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FRAMEWORK FOR
INTERPERSONAL VIOLENCE PREVENTION
FRAMEWORK DEVELOPMENT DOCUMENT

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EXECUTIVE SUMMARY

Interpersonal violence refers to ordinary, everyday violence against children and women and the elderly, among young men in urban settings, and within institutions, including schools and workplaces. Although less prominent in the media than the violence associated with war, its toll is equally destructive. This document is a discussion paper aimed at initiating the development of a prevention framework to consolidate the public health contribution to reducing the disease burden arising from deaths and injuries due to interpersonal violence. The development process will run from August 2001 to mid-2003, after which a final framework document will be prepared in the hope of submitting it to the 2004 World Health Assembly.

The proposed framework for interpersonal violence prevention aims to improve the co-ordination of prevention activities across all levels and sectors and in all regions and countries of the world. The framework is intended to provide guidance to countries and donor agencies interested in investing in interpersonal violence prevention. It will do this by providing for the strengthening of national action and promoting an international prevention response that mobilises the strongest possible collaborative, multilateral action. This framework will serve as the platform for future work on interpersonal violence prevention, by laying the ground for a wide-ranging and systematic programme that connects violence prevention resources with the regions, societies and communities that need them the most.

The framework once developed will specify the elements that societies should develop for interpersonal violence prevention to occur. It will identify these elements through studies of good and promising prevention practices, and will locate them within the context of international initiatives for preventing interpersonal violence. The framework development process will aim at creating a strong impetus for violence prevention through the stimulation of policy development processes, commissioning of advocacy documents, and conduct of case studies in selected countries.

This document begins by reviewing the forthcoming World Report on Violence and Health (due for publication in September 2002), which it is anticipated will create a demand for information about how to do prevention. It then addresses the definition of interpersonal violence and prevention, and lists the main underlying risk factors. Next, the document specifies the technical competencies and social conditions that must be met for interpersonal violence prevention to occur. The document then identifies the different levels of social organisation at which violence prevention may occur. The competencies and social conditions for prevention are then linked to the different social levels at which interpersonal violence prevention activities can be initiated. The resulting matrix is the framework for prevention.

By way of illustration, the framework is then applied to evaluate what seems to be in place at the international level, and to specify what is needed to satisfy the requirements for interpersonal violence prevention at this level. Finally, the document describes a strategy by which the framework contents will be filled out by conducting situation analyses at country and community level, and through input from a number of parallel projects for the evaluation of global and national capacity for interpersonal violence prevention.

The term interpersonal violence refers to the everyday violence of everyday life – sexual violence; homicide; fights between youths; child abuse and neglect; domestic violence; abuse of the elderly; violence in the workplace; violence committed during robberies and other crimes, and so on. Interpersonal violence is the ‘hidden face’ of violence - although it does not command anywhere near the same media coverage and investment in prevention as acts of terror and war, it produces as much if not more damage to societies, to communities, and to the fabric of inter-group relations. It is therefore imperative that the profile of interpersonal violence as a preventable problem be increased by focusing upon it as something distinct from, although not unrelated to, war and self-directed violence, and by providing decision makers with the knowledge of its preventability and guidelines for how to prevent it.

This document aims to stimulate thinking about a framework that will enhance interpersonal violence prevention efforts at community, national, regional and international levels around the world. The framework should provide a conceptual scaffold to organise thinking about prevention and will add value by:

1. Mapping some of the underlying risk factors that should be addressed and the technical competencies required for effective interpersonal violence prevention at different levels of society and identifying links between the levels
2. Specifying the resources required for implementing systematic investment in prevention across all levels
3. Outlining the potential preventive roles of sectors and settings within a specific level and showing how to improve the co-ordination of actions between them

Special efforts will be made to ensure that the framework development process incorporates the insights and experiences of violence prevention workers in countries at all levels of socio-economic development. It is imperative that the framework is as fully relevant to the low- and middle-income countries that often have the most interpersonal violence and fewest resources, as it is to high-income countries with comparatively little interpersonal violence and large resources.

Outline of the Anticipated Framework Document

The framework for the prevention of interpersonal violence will be a document that provides guidance for establishing the conceptual, advocacy, policy and practical foundations for prevention programmes that address the risk factors common to specific sub-types of interpersonal violence. Guidelines for the prevention of specific sub-types of interpersonal violence (e.g. child abuse and neglect, intimate partner violence, youth violence and elder abuse) will not form part of the framework document. The development of such guidelines is ongoing, and the framework is intended to enhance the effectiveness of specific prevention programmes by addressing risk factors and identifying prevention strategies common to the different sub-types of interpersonal violence.

The framework should function as a map by which prevention agencies can assess their current position in relation to the necessary or ideal conditions for the prevention of interpersonal violence, and on the basis of the assessment define what they should do next in order to move closer to the ideal conditions.

The conceptual dimension of the framework must address definitional issues in relation to interpersonal violence and prevention and identify risk factors that cross-cut the different sub-types of interpersonal violence. It should include a logic model that sets out the technical competencies needed to do prevention. It should highlight the need to address prevention at multiple levels of social organisation, and the importance of involving a broad spectrum of sectors and disciplines.

The policy dimension of the framework must identify the scope of potential areas for policy interventions, defined in terms of the risk factors contemplated for policy change, and on the basis of the societal levels implicated in the targeted risk factors.

The advocacy dimension of the framework must spell out what kinds of information, what types of lobbying activities, and which partners should be involved in attempting to secure the political will to initiate interpersonal violence prevention activities and to allocate the necessary human and financial resources for the long-term continuation of interpersonal violence prevention programmes.

The practical dimension of the framework must provide concrete examples of interpersonal violence prevention at different levels of societal organisation and in settings at different levels of socio-economic development. These examples should serve as models for those interested in establishing interpersonal violence prevention programmes in their own settings and should clearly show how prevention concepts are used to inform concrete prevention activities.

