The inclusion of violence in the health agenda: historical trajectory

A inclusão da violência na agenda da saúde: trajetória histórica

Maria Cecília de Souza Minayo [1]

Abstract *In this article, I seek to provide a systematic record of the historical trajectory of the inclusion of accidents and violence as a legitimate issue of the health area. It will be shown that the process is not concluded, and that it is going on under the pressure of actors and by force of the circumstances. In the beginning, the issue finds a restricted space in the health agenda through the concepts "accidents, injuries and traumas". Since the second half of the 20th century, the rights of different social subjects are incorporated, ranging from observation and notification of violent acts against children, women, the elderly, to the discussion of social violence in its broadest sense, affecting the health of populations. In Brazil, this doubtlessly slow and intermittent process shows some attempts and a pioneer action of the Ministry of Health, carried out in cooperation with and under pressure of social, academic and professional movements: a diagnosis of morbidity and mortality from all kinds of violence, documenting a national policy towards reduction of accidents and violence on national level.*

Key words *Violence and health, Policies for reduction of violence, Accidents and violence, External causes*

Resumo *Neste texto, busco sistematizar e registrar a trajetória histórica de legitimação do tema dos acidentes e violência na área da saúde. Mostro que se trata de um processo inconcluso e que ocorre pela pressão de atores e pela força dos acontecimentos. Inicialmente o tema se inclui de forma reduzida por meio dos conceitos de "acidentes, lesões e traumas". Já a partir da segunda metade do século 20, há a incorporação da pauta de direitos de vários sujeitos sociais, que vai desde a entrada da observação e notificação da violência contra crianças, contra as mulheres, contra os idosos, até a discussão da violência social, no seu sentido mais amplo, afetando a saúde das populações. No Brasil, esse processo, sem dúvida lento e intermitente, tem alguns logros e pioneirismos encenados pelo Ministério da Saúde, com a colaboração e a pressão de movimentos sociais, acadêmicos e profissionais: um documento de diagnóstico da situação de morbimortalidade por todos os tipos de violências; documento de uma Política Nacional de Redução de Acidentes e Violências e um Plano de Ação Nacional.*

Palavras-chave *Violência e saúde, Política de redução da violência, Acidentes e violências, Causas externas*

[1] Claves, ENSP, Fiocruz. Av. Brasil 4036, sala 700, Manguinhos, 21040-361, Rio de Janeiro RJ. cecília@claves.fiocruz.br

Introduction

In this article, I will show how the topic *violence* and *accidents* was introduced to the spirit and to the practices of the health sector. Violence and accidents, side by side with chronic and degenerative diseases, are currently giving a new shape to the profile of health problems in Brazil and over the world. This new profile is characterized by the impact of the new life style, the new social and environmental conditions and longevity due to quality of life, calling for new approaches to which the health system in general is still not used to. Since the 60s and 70s of the past century, we witness a strong theoretical, methodological and political effort to understand health as a comprehensive question, especially due to the complex epidemiological transition[1, 2]. But never a theme has provoked and continues provoking so much resistance with regard to its inclusion into the agenda of the sector as is the case with violence and accidents.

Two aspects will be approached: 1) the social and sectorial dynamics of the gradual legitimizing and inclusion of the theme into the health area on national and international level; 2) and an analytical description of Brazilian documents, plans of actions and initiatives that show the slow, sinuous but persistent legitimizing trajectory of the problem inside health theory and practice.

