

World Report on Violence and Health

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Introduction

This summary of the conference presentation made by a representative of the World Health Organization (WHO) has two objectives. The first objective is to provide a sense of the big picture painted by the *World report on violence and health* (Krug et al, 2002) so that readers will know what to expect when they study the Report itself. The second objective is to introduce the associated Global Campaign for Violence Prevention and indicate how readers can link up with this campaign, as a way of strengthening their own prevention activities whilst also contributing to increased global, regional and national awareness of the importance of investing in violence prevention.

Goals of the *World report on Violence and Health*

The *World report on violence and health* has three goals. First, to raise awareness that violence is a global public health problem and not only a problem for the police and justice departments, military commanders and international security councils that first come to mind when we hear the word violence. Secondly, the Report highlights the contributions of public health to understanding and preventing violence. The third goal is to increase the level of response taken by the public health community to preventing violence.

Content and Structure of the Chapters

The first chapter of the *World report on violence and health* provides a conceptual framework for understanding and preventing violence through a science-based, public health approach. It defines violence and presents a typology that breaks violence down into a number of distinct although causally related sub-types of violence. The chapter also defines what is meant by prevention, describes the public health approach and indicates the sources of information about violence and risk factors for violence that should be considered in any setting when prevention is being contemplated.

Violence has many faces, and after the first conceptual chapter the Report has seven topic-specific chapters, each of which deals with one of these different faces. Youth violence, largely occurring among persons aged 10-29 years, is one of the more visible forms of violence dealt with in the Report. One chapter deals with the most visible of all types of violence, namely collective violence, particularly armed conflicts. There is a chapter on sexual violence dealing with rape and other forms of sexual assault. One chapter focuses on suicidal behaviour, and there is a chapter on elder abuse, which is perhaps the most ignored of all types of violence. Violence by intimate partners, mainly involving the abuse of women by men, is another largely hidden form of violence that the Report addresses. The Report also covers child abuse and neglect by parents and caregivers. For each type of violence the Report presents the best available information on the magnitude and the impact of the problem; on key risk factors; on interventions and policy responses, including what has been scientifically shown to work in preventing each type of violence, and on recommended actions to build the knowledge base and strengthen the prevention capacity of communities, countries, regions and international networks.

After the topic-specific chapters there is a chapter on the way forward, which sets out nine general recommendations for violence prevention, which if effectively implemented would go a long way to reducing violence and making life safer for all. In addition, the Report includes a statistical annex with country and regional data from the WHO Database and Global Burden of Disease project for 2000, and a list of resources for violence prevention.

Defining Violence

The *World report on violence and health* defines violence as:

the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

This definition reflects extensive review of other definitions of violence and thorough consultation with international experts. While every word is important, it is worth emphasising that the definition identifies violence as including both threatened and actual physical force or power and that it does not limit violence to only those acts resulting in physical injuries but also includes psychological harm, deprivation and maldevelopment.

The definition of violence is complemented by a typology of violence. At the first level this differentiates between violence people inflict upon themselves, violence inflicted by another individual or small group of individuals, and violence inflicted by larger groups such as states. The three broad categories are further divided to reflect more specific types of violence. Self directed violence is divided into suicidal behaviour and instances of self-abuse. Interpersonal violence is divided into family and partner violence, and community violence. Collective violence is divided into social, political and economic violence. The typology also includes the nature of violent acts, which can be physical, sexual, psychological or involving deprivation or neglect.

Magnitude of the Problem

Deaths due to all types of violence. Deaths represent only the very tip of the violence iceberg. In 2000 there was a global total of over 1.6 million deaths due to violence. This was around half the number of deaths due to HIV/AIDS, roughly equal to deaths due to tuberculosis, somewhat greater than the number of road traffic deaths and 1.5 times the number of deaths due to malaria. Unfortunately, the size of the global violence problem is not matched by the investments to prevent it, and while investments in preventing AIDS, malaria and tuberculosis are to some extent commensurate with the size of the problem, investments in violence prevention fall well short of what they should be given its contribution to the global disease burden.