The framework for interpersonal violence prevention is targeted at a diverse audience. At the country level, it is aimed at government policy and decision-makers in sectors such as health, justice, welfare, education and home affairs at national, state/provincial and municipal levels. Also at the country level, it is aimed at public health researchers, NGOs and civil society organisations interested in doing prevention work and/or advocating for the prevention of interpersonal violence. At a regional level, the framework is targeted at economic and political blocs representing the shared interests of neighbouring countries. At an international level, the framework is aimed at all international agencies with activities that relate to the prevention of interpersonal violence, both directly (e.g. UNICEF efforts to prevent child abuse and neglect) or indirectly (e.g. World Bank interventions to reduce economic inequalities). These international agencies include all United Nations agencies, international NGOs, and donor countries that sponsor UN activities and provide bilateral support to countries. Internationally, the framework is also targeted at researchers in the fields of public health, safety and human security.

Because the framework is a WHO initiative (see Appendix I), it will foreground the public health orientation that WHO promotes for the prevention of violence (see Appendix II, III). However, because the public health approach advocates for multi-disciplinary and multi-sectoral prevention strategies, it is hoped that the framework development process will reflect the inputs of all stakeholders, and that the final document will be a resource for everyone interested in more effective violence prevention.

NEED FOR AN INTERPERSONAL VIOLENCE PREVENTION FRAMEWORK

Through the lens of a public health approach, the *World Report on Violence and Health* (due for publication in September 2002) has provided a global snapshot of how violence in the late 1990s affects societies and individuals, and, to a lesser extent, how societies have responded to the impact of violence.

The report shows that in 1998 an estimated 2.3 million people died as a result of violence. This was equivalent to 4% of all deaths in the world. Of these violent deaths, 26% were due to war, 32% resulted from interpersonal violence, and 42% were suicides. The violent death rate in low- to middle-income countries where interpersonal violence and war were most concentrated was over twice that in high-income countries (where suicide predominated). Country studies show that rates of youth homicide resulting from interpersonal violence are over 30 times higher in the poorest communities that have the fewest resources to cope with the financial, social and psychological strains produced by such deaths.

Fatalities represent only a fraction of the full violence problem, and there are many non-fatal cases for every death due to violence. Globally, the report estimated that 40 million children are abused each year, and one out of every three women will experience intimate/partner violence in her lifetime. While deaths and non-fatal injuries due to violence affect people of all ages and in all walks of life, the majority of victims and perpetrators are aged between 15 and 40 years. This age range spans the period of greatest economic productivity, and for every one of the thousands of millions of dollars spent on direct medical care for victims of violence many times more are lost due to indirect factors, such as time away from work and disruption of family routines.

The report shows that the root causes of violence and the majority of its consequences are scattered across different parts of society involving many areas of social, economic and political life. This broad distribution of the causes and consequences of violence is replicated in the equally wide scattering of prevention efforts. Groups as diverse as world economic agencies, human rights organisations, national governments, non-governmental agencies, local self-help groups and concerned individuals initiate prevention activities. Motivations for getting involved, definitions of the problem, prevention strategies, and the evaluation mechanisms employed are as numerous as the groups involved. The outcome is a piecemeal response with little discernible impact at the population level.

The *World Report on Violence and Health* does, however, identify some well-documented examples of outstanding successes in preventing interpersonal violence. These include early developmental interventions that significantly reduce the likelihood of perpetrating violence up to age 15 years, youth mentoring programmes and comprehensive city-wide interventions that reduce gunshot homicides through a combination of community mobilisation and directed policing. Added to these success stories are dramatic differences within and between societies in the levels of interpersonal violence, which strongly suggest that violence can be prevented. For instance, in Japan homicide rates for males aged 10 to 24 years dropped from nearly 3 per 100,000 in 1950 to just over 0.5 per 100,000 in 1990, whereas in the US over the same period rates increased from around 3 to over 12 per 100,000.

The existence of successful interpersonal violence prevention initiatives within a context of energetic though un-orchestrated prevention activities suggests that now is the time to act. The passion for interpersonal violence prevention is evident from the number and diversity of prevention efforts. The possibilities for success are shown by the scientifically evaluated success stories. The two must be combined, and achieving this combination is a major goal of the framework for interpersonal violence prevention.

AIMS OF AN INTERPERSONAL VIOLENCE PREVENTION FRAMEWORK

The framework for interpersonal violence prevention aims to consolidate the public health contribution to reducing the global disease burden arising from deaths and injuries due to interpersonal violence. It aims to serve as the platform for the global public health community's future work on violence prevention, by laying the ground for a wide-ranging and systematic programme that connects interpersonal violence prevention resources across disciplines and with the regions, societies and communities that need them the most. The framework will identify some of the major risk factors that should be addressed, and specify the technical competencies that societies should aim for in order to increase the likelihood of being able to effectively prevent or reduce interpersonal violence. It will identify these competencies through studies of good and promising practices, and will locate them within the context of regional and global initiatives for the prevention of interpersonal violence.

At **national level**, the framework for interpersonal violence prevention aims to strengthen prevention capacity by providing scientific guidelines and technical information on how to establish the knowledge, policies and practices needed to effectively prevent interpersonal violence. Recommendations for strengthening national action should stress the importance of setting up systems and institutions that can serve all phases of the public health response to interpersonal violence (surveillance, analysis of the determinants of violence, intervention evaluation and programme implementation), while also highlighting the need for multi-sectoral co-ordination to ensure parallel developments in the government and civil society sectors expected to deliver broad-band interventions that fall outside of the health sector's direct responsibility (e.g. social welfare; job creation; criminal justice).

At **international level**, the framework for interpersonal violence prevention aims to highlight the prevention potential of resources that to date have received little attention from the prevention community (e.g. international law and human rights), and to show the value of strengthening existing areas of work (e.g. international comparative research and the building of networks for improved communication between national and international stakeholders).

MOVING FROM A PROBLEM FOCUS TO A PREVENTION FOCUS

The challenge of developing an interpersonal violence prevention framework is to match the existing focus on problem definition and description with an equivalent focus on identifying solutions and finding ways to unlock the prevention potential of the many agencies that can contribute to prevention.

