

# Third Milestones of a Global Campaign for Violence Prevention Report 2007

---

## Scaling up



GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION  
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE

## Copyright

WHO Library Cataloguing-in-Publication Data

Third milestones of a Global Campaign for Violence Prevention report, 2007: scaling up.

“This report was written by Kidist Bartolomeos ... [et al.]” --Acknowledgements.

1.Violence - prevention and control. 2.National health programs. 3.Program evaluation. 4.International cooperation. I.Bartolomeos, Kidist. II.World Health Organization. III.Title: Milestones of a Global Campaign for Violence Prevention report, 2007.

ISBN 978 92 4 159547 6

(LC/NLM classification: HV 6625)

### © World Health Organization 2007

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: [bookorders@who.int](mailto:bookorders@who.int)). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: [permissions@who.int](mailto:permissions@who.int)).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The named authors alone are responsible for the views expressed in this publication.

Printed in Italy.

## Contents

- 4 Foreword
- 5 Acknowledgements
- 5 List of abbreviations
- 6 Violence prevention: what's at stake
- 7 Violence: a major risk factor
- 8 A global public health response
- 10 Country action to prevent violence
- 14 Global and regional action to prevent violence: what's been done 2002–2007
- 24 Key messages
- 26 Integrating violence prevention in the development agenda: WHO's commitment
- 28 Integrating violence prevention in the development agenda: what stakeholders can do
- 30 Contacts and resources

## Foreword

This report, the third of its kind, reviews the progress that has been made in the field of violence prevention since the October 2002 launch of the *World report on violence and health* and the Global Campaign for Violence Prevention. More importantly, it sets out what the World Health Organization (WHO) and its partners can do over the next 5 years to expand violence prevention programming and to demonstrate, in terms of lives saved and suffering averted, the impact of violence prevention.

Violence is a major obstacle to health and development, but as Nelson Mandela said in the foreword to the *World report on violence and health*, "Violence can be prevented. Violent cultures can be turned around ... Governments, communities and individuals can make a difference". As well as increased awareness that violence is preventable, notable achievements of the first 5 years of the Global Campaign for Violence Prevention detailed here include consolidating and disseminating normative guidance on how to prevent violence; carving a niche within government health ministries for focal persons to promote violence prevention; and taking stock of the scale and nature of the violence problem and the responses to it. At the individual level, tens of thousands of people in scores of countries have been touched by violence prevention programmes and thousands of victims have been helped to cope with the aftermath of their experience through services established as part of the Global Campaign for Violence Prevention.

There remains, however, much more work to be done. Through the activities described in this document and those initiated independently of WHO, violence prevention has arrived at a crucial turning point. Advocacy, normative guidance and the planting of programme seeds in many countries must now give way to scaled-up country level implementation, accompanied by a concerted effort to measure the effectiveness of interventions using the outcomes that really matter – rates of violence-related deaths, non-fatal injuries and other violence-related health conditions.

Over the next 5 years, WHO is committed to working with its partners at all levels – global, regional and country – to make the impacts of violence prevention visible by investing in proven and promising prevention strategies, as well as in data collection systems to support the monitoring of the effectiveness of prevention efforts. Visible results for violence prevention build confidence, and in turn, the political commitment and momentum required to intensify and expand the prevention of violence. In this way, we can capitalize on the heightened concern and harness the goodwill established by the first 5 years of the Global Campaign for Violence Prevention.

### **Margaret Chan**

Director-General  
World Health Organization



## Acknowledgements

This report was written by David Brown, Alexander Butchart, Alison Harvey, Kidist Bartolomeos, David Meddings, and Laura Sminkey of the Department of Injuries and Violence Prevention, World Health Organization (WHO). Contributions were received from several WHO regional office staff including Alberto Concha Eastman, Syed Jaffar Hussain, Freja Kärki, Olive Kobusingye, Hisashi Ogawa, Francesca Racioppi, Chamaiparn Santikarn and Dinesh Sethi. Claire Scheurer provided the administrative support.

The World Health Organization gratefully acknowledges the generous financial contributions towards the production of this report that were received from the Government of Belgium, the California Wellness Foundation, the F. Felix Foundation and the United States Centers for Disease Control and Prevention.

## List of abbreviations

<b>AVPP</b>	Armed Violence Prevention Programme
<b>CDC</b>	United States Centers for Disease Control and Prevention
<b>NGO</b>	Nongovernmental organization
<b>OHCHR</b>	Office of the United Nations High Commissioner for Human Rights
<b>PAHO</b>	Pan American Health Organization
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNDP</b>	United Nations Development Programme
<b>UNSG</b>	United Nations Secretary-General
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

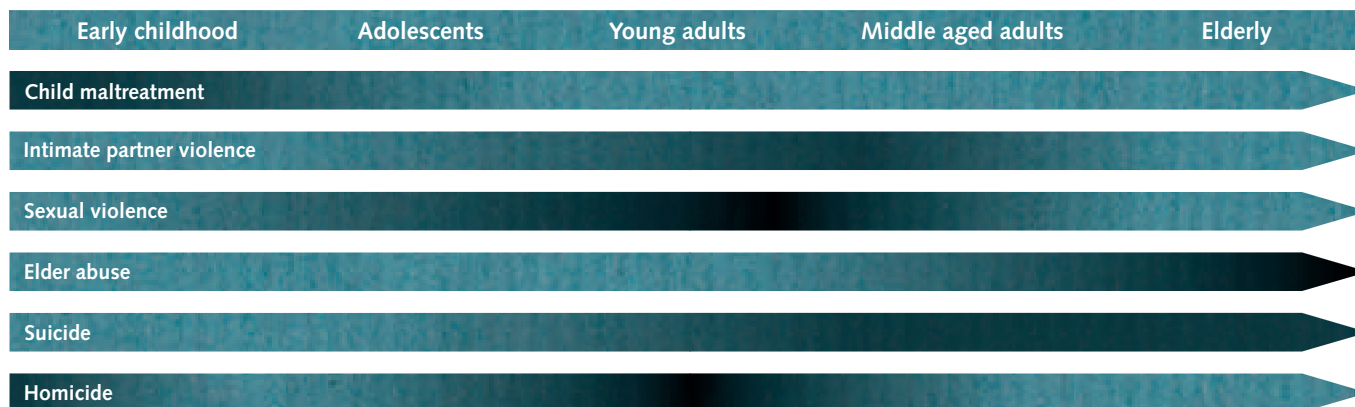
# Violence prevention: what's at stake

In 2002, an estimated 1.6 million people worldwide died as a result of self-inflicted, interpersonal or collective violence. To put this figure into perspective, this is roughly half the number of deaths due to HIV/AIDS, nearly equal to the number of deaths due to tuberculosis, somewhat greater than the number of deaths due to malaria, and 1.5 times the number of road traffic deaths. Of the total 1.6 million victims of violence, around a third (560 000) were homicides, a further 870 000 people killed themselves and an estimated 170 000 died as a direct result of collective violence. The highest rates of homicide are found among men aged 15–44 years from low- and middle-income countries, and the highest suicide rates are among men aged 60 years and over. In terms of capturing the full burden of violence, these figures only scratch the surface. In addition to the high annual death toll, each year millions of people suffer non-fatal health consequences of violence, for example, injury and disability, mental health and other behavioural disorders, and poor reproductive health, many of which can have long-lasting implications, including increased risk for chronic diseases.

Violence is not, however, an inevitable aspect of the human condition. In much the same way as infectious diseases and other threats to public health have been in the past, violence can be prevented and its impact reduced. Adoption of a public health approach to violence prevention, requires, as a first step, a description of the magnitude and impact of the problem. Published in 2002, WHO's *World report on violence and health* examines the global patterns of violence by person, place and time. What this report reveals is the fact that across the spectrum of violence — child maltreatment by caregivers, youth violence, violence by intimate partners, sexual violence, elder abuse, suicide and collective violence — violence in one form or another affects nearly everyone at some point during their lives.

Figure 1 below displays the burden of violence across the lifespan; periods of greater burden are indicated by darker shading. A quick glance is enough to see that there are few life stages during which individuals are not potentially affected by at least one type of violence. What is not shown in this figure is the links between different types of violence. In recent years, it has become increasingly apparent that the presence of one type of violence tends to directly increase the risk of an individual, family or community for another type of violence, and secondly, that cross-cutting risk factors, such as alcohol and substance abuse, mental illness and economic inequalities, increase the risk for most types of violence. Preventing one type of violence can therefore help to prevent other types of violence, and by addressing the cross-cutting risk factors it is possible to help reduce all forms of violence.

**Figure 1. The burden of violence across the lifespan**



Note: periods of greater burden are indicated by darker shades.

# Violence: A Major Risk Factor

Until relatively recently, only the immediate physical consequences (i.e. death, physical injuries, disabilities) of violence were widely recognized and dealt with by health systems. Evidence now suggests that in addition to the immediate physical consequences violence has a variety of other less obvious health, social and economic consequences. Moreover, the burden of violence extends beyond the discrete life stages of an individual. For instance, child maltreatment has consequences for health behaviours, communicable and noncommunicable diseases, and health-care utilization across the lifespan – from childhood and throughout adulthood. Similarly, intimate partner violence can influence physical, psychological or behavioural well-being, as well as sexual and reproductive health, in ways that extend beyond the mere fact of exposure to violence.

