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IMPACT OF VIOLENCE ON THE HEALTH OF THE POPULATIONS IN THE AMERICAS

In 1993 the Directing Council of the Pan American Health Organization assumed that violence in all its manifestations is a public health priority that threatens the development of peoples, undermines their quality of life, and erodes the social fabric, reaffirming that assumption in 1996. The Region of the Americas is one of the regions with the highest levels of violence, a phenomenon that has had a significant negative impact, particularly in the countries where the incidence is greatest. It is estimated that more than 120,000 people are murdered each year and more than 55,000 commit suicide. Women and children are the victims of domestic violence; young people are both victims and perpetrators of street violence; and sexual violence and violence in the workplace undermine the physical and psychological health of the people involved. Land mines leave their victims seriously compromised.

Violence is defined as intentional acts of aggression of multiple causality that are learned behavior—acts that by the same token can be prevented, avoided, or "unlearned" Diverse activities have been promoted in the countries or undertaken in the Pan American Sanitary Bureau, pursuant to the mandates of the Directing Council. There is a need to continue prevention projects, implement the guidelines of the Strategic Plan 2003-2007, and establish a second plan of action that adapts the recommendations of the first Plan of Action, approved in 1994, to the current situation. Furthermore, tools such as the *World Report on Violence and Health* and other documents are available for consultation and efforts to deal with various types of violence, providing information on successful and unsuccessful practices.

Greater commitment on the part of national and municipal governments is needed for the execution of sustained intersectoral plans and programs. The health sector plays a key role not only in treating and rehabilitating victims but in implementing prevention projects, developing information systems, and promoting research on the causes and risk factors of violence. Communities and civic organizations have the right to participate in the search for and implementation of violence prevention projects.

The Executive Committee is requested to study this document as the foundation for establishing a Second Regional Plan of Action on Violence Prevention.

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VIOLENCE IS PREVENTABLE

"Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"
WHO, *World Report on Violence, and Health*, 2002

Introduction

Why PAHO Should Continue its Commitment to Violence Prevention

1. Violence is a social and health problem that threatens the development of nations, undermines the quality of life, and erodes the social fabric. Although a global phenomenon, there is no doubt that the Region of the Americas is one of the areas with the highest levels of violence, a phenomenon that has had a significant negative impact, especially in some countries.

2. Violence has been a matter of serious concern for PAHO, demonstrated by its commitment in 1993 to work toward a solution with all stakeholders and manifested in Resolution XIX of the 37th Directing Council, urging the governments to establish national policies and plans for the prevention and control of violence, with special emphasis on the most vulnerable groups. Subsequently, in November 1994, PAHO convened the Inter-American Conference on Society, Violence, and Health, where for the first time in the Americas, a Regional Plan of Action on Violence and Health was proposed.

3. The 39th Directing Council of PAHO of 1996 (document CD39/14) reiterated that tackling violence in all its manifestations is a public health priority, requesting the Director to provide technical cooperation to strengthen the capacity of the Member States to set up epidemiological surveillance systems on violence, promote research, disseminate information, and promote technical cooperation among countries.

4. The public health approach to violence is based on the rigorous demands of the scientific method. Thus, five basic steps are proposed to move from the problem to the solution[1]:

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[1] For a broader characterization of the concept, see Violence—A Global Public Health Problem (Chapter 1). In: *World Report on Violence and Health*. Geneva: World Health Organization; 2002.

(a) Obtaining knowledge about all aspects of violence through systematic data collection on the magnitude, scope, characteristics, and results of violence at the local, national, and international levels. This will make it possible to characterize the problem as domestic violence, juvenile violence, violence against children, sexual violence, or violence of another type.

(b) Conducting research to obtain evidence that will make it possible to determine:

- the factors that heighten or diminish the risk of violence;
- behaviors, attitudes, and beliefs that can be modified through intersectoral and/or health interventions.

(c) Designing strategies and interventions that will prevent violence and facilitate the execution, monitoring, and evaluation of interventions, using the information described in the previous step.

(d) Implementing proven or promising interventions in varied circumstances, accompanied by broad dissemination of information and a determination of the cost-effectiveness of the programs.

(e) Auditing performance and reformulating projects, as needed.

5. From the standpoint of public health, violence is a problem because:

(a) It produces a heavy burden of avoidable mortality and morbidity that impacts children, women, and young people in particular and flares up where forced displacements of populations occur.

