - 34.6% and more than 60 years - 8.2%. Unfortunately, there was a problem in the survey so that 15.2% of the records could not be analyzed - which makes an adequate analysis of this topic impossible.

Turning to the question related to the professional profile of the participants in the survey, it can be observed, in Table 3, that the absolute majority was of family doctors (94%).

Table 3. Respondents and Professional Profile (n = 243).

Referred Profession	Percentage Contribution to the Survey
Family Doctor	94%
Primary Care Nurse	1.6%
Residents of Family Medicine	1.2%
Parent Educator	0.4%
Veterinarian	0.4%
Dentist	0.4%
Psychologist	0.4%
Psychiatrist	0.4%
Public health	0.4%
Social worker	0.4%
Total	100%

Source: Survey of the authors.

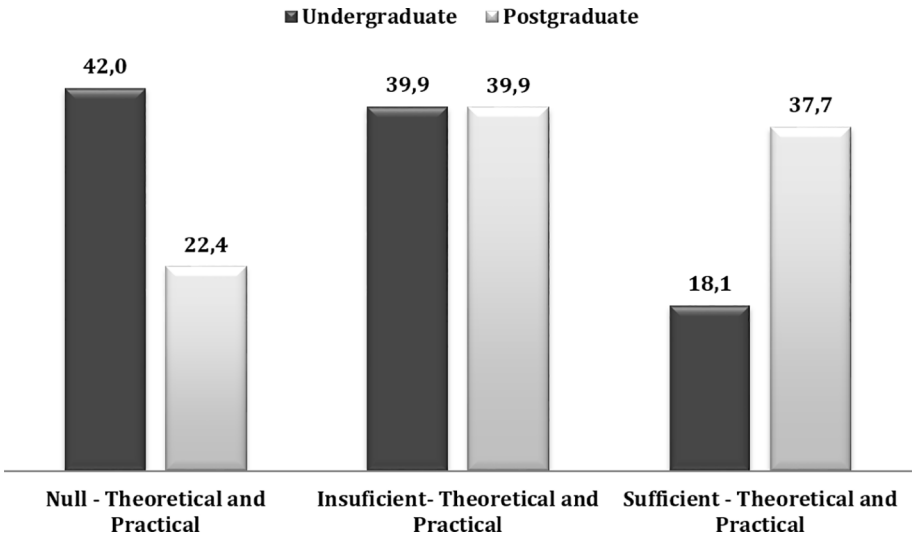
Regarding training as clinical or family medicine specialists: 93% of the specialties are related to Family Medicine and related to postgraduate training, about 50% of respondents had a master's degree (35%) or doctorate (9%) or post-doctorate (4%) at the time of the study.

The situation of the respondents related to their eventual scientific associations were grouped into 3 categories, namely: Scientific Societies related to Medicine and Family Health (60%); Other Scientific Societies with Different Interests (6%); Reports not belonging to Scientific Societies (34%).

2) Undergraduate training for the approach of violence

From the surveyed population, two central issues were reviewed that become part of the baseline for the discussion. It is about training in Violence and Peace. For this part of the survey, two components of

university education were reviewed, the theoretical and practical training spaces, both undergraduate and postgraduate. The results from these two components present in all the curricula are represented in Graph 1.



Graph 1. Self-perception (%) of the learning process to address violence in undergraduate (in = 243) and postgraduated (n = 223). Source: Survey of the authors.

At the undergraduate level, the respondents mainly located their response in two alternatives, the first and largest (42% of the respondents) is the one that shows that the training on Violence in theoretical and practical terms was null. This supposes a base of the important problematic, since it is not seen as a relevant topic in the processes of academic formation. The second alternative shows that about 40% of respondents acknowledge that there was some training, theoretical and/or practical, but they were insufficient**. It is relevant that 82% of the respondents have not had any training in undergraduate, or if they had, it was perceived as insufficient.** It should also be mentioned that 18% of the respondents perceive that there was Theoretical and Practical Training and this was sufficient.