## Health consequences

Aside from fatal events such as homicide and suicide, the damaging effects of violence on health include physical consequences (e.g. brain injuries, bruises and scalds, chronic pain syndromes, irritable bowel syndrome); psychological consequences (e.g. cognitive impairment, depression and anxiety, phobias and panic disorders, psychosomatic disorders); and behavioural consequences (e.g. alcohol, tobacco and drug use, physical inactivity). Violence can also be a risk factor for a range of sexual and reproductive health problems, such as infertility, pregnancy-related complications, unsafe abortion, pelvic inflammatory disorders, HIV and other sexually transmitted diseases, and unwanted pregnancy, as well as for various chronic diseases including cancer, ischemic heart disease and chronic lung disease, in part through the adoption of unhealthy behaviours (e.g. smoking).

## Social consequences

Violence destroys the social fabric of communities and has a disruptive impact on community and intra-familial relationships. Intimate partner violence, for instance, may result in isolation from social networks and problems with social integration. Childhood aggression has been shown to be a predictor of violence in adolescence and adulthood. Both child maltreatment and intimate partner violence are associated with relationship problems, poor school performance, employment difficulties and frequent changes in place of residence.

## Economic consequences

The effects of violence place an enormous burden on national economies through increased health-care and legal costs, absenteeism from work and lost productivity. For example, a study conducted in Cape Town concluded that serious abdominal gunshot injuries cost more than 13 times as much as the South African government's annual per capita expenditure on health.

Our understanding of the economic consequences of violence is hampered by the scarcity of studies in this area of research from low-and middle-income countries, which are known to be disproportionately affected by violence. Our understanding is further impaired by a lack of cost estimates that include those costs associated with risk behaviours and other health problems that have been linked to exposure to violence.

## Estimated lifetime impact of child sexual abuse

A recent WHO study estimated that the lifetime impact of child sexual abuse accounts for approximately:

- 6% of cases of depression,
- 6% of alcohol and drug abuse/dependence,
- 8% of suicide attempts,
- 10% of panic disorders,
- 27% of post-traumatic stress disorders.



# A Global Public Health Response

Since publication of the *World report on violence and health* in 2002, much has been achieved in terms of raising the profile of violence and its consequences. While in 2002 only a handful of health ministers could say why violence should be a public health priority, by 2007 three out of six WHO regional committees (i.e. those for Africa, the Americas and Europe) had adopted violence prevention resolutions. Over 50 countries have held national launches of the *World report on violence and health*, and over 25 countries have developed reports and/or plans of action on violence and health. Most encouraging of all, there are now more than 100 officially appointed health ministry focal persons for the prevention of violence (see Figure 2). There are also signs that increasingly countries are taking stock of levels and patterns of violence, the health consequences and also their responses to such violence. To support this effort, WHO has continued its work in consolidating and disseminating normative guidance on how to assess and thus prevent the problem of violence.

## Countries with a national report on violence and health

- Belgium
- Botswana
- Brazil
- Costa Rica
- France
- Jordan
- Malaysia
- Mali
- Mexico
- Mongolia
- Mozambique
- Nepal
- Russian Federation
- South Africa
- Sri Lanka
- Thailand
- The former Yugoslav Republic of Macedonia
- United Kingdom

## Countries with a national policy document

- Bolivia
- Botswana
- Brazil
- Costa Rica
- Finland
- France
- Honduras
- Jamaica
- Jordan
- Macedonia
- Mongolia
- Mozambique
- South Africa
- United Kingdom

## Legend

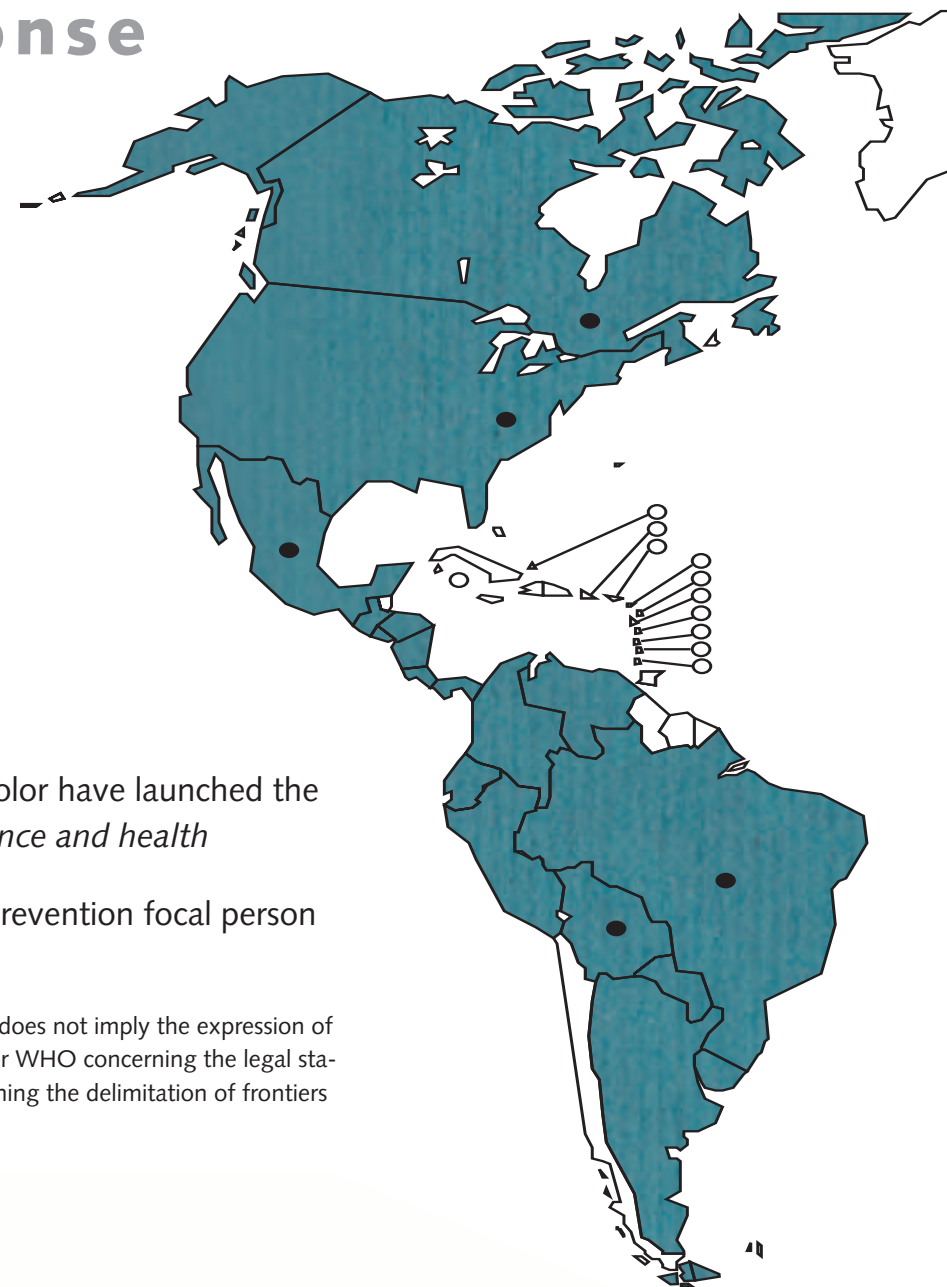


Countries shaded in color have launched the *World report on violence and health*

