MILESTONES
OF A GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION 2005

CHANGING THE FACE OF VIOLENCE PREVENTION

World Health Organization
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FOR VIOLENCE PREVENTION
2005

CHANGING
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PREVENTION
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VIOLENCE IS PREVENTABLE
UNITY IS THE KEY
VIOLENCE CAN BE PREVENTED. That is the clear message of the World Health Organization’s (WHO) Global Campaign for Violence Prevention. A wide range of positive strategies are available to help societies reduce violence. These include: training and supporting new parents; helping children learn social skills; assisting communities to control the availability of alcohol; increasing incentives for young people to complete their studies; enhancing services for victims of violence; and strengthening policies that promote gender, social and economic equality.

The Global Campaign for Violence Prevention aims to change the face of violence prevention by supporting science-based efforts to uncover the causes behind violence. The Campaign works to design and deliver prevention programmes to reduce the causes of violence and keep people from committing violent acts.

Since the global launch of the World report on violence and health in October 2002, its messages have reached many corners of the world. From January 2004 to August 2005, the number of national focal points for violence prevention rose from around 40 to nearly 70 and the number of countries preparing national reports or plans of action rose from four to 25. These developments demonstrate WHO’s work, in collaboration with partners worldwide, to catalyse this movement for violence prevention and drive the work forward.

These and other significant achievements are outlined in this document, Milestones of a Global Campaign for Violence Prevention 2005: Changing the face of violence prevention. I warmly invite you to give the document your attention and find out how you can become part of this worldwide movement. The goal is to change the perception that violence is an unavoidable element of the human condition and recognize violence for what it is, a problem that can be prevented.

LEE Jong-wook
Director-General
World Health Organization
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WHO gratefully acknowledges the generous financial support towards the production of this report from the Government of Belgium, the California Wellness Foundation and the US Centers for Disease Control and Prevention.
Vio\lence as a global public health problem is the central theme of the World report on violence and health (WRVH). Launched on 3 October 2002 in Brussels, Belgium, the report was the first report of its kind to describe the extent, characteristics and causes of different forms of violence, and review existing strategies and tools to prevent violence. It also articulates a public health-oriented prevention strategy, including nine recommendations to guide local, national and international policy-makers, practitioners and advocates towards achieving a world without violence [sidebar]. Since its release, over 30,000 hard copies of the report have been disseminated worldwide and it has been translated, in whole or in part, into at least 13 languages. To date the report has been launched in more than 50 countries.

The WRVH showed that while the scale and characteristics of violence vary radically from country to country — and from community to community within countries — violence prevention is a universal challenge. Child abuse, intimate partner violence, youth violence, abuse of the elderly and suicide are important causes of death and even more important causes of ill health everywhere.

The WRVH also showed that health has a leading role to play in preventing violence. Health services are on the front line and often are the first and only services to see — and treat — victims of violence; they are therefore well-placed to take stock of the otherwise invisible burden of violence taking place behind closed doors between intimate partners, children and parents, friends and acquaintances. In addition to the massive direct costs of treating injuries due to violence, health services also bear the brunt of the costs of the enormous non-injury health consequences of violence, including alcohol and drug abuse, depression and anxiety disorders, obesity and eating disorders, unsafe sexual behaviour and sexually transmitted diseases (including HIV-AIDS) and smoking.

The release of the WRVH has helped to lay the foundations of a systematic and coordinated approach to violence prevention. Momentum from the global and national launches and ensuing activities has been — and continues to be — channelled into advocacy on behalf of the Global Campaign for Violence Prevention, an ongoing set of actions to implement the report’s recommendations and, ultimately, to reduce violence in communities and countries around the world.

A World Health Assembly Resolution in 2003 urged Member States to promote the WRVH; appoint focal points for violence prevention within ministries of health; prepare national reports on violence and violence prevention, and requested the WHO Director-General to cooperate with

**Recommendations made by 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.
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.
Member States to support implementation of the WRVH recommendations. In response, more than 70 national health ministry focal points have been created, and at least 25 countries have completed or are currently in the process of preparing national reports and national plans of action on violence and health. WHO policy and technical guidelines on prevention and victim services are now available, and capacity in WHO regional offices to assist countries in their violence prevention work has been stepped up.

In January 2004 policy-makers and violence prevention experts from all WHO regions gathered in Geneva to share their strategies, successes and challenges in the 14 months since the WRVH launch. The meeting also served as a platform to launch Milestones of a Global Campaign for Violence Prevention which presented the variety of activities contributing to the implementation of each of the WRVH recommendations. Many of the strategies and next steps planned at that January 2004 meeting are now in the process of being translated into national campaigns for violence prevention and comprehensive violence prevention programmes.

This second milestones report, Changing the face of violence, describes the many activities that have been organized as part of the Global Campaign for Violence Prevention. A number of these activities are global in scope and led by WHO, but many of them are regional and local initiatives led by policy-makers, practitioners and advocates supported by WHO offices. The first section of this document, A Global Picture, reviews global activities coordinated by WHO and its collaborators. In the second section, violence prevention advisers from each WHO region — Africa, the Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific — present recent developments and highlight promising new programmes. The third and final section returns to the global level and reviews the work of the Violence Prevention Alliance and its progress in building global commitment to violence prevention.

Prevalence of violence around the world
Every year, over a million and a half people die of preventable acts of violence: 800,000 suicides; 500,000 homicides and 300,000 war deaths. Forty to 70% of female homicide victims are killed by their husbands or boyfriends. For every homicide among young people there are 20–40 non-fatal cases needing hospital care. Up to 10% of men and 20% of women report having been sexually abused as children. Rape and domestic violence account for 5 to 16% of healthy years of life lost by women of reproductive age.
Give Luve a Chance

Love can prevent violence
RAISING AWARENESS

Raising awareness among policy-makers and the general public about the nature, magnitude, and devastating consequences of violence as a global public health problem is a crucial first step. Political and social support needs to be galvanized before effective prevention programmes can come into existence. In recent years WHO has been involved in a range of activities to raise global awareness, and promote complementary efforts to raise awareness locally and nationally in all regions.

Following the global launch of the WRVH in 2002, WHO has supported nearly 50 national launches around the world. These events have significantly increased awareness of the pervasiveness of violence in our societies and contributed to a better understanding of its causes, consequences and preventability.

Advocacy materials have been prepared as part of awareness raising activities. These include outputs such as Prevent, the newsletter of the Global Campaign for Violence Prevention, which has provided information about ongoing activities, current publications and relevant events to a worldwide readership since January 2003. Three poster series were developed to visually represent the Global Campaign for Violence Prevention. The first two series: Violence in red and Explaining away violence were launched in 2002, while the third — the Family album series — was released during the 58th World Health Assembly in May 2005. Developed by a well-known advertising agency, the posters use strong images and hard-hitting messages to depict some of the consequences of sexual violence, child abuse, intimate partner violence, abuse of the elderly, youth violence, self-directed violence and collective violence. Translated into several languages, the posters have been widely distributed and used in national poster campaigns, and have featured in a number of international magazines (including Time and Vanity Fair).

A Fistful of Humanity is a television documentary on violence and violence prevention produced by a Swiss-based documentary production company with technical advice from WHO. The documentary will be completed before the end of 2005. Aiming to capture the hidden face of violence — including the many efforts at prevention — the film features interviews with victims and perpetrators of violence, prevention practitioners, and policy and decision-makers from around the world. The documentary will be made available free of charge to broadcasters around the world as well as violence prevention practitioners and advocacy groups.

