DEUTSCHER PRÄVENTIONSTAG

Preventing Violence: an Overview

by

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Preventing Violence: an Overview

The World Health Organization (WHO) mandate is to advance the attainment by all peoples of the highest possible level of health. WHO supports Member States to design, implement and monitor science-based prevention programming and service provision, and the Organization's agenda is set by the World Health Assembly (WHA). In 1996 and 1997, the WHA adopted resolutions calling on WHO to develop normative guidance on a public health approach to the prevention of violence, and to assist Member States in developing, implementing, and evaluating violence prevention policies and programmes. In 2002 WHO published the *World report on violence and health* (Krug et al, 2002) the first-ever comprehensive state-of-the-science review of violence and violence prevention. This was followed in 2003 by a second WHA resolution on implementing the recommendations of the *World report on violence and health*. Since then WHO has continued to produce normative guidance on violence prevention; to advocate at global and regional levels for increased investment in prevention, and to provide support for country-level activities.

Underlying WHO's involvement in the prevention of violence is the recognition that while violence is most often seen as a problem for the criminal justice sector to address (which of course it is), violence is also a health problem. Health care systems deal with victims of violence; violence has many long-term, far-reaching consequences for mental, physical and reproductive health, and the public health sector is explicitly set up to support prevention activities. By definition, public health is not about individual patients. Its focus is on dealing with diseases and with conditions and problems affecting health, and it aims to provide the maximum benefit for the largest number of people. This does not mean that public health ignores the care of individuals. Rather, the concern is to prevent health problems, and to extend better care and safety to entire populations (Dahlberg and Krug, 2002).

Defining and Categorizing Violence

WHO defines violence as "the intentional use of power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Dahlberg and Krug, 2002). Three general types of violence are encompassed by this definition: interpersonal, self-directed, and collective. Interpersonal violence includes forms perpetrated by an individual or small group of individuals, such as child maltreatment by parents and caregivers (Runyan et al, 2002), youth violence (Mercy et al, 2002), intimate partner violence (Heise et al., 2002), sexual violence (Jewkes et al, 2002), and elder maltreatment (Wolf et al., 2002). Self-directed violence includes suicidal behaviour and self-abuse where the intent may not be to

take one's own life (Deleo et al. 2002). Collective violence is the use of violence by groups or individuals who identify themselves as members of a group, against another group or set of individuals, to achieve political, social, or economic objectives. It includes war, terrorism, and state-sponsored violence towards its own citizens (Zwi et al. 2002). These types of violence can involve physical, sexual, and psychological abuse, as well as deprivation or neglect.

Magnitude and Consequences

Globally, it is estimated that 1.51 million people per year die due to violence (WHO GBD 2008). This is almost as many as the number of deaths due to HIV/AIDS, somewhat more than the totals for tuberculosis and road traffic injuries, and nearly twice that for malaria. Of all 1.51 million deaths each year due to violence, half (782,000) are due to suicide, a third (535,000) are homicides, and 12% (182,000) a direct result of war. WHO focuses on understanding and preventing interpersonal violence, while recognizing and addressing the links between this and the other main types of violence.

All forms of violence, but especially child maltreatment, intimate partner violence and sexual violence contribute significantly to depression, sexually transmitted diseases and unwanted pregnancies, while also increasing the likelihood of engaging in risky behaviours, such as unsafe sex, smoking and the harmful use of alcohol and drugs (e.g. Felitti et al, 1998; Norman et al, 2012). Via these behaviours, they can lead to cancers, cardiovascular diseases, diabetes, liver disease and other chronic diseases.