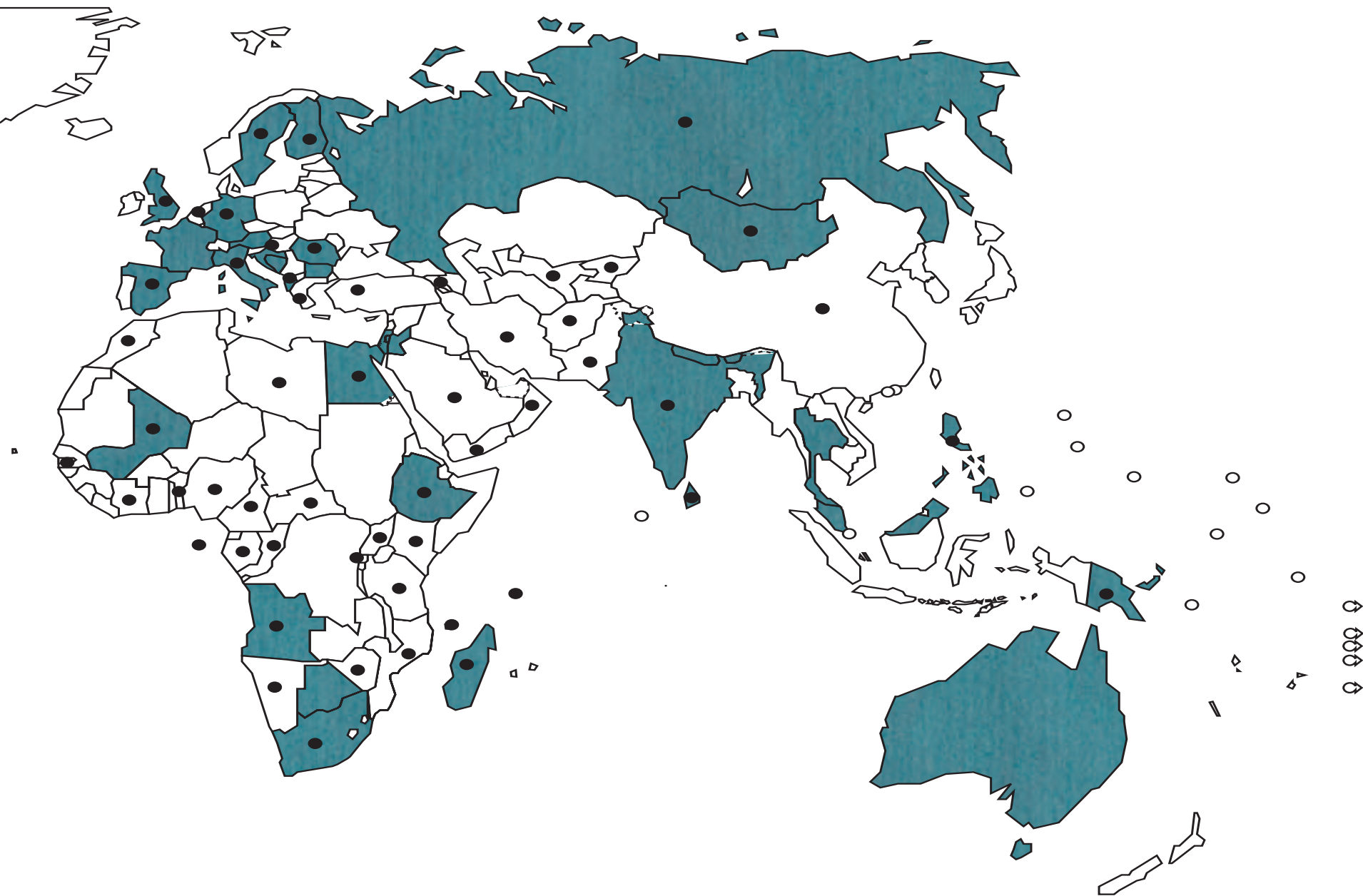


Designated violence prevention focal person

This map is for illustrative purposes and does not imply the expression of any opinion on the part of the authors or WHO concerning the legal status of any country or territory or concerning the delimitation of frontiers or boundaries.







# Country Action to Prevent Violence

In recent years, awareness of violence and violence prevention at the country level has increased significantly, as has the number of new initiatives and programmes being undertaken in this field. Although it is not possible to document all country activities here, the following reports provide a cross-section of the sorts of measures that are currently being implemented to prevent violence in different parts of the world, ranging from activities that rely on direct WHO support to those that are more or less independent of WHO involvement.

## Brazil

Brazil has advanced its national programme for violence prevention through initiatives led by its Ministry of Health and conducted in collaboration with the Brazilian Ministry of Justice, the Pan American Health Organization (PAHO) and various research centres and nongovernmental organizations (NGOs). Among the achievements of the last few years are the publication of a report on homicides in children and adolescents during the period 1980–2002 (in 2004), and the publication by the Brazilian Ministry of Health of a national report on the impact of violence on health (in 2005).

With the support of the Armed Violence Prevention Programme (AVPP), a joint United Nations Development Programme (UNDP)/WHO initiative, and various Brazilian government departments, the Centre for the Study of Violence, based at the University of São Paulo, in 2006 completed a national inventory of 330 violence prevention programmes. As part of this work, a retrospective evaluation of the effectiveness of two local violence prevention initiatives – one in Jardim Angela, a highly disadvantaged neighbourhood in the city of São Paulo, the other the Luta Pela Paz (Fight for Peace) project in the slum district known as the Complexo de Maré in Rio de Janeiro – was undertaken. The results suggest that while both initiatives have successfully established strong and

sustained links with high-risk youth – through the provision of support for the development of their educational, sporting and employment potential – methodological difficulties in identifying non-intervention comparison groups and measuring violent injury rates limit the ability to draw firm conclusions as to the impact of this type of intervention on the level of violence.



Rio de Janeiro, Brazil (17 March 2007) - 700 crosses are planted on Copacabana Beach by Rio de Paz as a remembrance of those killed by violence in Rio de Janeiro during 2007. Photo Courtesy of Reuters.

## Jamaica

Jamaica has continued to consolidate its national violence prevention activities through the combination of strong Ministry of Health leadership and the formation of the Jamaican Chapter of the Violence Prevention Alliance, which brings together several government departments, and a number of NGOs, civil society organizations and researchers. Violence prevention is prioritized in the National Strategic Plan for the Promotion of a Healthy Lifestyle, and recent efforts to document violence prevention programmes and to better estimate the economic impact of violence have helped strengthen violence prevention programming at national and community levels. One of the latest developments in this particular area is the establishment of the Jamaica Crime Observatory, a facility which integrates data about crime and violence from several organizations, including the Jamaica Constabulary Force, the University of the West Indies Peace and Justice Centre, and the Ministry of Health. Other recent prevention activities have included the establishment of a “Learning for life” programme to provide disadvantaged, out-of-school adolescents and young adults with job training and enrolment; a new structured after-school programme for older children and adolescents; and a variety of public advocacy campaign activities, including peace marches and a peace concert which involved over 10 000 Jamaicans of all ages.



“Violence is preventable in good times and bad times.”  
Poster courtesy of Violence Prevention Alliance Jamaica.

## Malaysia

In 2003, the Malaysian Minister for Health, in launching the “Global Campaign for Violence Prevention: Malaysia’s Response”, expanded the scope of the existing national injury prevention programme to include violence prevention activities. The unit responsible for implementing the programme, which is housed within the Disease Control Division of the Malaysian Department of Public Health, was duly renamed as the Violence and Injury Prevention Unit. Its *National report on violence and health in Malaysia* (published in 2006) contained nine recommendations which, among other things, called for the development of a national plan of action for violence prevention, strengthened primary prevention programmes and improved services for victims. The Violence and Injury Prevention Unit’s ongoing activities include awareness-raising among health staff and the public; sensitization and training of health sector staff on the prevention and the management of domestic violence and child abuse; and the development of a database on violence cases seen in hospitals.

Outside of the Violence and Injury Prevention Unit, Ministry of Health-led violence prevention activities have included the development of one-stop crisis centres for victims of child maltreatment, services for survivors of intimate partner and sexual violence in all government hospitals throughout the country (coordinated by the Hospital Division), screening for domestic violence (organized by the Women’s Health Unit of the Family Health and Development Division), and a Suicide Prevention Programme (coordinated by the Mental Health Unit of the Family Health and Development Division).



## Mozambique

With WHO support, violence prevention efforts in Mozambique have centred on developing surveillance systems for recording details of violence-related deaths and non-fatal cases presenting at morgues and hospital emergency rooms; improving services for victims of sexual violence; and integrating violence and injury prevention into key health and development policy documents, including national action plans. As a result of these activities, the impact of violence on development has been recognized and the importance of violence prevention reflected in the new Poverty Reduction Strategy Paper and the National Health Declaration Policy document. A national commission for violence and injury prevention, comprising experts on data, emergency care and disability, has since been established and within the Ministry of Health a focal point for promoting violence and injury prevention has been appointed.

Using WHO guidance documents, recommendations for strengthening provincial violence prevention services have been developed, and in Maputo, the availability and quality of medico-legal services for victims of sexual violence have been assessed. The latter assessment, and its recommendations, received widespread media coverage, which led to the development of an expanded report on sexual violence in Mozambique advocating for a nationwide strengthening of the health sector response to sexual violence. The results of a joint Mozambique Ministry of Interior, Small Arms Survey and WHO research study on firearm-related violence in Mozambique showed low

overall rates of firearm-related violence but considerably higher levels of non-firearm-related violence, particularly among youth living in peri-urban areas. Recommendations of this study called for the development of prevention strategies; increased coordination; greater data collection and analysis capacity to support monitoring and evaluation of the use of firearms and patterns of firearm death and injury; and improved public health response for victims of violence.

## South Africa

South African uptake of WHO-backed violence prevention research, recommendations and technical guidance has been largely independent of direct WHO support, driven instead by national, provincial and local government, research councils and nongovernmental agencies, such as the Soul City Institute for Health and Development Communication. Notable achievements include the development, in 2005 by the National Department of Health, of an intersectoral strategy for the prevention of deaths due to violence and injuries. A comparative audit



Women in Cape Town march for violence prevention. Photo courtesy of Soul City Institute.



of South African government violence prevention programmes, using WHO-recommended prevention strategies as the benchmark, was performed as part of this initiative.

In 2006, the National Department of Health established its Non-natural Death Prevention Subdirectorate to promote primary prevention programmes aimed at reducing the rates of death due to both violent and unintentional injuries. In Gauteng Province, this has involved the integration of violence prevention into the City of Johannesburg's human development agenda. In the Western Cape, violence prevention programming has been based on the results of a provincial level burden of disease study, which highlighted the need for a multisectoral approach that spans the criminal justice, health, infrastructure and policy domains. In preparing for the forthcoming season of its multimedia drama and entertainment series, *Soul City* has made extensive use of WHO violence prevention materials. These drama series reach 16 million South Africans and have also been broadcast in many parts of Africa, as well as in Latin America, the Caribbean and South-East Asia.