In postgraduate studies, the situation is somewhat different, so that the number of positive answers increases in terms of having had enough information, theory and/or practice (38%), although in this topic there were 9% of answers as only theoretical training.

But the percentage of those who do not report any training or insufficient training, remains high (62%).

3) Data related to the prevalence of violence and to the types of violence

3.1. Violence in the lives of people, families and communities

Related to the perception of the level of violence in the lives of people, in the country and in the workplace, the respondent had to dial in a number on a scale that varied from 0 (Not relevant) to 5 (The most elevated violence).

Although any level of violence is unacceptable, four categories were established for analysis purposes:

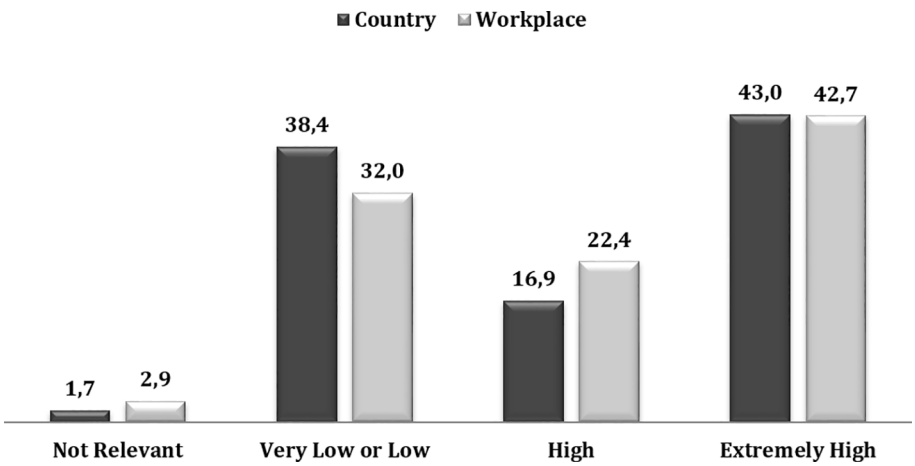
1st Level of Violence - Not relevant (for those who have marked 0);

2nd Level of violence – Very Low or Low (for those who have scored 1 or 2);

3rd Leve lof Violence - Elevated (for those who have marked 3);

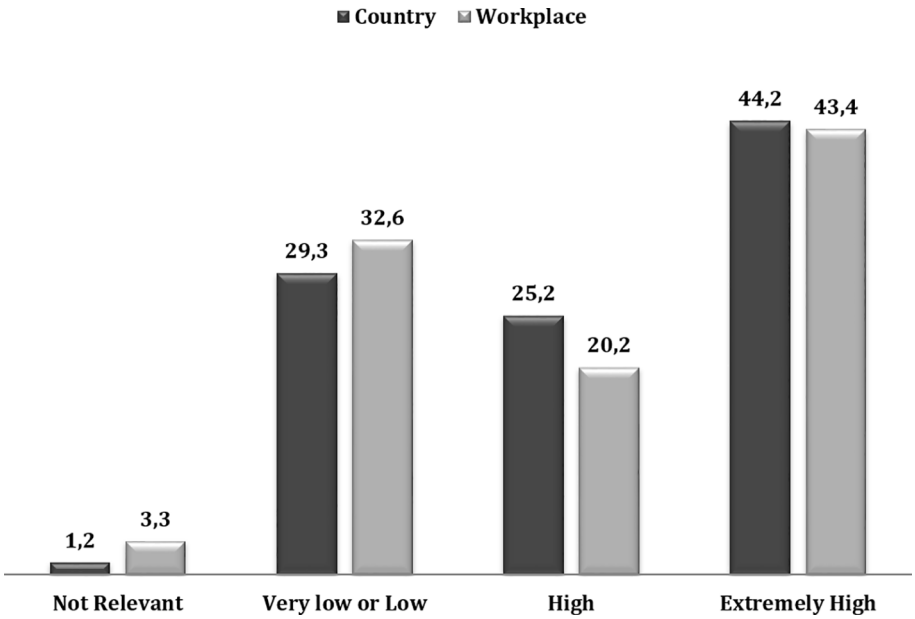
4th Level of Violence - Very high or extremely high (for those who have scored 4 or 5).

