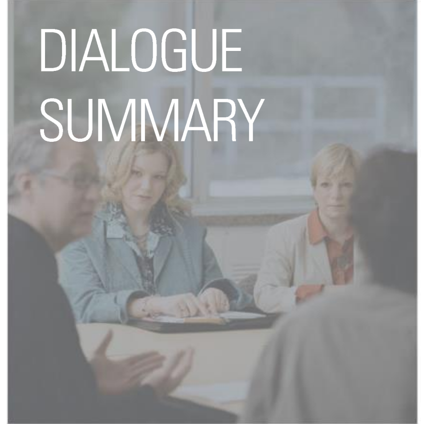
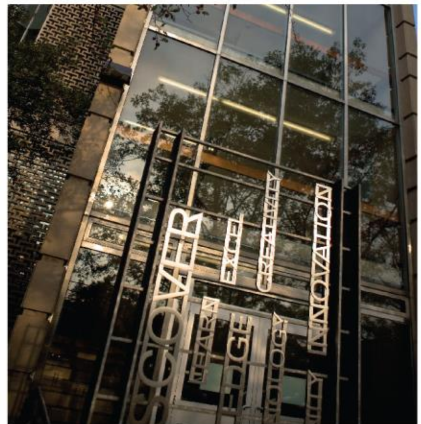
McMaster University

McMaster HEALTH FORUM



DIALOGUE SUMMARY

PREVENTING INTERPERSONAL AND SELF-DIRECTED VIOLENCE AND INJURIES IN THE CARIBBEAN



24 JUNE 2015

EVIDENCE >> INSIGHT >> ACTION

McMaster Health Forum

Evidence >> Insight >> Action

Dialogue Summary:
Preventing Interpersonal and Self-directed Violence and Injuries in the Caribbean

24 June 2015

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at regional/provincial levels and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

Authors

Ileana Ciurea, MD, Managing Director, McMaster Health Forum

Kaelan A. Moat, PhD, Scientific Lead, Health Systems Evidence and Learning, McMaster Health Forum

Andrea C. Yearwood, PhD, Senior Health Policy Analyst, Caribbean Public Health Agency

Funding

The funding for the stakeholder dialogue (and the evidence brief that informed it) were both provided by the Caribbean Public Health Agency (CARPHA) and the Pan American Health Organization. The McMaster Health Forum receives both financial and in-kind support from McMaster University.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary but the authors had final decision-making authority about what appeared in the dialogue summary.

Acknowledgements

The authors wish to thank the CARPHA Planning Team: Ms. Kershelle Hilaire, Ms. Christa Campbell, Ms. Jaselle Neptune and Mr. Khemraj Persaud. The authors also wish to thank Julie Baird and the staff of the McMaster Health Forum for assistance with organizing the stakeholder dialogue.

Citation

Ciurea I, Moat KA, Yearwood AC. Dialogue Summary: Preventing Interpersonal and Self-directed Violence and Injuries in the Caribbean. Port of Spain, Trinidad and Tobago: Caribbean Public Health Agency, 24 June 2015.

Dialogue

The stakeholder dialogue about Preventing Interpersonal and Self-directed Violence and Injuries in the Caribbean was held on 24 June 2015 at St. George's University in True Blue, Grenada, West Indies.

Product registration numbers

ISSN 1925-2226 (print)
ISSN 1925-2234 (online)

Table of Contents

SUMMARY OF THE DIALOGUE 5

SUMMARIES OF THE FOUR DELIBERATIONS 6

DELIBERATION ABOUT THE PROBLEM 6

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS 10

Element 1 - Strengthen efforts to establish and sustain inter-sectoral collaboration to facilitate the development and implementation of comprehensive violence- and injury-prevention strategies 10

Element 2 - Strengthen violence and injury monitoring and surveillance systems at the regional and national levels 12

Element 3 - Address the cross-cutting issue of harmful use of alcohol in the Caribbean region through targeted initiatives 13

Element 4 - Strengthen core elements of health systems related to interpersonal and self-directed violence and injury prevention 14

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS 16

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES 18

SUMMARY OF THE DIALOGUE

The majority of participants agreed that violence is a major health problem in the Caribbean, women and youth are especially vulnerable to the negative effects of violence, and young men are at higher risk of engaging in and being victim of violent acts. It was also clear that most participants agreed the problem should be understood in relation to the following themes: 1) there are numerous 'socio-cultural' factors that contribute to the problem; 2) there are several systemic and measurement issues that make monitoring of violence and injuries difficult; 3) in addition to alcohol, abuse of other substances (i.e. illicit drugs) contributes to violence and injuries in the region; 4) there is variability across countries with respect to the level of priority given to addressing violence and injuries; 5) the issue often lacks associated messaging that is compelling, consistent and action-oriented, and that can motivate stakeholders to engage in multi-sectoral action; and 6) coordinating efforts across sectors, with health assuming a leading role, is challenging for a number of reasons.

There was consensus among participants that the options originally presented in the evidence brief should be re-worded and discussed as elements of a comprehensive approach given they were all equally important and not mutually exclusive. After each of the elements were considered, there was broad agreement that: 1) countries need to take advantage of the emphasis being placed on priority health issues in the region and internationally in order to shift the framing of violence and injuries to align with these priorities, highlight value-for-money arguments within the context of these priorities, and align efforts to address violence and injuries with initiatives underway to address emerging priority health issues that require similar approaches such as inter-sectoral collaboration; 2) there is a need to ensure robust monitoring and surveillance systems that produce meaningful, context-appropriate, valid and useful data that can be used to support decision-making are in place at national and regional levels; 3) there is a need to establish formalized inter-sectoral arrangements to ensure accountability across sectors for preventing violence and injuries, which could be achieved through a number of potential approaches, including the use of instruments such as memoranda of understanding, or by embedding formal relationships in proposed legislation by spelling out responsibilities required by various sectors; and 4) there is a need to strengthen the core delivery and programmatic arrangements in health required to address violence and injuries. There was some uncertainty about whether and how the health sector could yield influence over other sectors to lead such initiatives, but participants were unanimous in emphasizing the important role played by national and regional champions.