Public Health Approach to Violence Prevention

WHO's public health approach to violence prevention perspective is set out in the 2002 *World report on violence and health* (Krug et al, 2002) and companion volumes that provide technical guidance on implementing its recommendations (see Box 1), and on the prevention of specific subtypes of violence (e.g. child maltreatment, youth violence, and intimate partner and sexual violence), all of which are freely available online at WHO's violence prevention website http://www.who.int/violence_injury_prevention/publications/violence/en/index.html). The public health approach to dealing with violence is population-based. It emphasizes primary prevention – doing something about the problem before it occurs. It draws on a wide range of expertise across many sectors, and it is based in science. It asserts that everything – from identifying the problem, to planning, testing and evaluating responses – should be based on sound research and informed by the best evidence.

Box 1. World report on violence and health recommendations

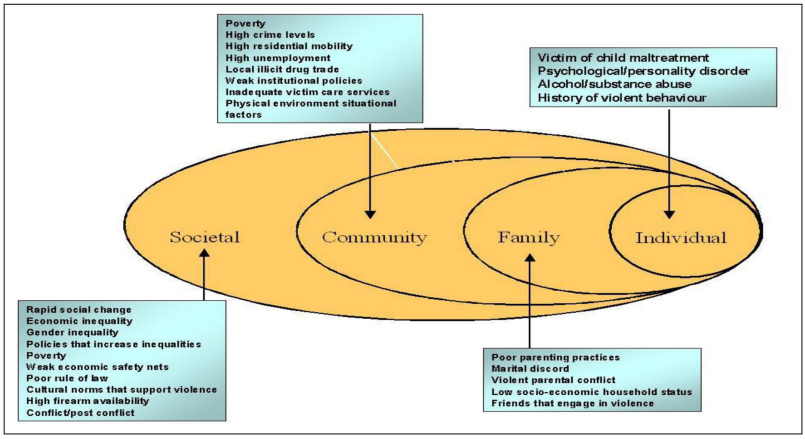
The *World report on violence and health* (Krug et al, 2002) and the 2003 World Health Assembly resolution 56.4 make nine recommendations, which are to:

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 drugs trade and the global arms trade.

In moving from problem to response, the public health approach has four steps. The first step is to statistically describe and monitor the extent of the problem to identify the groups and communities at risk. The next step is to identify and understand the factors that place people at risk for violence – to assess which factors may also be amenable to intervention. The third step is to develop and evaluate interventions to reduce these risks, and the fourth step is to implement and apply widely the prevention strategies that are found to work.

The public health approach adopts an ecological model for understanding the causes, consequences and prevention of violence (see Figure 1). The ecological model is based on evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence while others are more protected from it. Instead, the model views interpersonal violence as the outcome of interaction among factors at four levels: the individual, the relationship, the community, and the societal. In this model, the interaction between factors at the different levels is just as important as the influence of factors within a single level. For example, longitudinal studies suggest that complications associated with pregnancy and delivery, perhaps because they lead to neurological damage and psychological or personality disorder (individual risk factors), seem to predict violence in youth and young adulthood mainly when they occur in combination with other problems within the family (a close relationship factor), such as poor parenting practices.

Figure 1. Ecological model showing shared risk factors for sub-types of interpersonal violence (adapted from Dahlberg and Krug, 2002)



Among the risk factors for the different types of interpersonal violence, some are common to most sub-types, and Figure 1 lists some of these crosscutting risk factors at each of the four levels of the ecological model. At the individual level, personal history and biological factors influence how individuals behave and increase their likelihood of becoming a victim or a perpetrator of violence. Among these factors are being a victim of child maltreatment, psychological or personality disorders, alcohol and/or substance abuse, and a history of behaving aggressively or having experienced abuse. Personal relationships such as family, friends, intimate partners, and peers may influence the risks of becoming a victim or perpetrator of violence. For example, having violent friends may influence whether a young person engages in or becomes a victim of violence. Community contexts in which social relationships occur, such as schools, neighbourhoods and workplaces, also influence violence. Risk factors here may include the level of unemployment, population density, mobility, and the existence of a local drug or gun trade. Societal factors influence whether violence is encouraged or inhibited. These include economic and social policies that maintain socioeconomic inequalities between people, the availability of firearms and other weapons, and social and cultural norms such as those around male dominance over women, parental dominance over children, and cultural norms that endorse violence as an acceptable method to resolve conflicts.