Considering this classification, the level of violence **in people's lives** has been classified as **Very High or Extremely High** for about 43% of the respondents, either in the case of violence in the workplace of the professionals who participated in the survey, be it in your country. If we add the percentage of who has classified as high, we have a percentage of 60% of the level of Violence considered high to extremely high in the country and 65% in the workplace of the respondents (Graph 2).



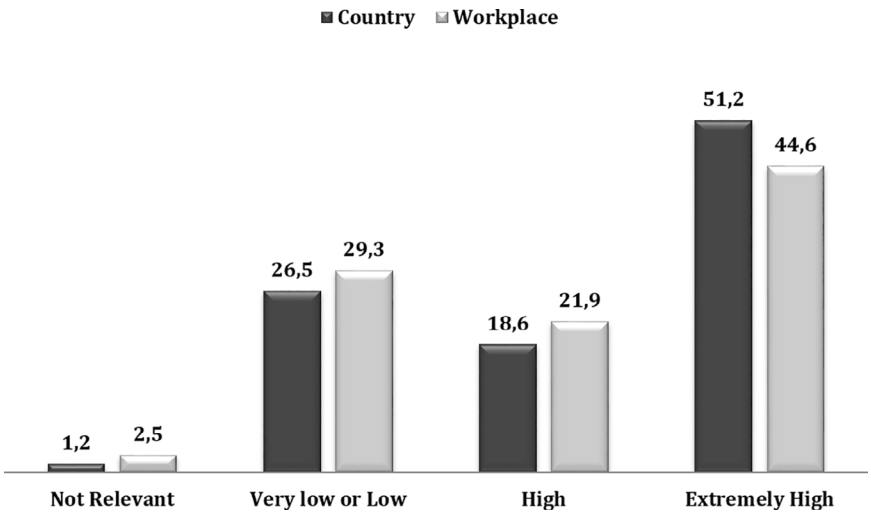
Graph 2. Classification (%) of the level of violence in the lives of PEOPLE, in the country and in the workplace, according to the perception of the respondents (n = 242). Source: Survey of the authors.

In the same sense, the same classification has been proposed, in this case, for the perception of the level of **violence in the lives of families** and the percentages were equally relevant, reaching close to 70% in the country and the same 64% at the family level (Graph 3):



Graph 3. Classification (%) of the level of violence in the life of the FAMILIES, in the country and in the workplace, according to the perception of the respondents (n = 242). Source: Survey of the authors.

The same question was asked to evaluate the perception of the respondents about the level of **violence in the life of the communities** and in this case the percentages are very high: 70% answered that they would classify the level of violence as elevated to extremely high, considering their country. Of these 70%, more than half (51%) marked values such as Very High to Extremely High. In the case of violence perceived by the respondents in the life of the communities in which they work, the values were lower, remaining around 67%, although the classification of Very High to Extremely High reaches about 45% (Graph 4). 2.5% and 2.1% respond that they didn't know, respectively to the country and workplace.

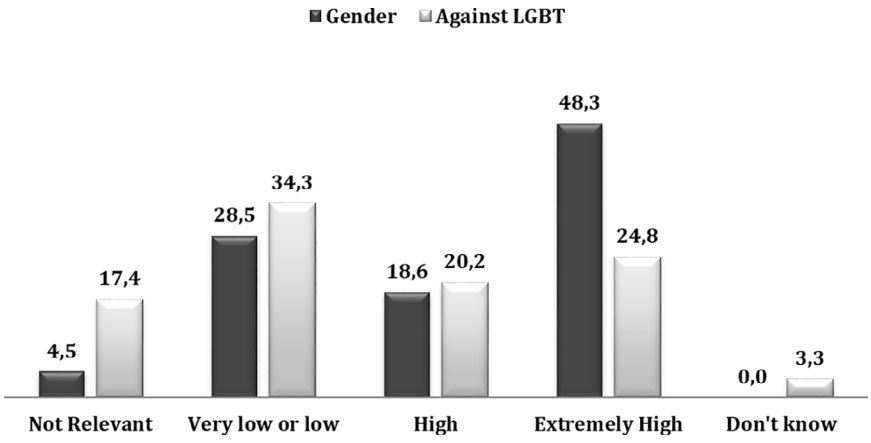


Graph 4. Classification of the level of violence in the life of the COMMUNITIES (%), in the country and in the workplace, according to the perception of the respondents (n = 242).