Seven priorities for action were identified by participants. In particular, participants suggested that in order to move forward they need to: 1) identify and integrate relevant Caribbean data and studies about inter-personal and self-directed violence and injuries with the evidence presented in the brief that informed the stakeholder dialogue; 2) develop an inventory of current violence- and injury-prevention initiatives in the region; 3) conduct an assessment of the status of implementation of the various options presented in the evidence brief; 4) develop a common set of indicators that can inform improved monitoring and surveillance across sectors and across countries in the Caribbean; 5) collaboratively develop an implementation plan, written with clear and consistent messages about priorities (i.e. what needs to be done), accountability (i.e. who does what), and timelines (i.e. by when); 6) take advantage of current opportunities to collaborate with other sectors that are clearly willing; and 7) take the lessons learned from the deliberative dialogue back to individuals who can prioritize the issues and instigate meaningful actions at the country level.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants agreed that the nature of the problem can be understood in relation to three of the dimensions outlined in the evidence brief: 1) violence is a major health problem globally, but places a particularly heavy burden on Caribbean countries; 2) women and youth are especially vulnerable to the negative effects of violence; and 3) young men are at higher risk of engaging in and being victims of violent acts, especially homicide and suicide.

However, while most participants agreed with the way the problem was framed in the evidence brief, deliberations also unveiled several other important aspects that needed to be explicitly acknowledged. In particular, the following themes emerged: 1) there are numerous 'socio-cultural' factors that contribute to the problem; 2) there are several systemic and measurement issues that make monitoring of violence and injuries difficult; 3) in addition to alcohol, abuse of other substances (i.e. illicit drugs) contributes to violence and injuries in the region; 4) there is variability across countries with respect to the level of priority given to addressing violence and injuries; 5) the issue often lacks associated messaging that is compelling, consistent and action-oriented, and that can motivate stakeholders to engage in multi-sectoral action; and 6) coordinating efforts across sectors, with health assuming a leading role, is challenging for a number of reasons.

Numerous socio-cultural aspects contribute to the complexity of the problem

While the underlying causes of the problem outlined in the brief resonated with many participants, deliberations also highlighted that there was broad agreement that there are several socio-cultural aspects that must be explicitly acknowledged. First, several participants suggested the family and community life, and the ways in which boys and young men are socialized, contribute to the 'genesis of violence'. For example, some participants noted that young boys are often brought up in environments where it is difficult to provide for everyone in the household, and as such they learn at an early age that men have to fight for everything. Additionally, a few participants suggested that this is compounded by the fact that young boys and men in several Caribbean countries are taught to be tough and

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in the Caribbean;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on four elements (among many) for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, four elements for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement, and understanding the reasons for and implications of specific points of disagreement. As well,even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

conceal their emotions, which can lead to insecurities about their feelings and agitation as they grow older. The same participants discussed how this combination of factors can result in a tendency towards violent behaviour (particularly when it is instilled from an early age), and can lead to the use of drugs and alcohol as coping mechanisms. One participant suggested that in families where the biological father is absent, other members of the extended family, for example uncles, may be contributing to the upbringing of boys in this way.

A few participants also discussed a second factor that may be contributing to violence, namely shifting demographics – in particular high rates of unemployment among young men and increasing numbers of highly educated women who are assuming roles as 'breadwinners'. This may be challenging the traditional gender roles played in society and could lead to increasing levels of frustration, disenfranchisement, and hopelessness among men in the Caribbean. It was suggested by some participants that this dynamic could be contributing to an increase in violent tendencies (e.g. reacting to a conflict with a woman using physical force), or engagement in activities that may be associated with violent behaviours (e.g. becoming involved in gangs). One participant noted in their country, the increasing incidence of men murdering their partners and then committing suicide following inter-personal conflicts.

A third socio-cultural dimension of the problem explored by participants was the role of women as perpetrators of violence. Some participants suggested that it was not only how boys and young men were socialized that should cause concern, given women are also increasingly found to be engaging in violent acts – both in family and in community settings. While not everyone agreed, one participant suggested that women are just as likely to abuse their partner or spouse, but the issue is likely underestimated and underreported given men are socialized to not complain about these types of incidents (a trait which may be compounded by traditional views about a man's role in the family). In response, one participant cautioned everyone about measurement issues surrounding the incidence of women perpetrating violence against their partners, and suggested that use of 'conflict tactic scales' may not be appropriate or accurate given the different vulnerabilities between men and women. Another participant brought up a point related to the increasing role of women in community violence, stating that in their country it was found that some gangs are now led by women. While no clear points of agreement emerged during this aspect of the deliberation, many participants felt it was important to understand this dynamic in order to obtain a comprehensive understanding of the underlying factors contributing to inter-personal violence and self-directed injuries in the Caribbean.

A fourth socio-cultural factor that participants felt contributed to the problem in a way that wasn't fully explored in the evidence brief was the role of the media (traditional as well as social media). In particular, participants noted that the media currently contributed to the problem in two ways: by sensationalizing violence, and by reinforcing cultural acceptance of behaviours that may increase the risk of violence. Examples of sensationalizing violence were provided by a few participants, such as news outlets highlighting violent stories on the front page of newspapers to get attention, and references to gang culture in both the news and in popular entertainment. Popular entertainment, and in particular the music industry, was also pointed out as a channel through which risky behaviours were glorified and reinforced as acceptable. One participant pointed to popular party 'rum songs' which are often heard on the radio as an illustration of how the harmful use of alcohol, which could be linked to violence, is promoted.