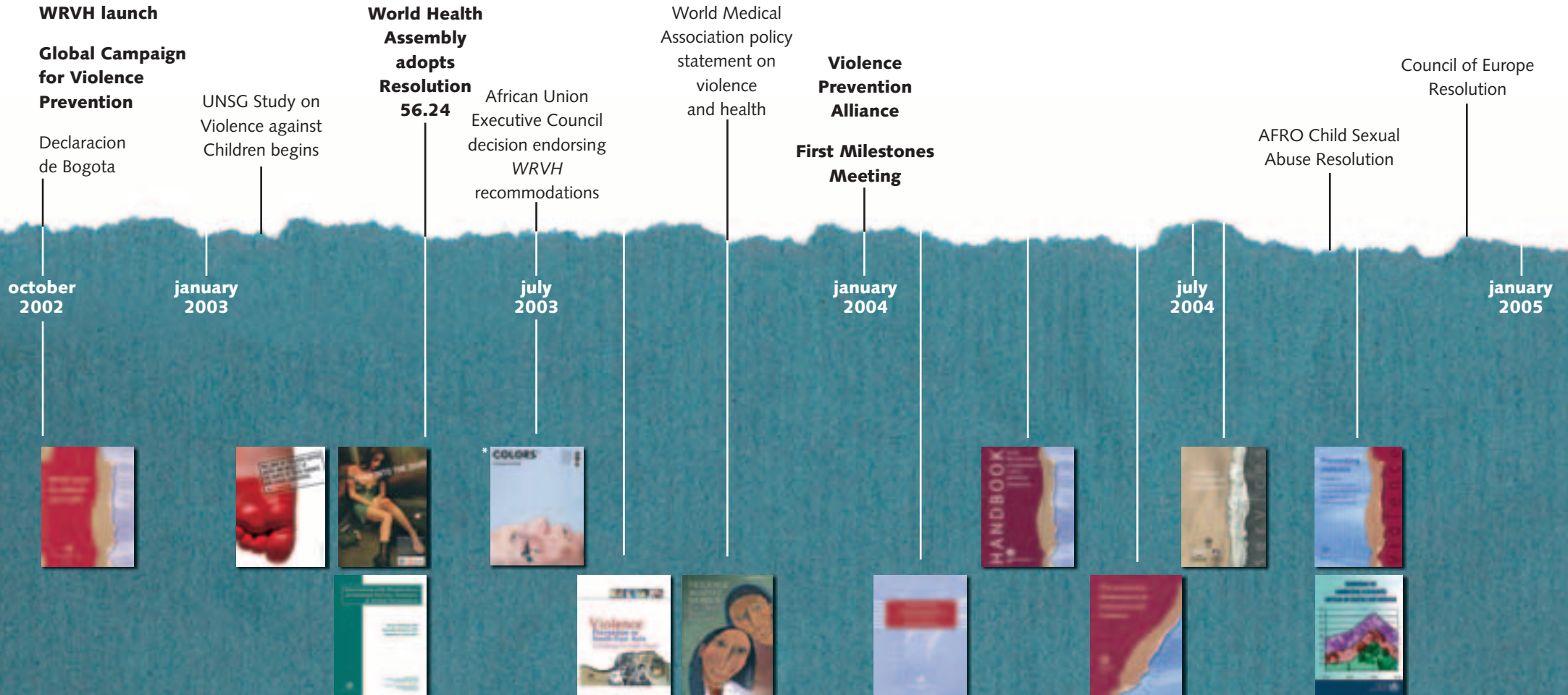
Centre Pompidou Exhibit les Yeux Overt including "Violence in Red" poster series, October 2006. Photo taken by Philip Harvey.

## United Kingdom

In the United Kingdom, violence prevention activities have made a significant contribution to the peer-to-peer learning network set up by the WHO-led Violence Prevention Alliance (see p.18). In 2005, a violence prevention team comprising senior officials from the Department of Health, the Health Protection Agency and the Liverpool-based John Moore's University Centre for Public Health embarked on a study tour of United States of America to review at first hand the impacts of violence prevention programmes at federal, state and municipal levels. Lessons learned from this visit not only informed the development of a national report on violence and health (*Violent Britain: people, prevention and public health*), but also provided the basis for a national violence prevention strategy document that is currently being finalized.

Regional activities include the establishment, by the Scottish Executive, of a Violence Reduction Unit as part of a wider Safer Scotland initiative. In 2006, the Violence Reduction Unit hosted a series of seminars, which provided the platform for the subsequent development of a collaborative network of representatives of the justice, education and health sectors (drawn from several levels of administration, including local authorities) and a shared agenda for violence reduction. In Wales, the pioneering work of the Cardiff Violent Crime Task Group on the use of integrated police and hospital emergency room data to inform prevention programmes has been promoted by the United Kingdom government as a model for community safety partnerships nationwide.

# Global and Regional Actions to Prevent



\*"Courtesy of Colors Magazine/Issue 56/Violence"



# Violence: What's Been Done, 2002-2007

## Second Milestones Meeting

HM Queen Rania agrees to serve as WHO Patron for EMRO



July 2005

Launch of Armed Violence Prevention Programme

EURO Resolution (EUR/RC55/10)

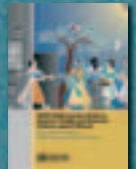


First Meeting of European National Focal Persons



January 2006

BBC World Service WHO 4-week radio programme "Violence Begins at Home"



Geneva Summit  
First Global Meeting of MoH Focal Persons  
African Health Ministers Summit



July 2006

UNSG World report on violence against children launch

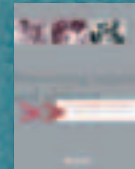


Centre pompidou Exhibit les Yeux Overt including "Violence in Red" posters series



Armed Violence Prevention Programme Phase I Consultation Review

January 2007

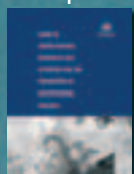


## Third Milestones Meeting

July 2007

# 2003

January  
2003



UNSG Study on  
Violence against  
Children begins



World Health  
Assembly adopts  
Resolution 56.24



African Union Executive  
Council decision  
endorsing WRVH  
recommendations



World Medical Association  
policy statement  
on violence and health



January  
2004

## Key events

In terms of the global response to violence, one of the most significant events to take place during 2003 was the World Health Assembly adoption of Resolution WHA56.24 on implementing the recommendations of the *World report on violence and health*. This milestone was preceded in February by the appointment of Professor Paulo Sérgio Pinheiro as the Independent Expert leading the United Nations Secretary-General's Study on Violence against Children. This study, which was carried out in collaboration with the United Nations Children's Fund (UNICEF), the Office of the United Nations High Commissioner for Human Rights (OHCHR) and WHO, is a response to a request by the United Nations General Assembly in 2001 for an in-depth review of the issue.

In April, during its annual meeting, the American Medical Association endorsed the *World report on violence and health*, and in May, at its General Assembly in Helsinki, the World Medical Association adopted a policy statement on violence and health. The World Medical Association also called upon the medical profession to contribute to developing more systematic approaches to dealing with violence, in particular, in the form

of improved data collection systems and medical training and targeted interventions to prevent violence. The recommendations of the *World report on violence and health* were also endorsed by the African Union Executive Council on Violence and Health (EX/CL/Dec.63 (III)) at their meeting in July. Shortly thereafter, in September, the WHO Regional Committee for Africa endorsed Resolution AFR/RC53/R3 on Injury Prevention and Control in the African Region.

In August, the **Malaysian** Minister of Health announced the establishment of a **Malaysian** Violence and Injury Prevention Unit within the Disease Control Division of the **Malaysian** Department of Public Health. Also, following the addition of questions on violence into the WHO Global School-based Student Health Survey, implementation of these questions began in selected countries. In October, the **Australian** Public Health Association voiced its support for the Global Campaign for Violence Prevention in endorsing the recommendations of the *World report on violence and health*, and called on health professionals to address, directly and explicitly, the issue of violence in **Australia**.

## Publications and technical documents

Among the documents published during 2003 were:

- *Guide to United Nations resources and activities for the prevention of interpersonal violence*,
- *Violence against women: The health sector responds* (by PAHO);
- *Violence prevention in south-east Asia: A challenge for public health* (by the WHO Regional Office for South-East Asia).

The World Health Organization published the first issue of the newsletter of Global Campaign for Violence Prevention, *Prevent*, and two further titles, *Intervening with perpetrators of intimate partner violence: A global perspective* and *Putting women first: Ethical and safety recommendations for research on domestic violence against women*.