The British Broadcasting Corporation’s (BBC) World Service is collaborating with WHO on a series of radio programmes on interpersonal violence and how to prevent it; the first of these programmes will be aired on 8 November 2005 and continue over a period of two to three weeks.
Programme editors are drawing on the key findings and messages of the WRVH, and the radio broadcasts will be complemented by a special violence prevention feature on the BBC’s web site.

ENHANCING DATA COLLECTION AND RESEARCH

The WRVH highlighted the need to enhance capacity for ongoing data collection and research on violence. An ongoing supply of national- and local-level information about the causes, characteristics and consequences of violence is essential to building a comprehensive understanding of the problem and for designing, developing and monitoring effective solutions. To this end, WHO is actively involved in producing tools to assist policy-makers, researchers and others to conduct or support data collection and research efforts in their regions and countries. For example, WHO’s Mozambique country office has worked closely with a number of government ministries to strengthen data collection on violence-related deaths in mortuaries; on non-fatal violent injuries treated in hospital emergency departments, and on self-reported violent victimization as recorded through a national household survey.

The economic dimensions of interpersonal violence

In June 2004 WHO published a research report *The economic dimensions of interpersonal violence* which includes information on the cost-effectiveness of prevention programmes and collates information from a wide range of sources including peer-reviewed articles, published reports and unpublished literature. The three key messages contained in the report are that the consequences of interpersonal violence are extremely costly; programmes to prevent violence are cost effective; and that we have insufficient descriptive information on the direct costs of treating the consequences of interpersonal violence in most of the developing world and
many developed countries. Together, these messages highlight one of the major challenges in years to come: to systematically establish a solid base of evidence on the costs of violence in all societies, and then feed this evidence into policy-making and advocacy where it can complement and strengthen moral arguments for the prevention of violence.

WHO and the US Centers for Disease Control and Prevention are jointly coordinating the development of a set of guidelines to help researchers estimate the economic costs of interpersonal and self-directed violence in high-, medium- and low-income settings. A two-day expert consultation was convened in April 2005 to formulate these guidelines and recommendations which are expected to be released in the first half of 2006. Widespread implementation of these guidelines in different settings should yield scientifically robust estimates of the economic costs of violence and could be used to advocate for greater investment in efforts to understand and prevent the problem at national and municipal levels.

**Guidelines for conducting community surveys on injuries and violence**

In many countries a large proportion of violent incidents are not reported to health workers, the police, or any other authorities, and so can only be identified and measured by interviewing individuals about past victimization experiences. WHO prepared the *Guidelines for conducting community surveys on injuries and violence* (2004) to assist researchers and practitioners to conduct population-based surveys on injury and violence and provide a step-by-step explanation on how to conduct a community-based survey to collect information on violence and the injuries it causes. Such surveys can provide useful baseline information on injuries and violence which can be extrapolated to the wider population.

**WHO multi-country study on women’s health and domestic violence against women**

The search for solutions to violence against women has been hampered by a lack of reliable data on the causes, magnitude, and consequences of violence against them. The *WHO multi-country study on women’s health and domestic violence* is being carried out in collaboration with the London School of Hygiene and Tropical Medicine, UK and the Program for Appropriate Technology in Health, Washington D.C., USA. The study aims to obtain reliable estimates on the magnitude and health effects of different forms of violence against women, document the association of intimate partner violence with physical, mental and reproductive health outcomes and identify risk and protective factors.

The study was implemented in partnership with research institutions and national ministries and women’s organizations in Bangladesh, Brazil, Ethiopia, Japan, Namibia, New Zealand, Peru,
Samoa, Serbia and Montenegro, Thailand and the United Republic of Tanzania. In each country cross-sectional population-based household surveys were conducted among a representative sample of around 1,500 women aged 15-49 years in one or two sites covering urban and rural populations. Findings on the prevalence and patterns of different types of intimate partner violence are to be presented in the first part of the multi-country study report to be released at the end of 2005. This initial report will include findings on the prevalence of physical and sexual violence by perpetrators other than partners aged 15 years and over, and the prevalence of sexual abuse before the age of 15 years. The report will also provide a preliminary analysis of the association between physical and sexual violence and health outcomes, and findings about the coping strategies used by women experiencing intimate partner violence.

PROMOTING PRIMARY PREVENTION

Primary prevention policies and programmes are the focus of the fourth WRVH recommendation and a central theme in the Global Campaign for Violence Prevention, and are designed to help prevent violent behaviour. They do so through interventions designed to eliminate the underlying causes and risk factors and strengthen protective factors.

Preventing violence: a guide to implementing the recommendations of the World report on violence and health

Preventing violence takes an in-depth look at each of the six country-level WRVH recommendations. Designed for programme planners and policy-makers, the guideline provides a conceptual background, discusses policy implications and gives step-by-step suggestions on how to implement the six targeted activities. Case studies based in high-, middle- and low-income countries are included to illustrate how the recommended actions have been implemented in different settings. Each chapter includes a list of resources that can be consulted for more information. This companion volume to the WRVH is intended to be used to guide primary prevention policy and programmes at different stages of development — even where resources are scarce — and for many is an invaluable planning tool both to generate resources and determine an optimal course of action.

Handbook for the documentation of interpersonal violence prevention programmes

Little is known about the target populations, interventions used, and outcomes achieved by the numerous violence prevention programmes that already exist around the world, a large number of which are supported through international development aid and cooperation. Consequently, the
richness of these prevention experiences is not recorded and the many lessons inherent in their successes and failures are not being shared with other violence prevention practitioners.

The *Handbook for the documentation of interpersonal violence prevention programmes* provides a conceptual framework and survey instrument to remedy the current information gap. Produced in consultation with experts from WHO regions and published in 2004, the *Handbook* provides a standardized format to capture the many violence prevention experiences by recording information on programmes in a given geographical area, such as by whom they are run; the groups they aim to benefit; the interventions they employ; and if and how they evaluate their effectiveness. In mid-2004, over 400 violence prevention programmes in municipal and provincial settings in eight countries were selected for documentation using the handbook. It is hoped that the information gathered in the documentation process will highlight innovative primary prevention models and areas where more programming is needed.

**TEACH-VIP**

TEACH-VIP (an acronym for Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention) was developed by WHO’s Department of Injuries and Violence Prevention in response to requests from Member States and professional groups involved in education in violence and injury prevention and control. Prepared in collaboration with some of the world’s leading experts, TEACH-VIP aims to provide public health training to students, professionals and practitioners to allow them to better apply key violence and injury prevention and control principles, as well as to help them develop preventive programmes and policies; design effective surveillance systems; evaluate intervention programmes and policies; and collect and assess violence and injury data. TEACH-VIP materials were pilot tested on training audiences in 23 settings during 2004–2005 and published in September 2005. The TEACH-VIP curriculum is available on a CD-ROM and includes all 60 lessons, as well as the full text PDF versions of additional WHO resources.

**STRENGTHENING HEALTH SERVICES FOR VICTIMS**

Strengthening services for the victims of violence — the fifth WRVH recommendation — is needed as they are currently inadequate or lacking in many developed and developing countries. Improvements in victim services could have a direct and rapid impact and could lead to a fall in violence-related mortality and non-fatal injuries, disabilities and other health consequences.
To support countries in making such improvements, WHO is working on a series of guidelines for service delivery organizations and health system planners in low- and high-resource settings to help them design and deliver the highest-quality services possible.

**Guidelines for medico-legal care for victims of sexual violence**

Sexual violence is a major global public health and human rights problem which profoundly impacts on its victims’ physical, mental and social well-being, even long after the assault itself. Yet, in many parts of the world available services do not meet the needs of survivors. Crucial forensic evidence is often left uncollected as health care providers do not have the right training in handling survivors of sexual violence. Conversely, women who report a sexual assault to the police may undergo a forensic medical examination, but may not receive the treatment they might require for preventing sexually transmitted infections (including HIV-AIDS) and injuries sustained in the assault.