The dynamics of inclusion of the theme violence and accidents into the agenda of the health sector

It is well true that in its origins and manifestations violence is a sociohistorical phenomenon, accompanying the entire experience of humanity. Thus, violence *per se* is not a public health question. It is transformed into a problem in this field for affecting individual and collective health and requires formulation of specific policies and organization of peculiar practices for preventing and facing it. There is undeniable evidence for the importance of this problem for the health area. The World Health Organization (WHO), on choosing trauma and accident prevention as a motto of the World Health Day of 1993, repeated an expression attributed to William Forge, according to whom: *From time immemorable, infectious diseases and violence are the principal causes of premature deaths*[3]. Currently the WHO reveals, in its *World report on violence and health* that *each year, more than one million persons loose their lives and many others suffer non-fatal injuries* from violent causes[4]. Only in Brazil, in the 90s, shall say within a space of ten years, more than one million persons died from violence and accidents; and from these, approximately 400 thousand died from homicides[5]. Throughout the world and in our country as well, inflicted or self-inflicted deaths constitute a serious social problem, with intense repercussions for individual and collective health. In Brazil, since the beginning of the 80s, accidents and violence constitute the second leading cause of deaths and for the large age group between 5 and 39 years, violence is the main victimization problem leading to death[5].

The damages, injuries, traumas and deaths caused by violence and accidents correspond to high emotional and social costs and to high expenditures with public safety. They cause economical losses due to days of absence from work, to the unmeasurable mental and emotional damage they provoke in the victims and their families and due to the lost years of productivity or life. The consequences of violence affecting the health sector show increased expenditures with emergencies, medical care and rehabilitation, much more expensive than the greater part of conventional medical procedures[5]. Calculations of the Interamerican Development Bank referred to by Briceño-Leon[6] estimate that approximately 3.3% of the Brazilian Gross Domestic Product-GDP are spent with the direct costs of violence, a number increasing to 10% when including indirect costs and transfer of resources. This author, talking about Latin America as a whole, affirms that the losses and the transfer of resources occurring in this field due to violence reach 14.2% of the GDP of the region, amounting to 168 million American dollars. To give an idea of the significance of this estimation of the direct costs of violence in the country (3.3% of the GDP), it is three times higher than the amount the country is investing today in science and technology.

All mentioned reasons notwithstanding, the inclusion of violence in the health agenda is advancing very slowly. The first form of introducing the theme, the one to which William Forge refers[3], occurs for centuries inside the biomedical logic itself, in the prompt and specific assistance provided in case of injuries, traumas and

deaths, traditionally contemplated in the International Classification of Diseases (ICD) under the term "external causes". The concept of mortality from external causes always included homicides, suicides and accidents, and the concept of morbidity, injuries, traumas, fractures, burnings and poisonings resulting from interpersonal and collective confrontations.

The concern with the theme as health care subject pioneers with the question violence against children. Although we know some historical documents since ancient times showing the concern of society with regulating the submission to punishment and ill-treatment during childhood, the first texts relating this kind of violence to health are based on the surveys of Tardieu in 1880[7]. In the 60s of the 20th century, health professionals started, by means of publications and debates, to denounce systematically the different modalities of violence against children and adolescents and their negative influence for the growth and development of the victims[8]. One decade after the pediatricians Kempe *et al.*[8] created the expression Shaken Baby Syndrome, different professionals in many countries came to recognize and diagnose this type of offense as a health problem. Programs for primary and secondary prevention and interventions, mainly in the dynamics of the families, responsible for the greater part of violent actions, neglects and psychological abuse, started to make part of the agenda of services provided by public and private institutions and NGOs.

Differently from the militancy that sprouted from the medical corporation in the second half of the 20th century, denouncing and seeking solutions for abuse of children and adolescents, the introduction of violence against women into the field of health occurred through the protagonism of the feminist movement. With a strategy focused on creating gender conscience in the most different environments and institutions, this movement forced and continues forcing the health sector to take action, to give concrete answers not only by means of treatment of the injuries from violence but by addressing its causes by means of a positive agenda. The most different problems were addressed to the field of health, such as confrontations between couples, mutilations, sexual, physical and psychological abuse, homicide, and a number of physical and psychosomatic symptoms associated with gender violence. The power of the feminist movement in diagnosing the situation and the proposal for action relating to gender appear clearly in the documents of international health institutions like that presenting the conclusions of the Conference on Violence and Health, organized by the Pan American Health Organization (PAHO) in Washington, in 1994[9, 10].