Violence Prevention Strategies

The publication *Violence prevention: the evidence* (WHO and Liverpool John Moore's University [LJMU], 2009, a-h) clusters the scientific evidence for violence prevention into seven strategies (WHO and LJMU, 2009, a-g), and within each strategy reviews

the evidence for the effectiveness of specific interventions. The prevention strategies selected are scientifically credible; include interventions at each of the four ecological levels; can potentially reduce multiple forms of violence, and represent areas where developing countries and funding agencies can make reasonable investments. The seven violence prevention strategies are:

1. Developing safe, stable and nurturing relationships between children and their parents and caregivers (WHO and LJMU, 2009, a);
2. Developing life skills in children and adolescents (WHO and LJMU, 2009, b);
3. Reducing the availability and harmful use of alcohol (WHO and LJMU, 2009, c);
4. Reducing access to guns, knives and pesticides (WHO and LJMU, 2009, d);
5. Promoting gender equality to prevent violence against women (WHO and LJMU, 2009, e);
6. Changing cultural and social norms that support violence (WHO and LJMU, 2009, f;
7. Victim identification, care and support programmes (WHO and LJMU, 2009, g).

An eighth briefing in the series provides an overview of the main findings for each of the seven strategies, showing which of the different types of violence each strategy has been shown to impact (WHO and LJMU, 2009, h).

Developing safe, stable and nurturing relationships between children and their parents or caregivers

Interventions under this strategy are those that deliver early, primary prevention services to avoid the development of child maltreatment and childhood aggression. They include parent training programmes; providing information and support for parents, and parent and child programmes (e.g. providing preschool education, family support and child/health services). The evidence shows that the ability of parenting programmes and parent and child programmes to reduce child maltreatment and aggressive behaviours in youth is well supported by evidence. One of the best examples of a parenting programme is the Nurse Family Partnership in the USA, a home visiting programme that reduced child maltreatment by 48% (see WHO and Liverpool John Moores University, 2009, a).

Developing life skills in children and adolescents

Interventions that aim to develop life skills in children and adolescents provide cognitive, emotional, interpersonal and social skills to enable children and youth to deal with the challenges of everyday life. They include preschool enrichment programmes that provide skills to children before they enter formal education and may focus on parenting education for adults; social development training in skills such as empathy, communication in relationships, conflict resolution, and anger management, and vo-

cational training, by providing at risk youth with skills to find work. There is some evidence showing that preschool enrichment and social development programmes can reduce aggression and improve social skills, particularly in at-risk children. For instance, an outcome evaluation study from South Korea showed that both social skills training for the children and parent education were highly effective in reducing aggressive behaviour among young children and in fostering positive parenting behaviours (see WHO and LJMU, 2009, b).

Reducing the availability and harmful use of alcohol

Strategies for preventing violence by reducing the availability and harmful use of alcohol include regulating alcohol availability through sales times and restrictions on outlet density, and raising alcohol prices, through taxation and minimum pricing. That alcohol-focused interventions can reduce violence is supported by emerging evidence. However, there are barriers to intervening - including commercial interests - and there are few high-quality studies. One example of an effective intervention is a ban on sales of alcohol sales between 11pm and 6am in Diadema, Brazil, which led to a 44% decrease in homicides, and a decrease in injuries resulting from intimate partner violence (see WHO and LJMU, 2009, c).

Reducing access to guns, knives and pesticides

Reducing access to lethal means – such as guns, knives and pesticides – can help to prevent violence and reduce the severity of its consequences. Strategies that show promise here include strengthening legislation through weapons bans and licensing schemes, and increasing the enforcement of legislation, such as test purchasing to identify illegal sales of weapons, and police stop and search measures. One example is from Colombia, where local legislation in Bogota and Cali banned the carrying of firearms on holidays, weekends after paydays, and election days. Studies showed that the incidence of homicides in both cities was lower on days when the ban was in place compared to similar days when people were allowed to carry guns (see WHO and LJMU, 2009, d).