(b) It requires major financial outlays to provide medical care to victims, frequently distorting care to other patients.

(c) It affects not only victims but their families and environment as well, producing an immediate negative economic, social, and psychological impact that lingers through the medium and long term.

(d) It also affects the individual who commits the violence, his/her family, and society as a whole—the latter not only because of the cost of incarcerating the perpetrator, but because that individual is not in a position to contribute to the social and economic development of his/her family, community, and nation.

(e) It has an adverse impact on the social and economic development of communities and nations.

(f) It affects out day-to-day existence, freedom of movement, and our right to enjoy public goods.

6. In addition to its impact on health, social and interpersonal violence has implications for society and development. For example:

(a) In the social and cultural sphere, it significantly undermines the quality of life of the population. In the case of domestic violence, it limits the political and economic participation of victims, as well as their intellectual development.

(b) In the economic sphere, it increases the cost of doing business, reduces the possibilities of foreign investment, and diminishes the social profitability of capital.

(c) With respect to urban security, violence considerably reduces the availability of recreational environments in cities, as well as the time to enjoy them, affecting health by reducing the number of safe places where people can engage in physical activity or sports.

(d) With respect to society, violence is harmful because it generates behaviors and attitudes that erode the foundations and principles of harmonious living and conflict resolution and destroys social capital. Social ethics, respect for the rights of others, or what Savater defines as the "effort to better individuals"[2] in terms of their relations with others" are seriously undermined, especially in countries where the level of violence is high and is manifested in many ways on a daily basis. Domestic violence weakens the societal link that was always considered the most secure, where members were bound by love, respect, and protection.

7. In short, violence has a high social, psychological, and economic cost for society as a whole, from the standpoint of both the victim and the perpetrator.

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[2] Savater F. *Ética, política y ciudadanía*. México: Editorial Grijalbo; 1998.

Progress of the Programs

8. Several PAHO programs have been charged with promoting different strategies to reduce violence in compliance with the resolutions of the Directing Council. The following is a summary of the progress made:

Gender Violence. Violence against Women. The Program on Women, Health and Development

9. In a joint effort with national and international institutions, the Gender and Health Unit (formerly the Program on Women, Health, and Development) has succeeded in bringing violence against women to the fore as an issue that should be addressed in public planning and one of the most important steps in the search for gender equity. New national laws or decrees have been promulgated in recognition of this problem, and the creation of special police stations or counseling centers for women and families has been promoted, where battered women or their children can obtain appropriate services.

10. A research project in several countries, entitled *The Critical Path Followed by Women Affected by Family Violence*, is one example of the contribution of applied research in combating violence against women. Its activities and studies have been concentrated in the seven Central American countries and three more in South America's Andean Area (Bolivia, Ecuador, and Peru). The successes in these countries include: more than 170 functioning community networks, with the participation of the health and education sectors, women's groups, community leaders, churches, and other community organizations; instruments for the prevention and treatment of violence, such as standards, protocols, and information and surveillance systems; training for over 30,000 health workers; and incorporation of the issue in primary school, university, and police academy curricula.

11. The external evaluation of the *Prevention and Treatment of Domestic Violence* project, conducted in 2001 and documented in the recent publication, *Violence against Women: The Health Sector Responds*, contains important lessons and recommendations for providers, activists, and policymakers, as well as victims of violence, on how to deal with this serious public health problem.

12. The website http://www.paho.org/genderandhealth contains material for raising awareness, together with and monthly fact sheets on gender and health issues, such as: the trafficking in women for sexual exploitation; gender and HIV/AIDS in the Americas; and gender equity in health. The Unit maintains a Listserv, gensalud@paho.org, which disseminates information about websites, publications, conferences, and workshops to its 1,000 subscribers.

Adolescent Health and Development

13. The Program on Adolescent Health and Development has held several meetings and carried out activities in the Central and South American countries with the highest levels of juvenile violence. In 1997 it held a Workshop on Adolescent and Juvenile Gang Violence in San Salvador, in collaboration with the Swedish International Development Agency (SIDA) and the IDB (IDB), to discuss the situation and analyze the lessons learned with various experts. The participation of gang members in this workshop was well received. Innovative studies on research, diagnosis, and the prevention of youth violence were reviewed.