There were marked differences in the ratio of male to female deaths due to these five causes. For road traffic injuries the ratio was 2.8 males per female; for violence 2.3 males per female; and for tuberculosis 1.7 males per female. Equal numbers of males and females died of HIV/AIDS, and for malaria there were slightly more female than male deaths.

In the year 2000, and contrary to the impression created by the massive media coverage of collective violence, the largest number of violent deaths was due not to war but to suicide: 815,000 cases, or one suicide every 40 seconds. Interpersonal violence accounted for 520,000 deaths: or one murder per minute. There were 310,000 deaths directly due to collective violence or one war death every two minutes. The gender gap was smallest for suicides at 1.7 males per

female. Homicides killed 3.4 males per female, and war deaths accounted for 3 male deaths per female death.

Homicide. Homicide rates were highest in Africa, Latin America and central and Eastern Europe, and lowest in Western Europe and some countries in the western Pacific. Studies show a strong relationship between homicide rates, economic development and economic inequality with poorer countries (especially those with large gaps between the rich and poor) tending to have higher rates of homicide than wealthier countries. By age and sex there were marked differences in homicide rates. Gender differences were least marked for the age groups 0-4 and 5-14 years. For the age groups 15-29 and 30-44 male rates were four times as high as female rates and for the remaining age groups around 2.5 times as high as female rates. From age 15 onwards, female rates showed little difference between age groups while male rates varied substantially.

Suicide. Suicide rates show a very different geographical distribution to homicide rates. Except for central and eastern Europe which have high homicide and high suicide rates, the highest suicide rates occur in regions where homicide is lowest, and at the country level, wealthier countries tend to have higher levels of suicide than poorer countries (though, this may also reflect gaps in information; for example, there is very little information on suicide in Africa). Suicide rates showed a clear trend towards increasing gender differences with age. At 5-14 years rates for males and females were roughly equal, whereas from age 45 onwards, male rates were nearly twice as high as female suicide rates.

War deaths. Owing to the inadequacies of regional data on collective violence this presentation does not include a similar map of war deaths, although the Report notes that the rates of war deaths, like the rates of homicide, were lowest in high-income countries and highest in low- and middle-income countries.

Deaths are only the tip of the iceberg, and even in terms of knowing the real size of this tip, there is a very long way to go. In well over half the world's countries there is currently no adequate information about how many people are killed by violence. That means that the statistics presented here, which are based on actuarial burden of disease projections using the best available data, almost certainly underestimate the true extent of the problem.

Non-fatal injuries due to violence. Non-fatal health outcomes are a far more likely outcome of violence than death, and to count these cases one could begin by looking at cases reported to health agencies or to the police. Only a small proportion of cases are reported to both these contact points, and the Report reviews studies from several countries which show that for every victim reporting to the police at least two more report only to health agencies. A sense of the health burden this represents is given by the fact that for every young person murdered there are at least 20 to 40 other young people that receive hospital treatment for a violent injury.

A larger proportion of violence is reported in surveys and special studies, and it is here that for some forms of violence female victims outnumber male victims. These studies have shown, for instance, that the overwhelming burden of intimate partner and sexual violence is borne by women at the hands of men.

For example, one in five women versus one in ten men report being sexually abused as a child. For 90% of cases involving female victims of child sexual abuse the perpetrators are male, as they are for 70% of female child sexual abuse victims. Depending on the country and the study, about 1 in 3 women have been physically assaulted by an intimate partner at some point in their lives and sexually abused by a partner in one-third to over one-half of these cases. In some

studies of child abuse, nearly half of the parents interviewed reported that they had hit, kicked or severely beaten their children. Women more often reported using harsh physical discipline against children than men did, while men emerged as the most frequent perpetrators of abuse that inflicts life-threatening injuries on children.