\*"Courtesy of Colors Magazine/Issue 56/Violence"



## National reports

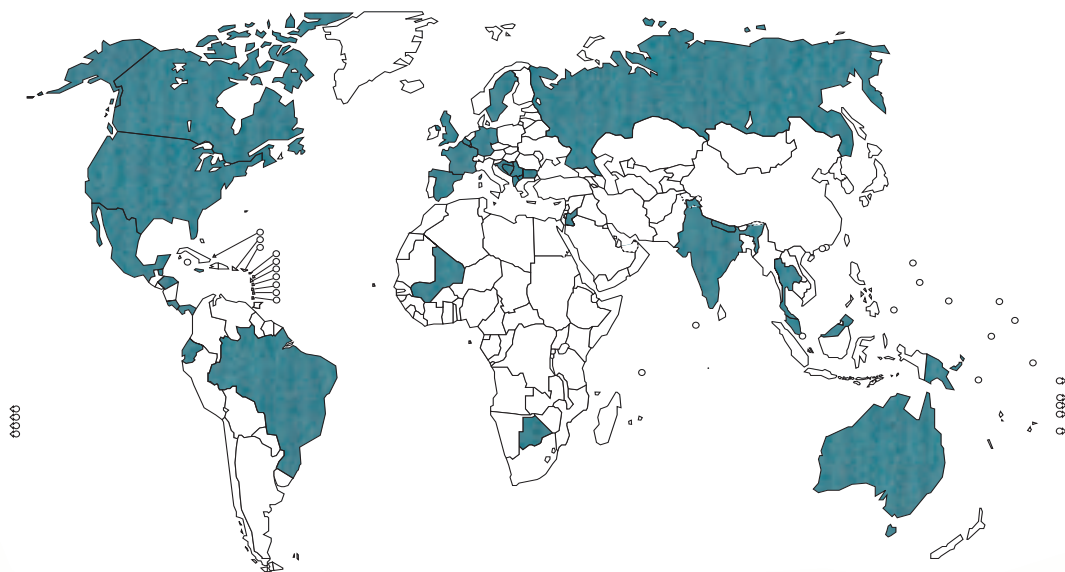
Resolution WHA56.24 (on Implementing the Recommendations of the *World Report on Violence and Health*) calls on countries to develop national reports on violence and health. During 2003, national reports on violence and health were completed for **Belgium** and **Costa Rica**.

## National launch of the *World report on violence and health*

National launches of the *World report on violence and health* involve policy discussions among representatives of different sectors about how to use the report and implement its findings in a country<sup>1</sup>. The following countries hosted such launch events during 2003: **Albania** (March), **Bosnia and Herzegovina** (March), **Botswana** (May), **Bulgaria**

(March), **Canada** (May), **Croatia** (March), **Ecuador** (August), **France** (June), **Germany** (June), **Honduras** (March), **India** (February), **Jamaica** (October), **Jordan** (February), **Malaysia** (August), **Mali** (April), **Mexico** (July), **Serbia and Montenegro** (March), **Nepal** (May), **Panama** (April), **Papua New Guinea** (July), **the Russian Federation** (July), **Spain** (November), **Sweden** (December), **Thailand** (January), **The former Yugoslav Republic of Macedonia** (November), **United Kingdom** (September), **United States of America** (September).

<sup>1</sup>Between October and December 2002, countries that convened national launches of the *World report on violence and health* and policy discussions on how to implement its recommendations included: Argentina, Armenia, Australia, Azerbaijan, the Bahamas, Bolivia, Brazil, Colombia, Costa Rica, El Salvador, Georgia, Madagascar, Mozambique, Nicaragua, Paraguay, Peru, the Philippines, Puerto Rico, South Africa, Sri Lanka, Uruguay and Venezuela.



## Lessons learned

### Collaboration: challenging but essential

A diverse range of organizations and individuals are engaged in violence prevention. Some focus on a particular type of violence (e.g. elder abuse, child maltreatment), while others work from a particular perspective, such as human rights or criminal justice reform, or within a specific sector or level of administration (i.e. at the local, national, regional or international level). It is not surprising therefore, that the various stakeholders who are involved in violence prevention do not always agree on priorities, strategies or even on how to frame a problem. They may even work, or perceive themselves as working, in direct competition with other actors.

Against this backdrop, bringing people together for effective collaboration can be difficult. It is intuitive, and easy, to say that violence prevention requires a comprehensive and intersectoral approach, but working out collaborative strategies in practice is rarely that simple. The complex and balanced solutions that are needed to address violence require their own form of diplomacy. Stakeholders must not only learn to understand the language used by other partners, who may not at first appear likeminded, but also to identify mutual interests and common goals. They must trust that in the long run, greater good will be achieved through investment in working together than could ever be accomplished by independent efforts. Fostering this trust will take considerable time, energy, humility and patience, but the potential gains are worth that effort

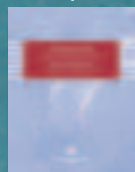
# 2004

## First Milestones Meeting

January 2004



## Seventh World Conference on Injury Prevention and Safety Promotion



## AFRO Child Sexual Abuse Resolution



## Council of Europe Resolution



January 2005

## Key events

In January 2004, the Global Campaign for Violence Prevention convened its First Milestones Meeting in **Switzerland**, at which the WHO-led Violence Prevention Alliance was launched.

June saw the start of the Seventh World Conference on Injury Prevention and Safety Promotion, which was held in **Austria**, and also the adoption by the **Canadian** Public Health Association of a violence prevention resolution. During the following month, the *World report on violence and health* was launched in **Romania** at an event jointly organized by the Romanian National Agency for Family Protection, WHO and the United Nations Population Fund (UNFPA).

The International Federation of Medical Students' Associations (IFMSA) General Assembly met during August in **The former Yugoslav Republic of Macedonia**, where the focus of discussion was on violence and health.

In September, the African Regional Committee adopted Resolution AFR/RC54/R6, approving the document *Child sexual abuse: A silent health emergency*, and in November the Council

of Europe adopted a resolution on the prevention of violence in everyday life. The launch of the **Jamaican** Chapter of the Violence Prevention Alliance also took place in November.

In November, the Council of Europe and the **Norwegian** Ministry of Justice hosted in Oslo the Ad Hoc Conference of European Ministers responsible for the prevention of violence in everyday life. The conference drew lessons from a three-year violence prevention project, including 12 principles for better violence prevention programming elaborated from this project and from WHO violence prevention guidelines.

## Violence Prevention Alliance

The Violence Prevention Alliance is a network of institutions linked by their adoption of shared violence prevention principles and policies derived from the *World report on violence and health*. It includes WHO Member State governments, nongovernmental and community-based organizations, and private international agencies working to prevent violence. Participants agree on common principles to guide their actions with respect to advocacy, funding, training and policy for interpersonal violence prevention. The power of the Alliance is to act from these shared principles. See: <http://www.who.int/violenceprevention/en/index.html> (accessed 10 April 2007).

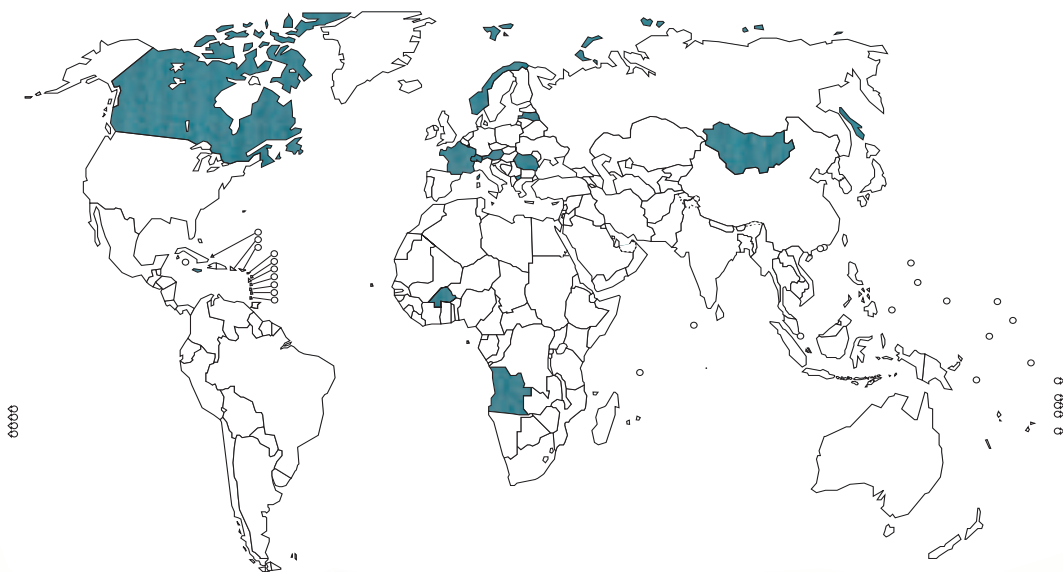


GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION  
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE

## Publications and technical documents

During the course of 2004, WHO released the following documents:

- *The economic dimensions of interpersonal violence,*
- *Guidelines for conducting community surveys on injuries and violence,*
- *Preventing violence: A guide to implementing the recommendations of the World report on violence and health,*
- *Guidelines for essential trauma care,*
- *Handbook for the documentation of interpersonal violence prevention programmes,*
- *Injury survey guidelines,*
- *Guidelines for medico-legal care for victims of sexual violence.*



## National launch of the *World report on violence and health*

The following countries hosted events to launch the *World report on violence and health* during 2004: **Angola** (February); **Burkina Faso** (April); **Latvia** (March); **Mongolia** (June); **Romania** (September).

## National reports

Consistent with Resolution WHA56.24, a national report on violence and health was completed by **France** during 2004.