To create a prevention focus this section first defines interpersonal violence, lists the risk factors common to different sub-types of interpersonal violence, provides a model of interpersonal violence, and defines prevention. Next, it sets out the logical and social conditions that if met should increase the likelihood of prevention activities being undertaken. These conditions suggest the technical competencies that societies need to develop in order to effectively prevent interpersonal violence. Third, this section identifies the different levels of social organisation at which prevention may occur. Fourth, the risk factors and technical competencies required for prevention are linked to the different ecological levels at which violence prevention activities can be initiated. The resulting matrix constitutes the framework for prevention.

Interpersonal Violence, Risk Factors and Prevention

Interpersonal Violence

According to WHO violence is defined as:

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

Within this definition, three broad sub-categories of violence are identified: self-directed violence, interpersonal violence, and collective violence. The prevention framework is directed at interpersonal violence, which includes:

- a) Family and partner violence occurring between family members and intimates;
- b) Violence between acquaintances and strangers that is not intended to further the aims of any formally defined group or cause.

Family and partner violence includes child abuse, intimate partner violence, and elder abuse. Acquaintance and stranger violence includes stranger rape or sexual assault, youth violence, violence occurring during property crimes, and violence in institutional settings such as schools, workplaces, and nursing homes.

Self-directed and collective violence are not addressed by the framework because of differences associated with their causation relative to interpersonal violence. Self-directed violence (which includes suicide and self-mutilation) has certain individual risk factors that are different from those associated with events where violence is aimed at others. Collective violence is usually characterised by a common goal within the group or entity that perpetrates or reacts to the collective violence. This goal is frequently of a political nature and includes violent acts between groups within a nation-state or between nation-states. But violence in the course of organized crime is also often orchestrated around common goals, and it is therefore difficult to separate acts of violence so distinctly. Violence presents itself more as a continuum where both groups and individuals can perpetrate and be subject to multiple different forms of violence depending on specific circumstances. Increasingly, the synergies between different forms of violence are becoming more evident, to reveal how individuals can belong to groups that conduct acts of collective violence, while at the same time they participate in acts of

interpersonal violence such as child abuse, youth violence or domestic violence, and may even engage in self-directed violence.

The classification of violence into collective, interpersonal, and self-directed sub-types is mainly done for institutional and operational purposes. However, given the increasing evidence that different types of violence appear to feed off one another, it is plausible that focusing on interpersonal violence prevention may also have a beneficial effect on preventing other forms of violence, and that programmes to prevent collective and self-directed violence could help reduce interpersonal violence.

Risk Factors for Interpersonal Violence

Knowing the risk factors for interpersonal violence is central to its prevention, since, as defined below, prevention involves intervening to eliminate or otherwise modify the influence of risk factors so that the likelihood of violence is reduced. This section therefore identifies some of the risk factors that are common to the different sub-types of interpersonal violence.

Risk factors for interpersonal violence are defined as factors that predict a high likelihood of violence. Table 1 is derived from a review of the scientific literature on risk factors for five main sub-types of interpersonal violence: child abuse and neglect; youth violence; intimate partner violence; sexual violence and elder abuse. Table 1 groups the identified risk factors by the level at which they influence violence into individual, family, community and societal levels. A total of 53 risk factors are listed for all 5 types of interpersonal violence combined. By defining cross-cutting risk factors as those implicated in three or more sub-types, 15 shared risk factors are identified (see Table 2).

This mechanical approach to identifying shared risk factors would have omitted firearm availability because this was listed only for youth violence. However, the empirically documented relationships between firearm availability and indicators such as homicide, long-term mental and physical disability and violence related to property crimes (e.g. burglary, car-theft, kidnapping and bank robberies) are powerful, and through the generation of fear and insecurity firearm-related interpersonal violence exerts a socially destructive effect far larger than that to date revealed in quantitative studies. Accordingly, firearm availability is listed in the World report as a cross-cutting risk factor, and is included in the list of shared risk factors (see Table 2).

Probably because most scientific investigations of interpersonal violence have been conducted in stable and intact states, the literature review also failed to identify the role of war in leading to post-conflict increases in interpersonal violence. Conflict and post-conflict societies show increased levels of civilian gunshot injuries, and anecdotal evidence suggests that there may also be post-conflict increases in sexual violence. Because war destroys the social fabric and amplifies economic inequalities, there are in addition to these epidemiological reasons strong theoretical grounds to assume that it will increase

Table 1. Risk Factors for Five Main Types of Interpersonal Violence*

RISK FACTORS	TYPE OF INTERPERSONAL VIOLENCE				
	CAN	YOUTH	INT. PART.	SEXUAL	ELDER
INDIVIDUAL LEVEL					
Male	P	P V	P	P	
Delivery complications at birth	P V	P			
Low heart rate		P			
Hyperactivity		P			
Impulsiveness		P	P		
Poor behavioural control	P	P			
Low IQ/poor school performance		P	P		
Young age	P V	P V	P	V	
Delinquent behaviour at 15 years		P	P		
Victim of child abuse and neglect	P V	P	P V	P V	
Problem drinking / substance abuse	P	P	P	P V	P
Mental health problems				V	
Involvement in sex work				V	
Personality disorder			P		P
Low self-esteem / sensed inadequacy	P	P			
Depression			P		P
Ideologies of male sexual entitlement				P	
Adversarial sexual beliefs				P	
Unwanted child	V				
Flawed knowledge about human development	P				
FAMILY LEVEL					
Male dominated household			P		P
Poor parental monitoring	P		P		
Marital discord	P	P	P		
Family isolation	P				
Parental conflict involving use of violence	P	P	P	P	
Poor parent-child bonding	P	P			
Teenage mother		P			
Single parent home	P	P			
Household crowding	P				
Family responses to sexual violence focused on restoring honor and blaming woman				P	
Low socio-economic status family	P	P	P		P V
COMMUNITY LEVEL					
Sexually aggressive peers				P	
Delinquent friends		P			
Urban		P			P V
High-crime community of residence	P	P			P
Drug-dealing community		P			P
High proportion of youth involved in gangs		P			
Tolerance of sexual violence				P	
Low social capital in community	P	P	P	P	
SOCIETAL LEVEL					
Rapid social change		P	P	P	P
Economic inequality	P	P	P		
Poverty	P	P	P	P	
Impunity from legal sanctions	P	P	P		
Lack of effective governance		P			
Weak economic safety nets	P	P	P		P
Culture of violence		P	P	P	P
High frequency of firearms		P			
Unemployment	P				P
Limited/no access to divorce			P		
Intimate relationship with a man				V	
Ageism					P
Gender inequalities	P V	P V	P V	P V	

* Based on findings reviewed in the World Report on Violence and Health. P – Perpetrator; V – Victim.