To help ensure that victims of sexual abuse have access to adequate care, WHO has begun an initiative to strengthen health-sector responses to sexual violence. This initiative includes the development of guidelines for providing care to sexual assault survivors and the development of a framework to guide health sector policies related to sexual violence. The *Guidelines for medico-legal care for victims of sexual violence* were released in 2003 and translated into Spanish and Arabic, with Portuguese and French translations in preparation. Field trials of the guidelines started in 2004 and are underway in Nicaragua, the Philippines, Jordan and Mozambique.

To improve care for victims of sexual violence in emergency settings, WHO has worked with the United Nations High Commission for Refugees (UNHCR), the United Nations Population Fund (UNFPA) and the International Committee of the Red Cross (ICRC) to develop the booklet *Clinical management of rape survivors*. The second edition is now available in English and French. The booklet facilitates the provision of quality care for rape survivors in emergency settings and is currently used by UNHCR and ICRC field staff.

**Guidelines for essential trauma care**

These guidelines were prepared to promote low-cost investments to improve the care and treatment of physically injured persons. With only minimal increases in expenditures, improvements in organization and planning can enhance trauma treatment services and the outcome for injured persons. The *Guidelines for essential trauma care* set standards for the human and physical services needed for trauma treatment services that can realistically be reached, and importantly be made available, to almost every injured person in the world. The *Guidelines for essential trauma care* were developed by WHO in collaboration with international trauma surgery associations and trauma care clinicians.
in Africa, Asia and Latin America. They are intended for use by hospital administrators, nursing service directors, medical service directors and clinicians, as well as by societies of surgery, anaesthesia, traumatology and other disciplines dealing with the injured patient.

**Prehospital trauma care systems**

Released in 2005 the *Prehospital trauma care systems* manual responds to a need for guidance on this issue on the part of health policy-makers and health systems planners. Prepared in collaboration with a network of experts, and lead by WHO; Emory University, USA; and Saint Stephen's Hospital, New Delhi India, the manual focuses on the most promising interventions and components of prehospital trauma care systems, particularly those that require minimal training and relatively little in the way of equipment or supplies. Non-specialists can be trained to work alongside professional health-care providers and within formal medical care structures to provide effective and sustainable prehospital trauma care. Areas covered by the manual include designing and administering prehospital trauma care systems, selecting and training prehospital trauma care providers, transportation, communication and ethical and legal considerations.

**PARTNERSHIPS FOR VIOLENCE PREVENTION**

In line with the seventh WRVH recommendation on collaboration and exchange, most of WHO’s violence prevention work involves collaboration with other organizations in the United Nations system and with independent agencies. The Violence Prevention Alliance, discussed in detail later in this document, brings together local, national and international, governmental and non-governmental agencies from around the world to strengthen both individual and collective efforts to prevent violence. WHO is involved in three other major partnerships, including the United Nations Collaboration for the Prevention of Interpersonal Violence, the Armed Violence Prevention Programme and the United Nations Secretary General’s Study on Violence against Children.

**United Nations Collaboration for the Prevention of Interpersonal Violence**

web-portal to be launched in 2005 resulted from this meeting. Other meetings to focus on research collaborations and country programming are planned for the future, each to be hosted by a different participating agency.

**Armed Violence Prevention Programme**

The Armed Violence Prevention Programme (AVPP) is a joint endeavour between WHO and the United Nations Development Programme (UNDP). It seeks to promote effective responses to armed violence by developing an international policy framework founded on a clear understanding of the causes, nature and impacts of armed violence.

A series of initiatives have been launched at the country level to survey national and local violence prevention initiatives, research the causes, nature and impacts of armed violence, and strengthen national policy and institutional capacities. The initiatives will serve as a platform to observe and analyse lessons learnt and serve as a conduit for channelling further technical and policy support from the international level to country programmes. Outputs to date include comprehensive reports on firearm-related violence in Brazil and El Salvador, which have contributed significantly to the national debate in those countries on the urgent need to develop more effective policies and programmes to prevent firearm-related injuries. At the global level, AVPP is promoting dialogue between key stakeholders and practitioners in the field of armed violence prevention, complemented by research, to mainstream the issue within broader development assistance frameworks and identify strategies to inform a broader international policy framework.

**United Nations Secretary General’s Study on Violence against Children**

In 2001, acting on the recommendation of the Committee on the Rights of the Child, the United Nations General Assembly commissioned a study on violence against children. The Study aims to integrate existing research and relevant information about the forms, causes and impact of violence against children up to 18 years of age. It will also make suggestions on how to strengthen prevention efforts at local, national and international levels. In 2003, United Nations Secretary-General Kofi Annan appointed Professor Paulo Sergio Pinheiro to lead the Study, working in close collaboration with the Office of the United Nations High Commissioner for Human Rights (UNOHCHR), the United Nations Children’s Fund (UNICEF) and WHO. The Study will also involve the participation of a range of other United Nations, governmental, nongovernmental and civil society organizations.

Study partners have stressed the importance of bringing together a human rights perspective with public health tools for prevention and victim services. WHO is providing extensive technical support for the Study, drawing upon the violence prevention knowledge and experience brought
together by the WRVH and the Global Campaign for Violence Prevention. Examples of WHO support during 2004–2005 include the preparation of global estimates of deaths, disabilities and disease associated with violence against children, participation in the Study steering and editorial committees, convening the consultation on violence against children in the home and family setting, and providing input to regional consultations.
CHANGING THE FACE OF VIOLENCE PREVENTION

The World Health Organization has a regional office in each of its six regions, namely in Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia and the Western Pacific. In 2002, at the time of the WRVH launch, only the regional office for the Americas had staff dedicated to violence prevention. As of 2005 all six regional offices have at least one Regional Adviser formally responsible for ensuring that violence prevention is promoted in the countries in their region.

In this section, each Regional Adviser shares some recent successes and challenges for violence prevention in their region and discusses where the violence prevention work is headed for the future.

WHO REGIONAL OFFICE FOR AFRICA: DR OLIVE KOBUSINGYE

Dr Olive Kobusingye is the Regional Adviser for Disability and Injury Prevention and Rehabilitation for WHO’s Regional Office for Africa (WHO-AFRO), based in Brazzaville, Congo. WHO’s African Region includes 46 Member States across Central, East, West and Sub-Saharan Africa.

1. What impact has the release of the World report on violence and health had on violence prevention policies in your Region?

The WRVH has received a great deal of attention across the African region, and appears to be widely used by violence prevention researchers and practitioners and nongovernmental organizations. In Botswana, Mali, Mozambique and South Africa, the report was officially launched during ceremonies in which there was representation from the highest levels of government. Following these launches, some countries have designated focal points for violence prevention, a first step in ensuring a government’s ability to begin addressing the problem. In some countries inter-ministerial discussions are under way about how to advance multi-sectoral prevention work. Nongovernmental organizations are very active in terms of advocacy, but it is worth recognizing that such groups are at times viewed as extreme, especially when they advocate for issues such as the recognition within the law of marital rape. Association with the medical profession assists in their coming across as
more credible and well intentioned, and also helps them to address other issues such as the limitations of existing data sources.

At the regional level, the 54th session of the WHO African Regional Committee passed a resolution on Child sexual abuse: a silent health emergency (AFR/RC54/R6) in September 2004. The resolution states the Committee’s alarm at “increasing reports of child sexual abuse in Member States and the culture of silence that surrounds it”, and will serve as a useful tool for African countries prepared to address this sensitive issue. In 2003, Member States of the African Union passed a resolution (EX/CL/Dec.63[III]) endorsing the recommendations of the WRVH and recommending that Member States develop national plans of action for violence prevention and systems for data collection on violence. The African Union resolution also requested that Member States declare 2005 the “African Year of Prevention of Violence” to catalyse scaling up and coordination of violence prevention policies and activities.