## Lessons learned

### Quantifying the high economic cost of interpersonal violence

It is generally accepted that the public sector and society in general bear much of the high economic burden of interpersonal violence. However, as highlighted in a report published in 2004, studies documenting the cost of interpersonal violence, especially from the low- and middle-income countries where the economic effects are likely to be even more severe, are few and far between. The report, *The economic dimensions of interpersonal violence*, also exposes the scarcity of economic evaluations of interventions for interpersonal violence in the scientific literature, and notes that the methodological differences which exist among studies makes comparisons across countries difficult. What emerges from this report is the need for rigorous methodological guidelines which can be applied at national and local levels in order to better estimate the economic impacts of violence, and, ultimately, monitor the cost-effectiveness of prevention strategies.

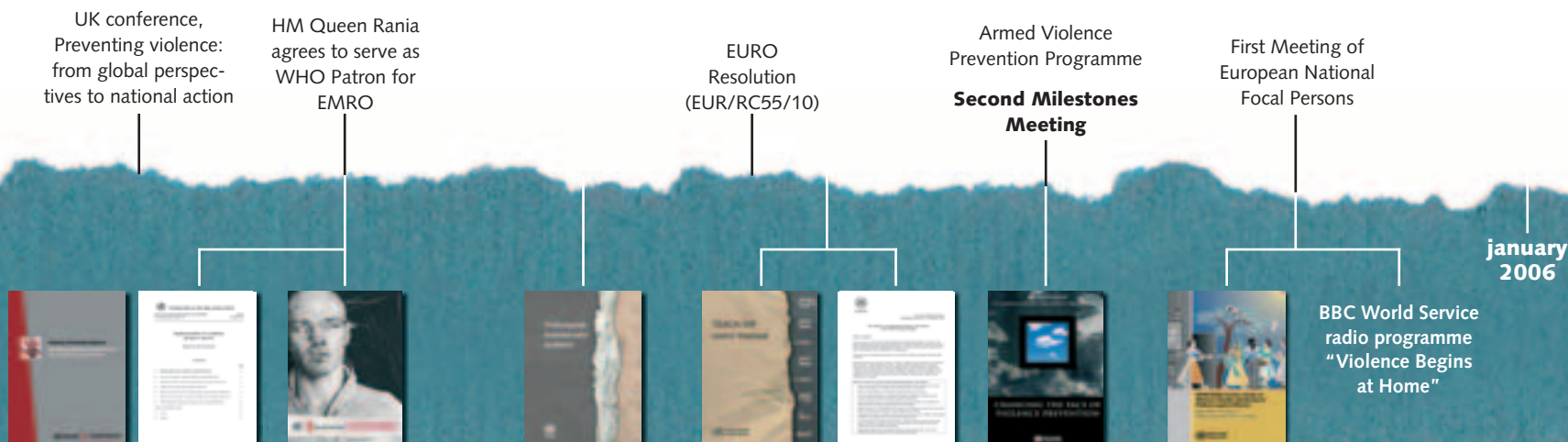


Mrs Janilee Abrikan, Executive Director, Peace and Love in Society (PALS), celebrating at the Peace Day 2006 church service (Jamaica). Photo courtesy of Jamaica Ministry of Health.



# 2005

january  
2005



## Key events

In May, Her Majesty Queen Rania Al-Abdullah of **Jordan** agreed to serve as WHO Patron for Violence Prevention in the WHO Eastern Mediterranean Region. In the same month, WHO commissioned a black and white "Family Album" poster series depicting how lives can be affected by violence.

In March, a 2-day conference, sponsored among others by the **United Kingdom** Ministry of Health, was held to draw attention to the need for a multi-agency approach to violence prevention in the **United Kingdom**.

In September, following the release of its report titled, *Injuries in the WHO European Region: Burden, challenges and policy response* (document EUR/RC55/10), the WHO Regional Committee for Europe drafted a resolution urging Member States to give high priority to the prevention of violence and unintentional injury. The resolution made specific reference to a number of activities for which there is a particular need, such as the development of surveillance systems, strengthening of technical capacity, and implementation of evidence-based approaches for violence and injury prevention and patient care.

The Second Milestones meeting, jointly hosted by WHO and the California Wellness Foundation, took place in the **United States** during October. The primary purpose of this meeting was to review progress towards preventing violence globally. Country level progress reports were presented by Her Majesty Queen Rania of **Jordan** and ministers and senior officials from **Brazil, Jamaica, Latvia, Mongolia, the United Kingdom** and the **United States**. The same month saw the launch of the Armed Violence Prevention Programme, a joint UNDP/WHO undertaking that aims to reduce armed violence in a number of settings.

Beginning in November, the BBC World Service in collaboration with WHO aired a four-part radio programme called "Violence begins at home" which served to show how difficult it can be to break the cycle of violence once it is established and also to highlight the difficulties encountered by people working to change the lives of victims and alter the behaviour of perpetrators. The First Meeting of European National Focal Persons for Violence and Injury Prevention also took place in November.

Held in the **Netherlands**, the objective of this meeting was to establish of a network of European focal points for violence prevention.



Her Majesty Queen Rania Al-Abdullah. Photo courtesy of the WHO Regional Office for the Eastern Mediterranean.

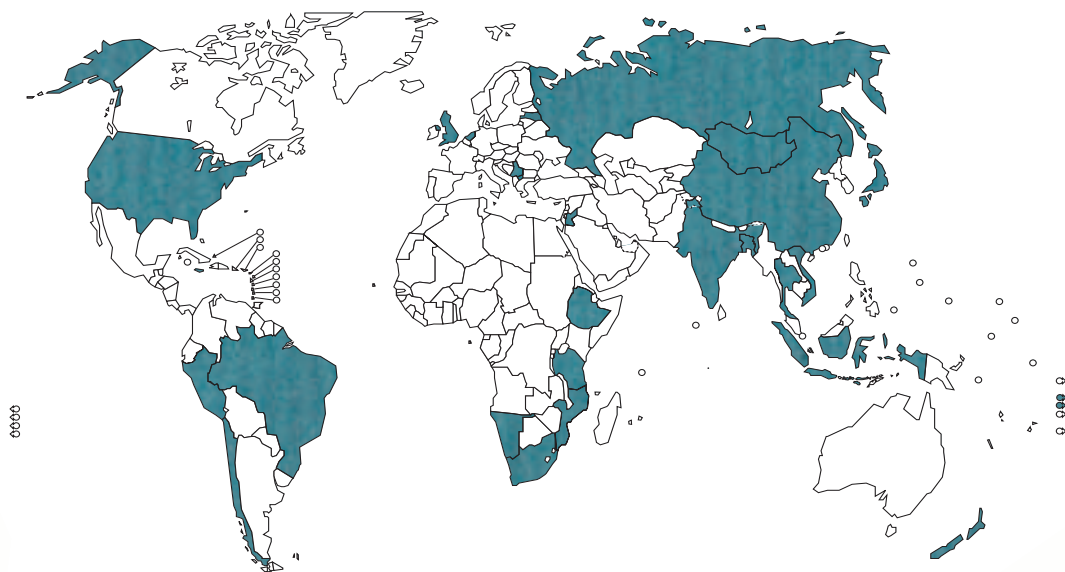


## Publications and technical documents

During 2005, the following publications were released by WHO:

- *Violence Prevention Alliance. Building global commitment to violence prevention,*
- *Manual on pre-hospital trauma care systems for victims of trauma,*
- *TEACH VIP Users Manual,*
- *The solid facts on unintentional injuries and violence in the WHO European Region.*

Preliminary results of the WHO Multi-country Study on Women's Health and Domestic Violence against Women were made available, and the findings of national analyses for each participating country (**Bangladesh, Brazil, Chile, China, Ethiopia, Indonesia, Japan, Namibia, New Zealand, Peru, Samoa, Serbia and Montenegro, Thailand, the United Republic of Tanzania and Viet Nam**) were summarized and disseminated at the local and national level.



## Examining the need to address trauma systems in developing countries

The majority of injury deaths occur in the pre-hospital setting, indicating the importance of injury prevention in nations at all economic levels. Additional efforts for trauma care improvement in both low-income and middle-income developing nations should focus on pre-hospital and emergency room care. Improved emergency room care is especially important in middle-income nations which have already established a basic emergency medical service.

## National reports

Consistent with Resolution WHA56.24, national reports on violence and health were completed for **Jordan, the Russian Federation** and **South Africa** during 2005. The **United Kingdom** launched its report on the costs and consequences of violence, *Violent Britain: people, prevention and public health*.

## Lessons learned

### Plenty of activity, not enough evaluation

As part of a multi-country study to document interpersonal violence prevention efforts, some 600 programmes in seven countries were reviewed during the course of 2005, according to published WHO guidelines. In all of the participating countries (**Brazil, India, Jamaica, Jordan, Mozambique, South Africa** and **The former Yugoslav Republic of Macedonia**) most of the programmes were found to be community-based and staffed mainly by non-professionals. Most focused on training and counselling individuals, and on raising awareness in the community. However, despite the wealth of violence prevention activity, the study found that in all settings very few programmes had been designed systematically, that is to say, had been based on data that defined the nature of the violence problem, its causes and the interventions most likely to work. Moreover, programmes that attempted to measure the effects of interventions on known risk factors for violence, and/or the frequency of new acts of violence, were very rare indeed.