About 4% and 6% of the elderly report having been abused in their homes by caregivers, with the Report showing that elderly males and females are equally at risk for being abused by spouses, adult children and other relatives. Many older citizens have also been subjected to abuse in institutions. Large numbers of women and girls have been bought and sold into prostitution or subjected to violence in schools, health care and refugee settings.

Unfortunately, a lot of violence never gets reported – whether due to fear, shame, the acceptance of violence as normal and therefore unremarkable, or the inadequacy of reporting and recording systems.

Other health outcomes of violence. Beyond counting the deaths and non-fatal injuries due to violence, the *World report on violence and health* also documents what is known about the other health effects of violence. These are many and include:

- physical consequences, such as gastrointestinal disorders and chronic pain syndromes;
- mental health consequences, such as depression, anxiety disorders and post-traumatic stress disorder;
- behavioural problems such as alcohol and drug abuse, eating and sleep disorders, unsafe sexual behaviour, smoking and other risk-taking behaviours;
- reproductive health consequences, such as infertility, gynaecological disorders, sexual dysfunction, unwanted pregnancies or pregnancy complications, and
- sexually transmitted infections, including HIV/AIDS.

In the case of collective violence, conflicts also destroy infrastructures and disrupt vital services such as immunization, medical care, and food production and distribution – contributing to infectious diseases and famine.

Economic Costs of Violence

The impact of violence is also evident in the economic costs it imposes on societies, which the *World report on violence and health* breaks down into direct and indirect costs. The direct costs of violence include, for example, the costs of emergency response and medical treatment (which in some countries, account for nearly 5% of the gross domestic product), law enforcement services and judicial services. Indirect costs arise from premature deaths, lost productivity, impaired economic development due to reduced investment and the loss of social capital, and other intangible losses. Combined direct and indirect costs can be staggering – for instance, the direct and indirect costs of gunshot wounds in the United States in 1992 amounted to US\$126 billion. By highlighting its costs violence can be seen as everyone's problem. The financial burden it imposes on societies is money that cannot be spent on community renewal, improving schools, or providing family social support services. Measuring the costs of violence is a critical area of investigation where far more work is required, especially in developing countries.

Causes of and Risk Factors for Violence

The Report leaves no doubt about the size of the violence problem. However, to prevent violence and reduce its consequences it is also necessary to understand the causes of violence. After reviewing hundreds of different studies a major finding of the Report is that no single

factor can explain why one individual, community or society is more or less likely to experience violence. Instead, it shows that violence is a complex phenomenon rooted in the interaction of factors ranging from the biological to the political. The Report captures this in an ecological model that organizes the risk factors for violence into four interacting levels: the individual level, close relationships, community contexts and societal factors.

- Individual-level risks include demographic factors such as age, income and education; psychological and personality disorders, alcohol and substance abuse, and a history of engaging in violent behaviour or experiencing abuse.
- The relationship level explores how relationships with families, friends, intimate partners and peers increase the risk of becoming a victim or perpetrator of violence by taking into account such factors as poor parenting practices and family dysfunction, marital conflict around gender roles and resources, and associating with friends who engage in violent or delinquent behaviour.
- The community level refers to the contexts in which social relationships occur such as neighbourhoods, schools, workplaces and other institutions, and seeks to identify the characteristics of these settings that increase the risk for violence – for example, poverty, high residential mobility and unemployment, social isolation, the existence of a local drug trade, and weak policies and programmes within institutions.
- At the societal level are broad factors that contribute to a climate in which violence is encouraged, including economic, social, health, and education policies that maintain or increase economic and social inequalities, social and cultural norms that support the use of violence, the availability of means (such as firearms) and weak criminal justice systems that leave perpetrators immune to prosecution.