2. Which are the main partners involved in WHO-AFRO’s efforts?

The partners at national level are many, including government ministries, academic institutions and nongovernmental organizations. In Mozambique, for example, the Ministry of Women and Welfare and the University of Eduardo Mondlane have worked closely with the Ministry of Health and the WHO country office on projects to implement the WRVH recommendations. International partners that have funded country-level activities related to implementing the WRVH recommendations include the Belgian, Italian, Netherlands and Swedish governments and the United States Centers for Disease Control and Prevention. The African Union has been a key partner in the region, and we hope this collaboration will extend well beyond commemoration of the African Year of Prevention of Violence. Also at the regional level, there are some very dynamic networks, mostly involving nongovernmental organizations, community groups and teaching institutions working on different types of violence. For instance, the Uganda-based Gender-Based Violence Prevention Network has a membership of more than 12 countries.

3. How do you expect the Regional Committee resolution on child sexual abuse to support and complement other efforts to prevent child abuse in the WHO African Region?

The resolution was very opportune, especially as it coincided with preparations for the United Nations Secretary-General’s Study on Violence against Children. Many national and regional consultations are taking place now that are aimed at increasing the understanding and raising the profile of this problem. The resolution by the Member States gave more energy to this process, and we hope that the recommendations the resolution makes for Member States will be reflected in national- and community-level prevention activities.
4. **What do you see as the greatest successes so far in WHO-AFRO’s efforts to support violence prevention activities in Member States?**

In terms of understanding the nature and scope of violence, countries such as Algeria, Ethiopia, Mozambique and South Africa have strengthened their data collection systems to better reflect violence, and to make this data meaningful for prevention. WHO’s *Injury surveillance guidelines* have been useful in this regard. A recent survey showed that in countries where the Ministries of Health indicated violence as a priority, functional data systems were more likely to be in place than in countries where health ministries had not made violence a priority.

Regarding prevention, almost all countries have multi-sectoral groups working at national and community levels to raise awareness about the importance of gun violence and to advocate for comprehensive measures to address this problem. The focus for much of these efforts has been on bringing in laws for gun control, establishing or improving information systems and providing appropriate care for those who suffer firearm injuries.

In terms of services for victims of violence, there has been increased uptake of related WHO guidelines, including the *Guidelines for medico-legal care for victims of sexual violence*, and the health sector has made some progress in terms of working with the police to ensure that services are provided in a sensitive manner.

5. **What major activities are you looking forward to in the months ahead for violence prevention in the WHO African Region?**

We are planning a region-wide situation analysis of violence and health, which should result in a regional report. We anticipate a concise analysis of the scope and magnitude of violence in the region and a reflection on what prevention initiatives exist, which of these are effective, and how to expand the effective programmes to cover more ground. We shall be working closely with the African Union on this and other initiatives for the rest of 2005 into early 2006.

In addition to the regional report on violence and health, we plan to develop a continent-wide strategy for violence prevention and control. The first step will be to organize a meeting of experts to review the different facets of violence and to find appropriate responses and solutions. Prevention, care for victims of violence and strengthening the health care services system in Africa will all be addressed. The meeting participants will produce a draft report and recommendations which we hope will then be formally adopted by the African Union and WHO-AFRO.

The last upcoming activity I’d like to highlight is the *Eighth World Conference on Injury Prevention and Safety Promotion*, which takes place in Durban, South Africa from 2-5 April 2006. This will be the first time this important conference takes place on the African continent, and it presents an excellent opportunity to focus global attention on African opportunities and challenges in the violence and injury prevention field. The South African Minister of Health, Dr ME Tshabalala-Msimang, has...
generously agreed to co-host as a pre-conference event the “First global meeting of health ministry violence and injury prevention focal points”, and to partially fund the participation of focal points from countries in the Southern African Development Community.

WHO REGIONAL OFFICE FOR THE AMERICAS, DR ALBERTO CONCHA-EASTMAN

Dr Alberto Concha-Eastman is the Regional Adviser for Violence and Injury Prevention for the WHO Regional Office of the Americas, also known as the Pan American Health Organization (PAHO). PAHO headquarters are in Washington DC, USA, and the Organization is made up of 34 Member States from North, Central and South America, and the Caribbean.

1. What activities have been developed to implement the recommendations of the World report on violence and health in the Americas?

The WRVH was officially launched by PAHO and national authorities in 14 countries. During these events, national and local authorities, as well as representatives from academic institutions and nongovernmental organizations, presented reports on violence in their countries and, based on the findings and recommendations of the WRVH, made suggestions on how responses for the prevention of violence could be strengthened. Some countries, notably Costa Rica and Mexico, have prepared their own national reports on violence and health. Other countries, including Brazil, El Salvador, Jamaica, Nicaragua and Puerto Rico, have initiated violence prevention activities such as national violence prevention commissions.

2. What are some of the exemplary programmes supported by PAHO?

In 2004, funded by a grant from the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), PAHO launched a project on youth development and violence prevention in Argentina, Colombia, El Salvador, Honduras, Nicaragua and Peru. The project aims to build the capacity of youth organizations, to advocate for the development of educational and recreational systems to better meet youth needs, and evaluate violence prevention activities currently in place.

Two projects developed in cooperation with the Inter-American Coalition for the Prevention of Violence, currently hosted by PAHO, also deserve mention. The first project, launched in 2004, involves working with mayors and other municipal authorities in Central American countries to establish violence information observatories and strengthen their capacity to design and implement violence prevention projects. So far this project is running in eight out of 12 municipalities where
mayors have committed their support.

The second project, an international conference on youth violence in Central America, was held in February 2005 and attended by over 280 participants. The conference was entitled *Voices from the field*, and it marked the beginning of a larger initiative with the governments of El Salvador, Guatemala, Honduras and Nicaragua to explore how best to prevent and respond to youth violence and youth gangs. An outcome of this conference was the Central America Coalition for the Prevention of Youth Violence, launched in Nicaragua in early June 2005.

3. Who are some of the main partners in PAHO’s violence prevention efforts?

PAHO is fortunate in that violence prevention has been identified as a regional public health priority for at least a decade. At a technical and resource level, the United States Centers for Disease Control and Prevention has supported PAHO violence prevention activities with regular grants, and, since 2002, has established technical collaboration with country staff for the implementation of violence and injury surveillance systems in selected hospitals of Colombia, El Salvador and Nicaragua. The US Centers for Disease Control and Prevention also support the secretariat of the Inter-American Coalition for the Prevention of Violence, whose members include the Inter-American Development Bank; the World Bank; the United States Agency for International Development; the Organization of American States and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Violence prevention partners also include officially designated WHO collaborating centres in Brazil, Canada, Colombia and the USA.

At the country level, United Nations organizations such as UNICEF, UNDP, the United Nations Office on Drugs and Crime (UNODC) and the United Nations Development Fund for Women (UNIFEM) work closely with WHO country offices and health ministries in planning and implementing prevention work, and, as noted earlier, Germany’s GTZ has since 2004 been a strong partner for the prevention of youth violence.

4. What do you see as the greatest success so far in PAHO’s efforts to support violence prevention activities in Member States, and why?

There’s no doubt that PAHO’s contribution towards the creation of national and municipal commissions for violence prevention is one of our greatest success stories. These commissions give high-level visibility to violence prevention and play an important role in mobilizing violence prevention resources. As a result, more national authorities and civil society organizations are calling for the development and mainstreaming of violence prevention strategies. I’d also like to highlight the fact that over the past few years PAHO has contributed significantly to processes that have led to the promulgation in many countries of new laws to protect women and children who experience family violence.
5. What violence prevention activities are you preparing in the months ahead in the WHO Region of the Americas?