Finally, while not discussed at length, participants raised several other socio-cultural issues that were considered important in the context of understanding the problem of interpersonal and self-directed violence in the region. For example, some participants noted that there has been an increase in violence in schools (bullying was mentioned in particular) and also that a link seems to exist between the broader trend of increasing school drop-out rates and the increase in violence in the Caribbean. A few other participants noted that the illicit drug trade, as well as trafficking of children and women, should also be considered as part of the problem. Furthermore, there was broad agreement among participants that vulnerable populations go beyond women and youth, and some participants suggested that the elderly, people living with physical disabilities, and people who are mentally incapacitated also need to be considered as the most vulnerable.

There are several systemic and measurement issues that make monitoring of violence and injuries difficult

While participants acknowledged that this theme related to one of the elements of the problem that was captured in the evidence brief, several felt that it was important to consider additional insights based on their own views and experiences. First, several participants highlighted that one of the most pressing challenges was the fact that the collection of data on violence and injuries is not consistent across Caribbean countries. Some countries have working surveillance systems, while others do not collect data at all, meaning that countries are starting from very different stages of development. Second, some participants pointed out that not all healthcare and social sector workers are trained to collect data, limiting the available capacity to monitor violence and injuries both within countries and across the Caribbean region. Third, participants noted that there was constant shifting in the way different sectors conceptualized and reported violence, which makes it difficult to monitor in a reliable way. For example, one participant noted that in some countries, police have changed their policy about how they respond to reports of domestic violence, which could influence whether and how incidence is now measured, and how these new approaches align (or don't align) with the ways in which other sectors measure and respond to violence. Fourth, some participants stated that despite the fact that the economic impact of violence is a very important dimension of monitoring and surveillance given that it can be used to compel policymakers to act, there is no strong data on the cost of violence. As one participant mentioned: "Economic impacts often tell a bigger story than the health impacts […] we should be able to translate the problem into money and how it affects the economy. What is the cost. "

In addition to alcohol, abuse of other substances (i. e. illicit drugs) contributes to violence and injuries in the region

While there was agreement among participants about the harmful use of alcohol as being one problem that underlies many different types of violence in the Caribbean region, several participants suggested (and most participants agreed) that the problem should be considered in relation to substance abuse in general, rather than alcohol alone. Some participants felt, however, that there is merit in staying focused on alcohol use as an element of the problem, and suggested that this focus would translate well into options for addressing violence and injury for which the health sector could play a lead role. In particular, some participants noted the link between the harmful use of alcohol and non-communicable diseases (NCDs) and suggested that targeting alcohol could have the added benefit of addressing NCD prevention and control. Another participant suggested that expanding the focus of the problem to include the wider range of substances, specifically illicit drugs, would require specific approaches and would make it insurmountably difficult to develop meaningful solutions for which the health sector in Caribbean countries could contribute. In particular, the participant noted that the issue of illicit drugs is extremely complex and intertwined with cross-border trafficking, national security and the legal and justice systems – all of which are areas that actors from the health sector would have a difficult time navigating or influencing. As such, it was the opinion of this particular participant that it would be more productive to remain focused on alcohol.

There is variability across countries with respect to the level of priority given to addressing violence and injuries

During deliberations about the problem, many participants suggested that while violence and injuries are among the top policy priorities in their own countries, this was not the case in all countries. One participant noted that given the low rates of mortality related to violence and injuries compared to other causes of death, the issue is not viewed as a significant problem in their country and was not a priority. Furthermore, several participants noted that, while violence and injuries were acknowledged as a top problem in the region, this acknowledgment did not always translate into the issue being viewed as a top health policy priority. These dynamics resulted in a general acknowledgment among the participants that prioritizing the issue across the

Caribbean as a whole may not be entirely appropriate, and that local contexts and priorities must be taken into account.

The issue often lacks associated messaging that is compelling, consistent and action-oriented, and that can motivate stakeholders to engage in multi-sectoral action

There was general agreement among participants that it is currently difficult to gain traction with respect to this issue across the Caribbean because the problem is not framed in a way that resonates with other sectors which are likely to be involved in or affected by decisions related to addressing the issue. Furthermore, the problem is not framed in a way that aligns with (or explicitly acknowledges the linkages with) other topics that are currently priority issues on the government's health policy agenda, such as primary healthcare, universal healthcare and the growing incidence and prevalence of NCDs.

While the exact approach to developing more compelling, action-oriented messaging was not considered during this deliberation, nearly all participants acknowledged that one of the major shortfalls now was a general failure to make much more explicit the economic impacts of violence and injuries in Caribbean countries and throughout the region as a whole. Several participants continually noted that this framing is most compelling to policymakers, and as such made a strong argument for the importance of showing both the economic costs of inaction, as well as the 'value-for-money' proposition associated with any proposed solutions.

One participant cautioned the group about the danger of weakening the overall message when focusing too much on vulnerable populations (e. g. violence against women, or against children, or against older people) as this situation would not allow for the desired traction. They suggested that a life-cycle approach should be taken and stated that, "we need a simple straight forward message to get the funders to understand they should not split the funding into small pieces; our message needs to be clear, simple and effective in what we want and how we're going to do it. "

In addition, several participants indicated that they consider violence and injuries to be a growing 'epidemic' and that the potential for rapid escalation of issues is becoming overwhelming for various sectors such as health and education. These participants felt that associating the term 'epidemic' with the issue could improve traction, while one participant expressed some reservations about the use of the term, given it is traditionally associated with problems that are health-oriented, which could alienate important actors from other sectors.