14. A survey on the health of adolescents and young adults with components on violence and protective and risk factors was conducted in 11 Caribbean countries. The first stage of the project *Promoting Youth Development and Violence Prevention* is under way in five countries (Argentina, Colombia, El Salvador, Nicaragua, and Peru), in coordination with the German Technical Cooperation Agency (GTZ). The studies that provided the underpinnings for the proposals to the GTZ will soon be published. In October 1996, the Family and Community Health Area (FCH)[3] held an international conference on violence and the media in Cartagena (Colombia), which studied the issue of how to encourage media participation in violence prevention campaigns.

Healthy Settings

15. Efforts have centered on developing and implementing epidemiological surveillance systems and providing assistance for the identification of preventive interventions. *Guidelines for the Design, Implementation and Evaluation of Epidemiological Surveillance Systems on Violence and Injuries* were published and distributed and have been utilized in several sectors. Epidemiological surveillance systems of this type have been set up in hospitals in Colombia, El Salvador, and Nicaragua in partnership with the U.S. Centers for Disease Control and Prevention (CDC), as have cross-sectional studies in Honduras on intentional and unintentional injuries. PAHO has also collaborated with countries of the eastern Caribbean in the design of information systems on violence and injuries. Moreover, the epidemiological surveillance systems that track injured people seen in the emergency rooms of 11 hospitals in Jamaica were studied, a pioneering effort in the Caribbean, and in 2002, the proposal for a "Strategic Plan for Violence Prevention" was drafted and submitted. National Committees for Violence Prevention have been created in El Salvador, Honduras, and Nicaragua, and similar groups are being promoted in some cities by the mayors' offices. PAHO has promoted a Plan for Violence Prevention in San Pedro Sula and the Sula Metropolitan Valley (Honduras), which will be executed with a loan approved by the IDB. The Mayor's Office of Quito (Ecuador) has created a team from

[3] In the former structure, Division of Health Promotion.

diverse sectors to form a Technical Committee for Security and Social Harmony and has implemented two TCC projects with Bogotá and Cali in Colombia.

16. The Andean Network for the prevention and epidemiological surveillance of violence was created in Cali (Colombia) with the assistance of the Instituto CISALVA of the Universidad del Valle, a PAHO/WHO Collaborating Center. Accessible at (http://www.redandina.org), the network disseminates information on the work under way in the countries.

17. The first *Bibliography on Child Abuse* was published in collaboration with the Integrated Management of Childhood Illness (IMCI) Program. This document contains more than 700 references on the topic from the last five years and has been distributed to all the Member States.

18. In San Salvador (El Salvador), the report *Inside the Neighborhood*: *Salvadoran Street Gangs' Violent Solidarity*, conducted jointly with the José Simeón Cañas Central American University, was completed and published. This report helped shed light on the problem of juvenile gangs, known as *maras*, which are a particular problem in that country and Honduras. In this latter country, the previous Administration approved the National Plan for Combating Social Violence in Honduras 2001-2005, with technical assistance from PAHO; however, the Plan has not yet been implemented.

19. Special mention must be made of the *World Report on Violence and Health*, published by WHO with the collaboration of all the Regional Offices. PAHO made a special contribution to the production of this document, participating not only in its preparation, but assuming responsibility for its translation into Spanish, its printing, and the printing of its summary. The findings of the *Report* have been disseminated through presentations in Costa Rica (for the countries involved in the Special Meeting of the Health Sector of Central America and the Dominican Republic—RESSCAD), Brazil, Colombia, Honduras, Nicaragua, and Peru, and launches are programmed for El Salvador, Jamaica, Mexico, Panama, and Puerto Rico, PAHO Headquarters in Washington, Canada, and Bogotá, Colombia's capital at an international conference organized by the mayor's office. This document is a working tool for violence prevention.

Multicenter Study on Cultural Norms and Attitudes toward Violence—Project ACTIVA

20. A major activity in regional research is the *Multicenter Study on Cultural Norms and Attitudes toward Violence*—Project ACTIVA. This study, the result of team research

coordinated by PAHO that involved surveys of 10,821 adults, showed how violence and insecurity are perceived and experienced in seven Latin American cities and Madrid (Spain). Project ACTIVA has made a valuable contribution, shedding light on the problem of cultural norms and attitudes toward violence and making it possible to establish a baseline for future research on victimization.