During the second half of 2005 and throughout 2006 our focus will be on youth violence in Central America. We intend to concentrate on activities to help strengthen country-level data collection systems and violence prevention programming capacity, as well as supporting the Central America Coalition for the Prevention of Youth Violence. Another key activity will be our ongoing work with WHO and UNDP on the Armed Violence Prevention Programme in El Salvador and Brazil. Finally, we’ll continue to support countries in their efforts to estimate the costs of violence, feeding into the joint WHO-US Centers for Disease Control and Prevention project on developing guidelines for estimating the economic costs of interpersonal and self-directed violence.

WHO REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN, DR SYED JAFFAR HUSSAIN

Dr Syed Jaffar Hussain is the Regional Adviser for Injuries and Violence Prevention in the WHO Regional Office for the Eastern Mediterranean, which has its headquarters in Cairo, Egypt. The region is comprised of 22 predominantly Arab-speaking Member States.

1. Has the war and conflict in countries such as Afghanistan, Iraq and Sudan made it difficult to raise awareness about interpersonal violence?

Responding to the health and humanitarian needs created by war is a priority for WHO-EMRO and for many of our Member States. But far from overshadowing interpersonal violence, the fact of war has made countries in the region even more keenly aware of the importance of addressing the underlying causes of violence, and ensuring that individuals, families, communities and societies are strengthened and supported in ways that will prevent all forms of violence.

Underlining the region’s commitment to interpersonal violence prevention, Her Majesty Queen Rania Al-Abdullah of Jordan received the 2005 United Arab Emirates Health Foundation prize for her support of health development, especially on issues related to family protection and child abuse prevention. Her commitment to family violence prevention and activities in support of the Arabic language version of the WRVH resulted in her consenting to becoming WHO Patron for Violence Prevention in the Eastern Mediterranean Region.
Seven WHO-EMRO Member States are also African Union members, and we are working in close collaboration with the African Union and the WHO Regional Office for Africa to ensure that these countries are fully integrated in all African Year of Prevention of Violence activities and outcomes.

2. **What are some of the main regional-level violence prevention activities initiated in response to the *World report on violence and health*?**

We are currently documenting existing violence and injury prevention practices in selected Member States, using the WHO *Handbook for the documentation of interpersonal violence prevention programmes*. This will help to identify particularly promising prevention programmes that can serve as models for others to emulate, and provide baseline information against which we can plan how to strengthen the region’s currently limited violence prevention capacity.

Supporting countries in the prevention of child maltreatment is another key area of work. In February 2004, Dr Haytham Al Khayat, Senior Policy Advisor with WHO-EMRO, gave a keynote address at the First International Society for the Prevention of Child Abuse and Neglect (ISPCAN) Arab Conference on Child Abuse and Neglect. This meeting resulted in the establishment of an Arab chapter of ISPCAN, and set the foundations for ongoing collaboration between WHO-EMRO and ISPCAN on developing child maltreatment prevention capacity in the EMRO countries.

In December 2005 WHO-EMRO and the Jordanian Ministry of Health will jointly organize a *Regional Conference on Family Protection*, followed by a TEACH-VIP training workshop for violence and injury prevention focal points within the health ministries of 10 countries and representatives of nongovernmental organizations in the region.

3. **The practice of female genital mutilation remains widely prevalent in some of the WHO Eastern Mediterranean Region countries. What is WHO-EMRO doing about it?**

A regional consultation on *Gender issues in health in the socio-cultural context of the Eastern Mediterranean Region* was held at WHO-EMRO in Cairo, in collaboration with the Islamic Educational, Scientific and Cultural Organization in December 2004. Female genital mutilation was a key topic for discussion, and participants highlighted the urgent need to set in place interventions that will discourage this harmful practice. WHO-EMRO also participated in efforts to achieve political and religious consensus for the abandonment of female genital mutilation by participating in a February 2005 sub-regional conference on female genital mutilation hosted by Djibouti and including representatives from Djibouti, Egypt, Somalia, Sudan and Yemen.

4. **Please describe the most important country-level violence prevention activities that you are supporting in the Eastern Mediterranean region.**

In Jordan, the National Council for Family Affairs has applied to become a WHO Collaborating
Centre for Injury and Violence Prevention. If successful, the Council will become the first WHO Collaborating Centre in the region working on violence prevention. It will contribute to family protection both nationally and regionally through the development of policy and technical guidelines on the prevention of family violence, the coordination of data about the incidence of and risk factors for family violence, the collation of promising prevention practices, and the monitoring of trends in family violence prevention work.

In September 2004, WHO assisted the Government of Yemen to prepare a five-year strategic plan of action for violence and injury prevention and control. The plan of action enjoys support from the highest level of government and represents a multisectoral approach to injury and violence prevention. In May 2005, WHO-EMRO held a regional expert consultation on the development of violence and injury surveillance systems, multisectoral plans of action and research priorities for nine countries: Egypt, the Islamic Republic of Iran, Jordan, Lebanon, Oman, Pakistan, Saudi Arabia, Yemen and Syria.

5. What are the major violence prevention activities planned in the Eastern Mediterranean in the next months and years?

A major focus of the EMRO Regional Office in the coming years will be on strengthening the capacity of the health ministries and other sectors in the planning and implementation of violence prevention programmes. Another major challenge faced by countries in the region is access to accurate and reliable data on the magnitude and characteristics of different forms of violence. WHO-EMRO will therefore also concentrate on assisting Member States to develop violence and injury surveillance systems at national and local levels.

WHO REGIONAL OFFICE FOR EUROPE: DR INGE BAUMGARTEN

WHO’s Regional Office for Europe (WHO-EURO) is based in Copenhagen, Denmark and Rome, Italy. The region includes 52 Member States from Western Europe, South Eastern Europe, the Baltic States and the Commonwealth of Independent States.

1. What do you see as the main challenges facing violence prevention in the WHO European Region?

The differences in income, social capital, health status, alcohol and substance abuse, and violence across the region are striking, and reducing these inequalities by bringing down the rates
of violent death and injury in countries and communities where these are particularly high is a major challenge.

Low- and middle-income countries, especially in eastern Europe, show some of the world's highest violence-related mortality rates. In the Russian Federation, for example, homicide and suicide rates in males aged 25–54 years are extremely high. In contrast, some of the world's lowest rates of homicide are found in the wealthy western European and Scandinavian countries, although even in these countries vulnerable and marginalized groups are at substantial risk of experiencing non-fatal violence. As in other world regions, a lack of reliable information about violence occurring in the family, such as intimate partner violence, sexual violence, child maltreatment and abuse of the elderly, will remain a major challenge for years to come.

2. What are the most important regional-level achievements in violence prevention since January 2004?

The September 2005 annual meeting of the WHO Regional Committee for Europe, which took place in Bucharest, discussed further scaling up of political commitment to and investment in health-based approaches to violence prevention. Member States expressed strong support for a resolution committing countries to greater investment in the prevention of violence and requesting WHO-EURO to increase the support it offers Member States to enhance national capacities for violence prevention and victim service provision.

In November 2004, the Council of Europe passed an inter-ministerial resolution entitled "Preventing Everyday Violence in Europe: Responses in a Democratic Society". This resolution provides a frame for the development and implementation of national violence prevention policies around Europe to create an integrated, comprehensive and coordinated response across the region. The resolution adopts the WRVH definition of violence, explicitly refers to the WRVH recommendations, and advocates the use by governments and other violence prevention partners of a number of WHO guidelines, including Preventing violence, the Guidelines for medico-legal care for victims of sexual violence and the Guidelines for essential trauma care.