Preventing Violence

The *World report on violence and health* shows how, in addition to the specific risk factors underlying each kind of violence, the different sub-types are linked by a set of common underlying risk factors. Some are psychological and behavioural characteristics such as poor behavioural control, personality and psychiatric disorders. Others are tied to experiences such as having family or personal histories marked by divorce or separation, a lack of emotional bonding and social support, and exposure to violence in the home (whether experiencing or witnessing family violence). Firearms are associated with most forms of violence. Alcohol and substance abuse are associated with all forms of violence, along with prevailing cultural norms, poverty, and inequalities as they relate to gender, other determinants of social position, and income.

These common underlying risk factors suggest a strong potential for prevention partnerships between groups that traditionally have tended to work in isolation – such as groups working on child abuse, on violence against women, on youth violence or on elder abuse – and between sectors that traditionally have operated independently of each other - such as education, health, justice and welfare. The building of prevention partnerships between different sectors to address underlying risk factors shared between different types of violence is a key theme that runs through the solutions that the Report presents.

Each chapter in the *World report on violence and health* reviews the preventive responses that have been tried and summarizes what is known about their effectiveness. Some examples of the

approaches targeting individuals, families, communities and societies described in the Report are listed below.

- Approaches for changing individual behaviour include pre-school enrichment and social development programmes, and vocational training and incentives to complete secondary schooling. These are designed to ensure academic success, manage anger, and build skills. Similar life-skills and educational approaches around issues of gender, relationships and power have been used to address physical and sexual violence against women.
- Among the most effective approaches described in the Report are those delivered in early childhood, such as parenting programmes, the provision of support and advice through home visitation in the first three years of a child's life, and family therapy for dysfunctional families. These approaches have been associated with reductions in child abuse and with long-term reductions in violent and delinquent behaviour among young people of both sexes.
- There are a number of measures that can be taken at the community-level, though few have been systematically evaluated, such as reducing the availability of alcohol, changing institutional settings (e.g., schools, workplaces, hospitals and long-term care institutions for the elderly) by means of appropriate policies, guidelines and protocols, and training to better identify and respond to the different types of violence, as well as improving health care and access to services.
- At the societal-level, accurate public information about the causes of violence, about its risks and preventability, is key to raising awareness and stimulating action; it is equally important to strengthen law enforcement and judicial systems, to implement policies and programmes to reduce poverty and inequalities of all kinds, and improve support for families. It is also important to reduce access to the means of violence and promote adherence to international treaties.

Overall, the scientific evidence for effective prevention is strongest for child abuse, youth violence and suicide and weakest for intimate partner and sexual violence and elder abuse. This imbalance almost certainly reflects the fact that systematic evaluation studies have been conducted more frequently for programmes aimed at preventing child abuse, youth violence and suicide than for the other types of violence.

Role of Public Health in Multisectoral Prevention

Because the risk factors for violence and the responsibility for implementing prevention programmes are spread across many different societal sectors, public health is just one of the sectors that should be involved in providing the solution. Others include welfare, education, employment, police, diplomacy and justice. Within this mix of sectors, the Report shows that the role of public health should be to add value by assisting with:

- data collection through mortuary, coroner and medical examiner reports, health agency records, surveys and other surveillance mechanisms;
- research into the underlying causes and risks for violence;
- prevention, by promoting a primary prevention approach and contributing advice on how to design, implement and disseminate prevention programmes;
- evaluation, by applying public health methods to determine the most effective responses;
- policy development;
- the provision of more effective medical and psychosocial services for victims of violence;

- advocating for prevention using the information at its disposal about the magnitude of the violence problem and about its preventability.

Recommendations for Violence Prevention

Over and above the many specific recommendations made in each chapter, the concluding chapter of the *World report on violence and health* makes nine general recommendations for preventive action.

Six recommendations suggest country-level actions for prevention, including:

- creating, implementing and monitoring a multisectoral national action plan for violence prevention;
- Enhancing capacity for collecting data on violence;
- Defining priorities for and supporting research on the causes, consequences, costs and prevention of violence;
- Promoting primary prevention responses;
- Strengthening responses for victims;
- Integrating violence prevention into social and educational policies and thereby promoting gender and social equality.