Inter-American Coalition for Violence Prevention (CIAPV)

21. From the outset, PAHO has supported the Inter-American Coalition for Violence Prevention (CIAPV), officially launched in June 2000 at PAHO Headquarters, with the participation of the IDB, the Organization of American States (OAS), the World Bank, the United Nations Educational, Scientific, and Cultural Organization (UNESCO), the CDC, and the U.S. Agency for International Development (USAID). The initiative reflects the resolve of these organizations to work together to cooperate with governments, civil society, and the private sector, joining efforts to prevent and reduce the level of violence in the Americas. The CIAPV has prepared the proposal for indicators to monitor violence, a document that is in the process of publication.

Relations and Collaboration with WHO

22. PAHO has maintained constructive ongoing relations with the Department of Injuries and Violence Prevention of WHO, actively participating in consultative meetings and with regional advisers at the global level. Its involvement in the joint preparation of the *World Report on Violence and Health* should be underscored.

Current Situation

Magnitude of the Problem

23. Despite the efforts of governments, international organizations, and NGOs, high indices of violence are currently found in the Americas. Data on the different forms of violence are provided below.

Deaths from Homicide and Suicide

24. Mortality data are generally utilized in estimating the magnitude of violence. According to the official reports sent to PAHO, nearly 120,000 homicides and 55,000 suicides are recorded annually in the Hemisphere, with an estimated underreporting of 10%. More than 12 countries of the Region have homicide rates per 100,000 population in excess of two digits. The rates for some of them are classified as very high or critical;

i.e., Brazil (28), Colombia (65), El Salvador (45), Guatemala (50), Honduras (55), Jamaica (44), and Venezuela (35).

25. When domestic armed conflicts are resolved, there are significant gains in life expectancy. Two examples are illustrative: in El Salvador, comparing figures for the early 1980s with those at the end 1990, there was a 12-year increase in life expectancy for men and a 9.4 increase for women, attributable to the signing of the Peace Accords in 1992. In Colombia, where the armed conflict continues, for that same period only a 2.8 and 4.1-year increase was obtained for men and women, respectively[4].

26. As for suicides, it should be noted that the rates are highest in Canada, Cuba, Grenada, the United States, and Uruguay, although in recent years outbreaks of suicide or suicide attempts have been observed among young people in a number of Central American countries.

Domestic Violence

27. National data from the demographic and health surveys indicate that the percentage of women who suffered physical violence at the hand of their spouse or someone else was 41.10% in Colombia (2000), 2.3% in Haiti (2000), 28.7% in Nicaragua (1997-1998), and 41.2% in Peru (2000). Surveys and studies have found that some 20% to 60% of households in the Region are the scene of physical and psychological violence against women, girls, and boys.

Youth Violence

28. According to police estimates in El Salvador and Honduras, approximately 30,000 young people are involved in *maras,* or juvenile gangs, in each of the countries. These gangs are responsible for most of the violence in the countries. Managua (Nicaragua) has an estimated 110 youth gangs, with some 8,200 members[5]. Gangs are also present in Argentina and Peru (known in these countries as the *barras bravas*—tough gangs—identified with rival soccer teams), as well as Brazil, Colombia, the United States, Guatemala, Jamaica, Mexico, Panama, Peru, Venezuela, and in recent years,

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[4] For more information on life expectancy by country, see *Health in the Americas*, Chapter 1, Table 9. Washington, D.C.: Pan American Health Organization; 2002:29. (PAHO Scientific Publication No. 587).

[5] Policía Nacional de Nicaragua. 2000. *Informe en el Taller Nacional de Prevención y Vigilancia Epidemiológica de violencia*. OPS, Managua, Nicaragua, 24-27 April 2000. ERIC Honduras, IDESO UCA Nicaragua, IDIES URL Guatemala, IUDOP UCA El Salvador. *Maras y pandillas en Centroamérica, Vol. I* Pg. 218-323. UCA Publicaciones, Managua, 2001.
ACJ, Save the Children. *Las maras en Honduras. Investigación sobre pandillas y violencia juvenil*, consulta nacional. Plan Nacional de Atención. Ley especial. Frinsa Impresos, Tegucigalpa, 2002.

Chile[6] and Costa Rica. The study *Inside the Neighborhood: Salvadoran Street Gangs' Violent Solidarity,*[7] conducted in metropolitan San Salvador, noted that young people join gangs for different reasons and described their experiences and expectations. Based on this and other studies in Central America, it is proposed that this situation be considered a high-risk social conflict and that national policies for preventive interventions be adopted.