3. Many European countries have taken steps to implement the World report on violence and health recommendations. Could you give some examples of national-level activities?
In June 2005, following up on the preliminary policy discussions described in the First Milestones report, the former Yugoslav Republic of Macedonia gazetted formation of the National Commission for Violence Prevention headed by the Minister of Health. This commission is charged with protecting the population from violence, and includes representatives from the ministries of health, interior affairs, justice, education and science, and labour and social policy, as well as Macedonian National Television and a number of nongovernmental organizations. The Commission’s work builds upon input from a number of WHO-supported violence prevention projects in the country.

In July 2005, the Government of Slovenia hosted a regional consultation to contribute to the United Nation Secretary General’s Study on Violence against Children. Nine such consultations were held across the globe to increase awareness and galvanize the commitment of government and civil society to protect children from all forms of violence. The regional consultation for Europe and Central Asia, entitled “Stop Violence against Children – Act Now”, was organized by the OHCHR, UNICEF, WHO, the Council of Europe, and the Study’s nongovernmental organization advisory panel.

The first representative study of violence against women in Germany was presented by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth in September 2004. As one element of the national action plan by the federal government to counter violence against women, the study endeavours to bridge the current information gaps and the need for prevention and victim assistance. The study investigated the extent and characteristics of physical and sexual violence, sexual harassment and psychological abuse of women. The findings of the report emphasize the high prevalence of physical and sexual violence against women, mostly at the hands of men.

In Latvia, a national campaign against violence launched in March 2005 was conducted by the United Nations country team in partnership with a broad range of ministries and civil society organizations. The Campaign targets politicians, professional groups and the Latvian public to raise awareness about various forms of violence. Press launches, a multi-media campaign in Latvian and Russian languages, round table discussions and trainings of prosecutors, policy-makers,

**Violence as a major public health and social threat in the Russian Federation**

People in the Russian Federation are at much higher risk of dying from homicide and assault than their fellows in the Western part of the Region. The difference in risk of dying from a violent attack (18.0 deaths per 100,000), compared to the UK as one of the lowest (0.9 per 100,000), being 32 times higher. When it comes to family violence, the figures are even worse. Women and children suffer violence most often by a person known and close to them. Alcohol is associated with a large proportion of violent attacks. Males are not only likely to be the perpetrators of violence, but also the victims: at all ages males are much more likely to die violently than females. And homicide is only the most visible tip of the problem. For every death there are many hospital visits (although hospital-based violent injury recording systems have yet to be developed and the precise numbers remain unknown), and an unknown number of self-treated cases, which never get reported.

To provide a platform for exchange on this important developmental challenge in the Russian Federation, a June 2005 meeting of technical experts on violence and health took place in the Moscow Research Institute of Psychiatry, organized by WHO and the Russian Federation Ministry of Health national focal point for violence prevention. The approximately 30 representatives from the ministry of health, research institutes, institutes of public health, nongovernmental organizations and networks working in the prevention of violence, as well as UNICEF, UNIFEM and UNFPA, agreed on the need for a strengthened and coordinated multi-sector, multi-agency action. They made a number of recommendations too: the establishment of a federal target programme for the prevention of violence, the creation of a task force for the coordination of further activities, and partnership and coordination approach across relevant sectors, ministries and civil society.
law enforcement officials and journalists are ongoing activities related to the Campaign. By linking the Campaign to WHO’s Global Campaign for Violence Prevention, the organizers highlight the national situation while placing it in a global context. Three posters based on WHO’s Violence in red poster series were widely displayed in the streets of Riga and the larger cities of the country, lending visual impact to the Campaign’s ongoing activities.

In France, the Haute Comité de la santé publique in May 2004 published a national report on violence and health, *Violences et santé*. The report examines interpersonal violence against children, between intimate partners, among youth, towards the elderly, and at work, and self-directed violence. For each type of violence, the report explores the epidemiology, risk factors and prevention strategies, and makes recommendations for the development of a multisectoral national plan of action to prevent violence. As of mid-2005 France was following up on this report at a very high level with the development of a national plan of action.

Later in this document, the section on the Violence Prevention Alliance highlights the significant violence prevention progress achieved in the UK. These examples are not a comprehensive list of activities, but do offer a glimpse into the ongoing dialogue and increasing awareness about violence at all levels of policy-making and society in the European Region.

4. What activities are you looking forward to in the coming months and years?

European Member States have achieved a great deal, but much more remains to be done to document the effectiveness of prevention programmes and to increase our knowledge about the extent and scope of the violence problem in the region. These types of knowledge have great potential to guide the development of policies that will assure coherent action across different sectors and between different nations. We are therefore hoping that in close collaboration with national and regional partners there will be a concerted drive to strengthen outcome evaluation studies; to improve cause of death statistics (especially in eastern Europe) and to strengthen the surveillance of non-fatal violence and injuries through hospital-based recording systems and household surveys.
The WHO Regional Office for South-East Asia (WHO-SEARO) is based in New Delhi, India. The region has 11 Member States, and includes countries such as Indonesia, Sri Lanka and Thailand which were severely affected by the December 2004 tsunami.

1. **WHO-SEARO took a leading role in coordinating the provision of health services and delivery of primary prevention interventions in the wake of the tsunami. How did this impact on regional violence prevention efforts?**

WHO-SEARO played a major role in helping organize health services and public health responses to the tsunami, and in the months following the disaster the world’s attention was focused on what could be done for the survivors. Injuries and violence, however, were not ignored. In fact, during the acute phase immediately after the tsunami, the vast majority of individuals presenting for medical assistance had suffered injuries of various sorts. The disaster highlighted the need for extensive investment in improving trauma care services, both to provide more efficient care in the wake of disasters and to improve the day-to-day treatment of injured patients. During this period, although violence was certainly less of a concern than unintentional injuries, it was seen as a problem, particularly for women and children in temporary camps, and with regard to access to emergency food aid and other supplies.

2. **How did countries in the region respond to the launch of the World report on violence and health?**

National launches of the WRVH were held in four of the 11 countries in the region: India, Nepal, Sri Lanka and Thailand. The latter three countries have been particularly active in promoting violence prevention by appointing ministry of health focal points and preparing national reports on violence and health with the goal of using these reports to inform the development of national violence prevention policies.

The work in Thailand deserves special mention. There, violence indicators have recently been integrated into the Thai national burden of disease project, and indicate that for persons 15-24 years of age, road traffic injuries, suicide, and homicide are the top three leading causes of death, and suicide and homicide are among the top five burden of disease contributors in the 25-44 age range. Based on these and other data on assault victims treated in hospital emergency rooms, the Thai Ministry of Public Health and the Ministry of Human Development and Security began joint work to develop a national violence prevention strategy. The Public Health Ministry has contributed to the joint WHO-US
Centers for Disease Control and Prevention project on developing guidelines for estimating the economic costs of interpersonal and self-directed violence, and in coming years will pilot these guidelines in Thailand.

3. **What about violence prevention activities in India?**

The sheer size of the Indian population means that to achieve a national-level policy response on an emerging public health issue such as violence, work usually has to start at a more local level. In India, the National Institute of Mental Health and Neuro Sciences (NIMHANS) in Bangalore is one of our Collaborating Centres for Violence and Injury Prevention, and is doing important work to develop Bangalore as a demonstration site for implementation of the WRVH recommendations. As part of this work, NIMHANS participated in the design and development of the WHO *Handbook for the documentation of interpersonal violence prevention programmes*, and during 2004–2005 implemented the handbook in Bangalore to establish baseline information on trends in violence prevention programming. Eventually, we hope that the example of Bangalore, along with numerous other efforts at preventing violence and improving victim services by municipal authorities and nongovernmental organizations elsewhere in India, will help to inspire national-level policy-makers to adopt the issue of violence prevention as one of their national health priorities.

