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VIOLENCE AND HEALTH

Violent behavior in the Region of the Americas constitutes both a serious public health problem and a cause of deterioration in the quality of life. Its consequences for community health and well-being, for social harmony, and for economic stability have taken on alarming dimensions.

Violence affects all social strata; however, certain highly vulnerable groups such as women, children, and the elderly suffer its impact disproportionately. The prevention of violence is feasible inasmuch as it is an expression of human behavior, attitudes, and lifestyles, all of which can be modified through activities aimed at health promotion.

The information available in the Region refers mainly to the fatal outcomes of violence, expressed in mortality rates and potential years of life lost. Data on morbidity and the consequences for the victims and for their immediate social groups in the short, medium and long term are more limited and less reliable.

The response of the health sector to the problem has been inadequate. The health services have focused on the immediate care of injuries, but even here, coverage is incomplete and the accessibility of services is limited. To a lesser extent there has been a focus on the psychosocial aspects and on rehabilitation. Actions geared toward prevention have been few, and have generally been limited to isolated cases.

There is urgent need to change the approach of the health sector to violence by modifying the structure and operation of the health care services and introducing effective measures of primary prevention, jointly with other concerned social sectors. Support for epidemiological and socio-anthropological research, personnel training, and the promotion of legal measures are some of the strategies that should be considered.

Health promotion programs, which encourage healthy behaviors, discourage unnecessary risk-taking, and favor rational solutions to conflicts, are the principal instruments within the health field for the prevention of violence.

When the item on this issue was presented at the 111th Meeting of the Executive Committee, several members intervened in the discussion. It was suggested, inter alia, that the definition of violence should be expanded to include self-inflicted violence, and it was emphasized that violence primarily affects young adults. Several members also emphasized the importance of the social and environmental factors that contribute to violence.

The Executive Committee adopted Resolution III on the subject, which is reproduced below.

RESOLUTION III

VIOLENCE AND HEALTH

THE 111th MEETING OF THE EXECUTIVE COMMITTEE,

Having seen Documents CE111/19, "Violence and Health," and CE111/6, "Report of the Special Subcommittee on Women, Health, and Development,"

RESOLVES:

To recommend to the Directing Council that it adopt a resolution along the following lines:

THE XXXVII MEETING OF THE DIRECTING COUNCIL,

Having seen Document CD37/_, "Violence and Health," and its Annex, "Report of the Special Subcommittee on Women, Health, and Development";

Considering that violent behavior is a public health problem of great magnitude and importance in the Region of the Americas and that it is a cause of economic loss, moral injury, avoidable premature death, and deterioration of the quality of life;

Recognizing that violence against women is a special problem with serious social repercussions, given the link that exists between discrimination and abuse;

Recognizing as well that violence against distinct vulnerable groups, especially children, youth, and the elderly, generates specific problems that have a negative impact

Acknowledging that the health sector should play a fundamental role, along with other sectors, in the search for solutions and the application of measures for the prevention and control of all forms of violence,

RESOLVES:

1. To urge the Member Governments to:

   a) Establish national policies and plans for the prevention and control of violence in collaboration with all the social sectors involved;

   b) Give priority to the establishment of support service networks for the management of violence against women and children with the collaboration of women's organizations;

   c) Identify and mobilize the necessary resources for establishing multisectoral health promotion and protection programs for the promotion of healthy behaviors, the reduction of exposure to unnecessary risks, and the adoption of legal measures that support the prevention and control of violence;

   d) Promote multidisciplinary research on the problem, and establish the necessary training programs.

2. To ask the Director, within the resources available:

   a) To formulate a regional plan of action on violence and health that contains a special component on violence against women;

   b) To collaborate with the countries on the identification and mobilization of financial resources for the execution of these proposals.

(Adopted at the fourth plenary session, 29 June 1993)

Annexes

VIOLENCE AND HEALTH

CONTENTS

1. Definition of the Problem

The Working Group on the Psychosocial Consequences of Violence, convened in The Hague in 1981[1], agreed to define violence as the imposition between human beings of a significant degree of avoidable pain and suffering. It would be fitting to add to that definition self-inflicted acts that produce suffering and harm to the individual himself and those immediately surrounding him. Such a broad definition--which says nothing about the intentionality or deliberate perpetration of the violent act, the victim's lack of consent, or the duration of the consequences--allows sufficient room for the concept to embrace the different forms of violence with specific effects on the health of the victims. It also makes it possible to exclude other events that do not qualify as expressions of violence; for example, certain accidents where the human factor plays a minimal role, as well as natural catastrophes and occurrences.

Two aspects of this definition deserve special mention. One is that violence is the product of actions that are carried out by humans and affect other human beings. The other is that the pain and suffering that violence induces are avoidable. A third implicit facet of the definition is the ethical unacceptability of violence, which is seen as an assault on the individual's human rights.

Violent acts are human behaviors with somatic, psychosocial, and ethical consequences, which manifest themselves in the short and long term. They include all kinds of aggression, both self-inflicted and that caused by others, in addition to some preventable accidents. They are closely related to the expression of aggressiveness, the presence of conflicts, and the socioeconomic conditions in which these develop, although the relationship is not necessarily one of linear causality. The study of such acts can suggest indicators with regard to risk factors, help to identify vulnerable groups, and guide the formulation of programs geared toward health promotion, treatment, prevention, and rehabilitation.

The Declaration of the International Conference on Health Promotion[2], held in Bogota in 1992, summarizes the principles that undergird the prevention of violence, affirming that the right to and respect for life and peace are the ethical values of the culture of health, and that the strategy of health promotion seeks to promote life, not to degrade it.

2. Rationale for Including Violence in the Agenda of the Health Sector

Violence affects individuals and communities in various aspects of their lives--most significantly, as mentioned above, in aspects related to health. Other factors, such as economic, legal, and political considerations, are also important and should be taken into account in any assessment of the health aspects, with which they overlap.

The health sector constitutes the "end of the line" where most of the consequences of violence for human health and well-being converge. Public health is concerned with the problem of violence to the extent that its effects jeopardize the physical and emotional integrity of the victims. The fact that violence results in deaths, injuries, disabilities, and suffering justifies its incorporation in the policies, plans, and programs of the health sector. Moreover, the analysis of its causes, the description of its natural history, and the assessment of its impact on the structure and operation of the health system, all provide ample evidence that violence is indeed an important public health concern.

The care that the health sector provides to the victims of violence involves mainly emergency services, specialized care, and rehabilitation centers. The sector has also established systems of classification and registry,[3] and it has taken part in activities concerned with the medical-legal aspects of violence. Only recently has the health sector directed its attention to the psychological and psychosocial aspects of violence, both in terms of the impact on victims and in relation to environmental factors, the characteristics of the victimizers, and the consequences for the latter.

What is needed, then, is to enlarge the spectrum of actions undertaken by the health sector in such a way that the services it offers incorporate or expand the psychosocial dimension in treatment and rehabilitation programs. In addition, the health sector should develop actions aimed at primary prevention, directed especially to high-risk groups, through the execution of interventions that seek to modify those factors within its scope of action.

3. Magnitude and Severity of the Problem

The different factors that influence the genesis, course, and outcome of violent acts must be viewed from various angles. The problem should therefore be approached from multiple perspectives, taking into consideration the apparent cause of the violence, its form of expression, the affected groups, and the nature and severity of the injuries inflicted on the individual, the family, and the society. However, the data currently being collected by the health services reflect only the identification and evaluation of physical injuries, the sex and age of the victim, and sometimes also the means used to inflict the violence.

4. Mortality Related to Violence

In the Region of the Americas the most readily available statistics relating to violence are those on mortality from violent causes, although they, too, suffer from obvious underregistration. Despite its importance, this information only hints at the magnitude and gravity of the problem, since it reports only those outcomes which are most extreme. These data refer to deaths; thus they do not reveal the impact of violence on those who survive an assault, on persons close to the victims, or on the aggressors.

In the Region of the Americas, mortality from causes associated with violence is alarmingly high[4]. These causes underlie a substantial percentage of all deaths. In Mexico, for example, violent acts accounted for 5% of total deaths in 1982, and for 8% of the total years of potential life lost (YPLL). In El Salvador violent deaths were 9% of total deaths in 1984 and accounted for 21% of the YPLL (Table 1).

Moreover, mortality from violent acts in Latin America is clearly on the increase, as can be seen in the evolution of mortality from homicide (not including war-related deaths) in the 1968-1987 period[5]. In general, the highest rates of homicides during that period occurred in men from 25 to 44 years of age (110-125 per 100,000 in El Salvador and 75-125 per 100,000 in Colombia). In Colombia the rates increased by 50% between 1972 and 1982 and tripled between 1983 and 1992.
(Graph 1).

Mortality from suicide, although in general relatively low in the Region, has shown some tendency to increase in certain countries (Graphs 2 and 3). In several countries and territories of the Region, among them Canada, the United States of America, Puerto Rico, and Suriname, suicide is among the five principal causes of death in the age group from 5 to 14 years. Suicide generally constitutes a problem of greater importance in the older age groups. In the United States of America the suicide rate in 1981-1985 was around 12 per 100,000, making it the fifth-ranking cause of YPLL. For the group aged 15-24 years it ranked second as a cause of death, following deaths from traffic accidents[6]. Homicide in the United States of America ranked 12th as a cause of death, and was the leading cause of premature mortality (YPLL)[7]. The problem in this country is especially severe among African American males aged 15-24. In this group mortality from homicide rose from 60.6 per 100,000 in 1984 to 84.7 per 100,000 in 1987.