Coordinating efforts across sectors, with health assuming a leading role, is challenging for a number of reasons

Most participants commented on the fact that while it is generally difficult to coordinate interventions across sectors, it is particularly difficult in the context of violence and injuries given the complexity of the issue. Several participants noted that it would be a major challenge for the health sector to take the lead on multi-sectoral strategies given the manner in which the health sector is traditionally organized and resourced. Re-orientation of the health system, including strengthening of primary health care and training of healthcare workers to perform new roles, would be required. Furthermore, due to power and funding imbalances and the emphasis placed on the role of other sectors (e. g. trade, crime and security), it would be difficult for the health sector in many Caribbean countries to assume a leadership role. Some participants also questioned whether the health sector is ready, willing and able to take on the leadership role in addressing the problem, and whether other sectors' plans actually envision and have a place for engaging others in inter-sectoral work.

Further complicating this aspect of the problem, some participants noted that health systems in the Caribbean may be considered weak for a number of reasons (e. g. capacity, size, funding), which would make it difficult to justify the health sector as a leader in inter-sectoral initiatives. However, one participant pointed out that while health systems may be considered 'weak' in some Caribbean countries with respect to their

core responsibilities in addressing violence and injuries, there are few, if any, comprehensive assessments of health system capacity for countries of the region, and as such it isn't particularly clear where health system strengthening initiatives should be targeted. This participant's point suggested that without this deeper understanding, it may not be possible to determine whether and how a particular health system is positioned to lead inter-sectoral initiatives.

As a final point related to the issue of coordination, one participant highlighted an additional issue within the health sector itself. In particular, the participant suggested that there were clear failures in communication and coordination among actors working within the health sector in the Caribbean – with a specific reference to a handful of regional organizations that don't seem to have aligned any of their work related to violence and injuries. This participant suggested that this was troubling because it increases the risk of duplication of efforts.

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS

Deliberations about options initially followed the structure of the pre-circulated evidence brief, in which four potential options for addressing the problem of interpersonal and self-directed violence and injuries in the Caribbean were presented for consideration. However, as the discussion unfolded, it became clear that many participants felt very strongly that use of the term 'options' was inappropriate in this context, given that it could be viewed as signaling the need to choose one over another. Furthermore, participants felt that each of the 'options' presented in the brief were not mutually exclusive, and actually represented elements of a comprehensive approach to addressing the problem. As such, there was consensus among participants that the 'options' originally presented in the brief should be re-worded and discussed during the deliberation as 'elements of a comprehensive approach'. The following elements served as the starting point for this re-focused deliberation:
1) Strengthen efforts to establish and sustain inter-sectoral collaboration to facilitate the development and implementation of comprehensive violence- and injury-prevention strategies;
2) Strengthen violence and injury monitoring and surveillance systems at the regional and national levels;
3) Address the cross-cutting issue of harmful use of alcohol in the Caribbean region through targeted initiatives; and
4) Strengthen core elements of health systems related to interpersonal and self-directed violence and injury prevention.

Element 1 - Strengthen efforts to establish and sustain inter-sectoral collaboration to facilitate the development and implementation of comprehensive violence- and injury-prevention strategies

Several participants suggested that before deliberating about this element, it was important to clarify the difference between the terms inter-sectoral and multi-sectoral. One participant offered the following distinction, which was supported by most other participants, and used as a jumping off point for deliberations: "Inter-sectoral implies collaboration across ministries, while multi-sectoral refers to a broader plan across the nation with multiple things happening but that may not necessarily intersect. " Another participant thought it was also important for participants to acknowledge that there are two levels at which collaboration would need to happen, one being the country level, and the other being across the Caribbean region as a whole.

During this deliberation, participants also considered two sub-elements, which were presented in the evidence brief: 1) establish or strengthen formal multi-institutional linkages across sectors within the area of violence and injuries, which could include (but would not be limited to) the creation of working groups, an inter-sectoral violence and injury 'task force', or a new government secretariat that routinely engages all stakeholders in coordinated planning and policy development initiatives; and 2) create opportunities in

existing policy development processes to facilitate inter-sectoral stakeholder input (e. g. by introducing mechanisms to prompt engagement and consultation at various stages in the policy development process).

During the deliberations about the first sub-element, four areas emerged as important for consideration:
1) the mechanisms that can be used to support inter-sectoral actions;
2) the leadership role, and who is best positioned to lead;
3) the timing of pursuing courses of action; and
4) the availability of funding.

With respect to the first area, participants agreed that mechanisms promoting concrete, action-oriented steps are necessary to support inter-sectoral action. These could include formal working groups, committees, networks and other structures that link sectors under the umbrella of violence and injury prevention. There was consensus among the participants, however, that due to the limitations of human and financial resources, a new vehicle such as a national commission should not be created for the sole purpose of fostering inter-sectoral action for prevention of violence and injury. One participant expressed the view that if a new entity was to be created, its mandate should also cover other health issues (beside violence and injury) which require an inter-sectoral approach. Other mechanisms for promoting action-oriented steps were also suggested. These included a clearly articulated and feasible action plan that makes clear the timelines within which actions will be taken, and formal arrangements for accountability such as memoranda of understanding among sectors.

A couple of participants suggested (and all agreed) that it was imperative to introduce an approach for the evaluation of any inter-sectoral initiative pursued, to assess whether and under which circumstances specific initiatives worked. As one participant stated, at present in the Caribbean there is "too much of a talk shop [but you need to] actually have documented evidence that there is inter-sectoral collaboration. " Additionally, one participant suggested that implementing a robust evaluation mechanism for any inter-sectoral initiative could be positioned as benefitting the upstream policy environment in general, and that such an approach would also create an environment where "people are held accountable to monitor, evaluate, review, revise."