Ill-treatment against the elderly was first mentioned in an English periodical in 1975, where it was called "Granny Battering"[11, 12], and since then the theme is slowly appearing in the international and national literature and in prevention and attention practices. In the health field, investigations and actions are still timid, even in countries with strong research tradition[13].

In the entire occidental society and most specifically in Brazil, the theme violence enters with more strength in the political and social debates and in health planning as from the 80s. Only since the 90s, the Pan American Health Organization and the World Health Organization begin to speak officially about *violence* (and not only about external causes), congregating the different discussions (always disperse and without much institutional legitimacy) that were occurring in different environments and in some countries. In 1994, PAHO gathered the Ministers of Health of the Americas, researchers and specialists, for a conference about this topic[9]. The preparatory documents and the final document include the traditional aspects that always marked the sector as well as a variety of other problems, which for the first time were included organically in the agenda. The participants of the Conference understood that the epidemiological transition of the countries of the region presented an old question with new colors and evidences, needing to be defined in its historical specificity, to be mapped, so that it can be dealt with, with the distinctions inherent to the sector and according to the aspects of interconnection between sectors: *Violence, due to the number of victims and to the magnitude of its physical and psychological consequences, assumed endemic character and became a public health problem in many countries* [...]. *The health sector is the crossroad to which all corollaries of violence converge, by the burden its victims represent to emergency services, specialized care, physical and psychological rehabilitation services and social assistance*[9].

In 2002, the WHO produced a world report[4], in which the term external causes, traditionally used for classifying the issue in the In-

ternational Classification of Diseases and Disability (ICD), was changed to *violence and health*. In 1997, the WHO had already convoked a world conference with Health Ministers of all member states of the United Nations, with this topic as part of the agenda, and reduction of violence was already among the five priorities recommended for the Americas[14]. In the 2002 document however, the problem makes doubtlessly part of the concerns of the international health organizations, being subject to definitions, classifications, contextualizing and planning. Detailed assessments are presented, and the proceedings contain a variety of recommendations for the whole sector. One of them is that each country should make its own diagnosis and planning. In attention to this recommendation, the Ministry of Health, in cooperation with the PAHO representation in Brazil and CLAVES/Fiocruz, produced and published a report, more or less following the example of the international document, entitled *The impact of violence on the health of the Brazilian Population*[15]. Besides, as will be shown later, a plan of action is implemented.

The trajectory of the inclusion of violence in the agenda of the health sector in Brazil

In Brazil, the presence of violence and criminality in the social agenda coincides with the (official) end of the military regime. The social movements for democratization, the legal institutions and the strong pressure of some nongovernmental and international organizations, capable of influencing the national debate, were fundamental for turning social violence into a public concern.

In the health area, the topic violence came to be taken into consideration in a fragmented way but progressively. The first to submit the problem to discussion were pediatric epidemiologists and psychiatrists, although nurses, social assistants and other health professionals were also well aware of the question. Pediatricians, as already mentioned[16], were following the tracks of Kempe *et al.*[8], and contributed with important studies on the magnitude of the problem and by showing trends; and the psychiatrists by analyzing the relation of aggressions with mental disease, mainly focusing studies on suicide[16]. Their work begins in the 70s of the 20th century but their scientific contribution to the topic increased since the 80s. Their contribution to scientific research and to care practice during the last 25 years is 90% higher than in any earlier period of history[16]. From the viewpoint of providing assistance, some pediatricians started services and preventive activities in the hospitals where they worked and founded some NGOs for dealing with special issued including and even transcending the traditional fields of the health sector. I emphasize here the pioneer actions of the Regional Centers in Attention to Ill-treatment in Childhood (CRAMI) in São Paulo; the Brazilian Multiprofessional Association for the Protection of Children and Adolescents (ABRAPIA) in Rio de Janeiro; and of the Brazilian Association for the Prevention of Child Abuse and Neglect (ABNAPI) in Minas Gerais[14], as organizations specifically intervening and thinking, acting and supporting public policies against violence in childhood and adolescence.