3.2. Gender violence and against the population of lesbian, gay, bisexual and transsexual (LGBT)

The perception of the respondents about the level of gender violence and also against the LGBT population was explored, using the same approach and classification.

Gender violence was recognized as quite high, adding 67% (48% considered Very Extremely High). Related to the violence against the LGBT population, the percentages are lower - adding up to 45% - suggesting a lower perception, once it is known that the levels of violence against this population are extreme (Graph 5).



Graph 5. Classification (%) of the level of gender violence and against the LGBT population that is attended by Family Doctors and/or their residents/students, according to the interviewees' perception. Source: Survey of the authors.

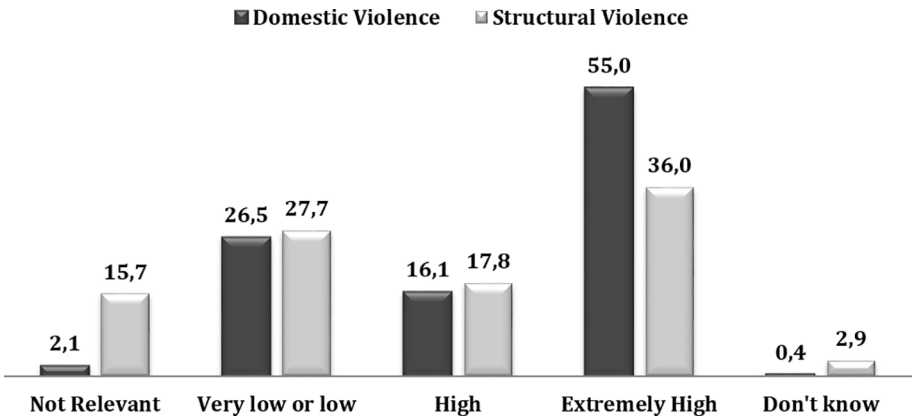
Next, he asked who were the people - among women, men, boys/girls and the elderly - who suffered the most from gender violence and against the LGBT population.

Related to gender violence, women were the most cited (54%), followed by adolescents (19%), boys/girls (16%), the elderly (6.6%) and finally men (4.4%).

Related to the perception of violence against the LGBT population, men appear first (40%), followed by adolescents (32%), then women (23%); children (4.1%) and the elderly (0.5%).

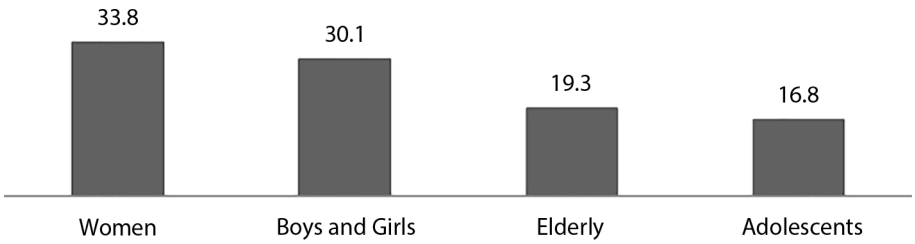
3.3. Structural violence and domestic violence

Structural violence is usually the most invisible of all forms of violence, although one of the most striking, because it is capable of keeping all others at high levels. Structural violence is that maintained, promoted or facilitated by the State. The State that should, precisely, care for and protect the population commits, through the application of its laws, its practice, or its absence in the defense of the most needy, a very violent form of violence. Related to the perception of Domestic Violence in the population assisted by the respondent professionals, the percentages are significantly high, since 71% classified it as Elevated to Extremely High. In terms of Structural Violence, the perception is lower, although it is in fact high (54%) (Graph 6).