While deliberations about this element acknowledged that there was very little evidence from systematic reviews about the effectiveness of inter-sectoral approaches (and particularly with respect to violence and injuries), several participants gave examples of existing models they were aware of that could be used to illustrate successful approaches that can be learned from. These included: 1) the mechanism used for implementation of a NCD strategy and action plan in one country which clearly formalized relationships and set expectations across the many sectors involved, gained support from cabinet and the prime minister, and included an evaluation component; 2) an HIV/AIDS program that was integrated into one country's existing mental health department programs, and which was viewed by some participants as a great example of assigning responsibility to different sectors; 3) the establishment of an inter-sectoral Road Safety Council in another country with the prime minister serving as committee chair, which served to signal for all sectors the political will behind the initiative; 4) the inter-sectoral Disaster Management Committees used in several countries; and 5) recent initiatives in some countries to couple family and community security programs.

Second, with respect to leadership, participants had divergent views. Some participants were very supportive of the leading role of the health sector, pointing to recent movements towards universal healthcare, health system strengthening and renewal of primary care efforts as evidence of initiatives that require leadership capacity. However, some participants weighed in and suggested that leading successful inter-sectoral action would require a broader understanding of issues that expanded beyond a narrow view on health services alone. Other participants were doubtful that the health sector could take the lead. While acknowledging that there is a desire, some participants stated that they were not convinced the health sector would have the political power or capacity to take the lead, and several participants shared this skepticism. As one participant put it: "We can want to and try to but our influence is not as great as our desire." In response, several participants suggested that while the health sector might not currently be best positioned to take the lead, it

could at least start 'nudging from behind' through the engagement and training of stakeholders who could justifiably assume leadership roles in inter-sectoral action.

Apart from the issue of leadership at the sectoral level, some participants also suggested that there is a need for a leader (a political, sporting or other influential personality) to champion interventions and inter-sectoral issues related to violence and injury.

Third, with respect to the timing for pursuing inter-sectoral collaboration, all participants agreed that right now is the right time to act. Some participants pointed to some specific opportunities, such as universal access to healthcare and the primary healthcare renewal strategy that have created the right 'windows of opportunity'. They felt that through these initiatives, countries have gained significant experience with inter-sectoral and multi-sectoral collaboration, and now have the right experience to enable them to coordinate actions across sectors and assign responsibilities to the relevant actors.

The fourth and last aspect of the discussion about inter-sectoral collaboration highlighted funding as one of the most important considerations. This was further discussed later in the dialogue as part of the deliberations about implementation considerations, but there was broad agreement among participants that, while resources are limited, inter-sectoral approaches should be conceptualized as creating opportunities to share resources, share training and capacity, and possibly even "venture [into] sharing budgets."

Element 2 - Strengthen violence and injury monitoring and surveillance systems at the regional and national levels

There was broad agreement among participants that the four sub-elements related to strengthening surveillance systems described in the evidence brief were necessary components of any approach to address violence and injuries in the Caribbean. These included efforts to: 1) engage stakeholders from multiple sectors to identify where data are already being collected related to violence and injuries in order to identify opportunities for integration; 2) integrate data from across sectors to create a comprehensive inventory of violence and injury indicators that can inform national policy development and planning; 3) integrate data across the region to inform regional policy development and planning; and 4) identify gaps in available data to prioritize the development of new data collection mechanisms.

During deliberations, many participants suggested that as a first step, a framework for strategic information and research is needed, and that successful existing systems (such as the HIV/AIDS surveillance) can be used as models for developing and implementing a comprehensive framework. As with the deliberations about inter-sectoral collaboration, many participants acknowledged that there is little evidence from systematic reviews about the optimal approaches for monitoring and surveillance in the context of violence and injuries. Deliberations therefore unfolded by drawing primarily on the views and experiences of participants, and focused on four thematic areas: 1) determining where monitoring and surveillance needs to be conducted (i. e. the settings and locations for monitoring); 2) establishing mandatory aspects of data collection and reporting and defining the optimal approaches; 3) mechanisms and tools that can be used to successfully monitor violence and injuries; and 4) establishing mechanisms to share lessons learned across countries.

First, with respect to determining where monitoring and surveillance of violence should be conducted, participants shared the following views: 1) while the majority of countries that collect data do so mostly at the hospital level, and to a much lesser extent in primary care settings, it is important to recognize the fact that not all cases of violence and injuries end up in the hospital, and as such this narrow focus could lead to significant underestimates; 2) most models for surveillance are currently based on local arrangements, however, it is vital that integration is pursued at both the national and regional levels; and 3) efforts are needed to take advantage of the potential for monitoring and surveillance at the level of communities and in primary care settings, with one participant stating that "it's complex place-based interventions that are required", and another participant suggesting that this would be an example of "local action leading to

national achievement". On the whole, most participants agreed that there is a need to strengthen national data systems (that pull from local data) and to facilitate the sharing of data at the regional level.

Second, within the discussion focused on how surveillance could be mandated, the majority of participants mentioned that where reporting is mandated by law (such as healthcare providers having to report violence of children) data are being collected more systematically. There are some promising models for inter-sectoral collaboration for surveillance in this respect, such as police involvement when injuries related to child abuse and drug related crimes are reported. Third, when participants discussed which approaches, mechanism and tools were optimally suited to facilitating better monitoring and surveillance of violence and injuries, the majority suggested that there were certain country experiences which could offer examples of components that are working well. In particular, the use of electronic systems, and purpose-built manual collection systems could work in the right contexts. Several participants also emphasized the need for solutions that allow capturing of unreported cases, which was a challenge that remains unresolved. Another challenge that needs to be overcome is the lack of mechanisms that can be used to link individuals across sectors – such as unique ID numbers – which could help to facilitate more accurate and consistent reporting across all sectors involved in data collection, as well as strengthen communication between sectors that are working together to prevent violence and injuries. Still another challenge related to the collection of psychological data (e. g. depression and anxiety), and mechanisms for incorporating drug and alcohol use into the surveillance system. In addition to these issues, one participant also noted that evaluation of health impact also needs to be included as a tool or mechanism for monitoring violence and injuries, for example, a question such as 'does community policing have the impact on health as we expect' ought to be answered.