4. **What activities are you looking forward to in the months and years ahead for violence prevention in WHO-SEARO?**

We are planning to launch and follow-up on the national violence and health reports for Nepal, Sri Lanka and Thailand. Preparation of these reports is proceeding with technical input from sectors such as justice, welfare, education and health, and we are preparing high-level ministerial representatives of these sectors to provide input on what their ministries can contribute to preventing the violence described in the reports, and in that way hope they will develop a clear sense of the important roles they can play in prevention.
mainland China and the Chinese enclaves of Hong Kong and Macao. The region also includes many small island societies, such as the Cook Islands and the Federated States of Micronesia.

1. Please describe the place of violence in the overall profile of injury deaths for the WHO Western Pacific Region.

In the year 2000, the WHO Western Pacific Region had an estimated 1.2 million injury-related deaths or 3300 deaths per day (accounting for approximately 24% of the world’s injury related deaths). The top five causes of these injury deaths were self-inflicted injury or suicide (approximately 318,000 deaths per year), road traffic crashes (292,000), drowning (137,000), falls (109,000) and poisoning (73,000). Although interpersonal violence is not among these leading causes of deaths at a regional level, special studies have shown that homicide is a leading cause of death in countries such as Papua New Guinea and the Philippines, and some of the smaller Pacific island countries. Special studies in countries such as Australia, Japan and the Philippines have also highlighted the tremendous disease burden associated with child abuse and intimate partner violence.

2. What has been the impact of the World report on violence and health on violence prevention policies in the WHO Western Pacific Region?

There were WRVH launches in six countries; there are violence prevention focal points in nine countries, and three countries (Malaysia, Mongolia and Papua New Guinea) are developing national reports on violence and health. China has made extensive use of the WRVH to promote suicide prevention and to inform its national contribution to the United Nations Secretary General’s Study on Violence against Children, and the Chinese delegation to the 2005 World Health Assembly expressed their country’s commitment to scaling up national violence prevention activities and requested additional support from WHO.

3. You mentioned special studies that some countries in the region have undertaken. Were any of these related to the World report on violence and health?

Yes. Two studies in particular state that they were inspired by the findings of the WRVH and aimed at providing information which can help to implement its recommendations. The first is a situation analysis of medico-legal services for victims of sexual violence in the Philippines. The study was conducted in 2004 by the University of the Philippines’ Psychosocial Trauma and Human Rights Studies Program and the Women’s Legal Bureau. Data were collected from the Department of Health, the National Bureau of Investigation, and from administrators and health care providers at eight facilities operating in Manila and in two rural provinces. The study found the Philippines to be quite progressive in its response to sexual violence, with a strong legal framework and 44 Women and
Children Protection Units in Department of Health Hospitals. Despite the progress it revealed, the findings also showed that care is often hindered by lack of basic equipment and medications, lack of specialized training, and lack of standardized care. The study’s major recommendations include the development of a national protocol for responding to victims of sexual violence, to standardize professional practice, and capacity building to improve the skills and awareness of health workers in contact with victims of sexual violence.

The second study is a groundbreaking Australian study that looked at the burden of disease arising from violence against women, particularly that occurring in the context of an intimate relationship. The study was carried out in the State of Victoria by VicHealth in partnership with the Department of Human Services, and is the first in the world to estimate the disease burden resulting from intimate partner violence. The study findings demonstrate that intimate partner violence is all too common, has severe and persistent effects on women’s physical and mental health and carries with it an enormous cost in terms of premature death and disability. Indeed, it shows that intimate partner violence is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking.

WHO-WPRO views these studies as tremendously important examples from which other countries can learn how to design and conduct research that is of practical value for changing the face of violence prevention by showing the true scale of the problem, the inadequacy of current policy and programme responses, and what must be done to improve the situation.

4. Have any countries in the WHO Western Pacific Region established national violence prevention programmes?

Some of the high-income countries in the region, such as Australia and New Zealand, have for many years had strong national violence prevention programmes involving multiple sectors. The Australian Institute for Criminology is an example, and it was an important contributor to the WRVH when it was being written. Subsequent to the WRVH launch, Malaysia has made excellent progress in establishing a national violence prevention programme. In August 2003, the Malaysian Minister of Health launched the “Global campaign for violence prevention - Malaysia’s response”. Responding to the World Health Assembly resolution on implementing the WRVH recommendations, the Ministry of Health expanded the scope of the existing Malaysian national injury prevention programme to include violence prevention activities, and renamed it the Violence and Injury Prevention (VIP) Unit. The VIP Unit is within the Disease Control Division of the Department of Public Health, and in close cooperation with other sectors carries out activities to reduce the incidence of violence and unintentional injuries and to improve services for victims.
5. **Which are the main partners involved in WHO-WPRO’s violence prevention efforts?**

Among our many partners, I would like to highlight the WHO Kobe Centre for Health and Development, which is also an important partner for violence prevention activities carried out by WHO-SEARO. Since 2004, the Kobe Centre has provided support for the development of national violence and health reports in Malaysia, Mongolia, Nepal, Papua New Guinea, Thailand and Sri Lanka.

6. **What major activities are you looking forward to in the months and years ahead for violence prevention in the Western Pacific region?**

In the coming months we can look forward to working with government ministries and other partners in Malaysia, Mongolia and Papua New Guinea to use the findings of their national reports on violence and health to develop national plans of action for violence prevention, and advance the policy-making and programme design processes in areas which the reports reveal to be particularly in need of strengthening.

More generally, I look forward to many more countries in the WHO Western Pacific Region examining the violence problem with a view to better understanding and preventing it, and to more countries expanding the scope of their activities to include youth violence and elder abuse in addition to building up the still insufficient work on child abuse and intimate partner violence.
TEACH OUR CHILDREN WHAT IS RIGHT FOR A BETTER FUTURE.
The WRVH and Global Campaign for Violence Prevention have inspired formation of the Violence Prevention Alliance, which was launched during the first *Milestones of a Global Campaign for Violence Prevention* meeting in Geneva, Switzerland in January 2004. While many governments and non-governmental organizations have already taken steps to prevent violence, their efforts have not been coordinated or linked with the shared vision of using data-driven planning and evidence-based programming and prevention methods.

The Violence Prevention Alliance is a network of institutions linked by their voluntary adoption of shared violence prevention principles and policies derived from the WRVH. Participation is open to WHO Member State governments, nongovernmental and community-based organizations, and private, international and intergovernmental agencies working to prevent violence. Violence Prevention Alliance activities will expand the number of agencies that apply a public health approach to implementing violence prevention programmes and services, and will enhance the impact of individual programmes on national and local policy and practice.

The Alliance is part of an ongoing effort to integrate more countries into the Global Campaign for Violence Prevention, while connecting similar groups at regional and local levels to facilitate better sharing of knowledge.

**VIOLENCE PREVENTION ALLIANCE ACTIVITIES AND PROGRESS IN 2004–2005**

In 2004 the Violence Prevention Alliance published a series of documents to define and promote the Alliance, and established the Violence Prevention Alliance web site. Beginning in 2005 activities have focused on supporting the sharing of knowledge between Alliance participants and expanding the number of formal Alliance participants.

**Information on the Violence Prevention Alliance**

In 2004 a brochure was prepared presenting the Alliance’s history, structure, purpose and methods of work. This brochure explains the conceptual bases for violence prevention, notably the public
health approach and the ecological framework, and contains a section with frequently asked questions on Alliance participation. A second document is a policy paper that presents the rationale behind the creation of the Alliance, describes the public health approach to violence prevention and states why violence is now a major global public health problem.