Table 2. Risk Factors for Interpersonal Violence

Individual
Victim of child abuse and neglect ¹
Alcohol / substance abuse problem ¹
Youthful ¹
Male ¹
Family
Marital discord ¹
Parental conflict involving use of violence ¹
Low socio-economic status of household ¹
Community
Low social capital in community ¹
High crime levels in community of residence ¹
Low access to medical care/inadequate medical care ²
Situational factors ²
Societal
Rapid social change ¹
Economic inequality ¹
Poverty ¹
Weak economic safety nets ¹
Poor rule of law and high corruption ¹
Culture of violence ¹
Gender inequalities ¹
High firearm availability ¹
Punitive response to perpetrators ²
Conflict/post-conflict ²
1. Risk factors applying to 3 or more sub-types of interpersonal violence as reported in the World Report on Violence and Health
2. Risk factors identified through other studies.

interpersonal violence of all kinds. “Post-conflict” was thus added to the list of societal-level risk factors.

Another group of risk factors not reflected in the literature review concern responses to victims and perpetrators of interpersonal violence after the occurrence of violence. Low access to medical care is associated with higher fatality rates and greater disability among severely injured victims and perpetrators. Therefore, although it conditions the severity of violent injury rather than the likelihood of violence “low access to medical care/inadequate medical care” was added to the list of shared risk factors. Finally it is argued that punishment, whether by public shaming or through legally mandated systems of punishment is among the most powerful stimulants for violence yet discovered. The risk factor “punitive response to perpetrators” were thus added to the list of shared risk factors.

A final group of risk factors that were added to Table 2 are the situational determinants of interpersonal violence. These influence the probability of interpersonal violence occurring in the “here and now”, and include characteristics of the physical environment

(e.g. dark streets, no telephones) and the social context (e.g. bystander provocation, routine activities).

A Model of Interpersonal Violence

To identify opportunities for the prevention of interpersonal violence it is important to have a model of how risk factors and situational determinants have independent, additive, interactive, and sequential effects.

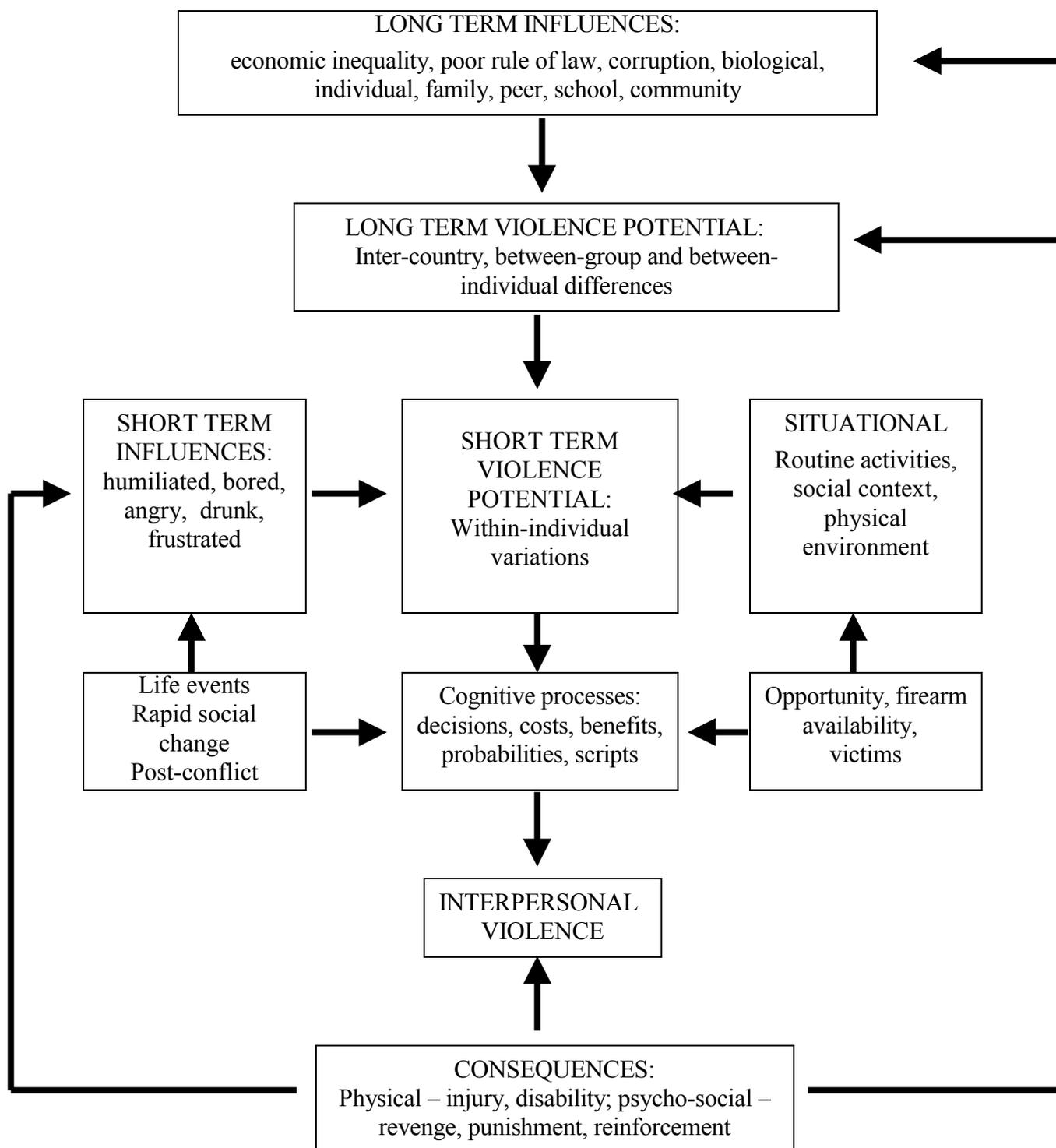
A model of interpersonal violence, shown in Figure 1, is intended to be consistent with existing theories and with knowledge about risk and situational factors. The model suggests that interaction between long-term influences (e.g. economic inequalities, biological, psychological/personality, community) lead to the development of long-term, fairly stable differences between countries, between groups, and between individuals in the potential for interpersonal violence. Superimposed on these long-term differences in violence potential are short-term within-individual variations in violence potential. The short-term variations depend on short-term motivating influences such as feeling humiliated, being bored, angry, drunk or frustrated, and on situational opportunities, including the availability of firearms and potential victims. These short-term variations may also be influenced by rapid social change leading to greater exposure to risks such as substance abuse, criminal opportunity and firearms.