As refers to the protection of children, professionals engaged with the health and comprehensive development of children and adolescents participated actively in a strong movement for civic recognition of this group, with the result of the creation of the *Statute of the Child and the Adolescent* in 1990. Today, we have a considerable number of programs and initiatives of the State and of society focusing this question, and this number of the journal *Science and Collective Health* contains some articles revealing the success of some of these initiatives. An extremely important document of the State Secretariat for Human Rights of the Ministry of Justice, of intersectorial character and as such containing contributions from the Ministry of Health and health professionals, is the National Program against Infanto-Juvenile Sexual Abuse of 2001[17]. Besides providing a diagnosis of the situation, this plan provides means for the defense of victimized children and adolescents, for holding the offenders responsible, and establishes norms for actions and prevention. Besides, it created indicators for monitoring and evaluating the efficiency of the actions carried out on national level.

The participation of the Brazilian feminist movement in the introduction of violence as a health issue found a pivotal expression in the creation of the Program for Comprehensive Health Care for Women (PAISM)[18], published in 1983. This program incorporates clearly the sexual and procreative rights with emphasis to

Ciência & Saúde Coletiva, 11(2):375-383, 2006

gender violence, officialization of the question in the entire environment of public services. It is noteworthy that the establishment, in 2004, of the National Policy on Sexual and Reproductive Rights[19], a plan for the period 2004-2007, reinforces the proposals of PAISM. According to the principles and directives of this policy, the Ministry of Health established as a goal a 30% amplification of assistance services for women and adolescents exposed to violence, by means of integrated networks acting in pole microregions during these four years.

The enactment of the *Statute of the Elderly* by the Special Secretariat for Human Rights in 2003[20] presented the problem violence as intersectorial issue, including the health sector. In 2005, an intersectorial plan of action[21] for facing violence against old aged people was officialized. The health sector is also in charge of promotional activities, prevention, providing assistance in the different forms of violence and for creating norms for hospitals and special clinics and institutions for long-term patients.

Since the middle of the 90s, many municipal Health Secretariats had already created strategies and services for prevention and assistance for victims of violence in cooperation with civil organizations. Since then such initiatives multiplied, in general performed in cooperation with public institutions, NGOs or research groups. Institutions deserving to be mentioned here are: the Faculty of Public Health of the University of São Paulo (USP)[13], since the 70s of the 20th century having a research line on "external causes"; and the Oswaldo Cruz Foundation who, in 1989, created in the National School for Public Health the Latin American Center for Studies on Violence and Health (CLAVES), in charge of carrying out interdisciplinary and strategic research, train professionals and perform advisory activity in the elaboration of public health policies in this field[14]. Today, the CLAVES pursues the same goals in association with the Fernandes Figueira Institute, with the Center for Information and Communication in Health and with Bireme (PAHO), for constructing and maintaining a center for scientific dissemination and documentation and a virtual library. The CLAVES is also a collaborating center of the Secretariat for Health Survey of the Ministry of Health. In 1998, the National Council of Municipal Health Secretaries (CONASEMS), assisted by the CLAVES, established a plan of action for prevention of violence against children and adolescents in association with UNICEF and UNESCO, including general guidelines for the municipalities[22]. In the last four years, this organization passed to make part and became one of the anchors of the Gandhi Network. Since then, the issue non-violence and peace passed to be integrated in the plans of action of several municipalities and is part of the agenda of all congresses of this Council, which gathers more than 5,500 Secretaries of Health from all around the country.