5. Morbidity Related to Violence

Violent behaviors which do not result in death can, nonetheless, cause physical injuries, mental suffering, and psychological disorders; these in turn may lead to functional limitations, disabilities, and handicaps. Available information on the frequency and severity of violent acts that do not result in death is much less reliable than the data on mortality. Not all the cases in this category come to the attention of the health services or the police; and even when there are obvious injuries, information provided by the victims or their family members is not always complete or reliable. This occurs especially in cases of domestic violence, where the victim is frequently a woman or child who may be incapable or reluctant, for various reasons, to report the abuse.

To these circumstances must be added the relative weakness of record-keeping by emergency rooms and outpatient health services. Most of the available information on morbidity from violent acts is derived from studies of specific population groups and from estimates based on field observations. For example, a study carried out in

Medellín, Colombia, revealed that 28% of the patients undergoing physical rehabilitation suffer from disorders or conditions caused by violence[8]. It has been estimated that 1% of the Central American population in 1985 was physically disabled as a result of the wars in this subregion[9].

It should be noted that deaths from violent causes have secondary effects in terms of their impact on the mental health of the survivors, especially with regard to mourning and its psychopathological aftermath (post-traumatic conditions). This "secondary victimization" is amply supported in the literature, which suggests that some survivors are especially vulnerable to emotional disorders[10] [11]. The situation is rendered even more serious by the fragmentation of the social support network that can occur at the same time, especially in situations in which the violence is associated with war or political persecution. Surviving children are especially vulnerable, and studies have shown that the loss of the parents through violence can lead to behavior disorders present four years later[12]. It can be assumed that when violent death is not an isolated incident, but rather a widespread occurrence--as is the case in wartime--the psychopathological effect is even more extensive and malignant. Added to the consequences of losing one or both parents at an early age are the effects of the violence itself as a self-perpetuating phenomenon, since a person who witnesses violence in the home or in the immediate social surroundings, in a context that rewards violent behavior, may be at higher risk for later engagement in violent acts[13].

6. Highly Vulnerable Groups

6.1 *Young Adults*

Violence stemming from war, social and labor problems, poverty, and inequity mainly affect young adults, particularly males. This has far-reaching repercussions on production and social well-being, and is reflected in disabilities and years of potential life lost.

The highest rates of homicide in the Region during the period 1968-1987 were recorded among males aged 15-24. In El Salvador the rates for this group in the same period ranged between 110 and 125 per 100,000, and in Colombia they ranged between 75 and 125 per 100,000. In the latter country homicide in 1990 was the leading cause of death among those under 30 years of age[14].

The problem of homicide in the United States of America is particularly severe among the black male population aged 15-24. In this group mortality from homicide increased from 60.6 per 100,000 in 1984 to 84.7 per 100,000 in 1987[15].

The role of young people as perpetrators of violence, especially urban violence, is of particular importance. Acts of vandalism, assaults on individuals, and homicides

committed by young people in groups or acting alone are occuring with increasing frequency. In Colombia the majority of hired murders are carried out by young people, often minors[16].

Suicides and attempted suicides among young people are a public health problem of increasing importance in the Region. Suicide is among the five leading causes of death in the 15-24 age group in 13 countries in the Region, in which the rates ranged between 4.3 and 26.7 per 100,000 in the period 1980-1985[17].

6.2 Children

Children are a group that is especially vulnerable to violent acts. A high proportion of these acts occur at home, but children are also mistreated frequently at school, in the street, and at recreation sites. Violence against children most commonly takes the forms of physical, psychological abuse, and sexual abuse, economic exploitation, and negligence on the part of caretakers. However, these make up only a small part of a spectrum that ranges from neglect, stemming from emotional detachment and lack of interest and incentives, all the way to abandonment and brutal physical abuse resulting in death.

Data for this subject suffer from underregistration, even in the most developed countries of the Region. However, information from the United States of America can provide an approximate idea of the dimensions of the problem. Cases reported in this country in 1991 included 2.7 million cases of negligence, physical abuse, or sexual abuse of minors under 18 years old, yielding an incidence of 2 per cent in this population group[18].

Several studies on child abuse in Latin America illustrate the situation. Research carried out in Colombia[19], for example, found that 41 of every 1,000 children seen by the pediatric services in one city had suffered some form of abuse. Another study from Colombia suggests that the greater a child's initial vulnerability, the higher the risk of abuse. Thus the risk of abuse for children with below-normal mental abilities was 16 times that of a control group of schoolchildren.

In a study carried out in the Dominican Republic on models of child-rearing[20], it was found that 47% of the children in the sample had been physically abused at home, in most cases by the parents; 10% of the abused children required medical attention. Of the children studied, 33% had suffered sexual abuse.

The World Declaration on the Survival, Protection, and Development of Children was approved by the World Summit for Children, held in New York under United Nations auspices in September 1990. The declaration represents a commitment on the part of the participating countries, and prescribes concrete measures for the protection

of children[21]. In accordance with the recommendations of this important gathering, a Regional Advisory Group on Child Abuse met under the auspices of UNICEF and PAHO/WHO in São Paulo, Brazil, in June 1992. Participants in that encounter pointed out the scarcity of reliable data on the frequency and distribution of violent acts against children. In the absence of better data it was agreed to accept the estimate, based on data collected by UNICEF, that at least 6 million children in Latin America are subject to severe abuse, with 80,000 per year dying violent deaths at the hands of family members and or other people close to them.

Documents presented at the São Paulo meeting[22,23] highlight the following:

-In Central America an estimated 1.5 million children have been displaced from their homes by armed conflicts.

-A considerable number of children in Central America, Colombia, and Peru have been used as soldiers, messengers, liaisons, and transporters of war supplies.

-It is estimated that Central America has 2.5 million displaced persons and 316,500 persons officially registered as refugees, a substantial proportion of whom are children. In Nicaragua alone, 7,200 children are believed to have been killed, wounded, or mutilated because of the war.

-It is estimated that more than 100,000 Central American children have been orphaned by the war. Many of them have witnessed the torture, rape, or murder of their parents.

-Statistics from 11 countries of the Region support estimates that between 7 and 8 million children have become "street children." They are often victimized by the types of violence prevalent in the urban environment.

-It is estimated that at least 30 million Latin American children of school age are working full-time and an indeterminate number are working part-time.

-Information from eight Latin American countries suggests that nearly half a million children are confined in closed institutions, which in general are deviating from the purposes for which they were designed.

-In Brazil, homicides accounted for 15% of the deaths from external causes among minors under 19 years of age in 1985. Research in an urban area of Brazil found that 32% of the youths interviewed received physical punishments, especially the youngest age group (11-13 years of age).

6.3 *Women*

Violence against women and girls is the maximum expression of gender discrimination and violation of the human rights of this population group, preventing them from attaining fulfillment as members of society.

Over the last 25 years there has been growing recognition that violence against women of all ages contributes to a deterioration in the quality of life, while hindering their full participation in economic and social development and the achievement of equality and peace. Important statements on the subject include the declaration of the International Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1981)[24], and the Nairobi recommendations (1985)[25] set forth in the Nairobi Forward-Looking Strategies for the Advancement of Women.

The United Nations General Assembly and the specialized agencies have dealt with the issue on various occasions, making specific recommendations for the introduction of legal provisions and measures to protect women and children from all types of violence and abuse[26,27,28,29]. Since the end of the 1980s, PAHO[30] and, more recently, WHO have been engaged in research on the problems that affect women who are victims of violence, especially domestic violence. In the technical discussions at PAHO on the subject of women, health, and development (May 1992), it was recommended that steps be taken to intensify the collection of data and information on the health problems of women, including the problem of violence[31]. The XIII Special Subcommittee on Women, Health, and Development of the PAHO Executive Committee recommended in April 1993 that the subject be treated as a major public health problem requiring the health agencies to respond with actions geared toward prevention as well as treatment and rehabilitation[32].

Violence against women and girls affects not only the physical integrity of the victims, but also their emotional, sexual, family, and work lives. The use of violence against women places them at a disadvantage in the exercise of power and authority relations in the various social spheres. It constitutes the most acute expression of the social inequality that exists between the genders, and serves as an instrument of domination aimed at maintaining the subordination of women in society. Violence denies women their autonomy and freedom and undermines their self-determination by preventing women from fully exercising their rights.

Governments in the Region have offered only a limited response to the problem of violence against women. Treatment and prevention programs run by nongovernmental institutions provide most of the coverage. Of 109 programs identified in the Region, 87 were run by nongovernmental organizations, 15 by government entities, 4 by academic institutions, and 3 by regional organizations[33].

The statistics on morbidity and mortality resulting from violence against women do not reflect the true magnitude of the problem, owing to the significant underregistration by both health care and law enforcement institutions. The women who turn to these agencies for help are, in general, those who find themselves in intolerable crisis situations. The rest, the vast majority, never come into contact with either system, or if they do, they do not provide sufficient information to establish violent acts or assault as the cause of their complaints.

According to a Canadian publication[34], gender-specific violence not only is widely accepted, but in some cultures is even expected. In Canada, 1 of every 10 women is beaten by her husband, and in the United States of America 4 women die every day as a result of violence. The same publication notes that in Peru, according to police sources, 70% of the crimes reported to the police involve women beaten by their husbands. Research carried out in Chile[35] in 1992 found that 33.5% of the women interviewed had been psychologically abused and 26.2% had suffered physical violence.

Among the reasons for the underregistration, both of domestic violence and of female morbidity due to violence, is the fact that most victims do not seek assistance from health care institutions. Moreover, health care personnel and even the victims themselves often believe that dealing with violent incidents is beyond the competence of the health sector and falls within the exclusive jurisdiction of the police. Another factor that causes underregistration is the focus of the health services on treating the injury, without recognizing that it resulted from human interactions that could have been avoided. Finally, the greater visibility of violent deaths diverts attention from other less tangible forms of violence that are primarily psychological or social in nature.