Fourth and finally, when considering dissemination of information about monitoring and surveillance of violence and injuries, some participants mentioned that, despite the lack of 'global' evidence from systematic reviews of monitoring and surveillance systems, there was much to be learned from local studies that have been published about surveillance systems in the Caribbean, such as those based on Jamaica's longest running electronic surveillance system, as well as work conducted in Belize and Trinidad and Tobago. Several participants suggested that a single point of access for all of these local studies would be the easiest way to achieve this kind of cross-country learning. One participant noted that the recent development of the CARPHA EvIDeNCe Portal could serve this function, given it indexes the full range of evidence (including single studies) focused on the region. Another participant suggested that the Council of Chief Medical Officers could be used as a platform for data sharing.

Element 3 - Address the cross-cutting issue of harmful use of alcohol in the Caribbean region through targeted initiatives

While participants recognized during deliberations about the problem that in addition to alcohol, substance abuse more generally contributes to violence and injuries in the region, most agreed to focus the discussion on the harmful use of alcohol. There was general agreement with the three sub-elements, as outlined in the evidence brief, which focused on developing and implementing interventions that reduce the harmful use of alcohol by targeting individual and group behaviours (e. g. adolescents and youth, adults, families) and entire communities (e. g. establishment of universal programs available to anyone living in a community, awareness campaigns, etc.), and by introducing new or changing existing laws, policies and regulations that aim to reduce the harmful use of alcohol in an entire jurisdiction. However, a number of points emerged during the deliberations about each sub-element.

First, with respect to developing and implementing interventions that reduce the harmful use of alcohol by targeting individual and group behaviours, a number of participants emphasized the importance of a 'reorientation and reorganization of how we see alcohol'. One participant mentioned that not everything about alcohol is harmful: it is a legal substance, and issues occur from its misuse and abuse. Additionally, many participants mentioned the importance of addressing core cultural aspects that contribute to its misuse and abuse. For example, since alcohol is 'accessible, affordable, and acceptable' (because it's legal), some

people think it is OK to drink and drink excessively, and some people think that you are considered anti-social if you came to a party and did not drink. As mentioned in deliberations about the problem, participants also acknowledged that the media perpetuates this acceptance through popular culture (e. g. 'rum songs') that glorifies alcohol abuse. On the whole, many participants' comments suggested that behaviours related to individual alcohol consumption hinge on the socio-cultural context in the Caribbean, and as such any strategies adopted need to clearly consider them. As one participant put it: "We need to break the back of the cultural nuance which says it is all right to drink excessively."

Second, with respect to developing and implementing interventions that reduce the harmful use of alcohol by targeting entire communities, several participants suggested that these approaches should be framed in the language of primary, secondary and tertiary prevention, as this would resonate with those who work in health and social services, and are the persons who would be required to develop the necessary interventions. Another participant noted that many people in the Caribbean use both alcohol and other substances, and this should be taken into consideration when designing interventions. Furthermore, some participants suggested that there were opportunities to gain traction by linking alcohol misuse to its impact on health in general, and in particular the issue of NCDs which are a growing priority in many countries in the Caribbean. Additionally, some participants felt that linking alcohol misuse to the impact it can have on health services (e. g. as an unnecessary resource burden) could help to promote this set of options, and most participants agreed that health education in schools would play an important role as part of this sub-element.

Third, with respect to introducing new or changing existing laws, policies and regulations that aim to reduce the harmful use of alcohol in an entire jurisdiction, there was a lot of discussion about the possible introduction of price and tax measures to reduce consumption. Most participants were skeptical that governments in the region would be willing to increase taxation or to introduce other policies to make access to alcohol harder (e. g. through restricted hours of sale) given that the economies of many Caribbean countries are tourism-dependent and this sector is heavily driven by alcohol use. One participant mentioned that there does not seem to be enough good evidence that pricing reduces demand in the context of the Caribbean. Another participant mentioned (and others agreed) that with respect to things that are not controlled by the health system, such as alcohol taxation, the most the health sector can do is to advocate.

Element 4 - Strengthen core elements of health systems related to interpersonal and self-directed violence and injury prevention

There was board agreement among participants with respect to element 4 and its sub-elements, and deliberations focused on this element were very brief compared to others. However two points were discussed. First, several agreed that much more emphasis should be placed on strengthening human resources capacity in the health sector generally, and in relation to the issue of violence and injuries more specifically. Some participants pointed out that there was not an adequate discussion of human resource capacity in the evidence brief, and as such future efforts should focus on clearly defining what the problems are with respect to human resources for health in the Caribbean, what options are appropriate to address them, and what existing evidence says about the issue. The second point that was raised by some participants was whether the sub-element were framed in broad enough terms. Specifically, some participants felt that they were narrowly conceived in terms of health services, rather than the health systems (which include a broader range of initiatives and 'core competencies' that extend beyond the traditional health sector). However, several other participants disagreed with this point, and felt that the focus was appropriate given that some of the sub-elements addressed technology (telehealth) and human resources development, which are among the core building blocks of the health system.

Considering the full array of options

After participants completed deliberations about each of the four options presented in the evidence brief, they generally agreed that the prevention of interpersonal and self-directed violence and injuries in the

Caribbean requires a comprehensive, sustained and inter-sectoral approach that prioritizes 'upstream' policy initiatives that are sensitive to the realities of socio-cultural influences on the problem, and that no single option (or narrow set of options) alone can tackle the full range of complex and interrelated causes. There was general agreement that four aspects should be considered in moving forward with a comprehensive approach in the Caribbean.