Another Alliance publication, *Interpersonal violence prevention in international cooperation and development: a multisectoral approach*, is a guideline to help partners in international cooperation and development to formulate interpersonal violence prevention programmes and policies. Target audiences include officials in donor and recipient countries and organizations, including individuals who write requests for proposals and those who respond to them. Background information is provided on interpersonal violence as a public health problem and the role of international cooperation and development in preventing it. The guideline also draws attention to the importance of data systems, data collection, research and programme evaluation; primary prevention programmes; and services for victims and perpetrators of violence, and is expected to be released in 2006.

**Violence Prevention Alliance participants**
The Alliance is made up of Member States, international organizations, and national- and local-level governmental and nongovernmental organizations whose activities are in accordance with, and supportive of, the WRVH recommendations, and have formally endorsed the principles contained in the Alliance’s terms of reference and policy documents. Founding Alliance participants were instrumental in shaping the Alliance’s vision and policies.

The Alliance’s founding participants are:
- California Wellness Foundation, USA
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, USA
- Centre for Public Health, Liverpool John Moores University, UK
- Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Germany
- Health Protection Agency North West, UK
- Hessisches Sozialministerium, Germany
- Inter-American Coalition for the Prevention of Violence
- Medical Research Council of South Africa
- Ministry of Health, Belgium
- Ministry of Health, Jamaica
- North West Public Health Team, Department of Health, UK
- Centre for Healthy Human Development, Health Canada
To date, after having satisfactory demonstrated their clear commitment to a systematic, public health approach to violence prevention, the following organizations are now formal participants in the Alliance:

- Violent Crime Task Group, Cardiff Community Safety Partnership, Wales, UK
- International Physicians for the Prevention of Nuclear War, USA
- International Society for the Prevention of Child Abuse and Neglect, USA
- Murray Mallee Community Health Service, Australia
- National Public Health Service for Wales, UK
- Partners Against Violence/Partners for Healthier Community, USA
- Rehabilitation and Research Centre for Torture Victims (RCT), Denmark
- The Waitt Institute for Violence Prevention, USA

As of September 2005, negotiations around formal participant status were under way with an additional 14 governments and organizations from all WHO regions that had expressed interest in joining the Alliance.

Alliance members can:

- Share information and network with local, national, regional, and international agencies working towards a common goal at all levels, including resource mobilization, programming, policy and development;
- Participate in Alliance annual meetings (at their own cost);
- Contribute to Alliance product development and share their experiences and publications, communications and advocacy expertise with other Alliance members;
- Exchange information with other Alliance participants, including advertising upcoming or recent Alliance-related events through the network; participating in web-based discussions and contributing to and receiving Alliance work plans, meeting reports, press releases and publications;
- Use the Violence Prevention Alliance logo on communications and publicity materials, provided that each such publication is approved by the Alliance secretariat at WHO.

COUNTRY ACTIVITIES IN 2004–2005

Violence Prevention Alliance in Jamaica

The Minister of Health of Jamaica, the Honourable John Junor, launched the Jamaican Chapter of the Alliance at the 13th Annual Research Conference and Workshop on Violence and Violence Prevention in November 2004. At the launch, the Minister reiterated the importance of the public
health approach and multisectoral involvement in preventing violence. Dr Rodrigo Guerrero, founder of the Inter-American Coalition for the Prevention of Violence, addressed the participants on Collective efficacy and youth violence. He stressed the importance of finding solutions to youth violence from within communities themselves and reminded the group that violence is indeed preventable.

Under the slogan Joining hands to find solutions, the Jamaican Chapter of the Alliance has developed six objectives to guide its work. In line with the WRVH recommendations, it will strive to:

- increase collaboration and exchange of information on violence prevention;
- support the implementation and monitoring of existing and proposed national action plans for violence prevention;
- enhance capacity for data collection on violence;
- promote the primary prevention of violence;
- strengthen support services for victims of violence;
- support the integration of violence prevention into social and educational policies.

To implement these objectives, the Chapter created a steering committee and a working group with representatives from the Dispute Resolution Foundation, the Guild of Students, Jamaica Agricultural Society, Jamaica Council of Churches, Jamaica Music Federation, Jamaica Teachers Association, Medical Association of Jamaica, PAHO, WHO and the University of the West Indies. One of the working group’s first tasks was to set up agreements with each agency in support of its existing violence prevention programmes. The Alliance will, for its part, share best practices on data collection and prevention programmes, offer strategic guidance and facilitate the sharing of information and experiences with and between these groups.

**Violence Prevention Alliance in the United Kingdom**

Supported by WHO and the Violence Prevention Alliance, the Centre for Public Health at Liverpool John Moores University, the UK Department of Health, and the UK Health Protection Agency hosted a national conference on preventing violence. The conference took place in Liverpool, England in March 2005, and promoted a multi-agency approach to violence prevention in the UK. The conference was also a showcase for international and national expertise on a wide range of violence prevention issues such as violence and injury surveillance; research to
identify the underlying causes and risk factors for violence, interventions and outcome studies to identify what works to prevent violence, and the mainstreaming of violence prevention policy in different sectors of government and society. A highlight of the conference was the launch of *Violent Britain: people, prevention and public health*; a report on the costs and consequences of violence and recommendations on how existing policies and programmes can be better coordinated to strengthen violence prevention.
CONCLUSION: CHANGING THE FACE OF VIOLENCE PREVENTION

AS FEW AS 20 YEARS AGO, the problem of violence in all but a handful of countries was almost exclusively approached from criminological and criminal justice perspectives. The face of violence prevention was the face of the police officer, the prosecutor, the judge and the prison warden, and the dominant assumption was that incarcerating and punishing perpetrators of violence would deter would-be offenders from engaging in violent behaviour in the future.

October 2005 marked the third anniversary of the launch of the WRVH and the Global Campaign for Violence Prevention. In the past three years, a host of new governments and agencies have committed themselves to applying science-based approaches for the development of prevention measures. Some of these have completed comprehensive reviews of the scientific research on what types of intervention are effective in preventing violence. The findings of these reviews are highly convergent and concur with the WRVH conclusion that violence rates can be significantly reduced through well-planned and multisectoral strategies that tackle multiple causes, using frameworks such as the public health approach. Furthermore, these studies all express reservations on the soundness of increasing expenditures on the use of policing and corrections to reduce rates of violence, particularly because of the costs involved to achieve minimal returns.

The violence prevention objectives and achievements by countries, regions and international agencies working to implement the WRVH recommendations described in this report are part and parcel of a broader shift in the violence prevention paradigm. We are confident that future editions of this document will further elaborate and build upon the initial success and continue to adopt an integrated approach which will include public health practitioners, community nurses, educationists, social scientists and social policy experts alongside police and criminal justice practitioners.
ONE LOVE ONE HEART

VIOLENCE IS PREVENTABLE

DO IT FOR THE CHILDREN
Available from the Department of Injuries and Violence Prevention, WHO at 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

**Advocacy and communications materials**
- Posters: *Violence in red* (2002); *Explaining away violence* (2003); *Family Album* (2005)

**Violence and injury surveillance**
- *Injury surveillance guidelines*, 2001
- *Guidelines for community-based surveys on injuries and violence*, 2004

**Research**
- *The economic dimensions of interpersonal violence*, 2004

**Primary prevention**
- *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

**Health services for victims of violence**
- *Clinical management of rape survivors*, 2004
- *Guidelines for essential trauma care*, 2004
- *Pre-hospital trauma care systems*, 2005

**Capacity development**

Violence Prevention Alliance
www.who.int/violenceprevention
*Violence Prevention Alliance* (brochure) (2005)