# 2006

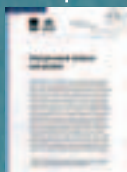
january  
2006

First Global Meeting of  
MoH Focal Persons

African Health  
Ministers Summit



Geneva Summit on  
armed violence and  
development



Pilot of Economic  
Costing Guidelines  
in Brazil, Jamaica,  
Thailand

UNSG World  
report on violence  
against children  
launch



Centre pompidou  
Exhibit les Yeux Overt  
including "Violence in  
Red" posters series



january  
2007

## Key events

In March 2006, the **Scottish** Executive joined with the Violence Reduction Unit of the Strathclyde Police to establish a Violence Reduction Alliance. The objective of the Alliance is to prevent violence by working with the health, education and justice ministries and other agencies to achieve long-term societal and attitudinal change, and to address underlying causes (e.g. economic and social inequalities, availability of weapons, alcohol misuse, family breakdown, adversities in infancy and childhood).

The First Global Meeting of Ministry of Health Focal Persons for Injury and Violence Prevention was convened in April in **South Africa** to further develop and strengthen injury and violence prevention programmes at the country level. **South Africa** also provided the venue for a 1-day summit on violence and injury prevention, aimed at urging African health ministers to further their commitment to increased efforts in advocacy, surveillance and violence and injury prevention, as well as to improving health-care services for victims.

In April the Government of **Switzerland** and UNDP co-hosted a 1-day high level ministerial summit on armed violence and development. The National Council for Family Affairs in **Jordan** was designated a WHO collaborating centre on violence and injury prevention.

During the course of 2006, outcome evaluation studies were conducted in both **Brazil** and **El Salvador** as part of the Armed Violence Prevention Programme. Proposed WHO guidelines for estimating the economic costs associated with injuries due to interpersonal and self-directed violence were piloted in **Brazil, Jamaica** and **Thailand**. The WHO STEPwise approach to Surveillance (STEPS) was revised to incorporate a module on violence and injuries, and was applied in country training exercises conducted in **Barbados, Curacao, Grenada, Saint Kitts and Nevis, Trinidad and Tobago**.



Save face walk away. Courtesy of Violence Reduction Unit and Safer Scotland, Scottish Executive

## Publications and technical documents

Several reports were published by WHO during 2006 including:

- *Developing policies to prevent violence and injuries: Guidelines for policy-makers and planners,*
- *Facts on interpersonal violence and alcohol,*
- *Preventing child maltreatment: A guide to taking action and generating evidence.*

A number of major collaborative reports and studies were also released in 2006, namely the United Nations Secretary-General's *Study on Violence against Children*, the *World report on violence against children*, and the United Nations Secretary-General's *Study on Violence against Women*.

## National reports

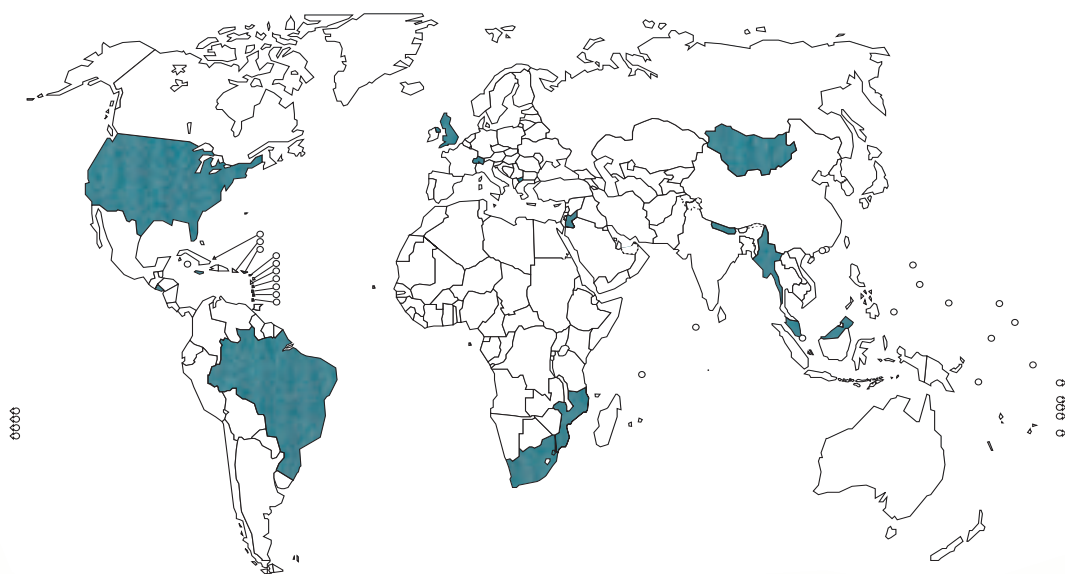
Consistent with Resolution WHA56.24, national reports on violence and health were completed for **Malaysia, Mongolia, Nepal, Thailand** and **The former Yugoslav Republic of Macedonia**. In addition, **Mozambique** published a study on firearm-related deaths.

## Lessons learned

### Outcome evaluation studies show that prevention works

Since few community-based programmes have the necessary resources to conduct their own evaluations, interventions to prevent violence can instead be assessed by independent research institutions using the same scientific methods as those that are currently employed in clinical trials of drugs and vaccines. Results of outcome evaluation studies published in 2006 and based on such methods indicate that investment in violence prevention can pay sizable dividends. For example:

- In a rural province of **South Africa**, a randomized cluster trial of a structural intervention aimed at reducing HIV infection in part by preventing intimate partner violence showed a 55% reduction in self-reported experience of physical or sexual violence by an intimate partner in the past 12 months among those receiving the intervention;
- Following a systematic review of scientific outcome evaluation studies that examined parent training and home visitation programmes for preventing child maltreatment, it was concluded that such programmes can reduce child maltreatment in the **United States** by over 40%;
- In the **Brazilian** city of Diadema, the monthly average number of homicides was reduced by nearly half following the implementation of laws to restrict alcohol sales.





# Key Messages

- Beyond an increased awareness of the burden of violence-related deaths and physical injuries, the last 5 years have witnessed a major growth in the understanding of how violence contributes to a wide spectrum of non-injury health consequences and health risk behaviours across the entire lifespan. Preventing violence is now widely perceived as an important means of promoting health and preventing chronic, noncommunicable diseases.
- Greater awareness that violence can be prevented by applying science-based approaches at the population level now needs to be matched by increased investment in programmes that not only implement proven interventions to address the underlying causes of violence but also monitor the impact of these interventions on both physical injuries and non-injury health outcomes.
- Attempts to document the number, nature and scope of community-based violence prevention programmes suggest that while many such programmes exist, there are very few that have used scientific data and evidence to inform their design. Future violence prevention investment must include greater provision for scientifically rigorous, large-scale outcome evaluation studies. This is especially relevant in the case of the low- and middle-income countries, where both the burden of violence and the cost of failure to invest in effective prevention are highest.

- The challenges of violence prevention demand a multisectoral approach that recognizes the many interlinkages between sectors and their collective impact on violence. Frameworks that enable efficient interagency prevention action at global, regional and local levels are also required.

- A clearer role for development agencies in violence prevention has started to emerge, at least in relation to some types of violence, such as armed violence, gender-based violence and violence against children. However, more work is needed to strengthen the contribution of development agencies to policies and services that integrate various violence prevention initiatives and which support sustainable systems for monitoring all forms of violence, as well as tracking responses to prevention efforts and other development interventions.

- Global norms and technical guidance have proven to be valuable tools for catalysing and giving direction to national and local-scale violence prevention activities, just as locally initiated violence prevention activities have stimulated action at regional and global levels. However, the sharing of technical knowledge between levels remains inadequate, and mechanisms that foster technical exchange across all levels need to be supported and further developed.



**GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION**  
**CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE**



# Integrating Violence Prevention in the

## World report on violence and health: recommendations and resolutions

The nine recommendations of the *World report on violence and health* – six country level recommendations and three international level recommendations – are the bedrock for all WHO violence prevention activities and provide a guiding framework for the coordination of WHO's violence prevention work with its partners at the global, regional and national levels (see outside back cover). All WHO Member States have committed themselves to supporting and implementing these recommendations in resolutions adopted by the World Health Assembly and several WHO regional committees, as follows:

- World Health Assembly Resolution WHA49.25 on Preventing violence: A public health priority;
- World Health Assembly Resolution WHA56.24 on Implementing the recommendations of the *World report on violence and health*;
- WHO Regional Committee for Africa Resolution AFR/RC54/R6 on Child sexual abuse: A silent health emergency;
- WHO Regional Committee for the Americas/Pan American Health Organization Resolution CD44.R13 on the Impact of violence on the health of the populations in the Americas;
- WHO Regional Committee for Europe Resolution EUR/RC55/R9 on Prevention of injuries in the WHO European Region.

## Country cooperation

WHO will continue to work with governments, United Nations agencies, NGOs and other organizations to support the development, implementation, monitoring and evaluation of national and local level violence prevention and service delivery programmes (including pre-hospital and emergency medical care), in accordance with WHO technical guidelines and other sources of best-available evidence. WHO will also facilitate peer-to-peer learning between violence prevention practitioners in different countries.