1) Countries should take advantage of the emphasis currently being placed on priority health issues (such as NCDs, primary health care and universal health access) in the region and internationally in order to:
   a. shift the framing of violence and injuries and position it as a prominent issue within these broader health priorities (particularly NCDs), which would raise the prominence placed on violence and injury;
   b. highlight the economic burden and value-for-money arguments that can help justify addressing the problem within the context of emerging priorities; and
   c. identify opportunities to align planned efforts to address violence and injuries with existing priority initiatives that will likely require similar approaches (i. e. 'upstream' policy intervention and inter-sectoral collaboration).
2) Ensure robust monitoring and surveillance systems, that produce meaningful, context-appropriate, valid and useful data that can be used to support decision-making, are in place both at the national and regional levels. This will require efforts to:
   a. engage stakeholders from multiple sectors to clearly identify and define a common set of indicators;
   b. create opportunities for countries across the region to share information on promising practices and to explore ways to integrate data regionally; and
   c. develop robust monitoring and evaluation plans to ensure we can learn 'what works', within countries, and regionally.

3) Establish formalized inter-sectoral arrangements to ensure accountability across sectors for preventing violence and injuries. These arrangements could be achieved through, a number of potential approaches including the use of instruments such as memoranda of understanding between health and other sectors, or could be embedded in proposed legislation by spelling out the responsibilities required of various sectors.

4) Strengthen the core delivery and programmatic arrangements in health required to address violence and injuries, while highlighting the likely benefits on the wider health system which these capacity development efforts may yield.

While participants broadly agreed on these elements, there were some diverging opinions with respect to the first aspect. In particular, some participants questioned whether there was sufficient convergence between the nature of the issues underpinning violence and injuries and other priority health issues, specifically NCDs, to enable a strategic alignment of goals and strategies. For example, while some participants stated that alcohol abuse could be framed as both a precursor to violence and to the development of some types of NCDs, one participant disagreed and stated that 'alcohol and violence' represents a stand-alone relationship, and disagreed with several other participants' suggestions about similarities of risk factors with NCDs.

Finally, participants were unanimous in emphasizing the role of influential champions from the political realm or from civil society in pursuing the comprehensive approach to address interpersonal and self-directed violence and injuries. This role was viewed by most participants as vital both at the country level and at the regional level.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Deliberations about implementation considerations led participants to identify five main barriers: 1) uncertainty about whether the health sector has enough influence; 2) the lack of a champion to promote the issue at the national and regional levels; 3) political will and the power of the alcohol industry; 4) the diversity across countries with respect to starting points and priorities; and 5) the significant investment required across all sectors.

Uncertainty about whether the health sector has enough influence

There was broad agreement that the health sector is not currently optimally positioned to have a significant influence on the issue of violence and injury prevention. Some participants suggested that this was partly because of the fact that in many countries the health sector isn't viewed as instrumental to development goals, which are often focused on improving economic growth and trade. This dimension is also reflected in the imbalance of budgetary allocations, with more resources allocated to other sectors such as trade, finance and national security, which can serve to reduce the health sector's influence. Several other participants stated that the health sector has also traditionally been focused on health alone without having to engage other sectors, and this has reduced its capacity to function in a leadership or coordinating role within broader inter-sectoral initiatives.

Participants also noted additional factors that have made it challenging for the health sector to take a leadership role. In particular, some noted that health human resources are not currently equipped with the capacity to take on inter-sectoral leadership roles, and that other priorities take away from the time available to those in the health sector to take on leadership roles. Some participants therefore noted that in order to overcome this barrier there would be the need for role clarity, namely, identifying which sector will lead, which will advocate, coordinate etc.

Lack of champions at national and regional level

The importance of identifying champions at both national and regional levels came up at several points during deliberations, and was highlighted again during discussions related to implementation considerations. In particular, some participants agreed that the current lack of champions is a barrier that would need to be addressed systematically, and that there is a need for clarity on who would be best positioned to champion and advocate for inter-sectoral collaboration in the context of violence and injury prevention. One participant expressed the view that this situation in fact presents an ideal opportunity to engage the use of credible sport and cultural icons to champion public service announcements about violence and injury prevention.

Political will and the power of the alcohol industry

Several participants raised the issue of industry interests with respect to alcohol, and many participants agreed that a major barrier in pursuing reforms that could potentially harm alcohol sales or reduce access to alcohol (i. e. taxation, reduced hours of sale) is the strong push-back from actors in the industry. One participant noted that the alcohol industry was very powerful and influential in many Caribbean countries, suggesting that it is 'highly laced and highly connected' with those in positions of policy authority. In addition, several participants commented that tackling issues related to alcohol sales would require tremendous political will because alcohol is tied to GDP in several Caribbean countries – particularly those who rely on tourism and/or exporting alcohol as a consumer product – and the government would stand to lose revenue.

Diversity across countries means different starting points and priorities

All participants agreed that one of the challenges that could hamper a coordinated regional effort is the diversity that currently exists across Caribbean countries, particularly with respect to how well their health

systems function, as well as the priority placed on violence and injury. This could make it challenging to develop compelling, consistent and action-oriented messaging that is appropriate across settings. In addition, several participants mentioned that each country had a different starting point: some countries may be doing some things very well such as monitoring and surveillance, but doing other things poorly, and this is not consistent across the region. Some participants suggested that this could also be considered an opportunity to share 'best practices' across countries and to build inter-country networks that serve as a first step to strengthening initiatives in the Caribbean as a whole.