The magnitude and importance of the problem of violence against women and children is also obscured by sociocultural patterns and by distortions arising from the structure and operation of the health services. The widespread belief that violence is inherent in the nature of the male, while the nature of the female is to be submissive and peaceful, contributes to the legitimization of aggression by men against women. Within the health services, the sole emphasis on the female reproductive function diverts attention from other psychosocial and health problems of women, particularly those linked to violent acts. The relatively low importance assigned to the problem of unwanted pregnancies adds to the risk of violence against the child and the mother.

6.4 *The Elderly*

Elderly people as a group are particularly vulnerable to violence. Factors contributing to their high risk include the frequency with which the elderly find themselves in situations of physical, psychological, and economic dependence; the diminution of their physical abilities; and their increasing social isolation. Demographic changes currently under way in the Region are leading to a progressive increase in the

absolute and relative number of elderly people in the population, with a corresponding increase in public health problems linked to this new situation. The mistreatment of elderly people and, more generally, the perpetration of all types of violent acts against this age group, thus constitutes a growing social and public health problem.

Violence against the elderly is not limited to physical and psychological abuse and negligent care, but may also include financial exploitation, violation of their rights, and sexual abuse. A review of 30 surveys carried out in the United States of America between 1979 and 1985 identified more than 12 categories of abuse[36]. The problem is extensive, especially in countries that have a high proportion of elderly people. A 1985 report by the U.S. House of Representatives Select Committee on Aging[37] estimated that each year 4% of the elderly (more than one million people) are subjected to physical, emotional, or financial abuse by family members or other persons close to them. In a review of research carried out in the United States of America, Wolf[38] suggests that the proportion of the elderly population subject to physical abuse ranges from 4% to 10%. It should be emphasized, however, that the studies cited have certain limitations that preclude application of their results to the entire country. A national study on abuse of the elderly carried out in Canada[39] in 1988 found that 4% of elderly people in that country had suffered one or more forms of abuse in the recent past, with the most frequent forms being financial (2.5%), verbal (1.4%), and physical (0.5%).

7. Environmental Factors Associated with Violent Behavior

Numerous studies have pointed to an association between violence and various social and environmental factors. Among these interacting factors are the frustrations stemming from the struggle for survival in situations of inequity, marginalization, and poverty. In such circumstances the intensity and frequency of violence may be determined by the perception that these neglected populations have of their effectiveness as an instrument for achieving individual and social improvement.

The shanty towns and deteriorated inner cities of the Region are characterized by social, environmental, and economic conditions that are likely to lead to aggressive behaviors. In the absence of substantive changes in the living conditions of their inhabitants brought about by the state and society, these foci of disease and violence tend to persist and expand, leading to the proliferation of aggressive behavior directed toward the achievement of concrete ends. The successful outcome of such behavior tends to make it more frequent, persistent, and widespread[40]. The weakening of judicial systems and legal controls, combined with the continued existence of conditions propitious for violence, may generate or reinforce **cultures of violence** that value and validate violence as a means of resolving frustration, disagreements, and conflicts. The fostering of **cultures of coexistence** that will lead to respect, tolerance, and dialogue constitute a challenge for the countries of the Region and a mechanism for the promotion of health and improvement of the quality of life.

Violent responses may be induced in children as a result of the verbal, physical, or symbolic aggression that occurs in families, at school, or in the community. An illustration is provided by the case of undesired children, who are subjected from birth to rejection and family aggression. As such they are victims of violence in their formative years, and it thus becomes a part of their personalities and a way of life. Consequently, they become agents of violence themselves when they reach adolescence and adulthood. In this way the circle of violence is perpetuated, and comes to be perceived as a normal element of daily life, with no attempt made to rectify the situation. A similar phenomenon occurs among mothers who are the victims of physical and psychological abuse who, in displaying similar behavior toward their own children, perpetuate in them the chain of abuse to which they themselves were subjected.

Although violence cannot be explained excusively from the standpoint of poverty, it is evident that this is an important determining factor. The overcrowding, undernutrition, unemployment, and family breakdown that go hand in hand with poverty are major factors contributing to the development of aggressive means of conflict resolution within the family and in the community at large. The economic crisis of the 1980s and the consequent aggravation of socioeconomic inequalities is one of the factors that have led to the increase in mortality from homicide in many countries in the Region.

The resolution of political conflicts through armed confrontation and war operations has been translated, in some countries, into a considerable increase in mortality, especially among young men. In El Salvador, for example, the armed conflict raised mortality in 1984 to 144.4 per 100,000 population[41]. Similar situations have occurred in other countries, such as Colombia and Peru.

Preventive activities have been proposed to control some of the risk factors identified, among them:

- Firearms. In various countries attention has been drawn to the frequency with which homicides and personal injuries are associated with the possession of easily obtained firearms. In the United States of America[42], according to the Public Health Service of the U.S. Department of Health and Human Services, a majority of the 21,000 homicides in 1987 were committed with a firearm in the course of a dispute between persons who knew each other. In the same country between 1979 and 1986, firearms were used in 60% of the homicides and suicides and in a high proportion of cases involving injury to the spinal cord[43]. Stricter regulation of firearms, howver, is still controversial in the United States.

- Drinking and drug abuse. Another environmental factor frequently linked with violence is the abuse of alcohol and other psychoactive substances by the victim, the victimizer, or both[44]. Research by Wolfgang[45] points to high alcohol consumption by the victims and the perpetuators of homicide. Hotaling and Sugarman[46] found a clear association between male drinking and aggression

against women and children. Ladoucer and Temple[47] demonstrate an association between excessive ingestion of alcohol and sexual assault. Violent acts related to the trafficking and consumption of psychoactive substances have reached epidemic proportions in some countries of the Region.

- Television. Research has been under way for several decades to determine whether television may be a risk factor that encourages violent acts. There is a general consensus that watching violent television programs may lead to an increase in the physical aggressiveness of children. Canterwall[48] asserts that the homicide rates in the white population of South Africa increased noticeably starting in 1975, when the existing ban on television was lifted in that country. He also points out that annual homicide rates in Canada and the United States of America nearly doubled in the 10-15-year period after television was introduced in both countries. (In the United States of America the rate rose from 3 homicides per 100,000 population in 1945 to 5.8 per 100,000 in 1974; and in Canada, from 1.3 per 100,000 to 2.5 per 100,000 in the same period.) The factors that intervene in the production of violence are numerous and complex, and include demographic, economic, and sociocultural influences. It would be an error to hold television exclusively responsible for the observed increases in the rates of violence in the foregoing examples; however, the accumulated evidence supports the conclusion that a connection can be demonstrated between television and violent or aggressive behavior.

The factors discussed in the preceding paragraphs are only a few of the many variables which have been linked to violence, and which have formed the basis of proposals for preventive actions. A broad spectrum of factors have been identified, ranging from personality traits and the psychological profiles of victims and victimizers to the histories, sociocultural characteristics, and economies of the communities where they live. Personal characteristics--determined in part by heredity, by early childhood experiences, and by the environment in which the child and adolescent grows up--have been the focus of various interventions. Grouped under the rubrics of education, primary prevention, and health promotion, these interventions seek to encourage peaceful behavior through activities focusing on interpersonal relations, conflict resolution, gender relations, the preservation of identity, and the struggle for survival. Furthermore, the social, political, and cultural factors related to violence--such as poverty, marginality, overcrowding, political persecution, and the lack of opportunities for minority groups--go beyond the immediate capacity of the health sector to respond. Nonetheless, the health sector, jointly with other sectors, can, in addition to pointing out these factors and their consequences, make important contributions to the development of policies, plans, and programs for the prevention and control of violence.

8. Impact of Violence on the Health Care System

Violence in all its forms is placing an ever-increasing burden on the health services, requiring an increasing allocation of resources of all types to cope with the demand. The provision of urgent care to the victims of violence is overloading the emergency services, outpatient clinics, general hospitals, specialized centers, and services of forensic medicine, and has made it necessary to provide them with additional human and material resources.

The consequences of violence in the medium and long term also compromise the structure and operation of the health services. The physical, psychological, and social repercussions of violence place a particular burden on physical and psychological rehabilitation services and those concerned with social welfare.

Violence and its consequences impose enormous costs on society, and on the health services in particular. For society, the most important consideration is the social cost, represented by years of potential life lost, suffering, and a deterioration in the quality of life. The most easily quantifiable element, years of potential life lost, is alarmingly evident in the statistics.

The costs that violence imposes on the health sector are related to the direct and indirect expenditures for the immediate care of victims, follow-up treatment, and rehabilitation. In the United States of America it is estimated that the cost of trauma and personal injury, whether purposely inflicted or not, reached US$158,000 million in 1985[49]. Violence can have a direct effect on the structure and operation of the health services by placing a strain on their facilities and personnel. It also directly affects the personnel and centers that train human resources, causing physical and psychological harm.

9. Basis for a Regional Plan of Action

The prevention and control of violence demands coordinated action by different social sectors, among them the health sector. An example that illustrates how actions can be coordinated toward this end is the "Peace, Security, and Development" program sponsored by the mayor's office of the city of Cali, Colombia[50]. The program, which is primarily educational, seeks to build relationships between the police and the community; promote social harmony, civility, and democracy; support families; facilitate the cooperation of volunteers; and encourage citizen participation, the modernization of the judicial system, and the involvement of young people. Another example, the Safe Communities Network[51], provides a unique opportunity for the development of programs to control violence.