Graph 6. Classification (%) of the level of Domestic ans Structural Violence against the population that is attended by Family Physicians and/or their residents/students, according to the perception of the respondents. Source: Survey of the authors.

When asked about the people who suffered most from these two types of violence, the largest percentages remained with women (34%), boys and girls (30%), the elderly (19%) and adolescents (17%). It is striking that men were not related to domestic violence (Graph 7).



Graph 7. Who do you consider are the people most affected by Domestic Violence? Source: Survey of the authors.

The perception of which people suffered the most from structural violence in the communities for which they provided assistance, the answers prioritized by women (24,8%), then the elderly (22,3%), adolescents (19,2%), children (17,4%), and men (16,3%).

4) Data related to the diagnostics of the different types of violence in professional practice

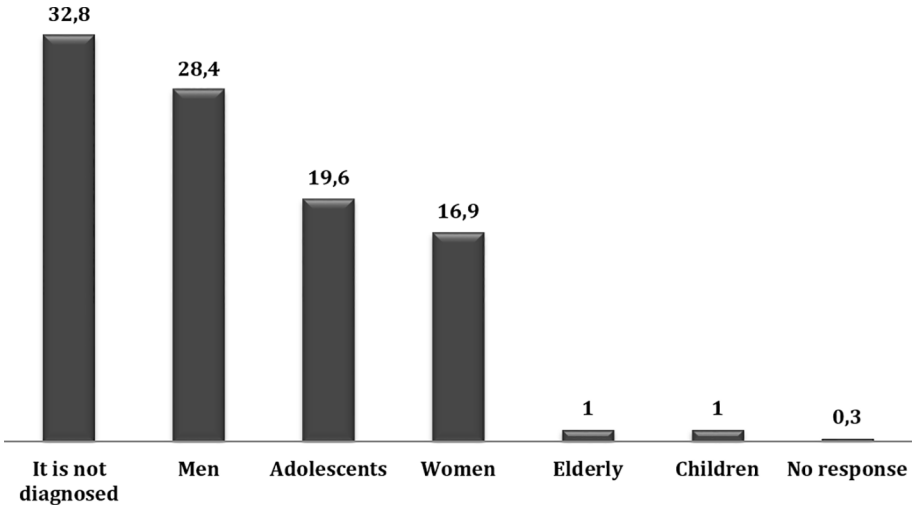
A good portion of respondents (64%) say they participate in violence diagnosis activities, although more than 30% of respondents report that they do not.

4.1. Diagnosis of gender violence and against the LGBT population

Regarding Gender Violence, professionals diagnose it mostly in women (73%), but 14% say they do not make this type of diagnosis.

Violence against the LGBT population (Lesbian, Gay, Bisexual and Transgender) is the least diagnosed. About 33% of respondents report that they do not make this type of diagnosis.

When the diagnosis is made, violence against men is the most diagnosed (28%) followed by adolescents (20%) (Graph 8).



Graph 8. Diagnosis (%) of Violence against the LGBT population. Source: Survey of the authors.

4.2. Diagnosis of domestic and structural violence

Regarding to the diagnosis of Domestic Violence, it is worth noting that more than one answer option could be marked. There were 413 bearings for 243 respondents.

The professionals reported that in the case of this type of violence the diagnoses were more prevalent when it came to women (39%), followed by children (25%); the elderly (19.4%); adolescents (11.6%). To follow there was the percentage of Not diagnosed (5.8%) larger than that of men (4.4%).

Structural violence is also relatively undiagnosed - the largest percentage (25%) is ***"Not diagnosed"***. When diagnosed, a relatively equal distribution of opinions among respondents is observed about those who suffer most from this type of violence (Table 4). The percentage sum more than 100% because it was allowed to mark more than one option.

Table 4. Diagnosis of structural violence.

	Frecuencia	%
Not diagnosed	98	25.1
Elderly	72	18.4
Women	68	17.4
Teenagers	55	14.1
Men	54	13.8
Children	43	11.0
No answer	1	0.3
Total	391	100

Source: Survey of the authors.