Still in the year 1998, the Ministry of Health established a work group for giving advice in the formulation of a National Policy for the Reduction of Accidents and Violence. In May 2001, the Ministry of Health enacted a directive, officializing the definition of the Policy[23], taking into consideration all areas of health services, information in health and lines of preventive actions. Recently, in 2005, a sectorial plan of action was published. About these last two instruments I will talk in more detail later. These and other initiatives of public organisms occurred under the pressure or articulated by national and international social movements and by intellectuals, who not only identified the extension of the problem but proposed strategies on different levels to reduce or overcome violence.

The basic document of the National Policy for the Reduction of Accidents and Violence[23], approved in 2001 by the Ministry of Health, deals with the subject primarily as a social and historical problem and situates it among the actions towards health promotion and quality of life. The document also defines concepts, distinguishing *violence* from *accidents* (seeing that traditionally these two terms were used together in the ICD regarding external causes). It then provides a general diagnosis of the problem, the forms in which it is affecting the health sector and how this sector, for being part of the society where violence takes place, also creates and reproduces it. Finally, it analyzes the sources of information and the existing official documents, their importance and deficiencies. The diagnosis, although based on compiled data relating to the whole country, presents in detail the different forms of violence (physical aggression, sexual abuse, psychological violence, omissions, interpersonal, institutional, social, political, structural, cultural, criminal violence, and violence related to work and to resistance). It also distinguished between the different forms of violence falling

on men, women and on the different age groups. Analyzing this official text we observe an increasing awareness of the problem, giving space to new debates. When the document was written, for example, there practically existed no programs of the Ministry considering violence and discrimination of race/origin/color and sexual choice (unless the directly related to AIDS) and the population with special needs. Thus, the National Policy does not include these issues, whose exclusion, in case persisting, would represent an unforgivable omission.

The document also describes and analyzes the different laws, directives, norms and sectorial and intersectorial instruments that interface and interact with the information of the health sector and its practice, as for example in the case of the National Traffic Law of 1997. With respect to legal instruments, the document focuses Death Certificates, Police Occurrence Books, Traffic Accident Registries and the Work Accident Certificate (CAT). With respect to existing data, it refers to the Information Systems of the Unified Health System on Mortality (SIM), Morbidity (SIH/SUS) and Poisoning and Intoxications (SINITOX). The text states the lack of a national system for systemizing and analyzing traffic accidents. The same occurs with the information related to public safety. The CAT is insufficient for informing only the data referring accidents and violence in work from officially registered workers.

The principles that formed the basis for the Policy are the same guiding the Unified Health System: 1) health as a basic right and requisite for social and economical development; 2) the right to respect for life as an ethical value: health promotion as a basis for any action towards reduction of violence and accidents. These principles are the fundament of the directives to be followed by the national, state and municipal plans.

In summary, the directives given with basis on these principles are the following: 1) promotion and establishment of safe and healthy environments; 2) monitoring of accidents and violence; 3) systematization and amplification/consolidation of prehospital care; 4) implementation of a form of multiprofessional assistance for the victims of violence and accidents; 5) structuring and consolidation of rehabilitation services; 6) investment in the capacity building of human resources, in specific studies and research, above all regarding questions able to improve the practical activities on all three levels, mainly the local one.

The text also distributes responsibilities in order to articulate the activities of the federal, state and municipal governments with those of the civil society in the spheres urban development, justice and safety, work, employment and social security, transports and science and technology. It mentions specifically the role played by the universities, saying that they cannot stay apart from this problem, today deeply affecting the Brazilian society. In this sense, the document urges universities to build professionals capable of dealing with the specific problems of violence and to conduct strategic research for creating a scientifically informed basis for the solution of the problem. Finally, the document under discussion dedicates a chapter to the question follow-up and assessment as a way of establishing and implementing public policies, especially due to the fact that we are dealing with a relatively new problem in the health sector. Such a monitoring must be seen very differently from the traditional, conventional epidemiological survey processes. Very wisely, the text refers to the need of developing guidelines, criteria and specific methodologies besides follow-up of experiences and periodical assessment.