Faced with an opportunity for violence, whether a person actually is violent depends on cognitive (thinking) processes, including considering the subjectively perceived costs and benefits of violence and their associated subjective probabilities or risks, and taking account of stored behavioural repertoires. It is also assumed that the consequences of violence (physical injury, punishment, desire for revenge, etc.) can have feedback effects in a learning process on long-term violence potential at the individual level (e.g. by influencing subjective perceptions of costs, benefits, and probabilities), and can impact at the societal level on the long-term influences (e.g. by leading to increased economic inequalities).

This model attempts to integrate developmental and situational theories about interpersonal violence. The interaction between the individual and the environment is seen in decision-making in criminal opportunities, which depends both on the underlying potential for interpersonal violence and on situational factors (costs, benefits, probabilities). Also, the double-headed arrow shows the possibility that encountering a tempting opportunity may cause a short-term increase in violence potential, just as a short-term increase in potential may motivate a person to seek out an opportunity for violence. The theory includes cognitive elements (perception, memory, decision-making) as well as the social learning and causal risk factor approaches.

This model goes some way to helping understand the dynamics of discrete violent events and identifying the interactions between long- and short-term factors that can be targeted to reduce violence. However, an additional layer of multi-level analysis is required to better show the interaction between different types of long term influences and the pathways linking long-term risk factors to the perpetration of violence.

Figure 1. A Model of Interpersonal Violence*



*Adapted from Mercy J, Farrington D, Butchart A, Cerda M. Youth violence as a global public health problem. Unpublished draft manuscript, 1999.

Prevention

Prevention means to stop violent events from occurring through activities specifically aimed at disrupting the risk factors for and situational determinants of violent events. Prevention must be distinguished from unintended developments that increase or reduce the frequency or severity of the target events independently of planned actions.

Prevention strategies and programmes can be classified along two dimensions. The first dimension concerns time, and classifies interventions according to where they are located in the chain of risk factors and situational determinants that stretches from long before the occurrence of violence to long after the attack has occurred and into the consequences incurred by victims and perpetrators. The second dimension concerns the level of social inclusiveness, and ranges from prevention strategies that target everyone to interventions that address victims and perpetrators only.

On the time dimension, primary, secondary and tertiary prevention levels are identified. Primary prevention includes any strategies or actions aimed at stopping violent events from taking place, and thus relate to the time before violence actually occurs. Secondary prevention includes any strategies aimed at minimising the harm that occurs once a violent event is taking place and examples include interventions to reduce the duration of an interpersonal violent event. Tertiary prevention includes all efforts aimed at treating and rehabilitating victims and perpetrators and facilitating their re-adaptation to society, and is thus concerned with the period after violence has occurred.

On the dimension of social inclusiveness, universal, selected and indicated levels of interventions are identified. Universal interventions effect everyone without regard to risk for violence. For example, the enactment and enforcement of laws to regulate access to firearms and the consumption of alcohol. Selective interventions target people at enhanced risk of violence only, such as parent training and home visitation for families in low-income and low-resource settings. Indicated interventions are applied to individuals and groups that have already demonstrated violent behaviour and/or been victimised by perpetrators of violence. For example, programmes that counsel victims and perpetrators after violent events in an effort to reduce re-victimization and repeat offending.

Competencies Required for Interpersonal Violence Prevention

To prevent interpersonal violence the experience of successful prevention programmes and a logic model for prevention suggest that a number of core competencies must be present at national, regional and international level. These competencies include technical abilities making up the chain of prevention, and the advocacy skills and resources needed to build the will to prevention.

The Chain of Prevention

The logic of violence prevention is the same as the logic underlying the prevention of any other injury cause, and can be depicted as a chain of five necessary conditions.

- i. That interpersonal violence is *predicted*
- ii. That the *risk factors* of the violent events are known
- iii. That *agents* potentially able to influence the causes exist

- iv. That the predicted events and known causes are *communicated* to those agents
- v. That the agents *act to disable the risk factors* of the predicted violent events

By specifying the conditions necessary for interpersonal violence prevention to occur as a set of logical rather than technical necessities, the framework opens itself to the possibility that there are a number of different ways in which each condition can be met.

Prediction is fundamental to prevention and refers to the ‘forecasting’ of violence. In the public health approach, the prediction of violence is usually accomplished at the aggregate level through epidemiological surveillance that uses past patterns of risks and violent events to forecast the future distribution of violence in respect of time, place, person and cause. However, interpersonal violence might be also predicted on the basis of local experience of the daily, weekly and monthly cycles of social behaviour (e.g. ‘there’s always fighting at the beer hall on pay days’).

Knowing the risk factors for interpersonal violence is more complex than predicting the occurrence of violence, since although many have been identified repeatedly across different studies and in different settings (as shown in Table 2), the mix of risk factors that drive interpersonal violence will vary from place to place. Furthermore, many risk factors are counter-intuitive or located at an aggregate level (e.g. economic inequality) that cannot be understood by studying individual behaviours. This creates the possibility that actions which at an individual level seem to confer preventive value (e.g. staying at home in order to avoid public spaces and evade the threat of stranger rape) may elevate the risk of other types of interpersonal violence (e.g. by increasing the likelihood of intimate partner violence).