4.3. Participation of the professionals in activities that address violence and organization of health services

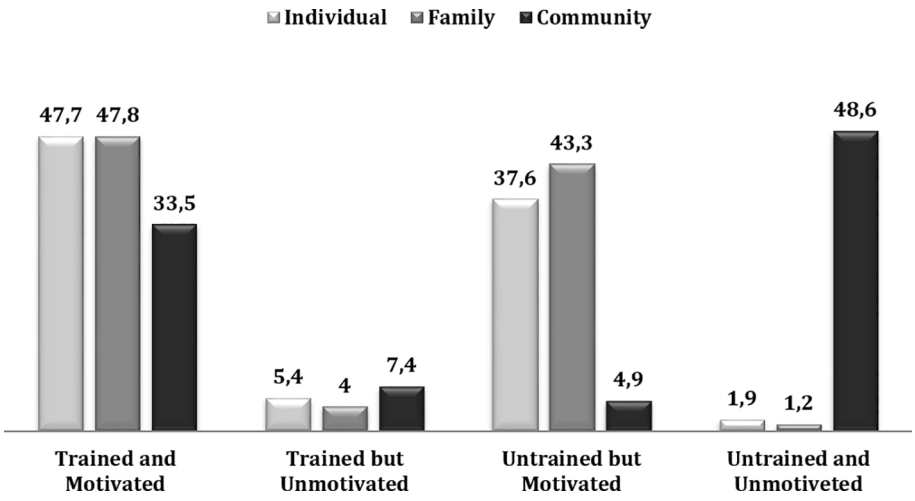
Related to participating, or not, in activities that address violence, the majority of professionals (64%) affirm that they do participate, although 36% do not.

Related to the organization of services to address violence, more than half respond that it is organized for women (54%). In second place, the percentage is **of Not addressed or not organized** (15.3%). The percentages related to the Adolescents (13.4%); Children (12.4%); Men (3.3%) and the Elderly (1.6%) are alarming.

Related to the organization of the services for the approach of the LGBTI population, close to 99% of the professionals did not answer that question, assuming that there is no organization. It is also the situation of the approach to domestic violence and structural violence, where about 99% have not answered.

5) Training and motivation for the approach of violence

Half of respondents feel trained and motivated (48%) to address violence at the individual and family level; and those who do not feel qualified (37.6% and 43.3% respectively), feel motivated, forming an absolute majority of interest in acting in these fields. But, related to violence in the community, 50% do not feel trained or motivated. (Graph 9).



Graph 9. Self-perception (%) on training and motivation to deal with the different types of violence that usually occur in PC (n = 243). Source: Survey of the authors.

The majority (89%) of respondents reported having their team (32%), other professionals (30%) or other institutions (26%) to address violence.

6) Legislation and Devices in the countries for people who go through situations of violence

The majority (78%) of the health workers who completed the form answered that there is legislation in their country that regulates what should be done for the health professional's actions in front of people or families who go through situations of violence.

Related to the knowledge on whether there is some kind of device in the respondent's country that guarantees access to some kind of attention, the absolute majority says that there is in the case of boys and girls and women (around 90%).

But the percentages decrease significantly, to just over 50% in the case of the LGBT population (57,4%) and men (55,8%).

In addition, half of the caregivers who participated in the study answered that they do not know the legislation that regulates the actions of health professionals, compared to the cases of people or families who go through situations of violence (49%).

Only one third of the caregivers who completed the form answer that there are mechanisms in their country that promote community participation in dealing with situations of violence (32%); half answer that they do not know what they are (55%). It is worth noting that of the mechanisms that have been referred, most are those promoted by the community or by Primary Care (14%).

7) Training in culture of peace

Regarding the training to face the discussions and approach of the Culture of Peace, 91% of the respondents said that she is Insufficient and/or Inadequate. The last question was open and asked: "In his opinion the CULTURE OF PEACE is:", so that people could answer what they wanted. The word cloud below highlights the 80 most-mentioned words:

Discussion

Although it was not a random sample, the participants of the survey, it can be considered that it was a sample that manages to represent the doctors and family doctors of the Ibero-American region either in terms of percentage distribution between the countries as gender.