Efforts to prevent and control violent behavior involve diverse factores, dependent on, among other circumstances, the severity of the problems, the relevant legal issues,

and the sociocultural environment. These three factors are distinguished by the following characteristics:

- An understanding of the magnitude and distribution of the problem of violence and of the factors that affect it is an indispensable condition for the development of rationally based actions. Information available on this subject is fragmented and somewhat unreliable or outdated. Hence the importance of promoting epidemiological research that can provide reliable and timely information to serve as a basis for the establishment of policies and strategies and for the development of operational plans and programs. The promotion of research in this field--aimed at the identification of the psychosocial factors, the economic impact, and the social repercussions of violence--together with quality control of the services, and the evaluation of interventions, constitute an important strategy for programs of prevention and control.

- Legal regulations, which provide the legal basis for activities to control violence, frequently suffer from imperfections, owing in part to their vagueness and ambivalence. Despite these difficulties, the law does provide generic mechanisms for protection against violence, applicable to all elements of society; some directly target the violence and its consequences, while others seek to reduce the vulnerability of high-risk groups. Thus, the constitutional provisions of the countries concur in recognizing the right to life and the right to be recognized as a person in the eyes of the law, which are frequently violated by acts of violence. Other provisions create institutions such as special prosecutor's offices for women, the elderly, or children, set up to receive complaints of aggression against these groups and to take the corrective and preventive measures appropriate to each case.

In the past decade, international law has incorporated principles intended specifically for the protection of the most vulnerable groups. The convention on women has already been mentioned; there exist in addition the Convention on the Rights of the Child[52] and the United Nations Principles for Older Persons[53].

- An analysis of the problem of violence from a socio-anthropological perspective constitutes the third pillar which must support actions proposed for the prevention and control of violence. This analysis must take into consideration aspects such as the structure of family relationships, child-rearing practices, the structure and operation of social networks, the use of free time, and the perceptions, attitudes, and beliefs regarding violence, both in general terms and with regard to specific problems such as "machismo," risk-taking, and territoriality, among others. In general, the application of the knowledge and techniques of the behavioral sciences has a relatively short history. It is only in the last two decades that some initiatives have been undertaken with a view to modifying collective behavior

related to health.

The strategies proposed for the development of a Regional Plan of Action are oriented toward intersectoral coordination, encouragement of citizen participation, promotion of a **culture of coexistence**, and the adjustment and adaptation of health services. To these must be added, as support strategies, the promotion of research, particularly epidemiological and sociocultural research, and the development of human resources.

Intersectoral coordination is a key element in preventing aggressive behaviors and their underlying economic and sociocultural factors. The variety of predisposing conditions and situations that must be corrected extend beyond the scope of the health sector and necessitate the involvement of various sectors and disciplines. Consequently, attention should be focused on achieving consensus in policy-making, coordinating efforts, and exchanging information in order to take joint action to prevent violence.

Fostering **citizen participation** in developing the plan is a fundamental strategy. Community members can make valuable contributions in assessing the situation, designing strategies and actions to deal with it, and collaborating in carrying out actions to improve it. The perception of violence as a problem that concerns all members of society and not only the authorities is a fundamental requisite for its prevention. Involvement of the population in analyzing the situation, proposing solutions, and carrying out remedial actions will both enhance the programs and encourage the change in attitudes that lies at the heart of prevention.

The promotion of a **culture of coexistence** through the extolling of values and behavior founded on tolerance and respect for the rights of others is a core ingredient of any education and training activities that accompany health promotion, and is an essential aspect of violence prevention.

The **adjustment and adaptation of the health services** should ensure appropriate care for the mediate and immediate victims of aggression. It is not only essential to guarantee the treatment of injuries but also their physical and psychological sequelae. Health services should become involved in rehabilitating victims and family members and in stimulating community participation in prevention programs.

The general strategies of the Plan of Action should be directed toward addressing the factors that lead to the various forms of violence and changing the aggressive behaviors they engender. Particular importance should be given to the design and support of projects that will:

- contribute to preventing family violence, specifically violence against women and children;

- maintain community awareness of the nature and impact of violence and keep it from becoming accepted as inevitable;

- promote appropriate resolution of interpersonal conflicts in the community and the workplace; and

- strengthen the capacity of health services to prevent violence and treat its victims.

The targets proposed include, inter alia, setting up national commissions, in countries that have not already done so, to study problems related to violence and advise the authorities on the formulation of policies, plans, and programs for assistance and prevention. The targets also include enabling the health services to attend to the needs in this area and involving the community in the control and prevention of violence.

The actions proposed for attaining these targets are broad in nature and include:

- The formulation of national prevention and control policies and plans;

- The development of national, provincial, and local programs, with special emphasis on multisectoral interventions;

- The formulation and implementation of special projects designed to protect highly vulnerable groups such as young adults, women, and children;

- The development of projects designed to sensitize the population with regard to the effects of violence on daily life and to prevent it from becoming accepted and tolerated as an unavoidable phenomenon;

- The development of projects to mobilize national and international human and financial resources (NGOs, cooperation agencies, etc.) to support the plans and programs;

- Support for epidemiological research;

- The establishment of a system for collecting, producing, and distributing technical information, in addition to general information to sensitize the population;

- Support for academic and in-service training programs on issues related to the prevention and control of violence;

- The establishment of liaisons with police and judiciary authorities and the

development of coordinated activities aimed at the enactment of appropriate legislation, legal protection of victims, and the provision of joint services; and

- Technical advisory services.

Health promotion activities, which encourage healthy behaviors, discourage unnecessary risk-taking, and promote tolerance and the rational solution of conflicts, are the principal instruments for the prevention of violence in the field of health.

Some of these programs, which seek to bring about changes in lifestyles through interventions during the formative years of the individual have proven to be an effective strategy for the control and prevention of numerous disorders and conditions. Their application to the prevention of violence can open promising avenues of action.

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TABLES AND GRAPHS

TABLE 1

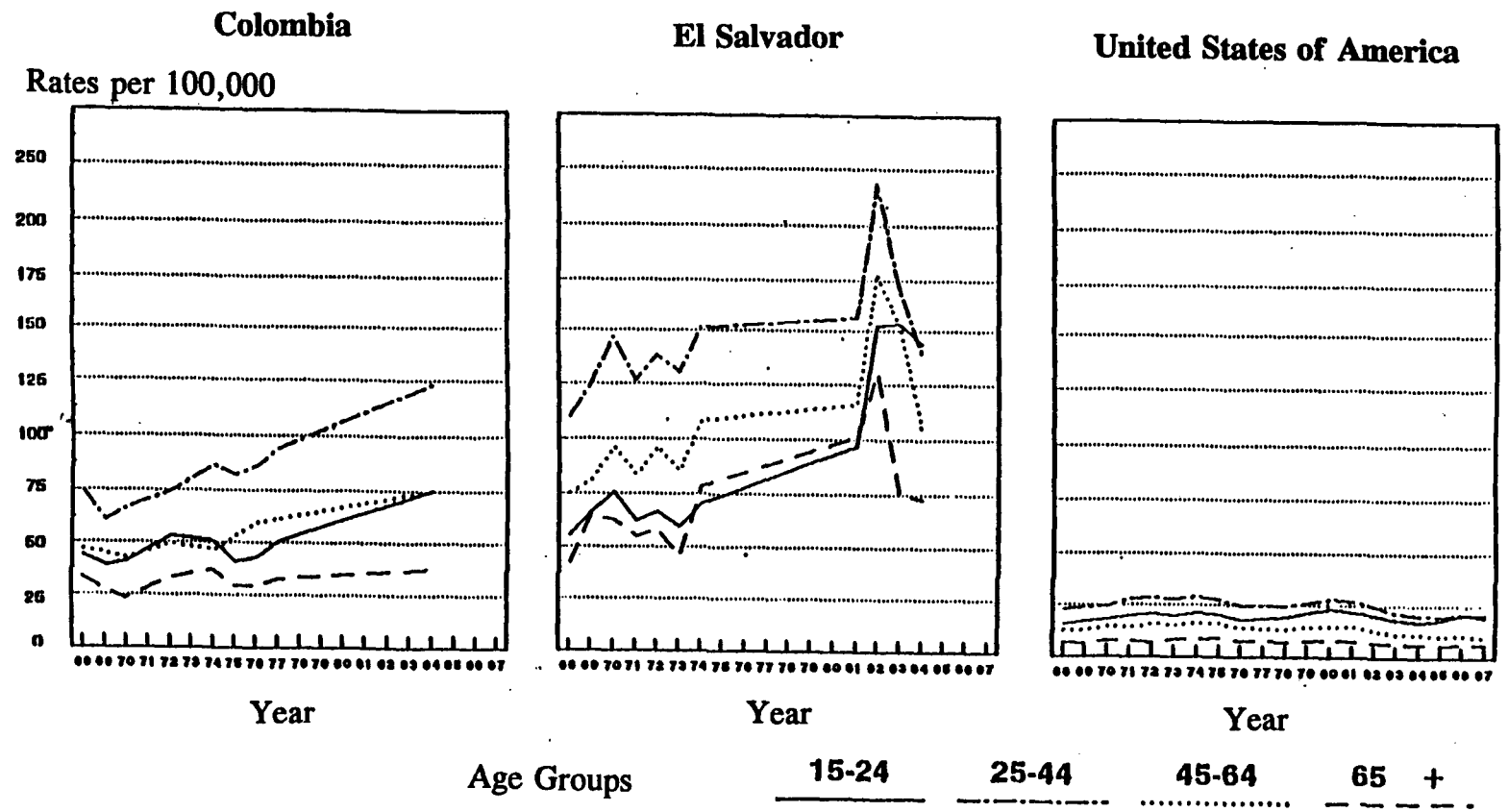
PERCENTAGE OF ALL DEATHS AND OF TOTAL YEARS OF POTENTIAL LIFE LOST DUE TO DEATHS ASSOCIATED WITH VIOLENCE: BOTH SEXES AND MEN ONLY, IN SELECTED COUNTRIES