It must be pointed out that the text introducing the Policy was written by a team of experts in different fields (following the idea of violence being a complex problem needing intersectorial action) together with technicians of the Ministry of Health. Prior to publication, it was extensively discussed in a national seminary, with researchers and professionals working in different kinds and levels of health care services and members of the civil society. It is thus a collective product. After this process, the document was submitted to the Tri-Partite Committee and approved by this authority of the Unified Health System, which gathers the most important representatives of the Ministry of Health, the Presidents of the National Council of State Health Secretaries (CONASS) and of the National Council of Municipal Health Secretaries (CONSEMS). In April 2001, the National Health Council confirmed the expert opinion of the Tri-Partite Committee and in May the text was officially enacted through directive no. 737, of May 16, 2001, published on May 18, 2001[23].

After the publication of this directive, the Technical Area for Accidents and Violence was

organized. Its purpose was to mobilize and articulate integrated intra and intersectorial actions, guiding technical, institutional and financial partnerships in order to create a national network for dealing with this question. A program for Reduction of Mortality and Morbidity from Traffic Accidents was created with funds from the Insurance for Personal Injury caused by Motor Vehicles. Different local actions in states and municipalities were encouraged, among them the implementation of a specific program for data collection, including variables that the traditional systems had not taken into consideration.

One of the most important steps, however, was the plan, whose elaboration started in 2003 and which was established and implemented in 2005[24]. The elaboration process involved a great number of governmental and nongovernmental actors and was officialized by the directive of the Ministry of Health, of May 18, 2004. It disposes the creation of the National Network for Prevention of Violence and Health Promotion and implementation of Centers for Prevention of Violence in states and municipalities. This instrument was formulated on the basis of a comprehensive indicator allowing the Ministry of Health to rank the municipalities where the violence rates (mortality from homicides, traffic accidents and suicide) were more dramatic.

Due to the scarce financial resources available for this plan, the Secretariat of Health Survey of the Ministry of Health, in charge of the violence prevention program, focused: 1) the first forty of the list; 2) the municipalities, where the Integrated Program against Infanto-juvenile Sexual Abuse (PAIR) was developed; 3) the boarder municipalities, where integrated actions for the prevention of violence were carried out; 4) states with more than one municipality in the situations mentioned above. All of them follow the guidelines of the Ministry of Health and count on funds for creating centers for the prevention of violence, for training human resources and for research.

These initiatives started in 2005 and are being implemented in 2006. One of the activities established by the plan was the creation of centers in 15 Brazilian universities in the mentioned regions, with different missions, according to their competence and to the directives of the Ministry of Health for each of them: establishment of networks; support to the training of human resources; research; monitoring of the implantation of the centers; and assessment of the reduction activities. As we said, this initiative is still in process and it will take at least two to three years to see results.

It must also be pointed out that a specific Call for Projects of the Secretariat of Science and Technology of the Ministry of Health provided funds for strategic research in this field. The initiative was preceded by a seminar gathering specialists from all over the country for establishing priorities according to the local and national needs of knowledge building. The results of this are expected for the end of 2006, since the selected projects will be executed during the period 2005-2006.

In summary, during the period 2001-2006, the Ministry of Health made considerable advances in support of the National Policy for Reduction of Mortality and Morbidity from Accidents and Violence (2001) by creating: 1) directive 1.968/2001[25] about the obligatory notification by health professionals of situations of suspected or confirmed ill-treatment of children and adolescents; 2) directive 1.969/2001[26], as refers to filling in the Hospital Admission Authorization form (AIH) for cases of external causes; 3) the directives SAS/MS nº 969[27] and 970/2002[28], offering a new admission registry form for patients of the Unified Health System, aimed at a better identification of patients admitted due to accidents and violence. These steps are important but not sufficient, because they could lead to only more paperwork instead of public debate.