Sexual Violence

29. Sexual violence constitutes a significant health and security concern that affects men and women throughout their lifetime. Studies in different countries found that up to 36% of girls and 29% of boys have experienced child sexual abuse. Rape and domestic violence account for an estimated 5%-16% of the healthy years of life lost to women of reproductive age.[8] Despite the unreliability and scarcity of information, sexual abuse is known to be a common form of violence against children in many societies.

30. Health care staff can provide comprehensive, gender-sensitive health services to the victims of sexual violence, can collect and document the evidence needed to identify the circumstances surrounding the violence, and can also serve as an important point of referral to other services that the victim may need. This is due to the fact that people who have been assaulted often seek medical treatment, even though they may not report the event. A gap exists, however, between the service needs of victims of sexual violence and the existing level of health services provided in most countries.

31. Sexual violence has significant consequences for health, including suicide, post-traumatic stress disorder, other mental illness, unwanted pregnancy, sexually transmitted diseases, HIV/AIDS, self-inflicted injuries, and, in the case of child sexual abuse, the adoption of high-risk behaviors such as multiple sex partners and drug use. Furthermore, women who have been physically or sexually abused have been found to

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[6] Ver Salazar G. Origen y motivos de la violencia urbana en Santiago y Rancagua (Chile, 1980-1999). In: Bodemer K, Kurtenbach S , Meschkat K, eds. *Violencia y regulación de conflictos en América Latina.* Caracas: Asociación Alemana de Investigación sobre América Latina—Adlaf. Editorial Nueva Sociedad; 2001:91-110.

[7] Some 938 active and former gang members were interviewed by other former gang members affiliated with *Homies Unidos* an NGO devoted to encouraging nonviolence among youth. These interviewers were trained and supervised by the Central University of San Salvador. See Santacruz M, Concha-Eastman A, Cruz JM. *Barrio adentro, la solidaridad violenta de las pandillas.*[Inside the Neighborhood: Salvadoran Street Gangs' Violent Solidarity]. San Salvador: Organización Panamericano de la Salud/UCA; 2002.

[8] World Health Organization, World Bank, Harvard School of Public Health. *Global Burden of Disease*. Geneva: OMS; 1990.

use health services more frequently than non-abused women.[9,10] All problems associated with sexual violence, such as physical and psychological problems and high-risk behaviors attributed to abuse, need to be addressed.

Violence in the Workplace

32. One form of violence in the workplace is violence perpetrated by an armed individual against an employee or client. Another more common form is violence against employees (verbal or physical threats, coercion, intimidation, and other forms of harassment—known collectively as mobbing), which creates a hostile work environment and has a physical and psychological impact on workers.

33. In the United States, nearly 20 workers are murdered every week and 1 million assaulted each year.[11] The economic sectors most commonly involved are institutional service providers, such as hospitals, social service agencies, and businesses. Mobbing generates high levels of stress and a range of illnesses, with an estimated one out of every five workers in the United States experiencing this type of harassment each year. Non-fatal assaults on workers in that country are responsible for losses of 876,000 work days and US$ 16 million in wages.

34. In Colombia, the percentage of workers who died in 2000 as a result of homicide in the workplace was 2.6%. The proportion of workers who were victims of non-fatal assaults was 6% in 2000[12].

35. In Argentina, 6.1% of men and 11.8% of women indicated that they had been assaulted. Some 16.6% of women reported incidents of a sexual nature in 1995. Argentina is one of the countries with the highest rates of assaults and sexual harassment in the workplace, according to the International Labor Office. In Bolivia, 0.4% of men and 0.9% of were women assaulted. Some 1.3% of women were experienced some kind of sexual incident in 1996. In Costa Rica, 0.8% of men and 1.4% of women were assaulted, while the percentage of female victims of sexual incidents was 2.2%[13].

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[9] Sansone RA, Wiederman MW, Sansone LA. *Health Care Utilization and History of Trauma among Women in a Primary Care Setting.* Violence and Victims; 1997;12:165-172.

[10] Koss MP, Woodruff WJ, Koss PG. Criminal victimization among primary care medical patients: prevalence, incidence, and physician usage. *Behav Sci Law* 1991; winter; 9(1): 85-96.

[11] What is workplace violence? *http://civil.nih.gov/whatis/facts.html*.