Promoting gender equality to prevent violence against women

Interventions that promote gender equality include schools-based interventions to address gender norms and attitudes, including programmes to prevent dating violence, and community interventions such as microfinance programmes combined with gender equity training. Schools-based programmes to prevent dating violence are well supported by evidence, and community-based interventions are supported by emerging evidence, but much more high quality research is needed in this area, especially from developing countries. One well-evaluated example is the Intervention with Microfinance and Gender Equity programme – or IMAGE - in South Africa. After the programme, women from villages where IMAGE was implemented reported 50% fewer acts of intimate partner violence than in similar villages where IMAGE was not implemented (see WHO and LJMU, 2009, e).

Changing cultural and social norms that support violence

Interventions for changing cultural and social norms are aimed at challenging expectations that support violent behaviour, and include mass media campaigns to provide messages on health behaviour to a wide audience, and edutainment; social norms and marketing programmes that target specific groups and aim to correct misperceptions of cultural norms, and enacting and enforcing laws and policies that make violent behaviour an offence. There is limited evidence for most interventions in this area due to a lack of research on their effects, so a priority is to do more rigorous evaluations, in particular studies that use actual violence as an outcome. One programme that has been evaluated - Soul City, again in South Africa – led to a reduction in the acceptance of intimate partner violence, and a strengthened belief that such violence could be prevented (see WHO and LJMU, 2009, f).

Victim identification, care and support programmes

The impact of violence can be reduced, and revenge attacks and re-victimization prevented, through victim identification, care and support programmes such as screening and referral programmes to identify and support victims of violence, and advocacy support programmes that provide support and guidance to victims, e.g. counselling, education, legal aid. There is some good evidence for the use of advocacy support programmes, and promising evidence for screening and referral, psychosocial interventions, and protection orders. For example, for every dollar invested in Child Advocacy Centers in the USA, over US$3 were saved in support services and costs on investigations. These centres offer enhanced multi-disciplinary services for abused children all in one location (see WHO and LJMU, 2009, g).

WHO Global Campaign for Violence Prevention

The WHO Global Campaign for Violence Prevention serves as the main platform for encouraging implementation by countries of the *World report on violence and health* recommendations, and the seven violence prevention strategies described above. The Global Campaign for Violence Prevention also provides a platform for collaboration and the exchange of information between actors at global and country level. This platform is the Violence Prevention Alliance (VPA), a network of WHO Member States, international and national agencies and civil society organizations working to prevent violence.

Through the Global Campaign, the *World report on violence and health* has had national launches in 50 countries, 25 national reports on violence and health have been published, and a wide range of regional- and country-level activities initiated. These efforts have resulted in a steadily increasing country-level demand for WHO to provide technical support for the development of prevention policies and programmes. Central to meeting this demand is the assistance provided by VPA participants, who play a key role in advancing the local implementation of WHO global recommen-

dations and guidance. Also central to the Global Campaign for Violence Prevention is the *Global status report on violence prevention*, by which WHO, with UNDP and UNODC, is surveying all Member States to obtain baseline information on violence prevention policies, data collection mechanisms; laws and prevention programmes, and victim services.

Regional- and Country-level Activities

The recommendations of the 2002 *World report on violence and health;* subsequent guidance on preventing child maltreatment and violence against women, and the seven strategies described in *Violence prevention: the evidence* (WHO and LJMU, 2009, a-h) have become the backbone of violence prevention policies and programmes in thousands of settings. Well over half of all WHO Member States have officially appointed Ministry of Health focal points for violence prevention. WHO provides technical support for prevention programmes in an increasing number of countries. Five out of six WHO regional offices – the Americas; Africa; Europe; South East Asia and, in October 2012, the Western Pacific – have adopted violence prevention resolutions, and several regions publish periodic reports on violence and violence prevention in their Member States.

Violence Prevention Alliance

The VPA is an informal network of governmental, non-governmental, international and private organizations. It aims to implement the nine recommendations of the *World report on violence and health*, and its participants are committed to the public health approach to violence prevention. The VPA was established at the first Milestones of a Global Campaign for Violence Prevention Meeting in January 2004, and as of January 2013 its membership stands at just over 50 participants. All participants actively support international violence prevention efforts, and they include, the United Nations Development Fund; the United Nations Office on Drugs and Crime; the International Center for the Prevention of Crime, the German Congress on Crime Prevention, and the Open Society Institute's Preventing violence and crime initiative. VPA strategic priorities for 2011-2015 include strengthening intersectoral collaboration for violence prevention; reinforcing the VPA as a network of networks; mobilizing resources for the VPA and for the field of violence prevention; contributing to violence prevention capacity building, and defining an international violence prevention research agenda. To achieve these aims, the VPA works through several project groups, including on parenting for child maltreatment prevention, criminal justice liaison, and research.

Another key mechanism by which the VPA is working to enhance coherence between different international violence prevention stakeholders is the *Plan of action for the Global Campaign for Violence Prevention for the period 2012-2020* (VPA, 2012). This aims to unify the efforts of the main actors in international violence prevention and identify a small set of priorities for the field, by presenting six national level goals

towards which efforts can be directed. These are closely tied to the *World report on violence and health* recommendations, and the evidence base for violence prevention. The first two goals aim to prioritize violence prevention within the global public health agenda; the next three aim to build strong foundations for on-going violence prevention efforts; and the last aims to promote the implementation of evidence-informed violence prevention strategies on parenting, life-skills, social norms, alcohol, the risks of firearm-related deaths and injuries, and services for victims. The objective of the Campaign in the coming years is to support the achievement of these goals in countries around the world. The target audience for the Plan of Action is the global violence prevention community, including governments, United Nations and official development assistance agencies, philanthropic foundations, nongovernmental organizations and academic institutions.

Global Status Report on Violence Prevention

To measure violence prevention efforts in Member States, WHO, with UNDP and UNODC, is preparing a *Global status report on violence prevention*. This report will evaluate the extent to which countries have been implementing the recommendations of the *World report on violence and health*. It will focus on child maltreatment, youth violence, intimate partner violence, sexual violence, and elder maltreatment. This snapshot of the state of interpersonal violence prevention in each country will serve as a benchmark for countries to assess their violence prevention efforts; a baseline to track future progress in violence prevention internationally; to identify gaps in national responses to violence that need to be addressed, and a catalyst for further prevention action by countries. Data collection will begin in 2013. In each country, a National Data Coordinator will collect data from violence prevention respondents from different sectors including justice, law enforcement/police, interior, education, gender and women, relevant non-governmental organizations, and research institutions. These respondents will then come together as a multi-sectoral consensus panel and provide one set of data that best represents the situation in their country. Following official government endorsement of the completed questionnaires, the data will be collated and analyzed to provide input for the *Global status report on violence prevention.* The *Global status report on violence prevention* will be launched in late 2014.

Discussion and Conclusion

While much has been achieved over the last decade by way of increased awareness about the importance of preventing violence using a science-based approach, progress by type of violence and country income level is uneven. For all types of interpersonal violence, low-income countries are still at the stage of needing to define the problem, and many still lack cause of death registration systems that would allow them to track violence-related deaths. Except for elder maltreatment, middle-income countries are mostly at the point where they are using their local knowledge of causes and risk factors to identify prevention strategies that work in their own settings. High-income

countries are scaling up child maltreatment and youth violence prevention, but are still at the point of identifying and evaluating effective prevention strategies for intimate partner and sexual violence, and maltreatment.

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