Country	Year	Percentage of deaths associated with violence		Percentage of total years of potential life lost due to violent acts	
		Both sexes	Men	Both sexes	Men
Paraguay	1985	1.8	3.0	5.9	8.5
Colombia	1981	6.5	10.6	14.3	21.2
Brazil	1983	2.9	4.2	9.8	13.2
El Salvador	1984	8.7	12.6	21.4	26.3
Mexico	1982	3.5	5.5	8.1	11.2
Puerto Rico	1985	3.5	5.4	16.8	20.9
Barbados	1984	1.0	1.5	6.9	9.4
United States	1985	2.4	3.4	13.8	16.2

Source: PAHO, 1989

GRAPH 1

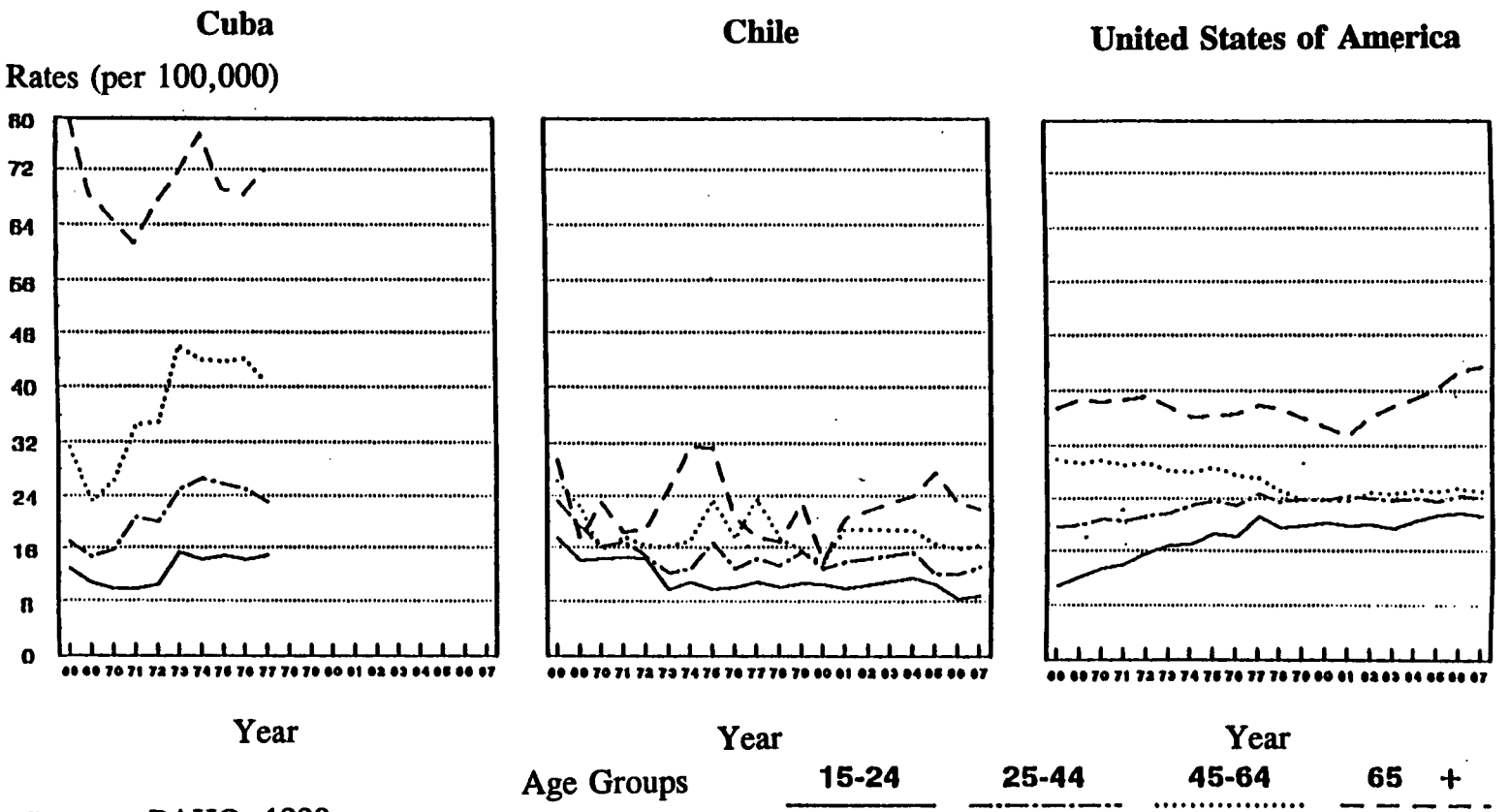
AGE-ADJUSTED MORTALITY RATES FOR HOMICIDES IN MEN
COLOMBIA, EL SALVADOR AND THE UNITED STATES OF AMERICA, 1968-1987



Source: PAHO, 1990

GRAPH 2

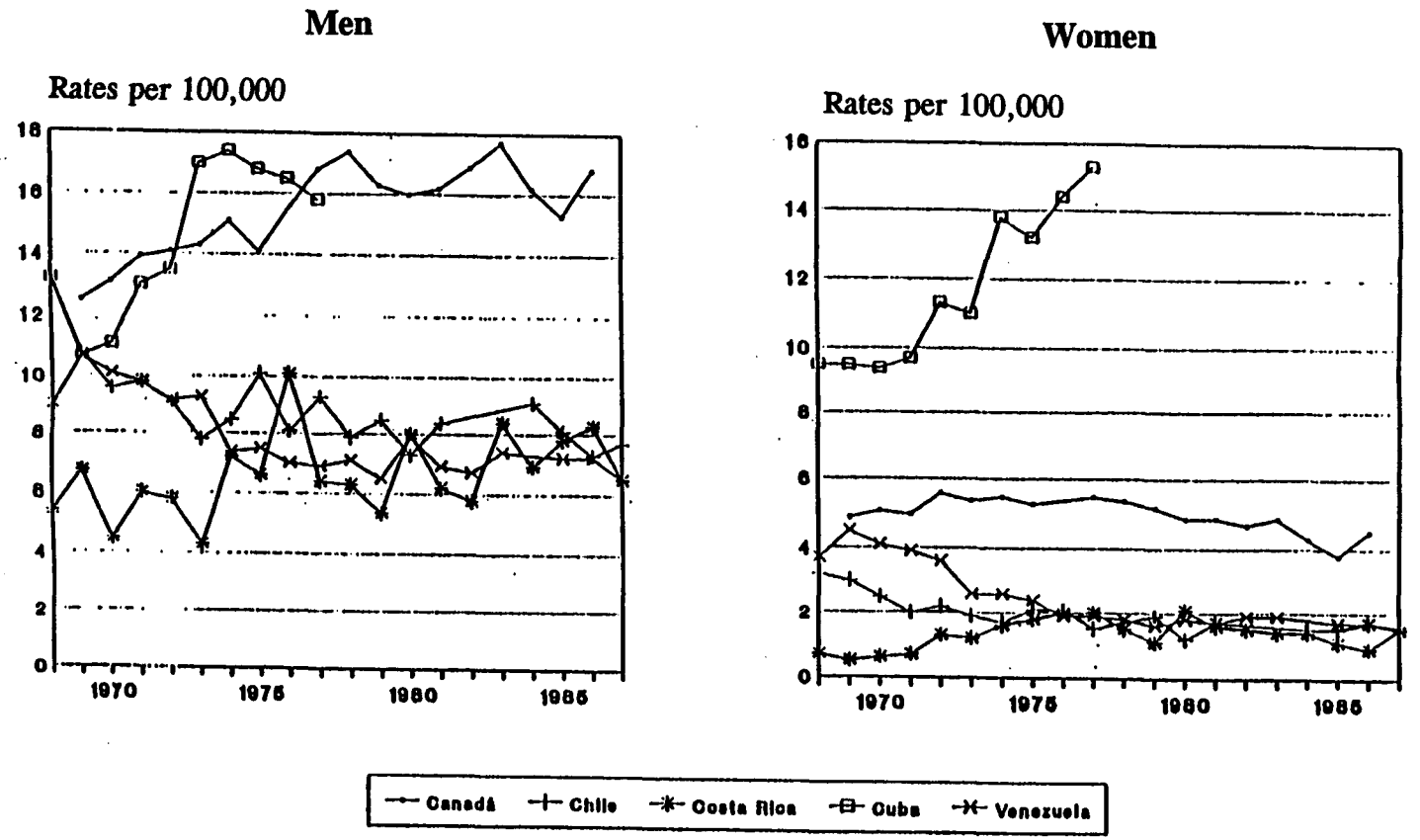
AGE-ADJUSTED MORTALITY RATES FOR SUICIDES IN MEN
CUBA, CHILE AND THE UNITED STATES OF AMERICA, 1968-1987



Source: PAHO, 1990

GRAPH 3

AGE-ADJUSTED MORTALITY RATES, BY SEX, FOR SUICIDES
IN SELECTED COUNTRIES OF THE REGION OF THE AMERICAS, 1968 - 1987



Source: PAHO, 1990

executive committee of the directing council

working party of the regional committee

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

111th Meeting
Washington, D.C.
June-July 1993

CD37/19 (Eng.)
ANNEX II

Provisional Agenda Item 3.2

CE111/6 (Eng.)
3 May 1993
ORIGINAL: SPANISH

REPORT OF THE SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

The 13th Meeting of the Special Subcommittee on Women, Health, and Development of the Executive Committee, the Final Report of which is annexed, was held at the Headquarters of the Pan American Health Organization, in Washington, D.C., from 5 to 7 April 1993. The meeting was chaired by Dr. María Elena de Rivas, of Honduras, with Ms. Maritza Tamayo of Cuba acting as Vice Chair and Ms. María Rodríguez de Tello of Peru as Rapporteur.

After hearing the report on the evolution, current situation, and prospects of technical cooperation on women, health, and development, the Subcommittee indicated that an important task for the future will be to define indicators that can measure progress and evaluate technical cooperation in this area. The members also emphasized that any effort at progress and evaluation will require the cooperation and participation of the countries.

The interagency preparatory activities for the World Conference on Women to be held in 1995 were described, along with the plan of work for the coming years.

Colombia's policy "Health for Women and Women for Health" was recognized as the first health policy to be formulated and implemented using a gender-based approach. The Subcommittee recommended that information about this pioneering effort be broadly disseminated in the Region, and requested the Secretariat to promote exchange and cooperation between countries with common interests in this area.

The proposals to promote equity in health by promoting women's health were examined. The delegates agreed on the need to have activities that are geared toward changing attitudes and perceptions regarding women's health and lifestyles. They

suggested that more emphasis be placed on the strategies of communication and promotion of self-care, taking into account sociocultural factors and local realities.

Violence against women and girls was discussed, and the proposed Regional strategies of action were approved. The delegates unanimously recommended the inclusion of this topic on the agenda of the Governing Bodies of the Organization and its recognition as a Regional public health problem that calls for urgent intervention strategies and the cooperation of the health sector. They requested the Executive Committee to study this problem and bring it to the attention of the Directing Council.

The proposal to promote and develop research on women, health, and development was examined and a plan of work presented on the subject of "Women, Gender, and Communicable Diseases," with emphasis on tropical diseases. It was also felt that the strategy of promoting specific topics had the potential to mobilize different areas, thus focusing interest on this field. The proposed plan was approved, with the recommendation that a report be submitted on its results.

There was a presentation on the research initiative for Female-Friendly Services, which, through a gender-based approach and a female perspective, seeks to help change and improve services so that they are better adapted to meet women's needs. The Subcommittee applauded the initiative and requested that the study be disseminated and that technical advisory services be provided to ensure its success.

There was also discussion of the proposal for a Regional system to monitor and evaluate the health status of women and sex differentials in health. The Subcommittee agreed that minimum indicators need to be established for the Regional level and for groups of countries in order to ensure monitoring and evaluation of the health conditions of women. The Secretariat was asked to prepare a proposal for discussion at the next meeting.

Finally, under "Other Matters," the Subcommittee discussed the status of women in the Pan American Sanitary Bureau, and a report was presented on the progress that has been made in appointing women to positions of higher authority. The Subcommittee expressed its thanks for the report and requested that the Secretariat examine the barriers that prevent professional women from being hired and promoted to high-level positions.

The agenda for the 14th Meeting of the Subcommittee in 1994 was discussed and approved, taking into account the issues examined and the recommendations made by the delegates.

Annex

PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE COMMITTEE OF THE DIRECTING COUNCIL

SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

13th Meeting
Washington, D.C., 5-7 April 1993

MSD13/FR (Eng.)
7 April 1993
ORIGINAL: SPANISH

FINAL REPORT

FINAL REPORT

The 13th Meeting of the Special Subcommittee on Women, Health, and Development of the Executive Committee was held at the Headquarters of the Pan American Health Organization, in Washington D.C., from 5 to 7 April 1993.

The following members of the Subcommittee, elected by the Executive Committee, were present: Cuba, the United States of America, Honduras, Peru, and Saint Vincent and the Grenadines. Colombia participated as an observer.

Also in attendance, as observers, were representatives from the following agencies: the Inter-American Development Bank (IDB), the Inter-American Commission of Women (IACW), the United Nations Children's Fund (UNICEF), and the United Nations Development Fund for Women (UNIFEM).

OPENING OF THE MEETING

Dr. Carlyle Guerra de Macedo, Director of PAHO, opened the meeting and welcomed the members of the Subcommittee and the other participants, wishing them success in their deliberations.

OFFICERS OF THE MEETING

The following officers were elected:

Chair:	Dr. María Elena de Rivas, Honduras
Vice Chair:	Ms. Maritza Tamayo Hodelín, Cuba
Rapporteur:	Ms. María Rodríguez de Tello, Peru
Secretary ex officio:	Dr. Carlyle Guerra de Macedo, Director, PAHO
Technical Secretary:	Dr. Rebecca de los Ríos, Regional Coordinator of the Program on Women, Health, and Development, PAHO

AGENDA

The Subcommittee adopted the following agenda:

1. Opening of the Meeting
2. Election of the Chair, Vice Chair, and Rapporteur
3. Adoption of the Agenda
4. Technical Cooperation on Women, Health, and Development: Evolution, Current Situation, and Prospects
5. Summary of Interagency Preparatory Activities for the World Conference on Women to be Held in 1995
6. Health for Women and Women for Health: A Policy of the Republic of Colombia
7. Violence against Women and Girls: Analysis and Proposals from the Perspective of Public Health
8. Health Promotion: Improving the Health Status of Women and Promoting Equity
9. Proposal for the Promotion and Development of Research on Women, Health, and Development
10. Proposal for a Regional System to Monitor and Evaluate the Health Status of Women and Sex Differentials in Health
11. Female-Friendly Services: A Research/Action Initiative
12. Other Matters

PRESENTATIONS, DISCUSSIONS, AND RECOMMENDATIONS

Presented below is a summary of the presentations and discussions on each agenda item, along with the recommendations of the Subcommittee:

Item 5: *Summary of Interagency Preparatory Activities for the World Conference on Women to be Held in 1995*

Dr. Rebecca de los Ríos, Regional Coordinator of the Program on Women, Health and Development of PAHO, summarized the principal activities carried out thus far in preparation for the World Conference on Women to be held in Beijing, China in 1995, and noted that this meeting will coincide with the 50th anniversary celebration of the United Nations. She reported that the Region of the Americas will present an interagency document at the conference which will be drawn up under the coordination of the Economic Commission for Latin America and the Caribbean (ECLAC), on the topic of "gender equity, sustained development, and consolidation of democracy."

Summary of the discussion

With regard to the health strategies that PAHO will propose for inclusion in the interagency document to be presented at the World Conference, the Cuban delegate said that while reproductive health should not be the central focus in the approach to the issue of women in development, it should not be ignored either, since it is still a major concern in many countries. The Peruvian delegate stressed that it was important to include discussion of the health of working women in the interagency document.

Other participants in the Meeting commented on the importance of the interagency effort, as a reflection of the collaboration within the United Nations system, as well as the wealth of activities being pursued by the governments and nongovernmental organizations.

Recommendations

The Subcommittee approved the proposed plan of work and recommended that the Subcommittee and the Member Countries be kept informed about the preparatory activities for the World Conference.

Item 4: Technical Cooperation on Women, Health, and Development: Evolution, Current Situation, and Prospects

The document on this topic summarized the activities carried out by the Regional Program on Women, Health, and Development of the Pan American Health Organization within its various spheres of action, and analyzed PAHO technical cooperation in this area, as well as future prospects. The item was presented by Dr. de los Ríos, who began with a follow-up report on the recommendations that the Subcommittee had made at its 1992 meeting. She continued by describing the evolution and current situation of the delivery of PAHO technical cooperation in WHD, pointing out that there had been three phases: (1) mobilization and creation of opportunities within the Organization; (2) organization and planning; and (3) institutionalization and technical and scientific development. She summed up the results obtained, as well as the activities carried out in 1992 with the collaboration of other Regional programs of the Secretariat, concluding her presentation with a discussion of the prospects for 1993.

Summary of the discussion

With regard to the follow-up on the agreements and recommendations adopted by the Subcommittee at the 12th Meeting in 1992, the Chair indicated that the Secretariat needed to facilitate technical and methodological support for the incorporation of the gender approach in health, as well as to provide cooperation for training. Several of the members expressed concern over the limited Regional efforts in the area of women, work, and occupational health. Dr. de los Ríos explained that, while the WHD Program had supported country initiatives during the year, there had not in fact been any activity at the Regional level, since priority had been given to other matters that had not been programmed originally, such as interagency activities in preparation for the World Conference on Women.

The members of the Subcommittee thanked the speaker for the presentation on the evolution and assessment of technical cooperation on women, health, and development, which had provided some perspective on the development of this area at the Regional level and in the countries. They suggested, however, that it would be useful to have indicators that could provide an accurate assessment of the advances, achievements, and problems that affect the health status of women in the Region, as well as any results that the countries have obtained.

Sir George Alleyne, Assistant Director, PAHO, addressed the subject of assessment and indicators, saying that it was important to specify the kind of assessment that was being talked about, given that an assessment of the evolution and situation of women's health in the Region is quite different from an assessment of the evolution and

current situation of technical cooperation on women, health, and development. Both kinds of assessment are necessary, and must be performed through the collaboration and combined efforts of the countries and the Secretariat.

The United States delegation stressed the relationship between equity, the status of women, and women's health, noting that policies and programs need to include a special focus on such critical areas as occupational health and violence against women.

Dr. Carlyle Guerra de Macedo, Director, PAHO, thanked the Subcommittee for its comments and contributions, and made several points regarding technical cooperation. He cited the importance that has been placed on the development of methodologies to implement the gender approach, and acknowledged that the Secretariat had not fully grasped this concept so as to be able to move beyond the stage of analysis to action. He indicated that several internal training activities were planned for 1993.

Dr. Macedo expressed satisfaction over the consolidation of the project on Comprehensive Health of Women in Central America, and disappointment over the relative lack of progress in research on women. With regard to occupational health, he noted that, while 1992 had been a year of intense activity, particular attention had not been given to the status of working women. He discussed the scope and limitations of the information available on occupational health, not only in relation to women but to both sexes, as well as the obstacles that needed to be overcome in order to define plans of action in the countries.

The Director reaffirmed his continued support for efforts in the area of women's health, and said that he was confident that the Subcommittee's deliberations would be fruitful.

Recommendations

After discussing and analyzing the presentations, the Subcommittee requested the Secretariat to: 1) complete the analysis of the barriers preventing women from being hired by PAHO and promoted to high-level positions, and to provide the Subcommittee with detailed information on the status of women within the Organization prior to the close of the 13th Meeting; and 2) continue its efforts to support the countries as they work to improve their information systems on occupational health, as well as promote and support research on occupational health from the gender perspective.

Item 8: Health Promotion: Improving the Health Status of Women and Promoting Equity

This item was presented by Dr. Gloria Coe, Regional Advisor in Social Communication of PAHO, who emphasized the contribution that health promotion has made to social and economic development, with a view to improving the health status of women and their families in Latin America and the Caribbean. She said that the aim of the document was to provide more information about the leading causes of death and disease among women in the Region, and the related social and environmental conditions. It also proposed lines of action to assist the Governments in the areas of policy, health and social programs, community organization, empowerment of women, education, and research. The document concluded with a proposal for lines of action in health promotion that PAHO and its Member Countries should implement, with the goal of promoting more human-centered and equitable development for both men and women, as well as improving the health status of the women in the Region. These guidelines are expected to help the Member Governments prepare concrete plans of action for health promotion.

Summary of the discussion

There was consensus among the participants with regard to the importance of implementing activities aimed at changing attitudes and perceptions regarding women's health and lifestyles. Several members suggested that there should be stronger emphasis on education and communication as a means of reshaping attitudes toward domestic violence, the risks associated with chronic diseases, etc.

It was stressed that the strategy of promotion of women's health needs to be implemented in the primary care context, and it was noted that women play a central role in health promotion. It was recommended that sociocultural factors be taken into account, and that language diversity be acknowledged so that health promotion efforts are not carried out solely in a country's official language. It was added that the countries need to more clearly define those women's health problems that merit a stronger and more sustained promotional and educational effort.

The Chair praised the document presented and agreed that primary health care needs to be a priority. The United States delegation shared that country's experiences with the "Healthy People 2000" project.

Dr. Alleyne stressed the idea of "missed opportunities" and talked about how it would be possible to take advantage of opportunities to provide education on health promotion in schools and health services, particularly on issues that affect women.

Recommendations

The Subcommittee requested that the Secretariat, in implementing the proposed activities in the field of health promotion, place emphasis on educating women about their own health, and that PAHO facilitate an exchange of information between countries. It underscored the importance of working in accordance with the epidemiological profile of each country, as well as the priority areas targeted for education and prevention efforts. The Subcommittee emphasized that health promotion should be a central focus and recommended that the initiatives to disseminate information on this and related subjects be supported. It also recommended that concrete initiatives to implement the suggested strategies and lines of action be developed in countries or groups of countries.

Item 11: Female-Friendly Services: A Research/Action Initiative

Dr. Néstor Suárez Ojeda, Regional Advisor on Maternal and Child Health of PAHO, presented this item. He noted that the document explored women's health care in Latin America and the Caribbean and discussed the differences and disparities that are observed in the delivery of health services and the resulting discrimination against women. Attention was drawn to the need to rethink the health care model from the gender perspective in order to make it more equitable and effective. The concept of "female-friendly services" was explained, and research/action methodologies were proposed for evaluating the existing services from the gender perspective and promoting positive changes in them. To that end, elements for preparing research protocols were provided, and several instruments for examining the services from the gender perspective were suggested.

The document proposed activities that PAHO might undertake as part of its technical cooperation and highlighted experiences that the Organization had supported in the countries of the Region.

Summary of the discussion

During their discussion the members of the Subcommittee agreed to stress the following points of action: involving other sectors and programs; analyzing efficiency factors and other indicators; developing a study of missed opportunities caused by lack of human resources; preparing a profile of services according to levels of complexity; and, particularly, ensuring the accessibility of these services and high quality health care for all women. Female-friendly services must be suitable from the human, technical, logistic, and information perspective, and should incorporate relevant cultural traditions in each instance.

In response to these concerns, Dr. Suárez Ojéda assured the participants that the process is being adapted to each country, and that it is the countries themselves that are taking the lead in implementing this initiative. Information on various experiences is being collected and instruments are being changed as the need arises in each country by adapting terminology to local usage and even eliminating certain points.

Dr. Alleyne expressed the opinion that the mere fact that there had begun to be talk of a change in the attitude toward women in the services was a major step forward.

Recommendations

The Subcommittee agreed with the Secretariat that the proposed instruments need to be revised before being sent to the countries so that they could be made more suitable, and recommended that PAHO provide technical advisory services on their use to the countries involved in the initiative.

Item 6: *Health for Women and Women for Health: A Policy of the Republic of Colombia*

The document prepared by the Ministry of Health of Colombia was presented by Dr. Wolfgang Munar Angulo, Deputy Minister of Health, who explained that the Colombian case was being presented as a means of sharing, for instructive purposes, the Ministry of Health's experience with a health policy that specifically targets women. The document reported on the socioeconomic, demographic, and political factors that had formed the context for the formulation and initial implementation of the policy.

The Colombian policy endeavors to bring about a reorganization of women's health care that meets women's needs and acknowledges biological, psychological, and social aspects, while shifting the focus in health care away from reproductive health. One year after formulation of this policy, the Ministry, at its central level, is at the stage of disseminating it and sensitizing the various health care levels, with a view to obtaining a commitment from all men and women and securing their participation in helping bring about the proposed changes. This will involve officials, NGOs, international organizations, (PAHO, UNICEF), and various institutions. The main effort has been concentrated on holding training seminars and disseminating information, as well as on presenting projects with a view to obtaining financing to underwrite the initial changes that need to be made in the local health systems.

Support for and efforts to implement this policy are still incipient. There need to be more extensive educational activities and efforts need to be stepped up--both in terms of research and action--to respond to the problems that affect women, including abuse, mental health disorders, and occupational health issues.

Summary of the discussion

The presentation by Dr. Munar was enthusiastically received by all the participants, who recognized the great importance of this pioneer experience in the Region, being the first policy on women's health with a gender approach, and concluded that many countries might follow the example of Colombia. Several members of the Subcommittee asked for more information about how the country had initiated and implemented the process of incorporating this policy into the Constitution and putting it into practice.

In response to the different questions with regard to the implementation of the process, Dr. Munar explained that Colombia had not attempted to create something from nothing, but rather had taken advantage of the existence of a variety of nongovernmental women's organizations who collaborated to support the proposed policy from the beginning. He specifically mentioned the contribution that the First Lady of Colombia had made in supporting the execution of this new pro-women policy, and noted that in implementing it the country had used the approach of focusing on a target population--in this case poor women--so that resources and efforts would not be spread too thin. He personally felt that what was most important was to ensure the policy's continuity through changes of government.

With regard to the incorporation of the policy on women into the 1991 Constitution, Dr. Munar explained that he had not been involved in that phase of the process, and asked Dr. Argelia Londoño of Colombia, who had been involved from the beginning, to provide more information. Dr. Londoño said that the strategy had been to approach the appropriate authorities at the local level, for which purpose some 200 groups of nongovernmental women's organizations were organized to promote this action.

Recommendations

The Subcommittee considered that this very interesting Colombian experience could serve as an example to other countries, and recommended that PAHO disseminate it and facilitate cooperation between countries who are interested in this subject.

Item 7: Violence Against Women and Girls: Analysis and Proposals from the Perspective of Public Health

Dr. Argelia Londoño, Consultant to the WHD Program of PAHO, presented this item. She stressed that during recent decades, abuse and violence against women and girls have increasingly become an important concern for nongovernmental women's organizations and United Nations agencies. She noted that it was widely recognized that discrimination and abuse are closely linked, and that violence against women is a health

problem with ethical and legal dimensions, as well as human rights implications. Violence against women erodes the fabric of community life, causing a breakdown of emotional ties, quality of life, and social well-being. It has become such a pervasive social pattern that more than half of women are affected. The family, school and work, and the health services are some of the social contexts in which violence disrupts human relationships.

The document recommended the adoption of a series of proposals for redirecting health sector responses in order to provide treatment and rehabilitation programs for victims of abuse, and to promote more democratic relations between human beings by teaching them how to live together peacefully. It also proposed conflict resolution and the establishment of epidemiological surveillance systems, as well as research and participatory action, with a view to ensuring diagnoses and interventions that are timely, effective, and humane. In addition, it recommended intersectoral strategies for dealing with the problem on a more comprehensive basis.

Summary of the discussion

The participants agreed that one of the principal problems with regard to violence against women is that sometimes the violence is so subtle and hidden that even the women themselves don't recognize it. Women need to be educated about their rights, and health professionals and members of the police force need to be taught to recognize violence. The delegate from Saint Vincent and the Grenadines observed that violence against women is frequently the product of child abuse, and that the perpetrator of this type of violence is usually the mother, who is the head of household in a large percentage of low-income homes. She added that nurses are usually in the best position to counsel women to prevent abuse of their children, since they can take advantage of the opportunity provided by the consultations around the time of childbirth.