[12] FISO; Instituto Nacional de Medicina y Ciencias Forenses. Caracterización de diferentes formas de violencia en el lugar de trabajo y exploración de sus factores asociados, primera etapa: Colombia 2002 – 2003. Bogotá, 25 July 2002. Research Group: Dr. Julieta Rodríguez Guzmán, Luz Janeth Forero Martínez, Héctor Wilson Hernández Cardoso, Patricia Castillo Valencia.

[13] Violencia en el trabajo: un problema mundial. Monday, 20 July 1998. Published simultaneously in Geneva and Washington, D.C. (OIT/98/30). ILO press release.

36. A third form of workplace violence involves working children, who in work in high-risk situations marked by abuse and exploitation. An estimated 17.4 million children in Latin America and the Caribbean work more than 45 hours per week, exposed to physical, psychological, and social risks and intolerable forms of exploitation, such as slavery, servitude, forced labor, and sexual abuse. In several countries, working children become involved in drug trafficking and organized crime [14].

Violence and Mental Health

37. Violence and mental health problems are often linked, inasmuch as the two are both a manifestation and a cause of violence. The relationship between these phenomena is complex, but there is evidence that the different types of violence can contribute to a significant increase in certain mental disorders, among them depression, anxiety, alcohol and drug abuse, psychosomatic disorders, and suicide.

38. There is little data to indicate the real impact of violence on mental health in Latin America and the Caribbean. In Brazil, a study in a population of poor children aged 4 to and 12 years showed that 10.1% had been the victim of serious assaults, and that 22.4% suffered from behavioral disorders. As to the impact of political violence, a study in Guatemala showed that the most significant problems experienced by victims of the civil war were fear (31%), sadness (29%), psychosomatic illnesses (15%), impotence (12.5%), a negative outlook (8.1%), and complicated mourning (8%). Another study devoted specifically to the problems of children and adolescents, conducted the year prior to the survey in that same country among a sample of children and adolescents who had experienced several forms of political violence, noted attention deficit disorders (27.6%), oppositional or challenging behavior (25.5%), acute anxiety (13.3%), and acute depression (7.1%).

Landmine Victims

39. The civil war in Central America left the Region littered with several thousand antipersonnel landmines and unexploded ordinance (UXOs). Today, 73,000 mines remain in Nicaragua, some 5,000 to 8,000 mines and other explosives in Guatemala, 2,000 mines in Honduras, and less than 1,000 mines along the border between Costa Rica and Nicaragua. In addition, an estimated 4,456,000 to 5,855,000 people in the Central American Isthmus have disabilities, attributable not only to war and antipersonnel devices but to natural disasters and other causes. The problem is most prevalent in groups of working age, where access to education and programs for economic and social inclusion is limited.

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[14] Every Child Counts: New Global Estimates on Child Labour. International Labour Office, www.ilo.org.

40. PAHO joined forces with both the Canadian International Development Agency, through the Canadian Mine Action Unit, and the Mexican Government to assist survivors of conflict and landmine victims—particularly disabled people—in Nicaragua, El Salvador, and Honduras. The goals of the Initiative were to strengthen national and institutional capacity while getting people with disabilities and local communities involved in the planning and implementation process.

41. This Tripartite Initiative addressed the physical, social, and economic problems of landmine survivors and people with disabilities. It has played a major role in advocating the creation of national coordinating committees comprised of the private and public sectors, getting local governments, civil society, and associations for and persons with disabilities involved to ensure inclusion of the elements needed for the prevention and treatment of disabilities in all levels of the health services and disaster practices, basic education, and family planning. The national coordinating committees have assumed responsibility for guaranteeing sustainability and ensuring the continuity of these activities**.**

42. Advocacy efforts since project start-up have paved the way for a better environment and better conditions for working with key counterparts in the countries. The result has been a more open dialogue and a willingness to collaborate in facilitating the formulation of activities.

Classification of Violence (Typology)

43. Violence takes many forms. Some classify it by the perpetrator or victim involved (youth violence, gender violence, violence against children or older adults), by where it occurs (street, home, or workplace), by the sector in which it occurs (public, private), by the underlying motive (social, psychological, economic, political), and finally, by whether or not it is self-directed. WHO proposes a three-level classification for grouping the various manifestations of violence: interpersonal, self-directed, and collective.[15].

[15] See *Informe Mundial sobre la Violencia y la Salud*. Geneva: Organización Mundial de la Salud; 2002;1:6-7.