Related to the gender, as well as in this research, it is now observed that most of the professionals in activity or undergraduate in medicine are female, which has been considered a trend in the region, as has been expressed in different studies.[11-13]

Regarding training to address violence at the undergraduate level, it was relevant that 82% of the respondents had no training in this field. It is also striking that 40% of the respondents have stated that the theoretical and/or practical training they eventually had was insufficient. These data are in accordance with other studies and show the seriousness of the situation, taking into account that violence is considered today one of the biggest health problems in the world.[14-16] Likewise, these and other studies indicate the need to improve the training of undergraduate students of Primary Care professionals in this subject.[17-19]

The numbers in relation to postgraduate training are more encouraging, but worrisome, considering that most, about 63% had no theoretical or practical training, or if they had was insufficient.

According to the perception of the majority of the respondents, the level of violence in the lives of people, families and communities was Very High or Extremely high (more than 60% in the country and more than 65% in the local job).

In the case of the communities, 70% answered that they would classify the level of violence as elevated to extremely high, considering their country and around 67% in their workplace.

These impressions are in accordance with the statistics about the different types of violence that we live in most of the Latin American countries, and that, as already seen, have to do with the great social and economic inequality and the multiple family, community, cultures that interact to create an environment that favors violence.

Related to the perception of gender violence, the result has also been impressive (67%) and women were the most cited (54%), as is often the case.

Meanwhile, related to violence against the LGBTI population, the percentages were lower - adding up to 45% - suggesting a lower perception, which is serious, once it is known that the levels of violence against this population are extreme. Men are listed first, followed by adolescents, in terms of this type of violence. In relation to the perception of Domestic Violence the percentages were very high and women and

children were the most cited. But in terms of structural violence (that maintained, promoted or facilitated by the State), the perception is lower, even if it is still high (54%). More relevant, still, is the fact that although there is a perception of structural violence, it is not diagnosed in health services, like the others.

As violence is a problem that has to do with social inequality, and structural violence has to do, just with the maintenance of inequality by part and action or inaction of the state, it seems that we have a subject that needs to be studied more and explored. Structural violence is one of the most perverse and affects all others. To not recognize structural violence is to have a very limited view of the problem of violence.

Another data that shows an important problem was the information of the respondents about the organization of the services for dealing with Violence: only half responds that it is organized, but, especially for women.

In relation to the LGBT population, domestic violence and structural violence, practically 100% of the professionals said that the services are not organized to address or deal with these problems. It is worth highlighting the serious problem about violence against the LGBT population in the region: The UN published a report in which the rate of violence against trans persons in the Americas was considered "extremely high".[20]

Regarding the motivation and training of respondents to address violence, the data are also worrisome: less than half feel trained and motivated to address violence at the individual, family or community level. But, among those who do not feel qualified, there is a difference in motivation for addressing community violence: a large part do not feel motivated for this type of approach.

One positive aspect is that most respondents report having other professionals on their team or with other professionals and with other institutions to address violence. Another positive element is that most of them answered that there is legislation in their country that regulates what should be done in front of people or families who go through situations of violence, especially the case related to children and women. But the percentages decrease significantly, in the case of the LGBT population and of men. But, although there is legislation, half answered that they do not know what the legislation is.

Only one third answered that there are mechanisms in their country that promote community participation in dealing with situations of violence and of those, half answered that they do not know what they are. It is worth noting that of the mechanisms that have been mentioned, most are those promoted by the community or by Primary Care.

Related to the Culture of Peace, it is observed that the majority (75%) of the surveyed population does not consider having received training in Culture of Peace issues. That could also be seen in the answers about what is the Culture of Peace: The response **I DON'T KNOW** was the most mentioned.

This result can be contrasted with a problem detected in the majority of health professionals' Curricula, where the contents related to the management of diseases are privileged over the contents related to the generation and maintenance of health. In this case it is observed how it is given greater importance, that in reality it is of reduced quality by the previous answers, to the theme of Violence and little is addressed the Culture of Peace.