Most of the discussion centered around the strategy that should be adopted to ensure that the problem of violence against women and girls, heretofore treated as a domestic conflict, is recognized as a public health problem as well and the countries take strong measures in this regard. The participants agreed to recommend implementation of the strategies outlined in the document and to place special emphasis on education and prevention, as well as special health care services for the victims.

The Subcommittee discussed several alternatives for bringing about the desired action by the Executive Committee. That body in turn could take the matter to the Directing Council, so that the specific problem of violence against women would be analyzed, and the health sector could take measures to support prevention, treatment for victims, and rehabilitation.

Recommendations

There was consensus among the Subcommittee members that it was important for this topic to be examined by the Executive Committee and then submitted by the Executive Committee to the Directing Council in the form of a proposed resolution recognizing that violence against women and girls is a public health problem and recommending the adoption of pertinent measures for its prevention and treatment by the health sector. The Secretariat was requested to mention this concern explicitly in the Final Report of the 13th Meeting.

At the same time the Subcommittee recommended that efforts be stepped up to sensitize those in the health and legal professions, to disseminate information, and to increase awareness of this problem, which will require coordinated action between the governments and civil society. It was also pointed out that closer coordination and communication is needed between women's groups and health services so that concerted action can be taken both in the area of prevention and treatment.

Item 9: Proposal for the Promotion and Development of Research on Women, Health, and Development

In presenting this item, Dr. Elsa Gómez, Consultant to the WHD Program of PAHO, indicated that the purpose of the proposed project was to promote and support in the Region, in a systematic and coordinated manner, the production and effective utilization of knowledge concerning the interactive relationships that exist between the biological, physical-environmental, and sociocultural elements that shape both the health of women and their contribution to development. She noted that the document described the institutional background of the initiative, pointed out the sizeable gaps in information in the area of women, health, and development, outlined the analytical approaches that it is hoped to stimulate, and proposed strategies to encourage and guide the development of research on this subject in the Region.

Dr. Gómez informed the Subcommittee that, in line with the recommendations issued by the 12th Meeting, the WHD Program has been promoting interprogram discussion of priority research topics and coordinated development of strategies to stimulate research using a gender approach. The Program is making progress in working out an agreement between several PAHO programs to conduct cooperative research on "Women, Gender, and Communicable diseases," with particular emphasis on tropical diseases.

Summary of the discussion

Particular concern was expressed over the fact that, of all the research protocols presented in the area of WHD by the countries of the Region in 1992, only two have been approved. Some members thought that perhaps the requirements of the Internal Advisory Committee on Research were too stringent; others felt that the solution was not to lower those requirements but rather to train and advise national personnel on how to prepare research proposals, or, in countries which already have that capability, to provide resource support. Still others believed that it was not important whether or not a proposal could be specifically categorized as research on women; what mattered was the actual content, and whether it encompassed aspects of women's health. All agreed that the essential task was to conduct simple research that could be translated into immediate action to benefit the recipients.

In response to the various concerns that were expressed, Dr. Alberto Pellegrini, Coordinator of the PAHO Research Coordination and Technology Development Unit, said that five countries of the Region account for 90% of the research, and that most of that work is clinical or biomedical. In 1988/1989, only 5% of the research projects dealt with public health. The area of research on applied social sciences, where research projects on women would be included, is also very weak. He indicated that a survey was being conducted to find out what is being taught about research methodology in graduate courses, and what students are producing once they graduate. As far as the requirements of the Advisory Committee were concerned, he said the criteria applied were intended to ensure the necessary scientific rigor.

Recommendations

The Subcommittee requested the Secretariat to carry out the proposed plan of work for the promotion and development of research on women, gender, and communicable diseases, and to report to the following year's meeting on the results.

Item 10: Proposal for a Regional System to Monitor and Evaluate the Health Status of Women and Sex Differentials in Health

The document on this subject was presented by Drs. Pedro Luis Castellanos and Edna Roberts, of the Program on Health Situation and Trend Assessment of PAHO, and by Dr. Renate Plaut, Consultant to PAHO, who pointed out that it summarized some of the characteristics of health situation assessment in general, and of assessment of women's health and sex differentials in particular. It was stressed that selection of the data whose production is to be promoted and supported must be preceded by definition of the health problems that are to be targeted for action. Three criteria for selecting

health problems to monitor were described, and some general characteristics of the indicators were discussed.

The procedures suggested for the evaluation included: the compilation and refinement of indicators which, while specific--for example, figures on maternal mortality--have information value that relates to broader aspects of health; the use of statistics from health establishments to get an approximate idea of the amount of resources absorbed by major groups of diagnostic categories for both hospitalization and outpatient care; surveillance based on procedures that do not cover the total population (e.g., surveys of households and sentinel institutions); and the analysis of preventable or excess mortality.

Finally, the document proposed several lines of action for the different technical programs to implement in conjunction with the corresponding national groups and at PAHO Headquarters, in order to formalize the desired regional surveillance system.

Summary of the discussion

The participants agreed that this was a crucial and very complex area that bore a close relationship to what had been said initially about the assessment of trends in the health status of women. Some countries produce a large quantity of data which then goes unused because there are not enough human and/or financial resources available to process them.

Several members of the Subcommittee shared their concern over the numerous requests for information that the countries receive from international agencies. The Chair emphasized that it was important for the agency soliciting the data to specify what type of information it needed at every level of government, and to state the purpose for which it would be utilized.

Another concern shared by several members was the lack of indicators on women's health.

The Secretariat staff who had made the presentation assured the Subcommittee that PAHO was endeavoring not to make excessive requests for information and was attempting to improve statistical data, but noted that it was difficult to transform such data into usable information.

Recommendations

The Subcommittee requested that the Secretariat draw up and present to the next meeting a proposal on key indicators to be used in the monitoring and evaluation of women's health at the Regional level, and by groups of countries.

Item 12: Other Matters

THE STATUS OF WOMEN IN PAHO

In response to the request of the Subcommittee that the Secretariat present detailed information prior to the close of the 13th Meeting on the status of women in PAHO, Dr. Diana Lavertu, Chief of Personnel of PAHO, presented the latest statistics on the Organization's professional staff. She reported that the target figure of 30% had been surpassed at Headquarters and similar success was expected in the field. She said that much remained to be done, but not enough applications were being received from the countries when vacancies opened up.

Summary of the discussion

Several members of the Subcommittee mentioned that the lack of timely information made it difficult to apply for vacant posts. At times the announcements were being received after the cut-off date for the submission of applications or else they were not being channeled to the appropriate levels when they were received in the ministries.

The delegates from Cuba and Saint Vincent and the Grenadines emphasized that Cuba and the Caribbean certainly did not have a scarcity of qualified personnel. PAHO support would be needed to create a cadre of women who have already been trained, as well as to promote adequate education for young girls in school, with a view to qualifying them for international service.

The United States delegation added that some of the requirements for certain posts were unnecessary and might be creating another barrier. It applauded the recent promotions of qualified women in PAHO.

Dr. Alleyne said that the Organization was not just trying to reach the established targets, but was sincerely interested in having a more even distribution of men and women in decision-making posts.

Recommendations

The Subcommittee decided that the agenda for the 1994 meeting should include a study of the barriers that keep professional women from being hired by the Pan American Sanitary Bureau and promoted to high-level posts. In addition it asked the Secretariat to present another progress report on the status of women in the Bureau at that meeting.

PROPOSED AGENDA FOR THE XIV MEETING

The Rapporteur presented the proposed agenda for the 1994 meeting to be considered by the Subcommittee.

Summary of the discussion

Dr. Carlyle Guerra de Macedo, Director, PAHO, joined the group during the discussion of the proposed agenda and expressed satisfaction that several of the items under consideration were a continuation of what had been discussed at the 13th Meeting. He suggested that the agenda include a follow-up report on the preparations for the World Conference to be held in 1995, but added that, in order to keep the agenda from becoming too long, two of the proposed topics should be eliminated: occupational health from a gender perspective, and the study on the role of the female work force in the health sector.

Recommendations

The Subcommittee accepted the Director's suggestions and approved the following proposed agenda for the 14th Meeting:

1. Quadrennial Report on Technical Cooperation in Women, Health, and Development during 1991-1994. Analysis of the Implementation of the Strategic Orientation by the Secretariat and the Member Governments.

2. Follow-up Report on the Interagency Preparatory Activities for the World Conference on Women to be Held in 1995.

3. Case Study (of a country or subregion).

4. Results of the Plan of Work for the Promotion and Development of Research on Women, Gender, and Communicable Diseases.

5. Proposal for Basic Indicators to Monitor and Evaluate the Health Status of Women at the Regional Level and by Groups of Countries.

6. Study on the Barriers that Limit the Appointment of Women to Professional Posts in the Pan American Sanitary Bureau.

CLOSING SESSION

The Rapporteur read out a preliminary Final Report, which included the recommendations made under each item.

Dr. Macedo commended the members of the Subcommittee for the work they had done and assured them of his support in connection with the problem of violence, for which they thanked him.

The Chair declared the 13th Meeting closed, thanking all the participants for having attended and contributed to the meeting.

Annex: List of participants

PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE COMMITTEE OF THE DIRECTING COUNCIL

SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH, AND DEVELOPMENT

13th Meeting
Washington, D.C., 5-7 April 1993

SMD13/2, Rev. 2
16 April 1993
16 abril 1993

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