Agents potentially able to prevent interpersonal violence range from individual citizens to international agencies. The prevention potential of an individual, group or organization depends upon the scale of prevention and the nature of the risks targeted for modification. Ordinary citizens acting as individuals could, for instance, prevent individual violence incidents by stopping themselves or those they interact with from entering high-risk situations or engaging in risky behaviours. Of course, the extent to which individuals do engage in preventive behaviour will be shaped by their threshold of acceptance for violence, which itself is a function of society-wide risk factors that impact on personal emotions around violence and attitudes towards it. By contrast, the creation and enforcement of firearm laws to achieve universal prevention necessitates the involvement of parliamentary and government agencies (such as the judiciary and the police). As a final example, where inter- and intra-national economic inequalities are among the risks driving interpersonal violence, regional and international organisations may represent the most likely source of preventive intervention.

The logical requirement that information about predicted violence and known risk factors is communicated from the entities (e.g. communities, research agencies) that do the prediction to the potential prevention agents may be particularly difficult to meet when the two sets of agencies represent competing interests or constituencies. For instance, where the prediction and analysis of interpersonal violence is carried out by an academic or non-governmental institution that is perceived as antagonistic by government, government agencies are unlikely to be receptive to such information.

The chain of prevention is complete when the prevention agents take concrete actions to modify the identified causes and risks. Supports for prevention include policies for interpersonal violence prevention that specify prevention targets, define responsibilities for action and ensure its inclusion in official budgets. Barriers to realising this condition include weak and disorganized structures of governance, corruption, lack of awareness and knowledge about the prevention of interpersonal violence, and a lack of political will to engage in prevention.

The Will to Prevention

Given the complexity of the world in which violence prevention occurs, the sequence of prevention elements as set out in the chain of prevention is rarely followed. Both the scientific definition of violence and the logic of prevention compete with divergent and even opposing perceptions, practices and interests. For instance, citizens may consider that increased safety is provided by greater access to firearms, while prevention agents may consider firearms a major risk for the severity of violence and so aim at reducing their availability. Because of this potential for conflict, violence prevention requires that the different interests, disciplines, practices and perceptions be identified as a basis for developing strategic alliances with the other agents. The creation of such alliances is essential to what can be termed the will to prevention, and building the will to prevention is perhaps the most complex and difficult aspect of the prevention process. The will to prevention requires that two conditions be met.

- i. The *benefits* (ethical, economic, social, political) of disrupting or eliminating the causes of violent events must be seen by potential prevention agents to outweigh the costs (ethical, economic, social, political) of their continuation
- ii. The activities aimed at the causes must be seen by potential prevention agents as highly likely to be *effective*

Demonstrating that the benefits of preventing interpersonal violence outweigh the costs of its continuation requires advocacy on a number of fronts. For instance, increasing the political costs of interpersonal violence may require the emergence of broad-based citizen movements to convey popular dissatisfaction with government over the matter. Showing the ethical costs of interpersonal violence could require linking its occurrence and the distribution of risk within society to rights-based arguments for social justice. Arguments for the economic benefits of preventing interpersonal violence would require information about its direct and indirect costs to individuals and society as a whole, including, for instance, per capita measures of income lost to the medical treatment of injuries due to violence, or cost-effectiveness statements that show the savings of prevention programmes.

The ability to demonstrate that prevention strategies have a high likelihood of being effective requires the availability of scientifically evaluated studies of programmes for the prevention of interpersonal violence. Scientific evaluation makes it possible to conclude whether desired outcomes were achieved after the programme, and whether the changes can be attributed to the intervention itself rather than other factors in the environment. To draw such conclusions it is necessary to establish criteria for evaluation, including: definition of adequate indicators of desired change, development of valid measures to evaluate desired changes in attitudes, beliefs, behaviours, practices and injuries; collection of baseline, process and outcome data on measures of change,

and establishment of an intervention group and a comparable control group in order to compare the magnitude of outcomes in the two groups.

Capacity for Interpersonal Violence Prevention

The extent to which the five conditions making up the chain of prevention and the two conditions described under the will to prevention are met will determine the capacity for interpersonal violence prevention in any social system. The likelihood that successful violence prevention programmes will be established is highest when the conditions specified in the logical chain of prevention have all been met and the will to prevention has been established.

Levels of Prevention

The logical and social conditions for violence prevention can be applied to different levels of human system. These levels could be defined in many ways, but perhaps the most useful distinction is one that coincides with the different ecological levels at which people attempt to influence their environment. Seven levels seem important.

i. **Individual:** skills, attitudes and beliefs at the level of the person that can be targeted to develop pro-social behaviours and reduce the likelihood of violence.

ii. **Family:** refers to any group of individuals who through extended cohabitation have developed a system of financial or physical interdependence and shared responsibilities for the daily care of one another. Families have the potential to serve as prevention agents through the establishment of non-violent value systems and adequate social and cognitive skills in infants and children.

iii. **Community:** refers to an interacting population of individuals in a common location. Some communities have the potential to organize themselves around the achievement of common goals (such as the prevention of violence among their members).

iv. **Sub-national entities:** population in a territorial part of the state governed by authorities whose powers are attributed and regulated by the constitutional order of that State (provinces, states, departments, autonomous regions). Sub-national entities such as provincial governments and municipalities are in many countries the front line for delivery of state-sponsored prevention programmes, and in some instances have close working alliances with non-governmental agencies.

v. **Nation** (i.e. the nation state as embodied in the constitution, government, etc): a population governed by a sovereign authority on a given territory. Governmental, non-governmental and private institutions at the national level can act to reduce structural determinants of violence, and government departments are responsible for formulating policies and for promulgating and enforcing laws concerning violence and risk factors for violence.

vi. **Regional:** international actors that can exercise their powers in a restricted geographical area (e.g. the Arab League, Asian Development Bank, Southern

African Development Community, European Union, Inter-American Development Bank, Organization of American States, European Court of Human Rights). Such agents have an important role to play in providing economic and policy support to countries.

vii. **International** (i.e. international agencies such as World Bank, UNICEF, WHO, Red Cross): entities that act across international borders and can exercise their powers in the international sphere. Some international agencies are mandated by their member states to promote global and local activities aimed at protecting individuals from physical harm due to violence of all kinds, and others are mandated to improve the economic health of societies, tasks with major implications for societal vulnerability or resistance to interpersonal violence.