Other advances can be observed since 2001 in the field of mental health, where the inclusion of women, children and adolescents exposed to violence in the Centers of Psychosocial Support (CAPS) was discussed; in the field of Adolescent and Juvenile Health, by supporting juvenile protagonism as a means to prevent violence; in the field of health for the elderly and the disabled, by including violence in its sphere of action. In 2005, the Ministry of Health published a number of guidelines regarding injury due to sexual abuse[29]; emergency contraconception in case of sexual abuse of women and adolescents[30]; and humanitarian assistance in situations of interruption of pregnancy foreseen in the law[31]. In 2004, the directive GM/MS 2.406 established the obligatory notification of violence against women according to Law 10.778/2003[32], establishing this form of notification, and Law 10.886/2004[33]. More recently, in 2006, a pedagogic

guideline for Centers of Comprehensive Care for Women and Adolescents exposed to Domestic and Sexual Violence[34] was established.

It also must be said that there is a great number of experiences directed to the prevention of violence in the country. Some articles published in this number of the journal focus experiences one can consider successful. All of them are intersectorial, articulating actions of the state and of civil society and count on the support of universities. Some initiatives directed to citizenship and assistance to young people already resulted in a decrease of local homicide rates as for example the experiences in Diadema, São Paulo, and Belo Horizonte. As refers to traffic accidents, killing almost 30,000 Brazilians yearly, the multidisciplinary actions also show positive results in cities with high death rates such as Recife, Curitiba, São Paulo, Belo Horizonte and Goiânia[35].

Finally, a long distance course (promoted by ENSP/CLAVES/Fiocruz in cooperation with the Ministry of Health) is under way for 2006, aiming at training 500 professionals for increasing the quality of information on violence and accidents, producing local diagnoses and promoting health through preventive actions. Undoubtedly, this initiative will be an important step in socializing and integrating the theme in the health sector.

Conclusions

My purpose in presenting this trajectory of insertion of the issue *violence and accidents* in the field of health was on one hand to show the difficulties in legitimizing it, mainly in the environment establishing the directives for actions. The greatest difficulty lies in convincing a sector deeply marked by biomedical reasoning to accept in its model and dynamics complex problems of social character and not diseases. Many times I ask myself: *Does one die more when dying from AIDS or cancer than when dying from a traffic accident or murder?*

This is not a question of quantity (because the number of people dying from the first mentioned causes is much lower than that of victims of violence). This is not a question of comparing the torment of those, who suffer from degenerative of disabling diseases, to that of people who suffer violence. All of them die and every life is precious, therefore it is important and crucial to invest in any field. Resources (financial, administrative, human and cultural) for approaching a complex problem and for providing proper solutions developed inside the sector, or in cooperation with other segments such as public safety, however are still very scarce.

On the other hand, I also wanted to praise the progress already made. The difficult steps already taken show gains and positive results, people are going on with more confidence and courage. Therefore I engaged myself in relating the slow and tortuous ways of the inclusion of the issue violence into the health agenda. There are at least three facts that symbolize the results achieved in the course of the process. One is the joint construction of the National Policy for Reduction of Accidents and Violence, because it seems that this is a pioneer initiative of our country. The second is the elaboration of a National Plan for putting this policy into practice, based on studies and epidemiological principles. With this Plan of Action, Brazil seems to be ahead of others as well. Finally, in the third place, the document entitled *The impact of violence on the health of the Brazilian Population* attends the recommendation of the WHO that every country should make its own diagnosis for planning its actions. Also in this case, Brazil is a pioneer nation. Who knows, all efforts for creating guidelines and directives, fruit of so many voices claiming jointly for quality of life and mourning so many avoidable deaths, will be translated into suitable and necessary sectorial and intersectorial actions. The *ethos* of the health sector, traditionally focused on prevention and care, is different from the practices of the public safety sector, aimed at restraining crimes and contraventions. It is this tradition of care and prevention that can make all the difference!

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