The field of study of the family doctor is focused on working with individuals, families and communities, from a comprehensive perspective. It is worth noting that the person-centered model, inherent in the work of family and community medicine, arises in full connection with the humanist movement and the ethics of

care and is an ally for Family Physicians to promote the Culture of Peace and the Ethics of Care. It seeks an unrestricted commitment to the person, their context and, in particular, their dignity and autonomy. This is also the Spirituality, an ally of the Culture of Peace and the confrontation of violence. Spirituality is a dimension that crosses all these variables, renewing the health focus, which attempts to capture those areas of knowledge that have not been explicitly included in the policies and practices of conventional health systems. The scientific literature supports the incorporation of the approach to spirituality and religiosity of the person in health care.[21]

The formation of skills in spiritual care is an emerging issue in many universities worldwide.[22]

The spiritual care is not exclusive of the doctor but is part of the desirable competences in the whole professional and technical health team.

Conclusions

Despite the presence of postgraduate training programs in Family and Community Medicine (MFyC) in the countries of the region, the appropriate approach to violence in training and professional practices seem to constitute an important gap that needs to be covered. Violence is a serious public health problem. Health systems, although based on PC, have not managed to appease their causes, considering that this is a complex problem, of social, political and economic plots. But violence only exists if it is allowed and practiced by individuals, families and communities, just as it is for peace. It can be thought that if it is the people, families and communities that produce acts of violence, they will be the ones that can produce acts of peace.

Just as the absence of disease does not guarantee health, it is hardly possible to build a Culture of Peace solely by discounting violence. Social welfare does not depend exclusively on the effective approach of the conditions that generate social unrest. This principle of positivist approach is repeated in the model of risk factors and protection factors, as well as in the field of health promotion, which emphasizes the need to strengthen those resources that protect, maintain and enhance health.

Another important factor related to the culture of peace is rehabilitation centered on the human being, that is, the possibility of effectively thinking about mechanisms that allow social inclusion and reintegration into society.

At this point, the regulation partially favors the ideology, but not its operation.

The conditions for peace need two processes of democratization: one at the micro level from the municipalities and another at the macro level, supra-state and in both the ethic of care[23] can be applied. This perspective, which covers the journey from the box to the global social fabric, invites education for a global citizenship. This does not mean homogeneity, but a feeling of need and mutual union that precisely lies in the differences that enrich us. From the perspective of a world citizenship, we should not have alien laws, which exclude, but hospitality[24] laws.

Family and community medicine knows about this multiplicity of contexts and can contribute, from a person-centered model and a “trans-box” care ethic to a Culture of Peace and the confrontation of violence.

In terms of Primary Care and Family Medicine, we identified some general measures needed:

1. The insertion of tools for the Family and Community Approach at postgraduate level is strategic for the MFyC to value and integrate the community, supporting its mobilization against violence and for the Culture of Peace.
2. The MFyC must be introduced in a longitudinal way in the undergraduate because it is the specialty that is in a strategic position to contribute alabordaje violence and promote the Culture of Peace.
3. It is necessary to work from an intersectoral perspective to identify inequalities and plan more comprehensive actions, although the MFyC, from the perspective of the PC, has a role and makes a fundamental contribution to the construction of the Culture of Peace and the fight against violence.

Therefore the implementation in the short and medium term of the following recommendations are imposed:

1. Include necessarily in the undergraduate and postgraduate programs in Family Medicine theoretical and practical contents necessary and appropriate to each level of training, for the development of competencies (knowledge, skills, abilities and attitudes), including communication and family approach and community, which allows facing the diversity of violence in the context of professional practice.
2. Urge the authorities, in the areas of training and professional practice, to promote self-care and inner peace for families and communities for the construction and implementation of public and educational policies transversal to human development, focused on the Culture of Peace, from a human rights perspective in an intersectoral and transdisciplinary work.
3. Establish financing policies that encourage research to identify the protective and deteriorating factors linked to violence, promoting the empowerment of the population in peace issues, through participatory methodologies and tools to address the community scenario from Primary Care.

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