Proposed Actions

Contributions, Value Added, and Gains for PAHO

44. PAHO's work and responsibilities in prevention are concentrated chiefly in social or interpersonal violence, gender violence, economic violence with little or no institutional basis, and self-directed violence. It is known that one form of violence can lead to the appearance or persistence of other forms. This association reveals the need for intersectoral action, since the causes of this violence are rooted in situations that are not solely the responsibility of public health or some other isolated sector.

45. The mission of the Pan American Health Organization guides our actions toward the neediest sectors and the situations with the greatest adverse impact on health and the quality of life, seeking effective and sustainable efforts.

46. The proposals for combating violence are found in the guidelines of the Strategic Plan for the Pan American Sanitary Bureau 2003-2007, which are to pursue social and human development, fight inequity, and promote institution-building in the health sector through cooperation based on the priorities and decisions of the countries. In methodological terms, they begin with the definition of strategies, programs, and projects based on good information and the analysis of protective and/or risk factors for violence.

47. PAHO's mission is to help to reduce violence, promoting the adoption of strategies and lines of action established by mutual consent with the authorities and communities. Its function is geared to:

(a) encouraging national and municipal governments to adopt and execute specific plans or programs appropriate to the nature and magnitude of the problem in each country or city;

(b) promoting research, situation analysis, and the evaluation and dissemination of the most successful programs and projects[16];

(c) improving upon and developing information systems on the various manifestations of interpersonal and social violence;

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[16]Many programs and projects are under way in Latin America and the Caribbean that are suited to the conditions and specific needs of the countries, even though the majority have not yet been evaluated and there are no published reports. One of PAHO's activities is to evaluate these programs and disseminate information on their results.

(d) strengthening the health sector response, improving care for the victims of violence and prevention programs at the grassroots level;

(e) improving networking and building strategic partnerships, and

(f) helping to address the countries' needs in terms of training and institution-building to address violence.

48. Priorities are defined on the basis of:

(a) the particular form of violence: social or interpersonal, gender, psychological, and self-directed, and

(b) social groups considered high-risk because of the inequity and specific vulnerability in which they live and as a result of gender analysis; namely: children, women, the elderly, and young adults, who are most affected by violence.

49. PAHO shares the view that violence and injuries are preventable. It therefore employs a multisectoral approach that addresses the multiple causality of violence. In the present document, PAHO reaffirms its commitment to work with all stakeholders toward a solution to the problem of violence and injuries.

Internal Proposals to the Pan American Sanitary Bureau: Improve Cooperation among and within Units and with the Representative Offices

50. It is necessary to continue the process with a second plan. The first plan contained guidelines for action; these have proven useful in policy-making and in lending visibility to the problem in order to raise awareness and emphasize the need to work together to find solutions to violence and its squeal, as demonstrated in the summary above. The first plan's emphasis on prevention remains a criterion. The new proposal defines the role of the PASB, suggests priorities and work strategies, and adapts the PASB program to the changes in the situation.

Proposals for the Member States:

51. The IMVS makes nine recommendations, some of which are mentioned below:

(a) Raise awareness and provide assistance for the development of national and/or municipal violence prevention plans. Make violence prevention, including gender- and sexual violence, part of public plans.

(b) Create or strengthen information systems:

- in rehabilitation hospitals;
- for joint working groups that include medical examiners and the police (for deaths by any external cause);
- in units that deal with domestic violence;
- for monitoring outbreaks (suicide is a growing problem in Latin America and the Caribbean);
- for monitoring juvenile violence;
- for monitoring occupational injuries.

(c) Promote research and the dissemination of information.

(d) Develop plans for prevention and the treatment (secondary or tertiary) of victims.

(e) Propose networks and carry out intersectoral work in the countries through coalitions.

52. The proposed actions must be adapted to the countries, and their implementation will have to begin both there and in the Secretariat. This implies the need to strengthen the units in charge of this area, particularly through extrabudgetary funds.

Key Points for Discussion

53. Secure a real commitment from national and municipal governments to draw up intersectoral prevention plans and projects to combat social, interpersonal, and self-directed violence. These plans and projects should be sustainable and have the necessary financial and human resources allocated.

54. Determine the health sector's contribution to the detection, prevention, treatment, and referral of victims of violence.

55. Develop information systems, indicators, and methods for analyzing the data on the different forms of violence and implement them.

56. Coordinate efforts between government sectors and civil society and its organizations.

Action by the Executive Committee

57. The Executive Committee is requested to study this document as the foundation for a Second Regional Plan of Action on Violence Prevention.

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