A FRAMEWORK FOR INTERPERSONAL VIOLENCE PREVENTION

By integrating the risk factors, competencies needed for prevention and levels of prevention into a matrix, an organising tool by which to allocate responsibilities and create links between different prevention levels is created. This is shown in Table 3. On the left hand side are the different potential prevention agents ranging from international agencies to families and individuals. While every level of agent could be targeted for the building of prevention competencies, formal systems for the prediction of violence analysis of risk factors and so on would probably be limited to community, government and international levels. On the horizontal axis are the risk factors for interpersonal violence, and each column intersects with the different prevention levels to help map what resources are available to address each factor. For instance, interventions to reduce economic inequality and enhance social safety nets are part of the World Bank's "Comprehensive Development Framework" and this could be listed as a potential global-level resource for these risks. Of course, the matrix is most usefully applied at the country-level, where large differences could be expected between developed and developing countries in the weightings allocated to the different levels of risk factor and the extent to which prevention responsibilities and resources are located to regional and international agencies.

If the risk factors are omitted, the matrix can be used to highlight what is needed in the area of capacity development around the different links in the chain of prevention and the will to prevention. Table 4 (p.14) illustrates this application at the international level, based upon what WHO staff in the Department of Injuries and Violence Prevention knew about the work of other international agencies. It suggests that there is little mutual awareness among international agencies of what they do in relation to interpersonal violence prevention, and highlights a number of priority areas for research and product development. For instance, the Global Burden of Disease (GBD) programme was the only international-level tool for predicting interpersonal violence that the group could identify, and it was noted that the GBD has many weaknesses owing to the inadequacy of country-level mortality data for some regions. Staff also highlighted the poverty of existing resources in areas that concern building the will to prevent interpersonal violence. Priority work areas suggested by these gaps included research into the economic dimensions of interpersonal violence and its prevention, the development of a good practice database, the improvement of communications between international

TABLE 4. INTERPERSONAL VIOLENCE PREVENTION COMPETENCIES: INTERNATIONAL LEVEL ILLUSTRATION

Definition. Agents that act across international borders and can exercise their powers in the international sphere.		
Targets for intervention. Structural adjustment programmes; economic embargoes; war; manufacture and trade in small arms; illegal drug trafficking; international humanitarian and criminal law; resources of international specialist agencies (e.g. UNDCCP, ICPC, WHO, UNICEF); donor countries.		
Disciplines. Framework questions should be answered from the perspective of disciplines that study these areas, including development economics; international economics; sociology; political science, and international law.		
	What exists?	What is needed?
Prevention chain		
Is IPV* predicted?	Unsure, but GBD one example	Knowledge of other IPV prediction tools, better GBD
Are IPV causes known?	Correlation only	WVR [†] ; Definitive studies of development and violence, development of methods to study determinants of violence in developing settings
Do potential prevention agents exist?	UN institutions, NGOs, regional inter-governmental institutions, development banks, industry	More investigation into what different agents can offer and evaluation of their approaches
Are predictions and causes communicated to prevention agents?	Poorly	WVR; international information hub; consultative meetings; electronic networks
Is preventive action taken?	Uncertain, but probably fragmented and contradictory	Framework for co-ordinated international action
Will to Prevent		
Are benefits of prevention seen to outweigh costs of ignoring IPV?	Arguments for ethical benefit only known so far	Show how rich and poor nations can derive economic and social benefits; use international laws to increase the costs of violence promoting practices
Are clearly effective intervention examples available?	Not shown	More learning from other international prevention examples (e.g. Alliance Against HIV/AIDS; TFI); national level success stories
Barriers identified and addressed?	Probably in fragmented manner	Review of international violence prevention initiatives across sectors, and identification of common types of barriers experienced.
		Evaluation of strategies used to overcome existing barriers. Lessons learned from other international health promotion and development examples.
Prevention Capacity		
Do agencies have the required human and financial resources?	Fragmented and uncoordinated.	Capacity of different agencies analysed and harnessed in strategic manner to ensure maximum efficiency and regional coverage.
		Information sessions on violence and human rights for members of treaty bodies.

*IPV = interpersonal violence; WVR = World Report on Violence and Health

agencies, and creation of guide to United Nations resources and activities for the prevention of interpersonal violence.

COMPLETING THE FRAMEWORK DOCUMENT

Further development of the framework for interpersonal violence prevention will involve reviewing the concept with international experts in the field, and completing the matrices included in this development document for a cross-section of international agencies and selected countries and communities chosen according to levels of interpersonal violence and patterns of response.

The framework development process is intended to ensure that it reflects the scientific knowledge and prevention experiences of practitioners in all regions of the world. To capture this wide spectrum of perspectives, the development process will use the violence prevention networks identified by WHO staff, collaborating centres, and regional violence and injury prevention networks, in particular the Injury Prevention Initiative for Africa, and the Inter-American Coalition for the Prevention of Violence. Special efforts will be needed to identify commentators from Eastern Europe, the Eastern Mediterranean region, and Asia, where relatively little is known about interpersonal violence prevention activities. The reviewers will be asked to answer the matrix questions with reference to their own countries, to indicate if and how the framework adds value to their own endeavours, and to suggest amendments that will increase its value as a tool for organizing different sectors and groups around the goal of preventing interpersonal violence.