Significant investment required across all sectors

One of the biggest and most challenging barriers that participants were nearly unanimous in pointing out was the need for significant and sustainable financial investments to bolster the capacity in each sector that would be engaged in violence and injury prevention, and also to facilitate inter-sectoral collaboration. As one participant put it: "It takes cash to care, and you have to care to find the cash." Related to this, many participants agreed that any attempts to make the case for more investment would have to be oriented towards the economic impacts, value for money and return on investment arguments.

Despite these barriers, participants also highlighted several opportunities that could support implementation of the comprehensive approach to preventing interpersonal and self-directed violence and injuries in the Caribbean.

Leverage existing health care reforms and initiatives from developmental partners
The first opportunity was one that was discussed throughout a number of the previous deliberations by many participants, and related to the fact that several countries in the Caribbean are currently pursuing a range of other healthcare reforms (e. g. those related to NCDs, primary care and universal health coverage) that could serve as a way in for discussions about preventing inter-personal and self-directed violence and injuries. While not all participants agreed on the exact approach that should be taken to build on this momentum, most agreed that it did present a legitimate opportunity.

Other opportunities that were mentioned by participants included the current development of the Sustainable Development Goals for the post-2015 (and post-Millennium Development Goals) development agenda, which will soon be released by the United Nations, and could help present an opportunity to prioritize violence and injuries. Furthermore, PAHO has recently completed an initiative to collect data from a number of Caribbean countries in order to document the status of violence-prevention initiatives across the region, and is now in the process of expanding the number of countries included. This was viewed by several participants as an important opportunity given it is a strong indication of the priority placed on the issue in the region. Some participants also suggested that this initiative would provide the first baseline assessments of what policies and programs are actually being pursued in countries across the Caribbean, which will help provide a much-needed starting point for many nations who are grappling with next steps, while also highlighting gaps and areas for cross-country learning.

Foster partnerships with key sectors

One participant also emphasized the opportunity for partnership with actors in the crime and security sector, which resulted in interest from several other participants and led to a group discussion. Most participants embraced the idea noting that working with security could help overcome financial barriers, given this ministry tended to receive the largest share of the national budget. In addition, one participant noted that existing security programs may be looking to engage with other stakeholders to address common challenges, including those related to crime and security (and indirectly those that relate to violence and injuries). Within this discussion, several participants suggested that agencies such as CARPHA, for which addressing violence and injuries is seen as top priority, could explore areas of common interest with regional security agencies

such as the Caribbean Community Implementation Agency for Crime and Security (CARICOM IMPACS) to explore the potential for partnering to achieve common regional goals.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Participants identified seven priorities or necessary 'next steps' for moving forward.

1) **Identify and integrate relevant Caribbean data and studies about interpersonal and self-directed violence and injuries with the evidence presented in the brief that informed the stakeholder dialogue**. This would complement the available global evidence from systematic reviews outlined in the brief, and most importantly fill the gaps in evidence that were identified in the document and reinforced during the deliberations.
2) **Develop an inventory of current violence- and injury-prevention initiatives in the region.** Several participants suggested that a common data collection tool could be created and circulated to violence and injury focal points within Caribbean countries to facilitate development of this inventory.
3) **Conduct an assessment of the status of implementation of the various options presented in the evidence brief.** In addition to developing the inventory of existing policy and program initiatives, it was also suggested that an assessment should be conducted to determine where countries are with respect to implementation of the various elements presented in the evidence brief.
4) **Develop a common set of indicators that can inform improved monitoring and surveillance across sectors and across countries in the Caribbean**. This would be a first step in establishing a robust baseline of indicators that are mindful of the needs of policymakers across sectors and that could be used to prioritize future policy initiatives. Upon development of the common set of indicators, consideration should also be given to the development of an information-sharing network for the region.
5) **Collaboratively develop an implementation plan, written with clear and consistent messages about priorities (i. e. what needs to be done), accountability (i. e. who does what), and timelines (i. e. by when).** This strategic direction would clearly outline these dimensions in a way that is appropriate for the Caribbean, and action-oriented. The plan should include development of a research agenda required to close existing knowledge gaps. CARPHA and CARICOM IMPACS should play a coordinating role with respect to the plan.
6) **Take advantage of current opportunities to collaborate with other sectors that are clearly willing.** Specifically, participants made suggestions for closer collaboration between the health and national security sectors. The health sector brings skills and capacity related to data collection and management to the table, which is of value to the security sector, and could therefore be a meaningful partner. It was indicated that this engagement could be facilitated by ensuring that the process for the development of National Crime Plans includes health as a stakeholder. Additionally, participants made suggestions to engage with CARICOM IMPACS and other key development partners operating in the region (e.g. the Canadian International Development Agency, the Department for International Development (UK), the World Bank, the Inter-American Development Bank and the United Nations Trust Fund for Human Security) to ensure the key issues were addressed.
7) **Take the lessons learned from the deliberative dialogue back to individuals who can prioritize the issues and instigate meaningful actions at the country level**. Various approaches to this were suggested. Several participants, some of whom held positions as, or worked closely with senior policymakers, indicated that they will communicate key messages to their ministries, with the hope of positioning violence and injuries as a priority issue. Another participant suggested that these messages will be communicated at an upcoming meeting of regional chief nursing officers, with the same intention. One chief medical officer indicated that steps would be taken to place the issue on the agenda of the Council of Chief Medical Officers.

McMaster
HEALTH FORUM

>> Contact us

McMaster Health Forum
1280 Main St. West, MML-417
Hamilton, ON Canada L8S 4L6
Tel: +1.905.525.9140 x 22121
Email: mhf@mcmaster.ca

>> Follow us

mcmasterhealthforum.org
healthsystemsevidence.org
healthsystemslearning.org

tinyurl.com/mhf-iTunesU
tinyurl.com/mhf-YouTube
tinyurl.com/mhf-Facebook
tinyurl.com/mhf-Twitter

EVIDENCE >> INSIGHT >> ACTION