Three recommendations promote international prevention actions, including:

- Increasing collaboration and exchange of violence prevention information;
- Promoting and monitoring adherence to international treaties, laws and other mechanisms to protect human rights;
- Seeking practical, internationally agreed responses to the global drugs trade and the global arms trade.

WHO Global Campaign for Violence Prevention

Following the 3 October 2003 launch of the *World report on violence and health* in Brussels, Belgium, Dr Gro Harlem Brundtland, Director-General of WHO, launched the Global Campaign for Violence Prevention. The objectives of this campaign are:

- to raise awareness about violence as a major public health problem, including raising awareness about the impact of violence on public health and the role that public health can play in the prevention of violence;
- to campaign for increased human and financial resources for violence prevention at local, national and international levels.

The Campaign aims to promote discussion and debate about violence and concrete ways of implementing the Report's recommendations. Up to the end of the year 2002, 18 national or regional releases of the Report had taken place, with strong support from WHO regional and country offices. These launches bring together the various sectors involved in violence prevention, and provide a useful means for highlighting the impact of violence in the particular country or region and discussing prevention activities at national and community levels.

As of January 2003, some 15,000 copies of the Report had been disseminated – to Ministries of Health, WHO Collaborating Centres, non governmental organizations, libraries, academic journals and commercial book distributors throughout the world. A number of educational institutions have announced that they will use the Report as required reading for their courses. In

In addition, extensive media coverage has been important in spreading the Report's messages. More than 500 press articles on the Report have already been published in over 50 countries. The Report has also stimulated discussion on violence as a public health issue in the scientific press. Some 20 editorials, articles or reviews have appeared in leading journals such as the *Australian and New Zealand Journal of Public Health*, the *British Medical Journal*, the *Indian Journal of Medical Research*, *Injury Prevention*, *The Lancet*, and the *South Africa Medical Journal*, with more articles scheduled for the year 2003 editions of journals such as *Health and Human Rights*, *Paediatrics* and the *International Journal of Mental Health*.

Looking ahead, to the first half of 2003, a number of important events have been planned.

- In mid-January 2003, the WHO Executive Board will discuss the *World report on violence and health* and consider a proposed World Health Assembly resolution on implementing the Report's recommendations.
- Some ten countries – including Croatia, Jamaica, Jordan and Thailand – have proposed or are committed to hosting country launches.
- The WHO office at the United Nations in New York is planning to hold a major event on violence on 30 January 2003, in collaboration with the Permanent Mission to the UN of Costa Rica and a number of non governmental organizations attached to the UN.
- The African Union has indicated that it may propose a resolution on violence prevention based around the Report's recommendations.

Conclusion

In conclusion, everyone, in his or her own way, is invited to join the Global Campaign for Violence Prevention. As Gro Harlem Brundtland wrote in her contribution to the interactive exhibition accompanying the GTZ conference:

Violence against women is violence against all of humanity. It stunts our potential for health and development. Violence against women is not some abstract force. It is close by. We all have to contribute to defeating it.

Reference

Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R (eds.). *World report on violence and health*. Geneva: World Health Organization; 2002.

Obtaining the *World report on violence and health*

The *World report on violence and health*, edited by

E. Krug, L. Dahlberg, J. Mercy, A. Zwi, and

R. Lozano is available in PDF format at: http://www.who.int/violence_injury_prevention/

or can be ordered by writing to bookorders@who.int.

Contacting the Global Campaign for Violence Prevention

For more information on the Campaign visit http://www.who.int/violence_injury_prevention/ or contact Sabine van Tuyl, Communications Officer, Injuries and Violence Prevention, WHO, CH-1211 Geneva 27, Switzerland; tel: +41 22 791 3342; e-mail: vantuyls@who.int

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