## Partnerships for prevention

Partnerships are crucial to expanding violence prevention efforts around the world and to improving their coherence and effectiveness. WHO is committed to its participation in existing partnerships (for example, various United Nations interagency working groups, the UNDP/WHO Armed Violence Prevention Programme, the WHO-led Violence Prevention Alliance and the Sexual Violence Research Initiative, and the various WHO networks of collaborating centres and NGOs in official relation with WHO), and will engage in new partnerships where appropriate.



# Development Agenda: WHO's Commitment

## Follow up of specific violence prevention conventions and resolutions

The World Health Organization has contributed to a number of United Nations processes and studies on specific forms of violence that have since led to General Assembly reports and resolutions, and will follow up on recommendations contained in these instruments, in particular:

- the United Nations Secretary-General's Study on Violence against Children,
- the United Nations Secretary-General's Study on Violence against Women,
- the United Nations General Assembly Resolution 60/68 of 2005 calling for comprehensive armed violence prevention programmes, integrated into national development strategies.

## Global and regional advocacy for violence prevention

The World Health Organization will advocate for support from the international development community for an increasingly science-based approach to violence prevention, elements of which are large-scale outcome evaluation studies of prevention and services, and the development of internationally agreed violence prevention indicators and their inclusion in such key documents as the annual UNDP human development report.

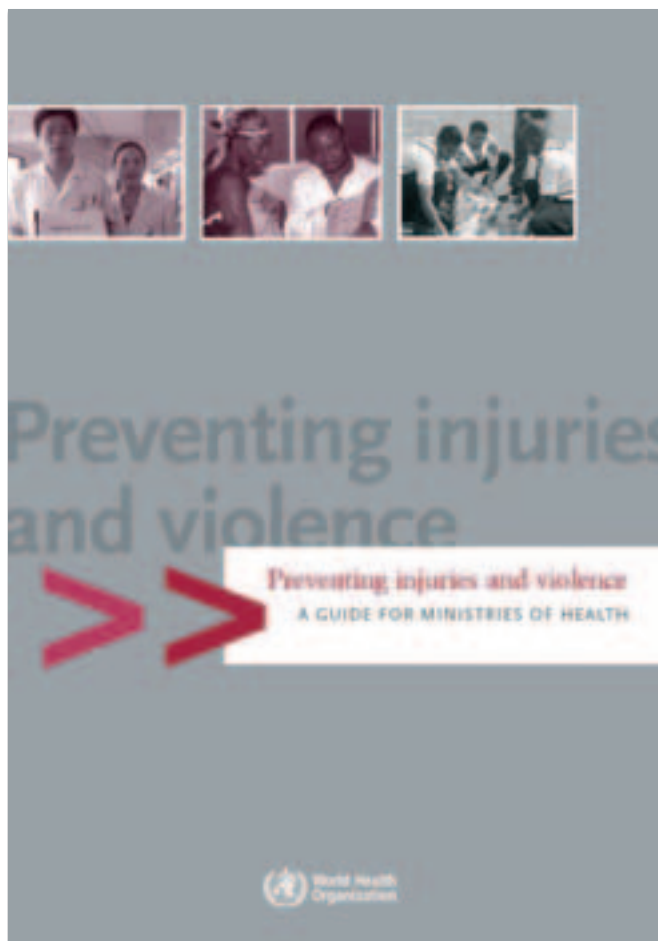
## Ongoing provision of normative guidance

Based on feedback from countries engaged in implementing violence prevention programmes, and drawing on the expanding body of scientific knowledge about the causes and preventability of violence, WHO will continue to prepare and disseminate guidelines and other normative documents in key areas such as data collection and monitoring systems; risk factor identification and monitoring; intervention effectiveness; and violence prevention policy-making and programming.

# Integrating Violence Prevention in the

## Governments

As the main governmental body responsible for public health, it behoves the health ministry to take the lead role in coordinating the public health response to violence. However, given the complex and interrelated nature of the causes of violence, prevention is not purely the remit of the health sector, but requires action across a range of sectors. Within this mix, the health sector offers an evidence-based, prevention-oriented approach to the problem of violence, and direct access to health impacts data. In some cases, these attributes may not be shared among other government sectors, and therefore governments should encourage their health ministries to take the lead in mainstreaming the prevention of violence in all national health and development plans.



To assist governments in the process of mainstreaming violence prevention, WHO published a guidance document, *Preventing injuries and violence: A guide for ministries of health*, May 2007.

## Development agencies

There is good evidence to suggest that traditional development activities in sectors such as economic development, education, employment, governance, social services and urban development have a potent influence on levels of violence. Development agencies can strengthen their contributions to violence prevention by linking indicators for violence and violence prevention to these sectoral activities. This will allow the influence of sectoral activities on levels of violence to be monitored and evaluated, and in turn their violence-reducing effects maximized.

# Development Agenda: What Stakeholders Can Do

## Nongovernmental organizations

Nongovernmental organizations can participate directly in the implementation of violence prevention programmes and in the delivery of services for victims. They also have a critical role to play in lobbying governments to make good on their commitments to violence prevention, when this commitment is expressed in the form of endorsement of relevant international and regional conventions and resolutions, including agreements on armed violence, violence against children and gender-based violence, and those which commit governments to multisectoral activities, such as the development of national violence prevention programmes and policies, information systems to support monitoring and evaluation, services for victims, and responsible crime prevention.

## United Nations agencies

Many United Nations agencies that are engaged in violence prevention tend to either focus on one form of violence (e.g. armed violence, gender-based violence) or on a particular population subgroup (e.g. children, refugees, women), or to work with a particular sector (e.g. education, employment, health, justice). Agencies can increase their effectiveness by improving the coordination of violence prevention activities at global and country levels; by working towards shared criteria for the development of more integrated information systems, shared prevention objectives, targets and strategies, and common standards for victim services; and, at the operational level of country work, by defining the division of roles and responsibilities between agencies.

## Research institutions

In the past, major public health gains – in relation to infant mortality, infectious diseases and noncommunicable diseases – have been achieved through outcome evaluation research directed at the identification of effective interventions. The impressive results of recent violence prevention outcome evaluation studies, especially in low- and middle-income countries, coupled with now widespread national awareness of the need for prevention, suggests that the time is ripe for increasing investment in health research and development for violence prevention.



# Contacts and Resources

## Contact

Department of Injuries and Violence Prevention  
Noncommunicable Diseases and Mental Health  
World Health Organization  
20 Avenue Appia  
1211 Geneva 27  
Switzerland

Phone: +41-22-791-2064

Fax: +41-22-791-4332

E-mail: [violenceprevention@who.int](mailto:violenceprevention@who.int)

## Resources

The following reports and related materials are available from the Department of Injuries and Violence Prevention, WHO, or via the WHO web site ([http://www.who.int/violence\\_injuries\\_prevention/publications](http://www.who.int/violence_injuries_prevention/publications)):

### Reports

World report on violence and health (2002), Milestones of a Global Campaign for Violence Prevention (2004), Milestones of a Global Campaign for Violence Prevention: Changing the face of violence prevention (2005)

WHO Multi-country Study on Women's Health and Domestic Violence against Women (2005)

### Advocacy and communications materials

*Posters:* Violence in red (2002), Explaining away violence (2003), Family Album (2005)

*Newsletter:* Prevent: the newsletter of the Global Campaign for Violence Prevention (2002 onwards)

*Fact sheet:* Facts on interpersonal violence and alcohol (2006)

### Violence and injury surveillance

Injury survey guidelines (2001), Guidelines for conducting community surveys on injuries and violence (2004)

### Primary and secondary prevention

Intervening with perpetrators of intimate partner violence: a global perspective (2003), Handbook for the documentation of interpersonal violence prevention programmes (2004), Preventing violence: A guide to implementing the recommendations of the World report on violence and health (2004), Preventing child maltreatment: a guide to taking action and generating evidence (2006)

### Research

The economic dimensions of interpersonal violence (2004), Putting women first: Ethical and safety recommendations for research on domestic violence against women (2003)

### Health services for victims of violence

Guidelines for medico-legal care for victims of sexual violence (2004), Guidelines for essential trauma care (2004), Manual on pre-hospital trauma care systems for victims of trauma (2005)

### Policy documents

Developing policies to prevent violence and injuries: Guidelines for policy-makers and planners (2006)

### Capacity development

TEACH VIP (Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention): user's manual and CD-ROM (2005)



## Recommendations of the *World report on violence and health*

- 1 Create, implement and monitor a national action plan for violence prevention
- 2 Enhance capacity for collecting data on violence
- 3 Define priorities for, and support research on, the causes, consequences, costs, and prevention of violence
- 4 Promote primary prevention responses
- 5 Strengthen responses for victims of violence
- 6 Integrate violence prevention into social and educational policies, and thereby promote gender and social equality
- 7 Increase collaboration and exchange of information on violence prevention
- 8 Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights
- 9 Seek practical, internationally agreed responses to the global drug trade and the global arms trade

[www.who.int/violence\\_injury\\_prevention](http://www.who.int/violence_injury_prevention)

[violenceprevention@who.int](mailto:violenceprevention@who.int)



GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION  
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE

