World Health Organization
Organisation mondiale de la Santé

FIFTIETH WORLD HEALTH ASSEMBLY

Provisional agenda item 19

A50/INF.DOC./4
12 March 1997

Prevention of violence

The Forty-ninth World Health Assembly in resolution WHA49.25 declared the prevention of violence a public health priority. This document contains a plan of action for progress towards a science-based public health approach to violence prevention, as requested in the resolution.

Within its constitutional mandate and in its capacity as the coordinating agency for international public health work, WHO has set up a task force on violence and health to devise an operational framework for public health involvement in the prevention and control of violence as well as a rationale for WHO action. The preparation of the WHO plan of action, including input from several technical programmes at headquarters through the task force, has also given rise to broad consultation with regional offices and to a meeting of heads of collaborating centres on injury (4-5 December 1996). Finally, the plan was reviewed by a WHO global consultation on violence and health, whose recommendations have been incorporated into this document (the full report of the consultation is available on request). The Executive Board at its ninety-ninth session in January 1997 reviewed and welcomed the plan of action as proposed.

INTRODUCTION

1. The burden of ill-health caused by violence is staggering. Violence undermines the social and economic conditions of communities. The atmosphere generated by frequent and severe personal or organized violence discourages investment, destabilizes national labour and industry, discourages tourism, and contributes to the emigration of skilled citizens. Violence in the home, on the street, and in the classroom disrupts education and the provision of basic services; it inhibits the delivery of curative and preventive health care. As an expression of power, it increases gender and social inequity. For various reasons the attitude of the health sector to violence has been until now ambivalent, insufficiently committed to preventing it and resorting to ad hoc solutions. Without a new public health vision to tackle the growing problem of violence, the cost to society can only increase.

2. While there is no universally accepted typology of violence, the groupings commonly used are:

Self-inflicted violence, for which suicide represents the fatal outcome. Other types include attempts to commit suicide and non-lethal self-mutilation;

Interpersonal violence occurs in many forms and can best be classified by the victim-offender relationship: domestic violence (family and intimate partners), violence among acquaintances, and

violence involving strangers. It may also be specified according to the age or sex of the victim (child abuse, or rape). Social institutions may be the setting for violence: bullying, harassment or criminally-linked violence may be found in schools, the workplace, the commercial sector, and the military.

Organized violence is violent behaviour of social or political groups motivated by specific political, economic or social objectives. Racial or religious conflicts are other forms of violence occurring among groups. Armed conflict and war are the extreme form of organized violence.

3. Given the many forms, circumstances and consequences of violence, measurement of the magnitude of the problem, until now, has been very unsatisfactory. Analysis of cause- and age-specific mortality statistics has been the most widely used approach, but deaths from violence are only the tip of the iceberg, merely suggesting the scale of the underlying problem. Data on morbidity, other consequences like unwanted pregnancy and family dissolution, disabilities, and socioeconomic costs are scarce and often unreliable.

4. In 1990 there were almost two million violent deaths in the world from homicide, suicide and war: some 800 000 people took their own lives, 560 000 died as the result of homicide, and 500 000 were victims of wars and civil unrest. These statistics obscure the disproportionate impact of violence on specific subgroups throughout the world, most notably young people (and especially young adult males), women and children, and socially and economically deprived groups. In many developing and developed countries, between 20% and 40% of deaths in males from 15 to 34 years of age are from homicide or suicide.

5. The consequences of violence extend far beyond physical injury: violence has profound psychological implications for its victims, perpetrators, and witnesses as well as close surviving relations and friends. For others, such as women and children who live under the daily threat of violence from partners or parents, the quality of life is drastically affected.

WHO INTEGRATED PLAN OF ACTION ON VIOLENCE AND HEALTH

6. This plan is the first step in consolidating the activities of several WHO programmes concerning violence, and in building a coherent WHO public health approach to violence and health. During the first three years the first objective and the highest priority will be better to define the problem.

Objective 1. To describe the problem (first priority)

WHO will seek to characterize different types of violence, define their magnitude, and assess the public health consequences: it will establish operational definitions for different types of violence, with data systems and methodology, to quantify burden of violence in terms of its impact on mortality, morbidity and quality of life of the population.

Activities:

- to survey the capacities of current data collection systems to obtain, analyse and use information about violence; and to develop accurate, affordable and valid measures for collecting information about non-fatal violence and its costs and consequences;

- to develop a typology and definitions of different types of violence, related risk behaviour and consequences;

- to collect data on deaths from all external causes in order to assess the accuracy of classification, and to collect accurate demographic data for calculation of rates;

- in collaboration with other sectors concerned, to improve baseline data on suicide and homicide, especially those coming to the attention of the health sector, including information on sex, age, relationship of victim/perpetrator, and circumstances;

- to facilitate the development and adaptation of research methodology to describe and measure violence better in its different forms, with its determinants and physical, psychological and social consequences;

- to promote and provide technical support for the compilation of local and national analyses of data on different types of violence, and for international comparisons (the analyses must be informed by a gender and equity perspective);

- to carry out district- or community-based surveys of violence in order to determine the nature and extent of interpersonal violence, especially in relation to women, children and adolescents;

- to ensure that the information collected is disseminated and used appropriately.

Objective 2. To understand the problem: conduct risk-factor identification and research: to promote research and increase information on determinants and consequences of violence through all appropriate technical programmes of the Organization.

Activities:

- to strengthen and support research related to violence in all appropriate WHO programmes;

- to advocate the development of research on violence through the global ACHR and its regional committees;

- to use available mechanisms and resources to promote research "networking" among WHO collaborating centres, nongovernmental organizations and other institutions as a priority, confirming the need for a public health approach to violence and health;

- to promote research on the costs of violence;

- to create an inventory of research activities on health-related violence in order to facilitate "networking" and the exchange of data and information;

- to organize and disseminate the results of such research so that they can be effectively used for policy formulation and programming.

Objective 3. Identification and evaluation of interventions: to determine measures and programmes aimed at preventing violence and mitigating its effects, and to assess their effectiveness.

Activities:

- to identify and document existing activities for preventing different forms of violence and for managing their consequences;

- to foster the development and evaluation of demonstration projects, promoting innovative, challenging and non-traditional responses, in order to determine which methods are effective and why, and what are the impediments to effective action, with special attention to community-based interventions;

- to assess curricula for conflict resolution and promote their inclusion in the training of health workers and teachers dealing with children and adolescents, and to promote the adaptation of such materials for health education of parents and children.

Objective 4. Programme implementation and dissemination: to strengthen the capacity, primarily of the health system but also of all concerned parties on the basis of the evaluation of existing activities, in order to implement coherent programmes.

Activities:

- to provide technical support and guidance to the health sector in improving the quality, effectiveness, equity and efficiency of services for those affected by violence, and in particular to devote attention to the coordination and interfaces of the health sector with other sectors, in order to ensure that secondary victimization does not occur;

- to promote, as part of the curriculum for training and the continuing professional development of health professionals at all levels, the incorporation of an understanding of violence and its health consequences, as well as the requirements for the provision of sensitive services;

- to adapt and evaluate methods of preventing violence and managing its health consequences that facilitate the involvement of families, communities, women and young people, the health sector and other appropriate sectors, in the analysis, formulation, implementation and evaluation of locally suitable strategies;

- to promote and support community-based approaches in the prevention of violence, and the management of the consequences, through coordinated regional and national intersectoral policies, legislation and services that strengthen the related capacity of communities;

- to promote greater intersectoral involvement in the prevention and management of violence;

- to promote the integration of violence prevention into local development programmes and efforts to empower communities;

- to promote joint projects of developed and developing countries, given the increased importance of violence as a public health issue in both North and South, and considering the potential for each to learn from the other;

- to disseminate information and new knowledge generated by data collection and the results of research as a basis for policy development and action at all levels.

Resources and means of implementation

7. If WHO is to respond to the challenge of violence prevention as a public health priority, complementary and more efficient use of its resources will be necessary, maximizing its expertise and experience. WHO will also have to strengthen the role and responsibilities of its networks of collaborating centres, as well as to increase its cooperation with competent national institutions and nongovernmental organizations. Furthermore, WHO will have to mobilize additional extrabudgetary resources, giving priority to the need for investment in monitoring and surveillance as the foundation for appropriate policies and cost-effective and efficient programmes. The Organization will take a lead in mobilizing and coordinating action to prevent and control violence. In this global endeavour the task force will continue to monitor the whole process, working in close

collaboration with all interested parties. It will make every effort to develop this new initiative for violence prevention and health in the framework of the renewed health-for-all strategy.

Evaluation

8. At the end of the first three years of activity sufficient data and experience should have been accumulated to allow for the formulation of precise goals and quantifiable targets to evaluate the programme in subsequent years. By that time it should also be possible to establish operational targets based on the concept of "best practices". Furthermore, it is likely that authorities will be better able to determine the areas and circumstances amenable to public health interventions, either to prevent violence or to mitigate its effects. Indicators for such an evaluation should have been selected by then.

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