A second major source of input for the framework development process will be information derived from three parallel projects that WHO has initiated. First, the work of agencies within the United Nations system as it applies to the prevention of interpersonal violence is being documented through a survey following an ad hoc consultation held in Geneva in November 2001. Second, input on country-level investment in and policies for preventing interpersonal violence will be provided by a survey of all WHO member states. This survey will commence early in 2002 and should have results by the end of 2002. The responses will help identify some national level programmes and their focal points, but follow-up investigations will be required to obtain in-depth information about the policy process and practices. Third, the framework development process will be informed by information on good practices for interpersonal violence prevention that will be documented by researchers in different regions using a specially developed handbook for the documentation of such practices. It is anticipated that this handbook will be ready in the second half of 2002, and that the collection of good practices will begin early in 2003.

Ultimately, it is planned to combine the information from the consultative process, case studies and surveys into a formal document to be published by WHO. The development process will run from August 2001 to mid-2003, after which a final framework document will be prepared in the hope of submitting it to the 2004 World Health Assembly.

APPENDIX I: WHO RESOLUTION 49.25

WHA49.25 Prevention of violence: a public health priority

The Forty-ninth World Health Assembly,

Noting with great concern the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, but especially women and children;

Endorsing the call made in the Declaration of the World Summit for Social Development for the introduction and implementation of specific policies and programmes of public health and social services to prevent violence in society and mitigate its effect;

Endorsing the recommendations made at the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) urgently to tackle the problem of violence against women and girls and to understand its health consequences;

Recalling the United Nations Declaration on the elimination of violence against women;

Noting the call made by the scientific community in the Melbourne Declaration adopted at the third international conference on injury prevention and control (1996) for increased international cooperation in ensuring the safety of the citizens of the world;

Recognizing the serious immediate and future long-term implications for health and psychological and social development that violence represents for individuals, families, communities and countries;

Recognizing the growing consequences of violence for health care services everywhere and its detrimental effect on scarce health care resources for countries and communities;

Recognizing that health workers are frequently among the first to see victims of violence, having a unique technical capacity and benefiting from a special position in the community to help those at risk;

Recognizing that WHO, the major agency for coordination of international work in public health, has the responsibility to provide leadership and guidance to Member States in developing public health programmes to prevent self-inflicted violence and violence against others,

1. DECLARES that violence is a leading worldwide public health problem;
2. URGES Member States to assess the problem of violence on their own territory and to communicate to WHO their information about this problem and their approach to it;
3. REQUESTS the Director-General, within available resources, to initiate public health activities to address the problem of violence that will:

(1) characterize different types of violence, define their magnitude and assess the causes and the public health consequences of violence using also a "gender perspective" in the analysis;

(2) assess the types and effectiveness of measures and programmes to prevent violence and mitigate its effects, with particular attention to community-based initiatives;

(3) promote activities to tackle this problem at both international and country level including steps to:

(a) improve the recognition, reporting and management of the consequences of violence;

(b) promote greater intersectoral involvement in the prevention and management of violence;

(c) promote research on violence as a priority for public health research;

(d) prepare and disseminate recommendations for violence prevention programmes in nations, States and communities all over the world;

(4) ensure the coordinated and active participation of appropriate WHO technical programmes;

(5) strengthen the Organization's collaboration with governments, local authorities and other organizations of the United Nations system in the planning, implementation and monitoring of programmes of violence prevention and mitigation;

4. FURTHER REQUESTS the Director-General to present a report to the ninety-ninth session of the Executive Board describing the progress made so far and to present a plan of action for progress towards a science-based public health approach to violence prevention.

Hbk Res., Vol. III (3rd ed.), 1.11

(Sixth plenary meeting, 25 May 1996 - Committee B, fourth report)

APPENDIX II
WORLD HEALTH ORGANIZATION:
EXECUTIVE BOARD 109th SESSION
Provisional Agenda Item 3.11

VIOLENCE AND HEALTH

Report by the Secretariat

1. In the year 2000, 1.7 million deaths in the world were due to violence. Owing to underreporting and inadequate surveillance in many regions, this figure probably underestimates the true proportion of violent deaths. Of the estimated total of violent deaths, nearly half were due to suicide, about a third were homicides and a fifth were due to armed conflicts. Among people aged 15 to 44 years, it was estimated that suicide was the fifth leading cause of death, homicide the sixth, and armed conflicts the eleventh. Estimated rates of homicides are higher in low- and middle-income societies, while estimated rates of suicide are higher in high-income societies.
2. An even larger number of people survive acts of violence. Around 40 million children are subject to abuse and neglect each year; adolescents and young adults are the primary victims and perpetrators of interpersonal violence in every region of the world; rape and domestic violence account for 5% to 16% of healthy years of life lost by women of reproductive age, and, depending on the studies, from 10% to 50% of women experience physical violence at the hands of an intimate partner during their lifetime.
3. Beyond the millions of deaths and physical injuries that it leads to each year, violence may have profound health and psychological implications for victims, perpetrators of violence and witnesses to violence. These include mental illness, behavioural disorders and reproductive and sexual health problems, some of which are themselves the cause of more violence. The costs of the consequences of violence are enormous. Alongside the annual financial costs to health care systems, estimated to be in the thousands of millions of United States dollars, violence has even larger indirect and human costs that result in untold damage to the economic and social fabric of communities around the world.
4. The United Nations Millennium Declaration adopted by the United Nations General Assembly at the Millennium Summit (New York, 6-8 September 2000), noted that men, women and children have the right to live their lives in freedom and without fear of violence, oppression and injustice. The Health Assembly in Resolution WHA49.25, declared violence to be a leading worldwide public health problem; it urged Member States to assess the problem of violence in their own territories, and requested that WHO present a plan of action for the prevention of violence. The Health Assembly subsequently endorsed the plan of action and called for its further development (resolution WHA50.19). In a separate resolution (WHA51.8) the Health Assembly called for concerted public health action on anti-personnel mines.
5. WHO responses to these resolutions have included preparation of the first World report on violence and health. This report aims to raise awareness about the public health aspects of violence and highlights the contributions that public health can make to understanding and preventing the problem. Nearly 100 experts from around the world have contributed, and it has been reviewed by an additional 60 experts from all WHO regions. The report will be issued in 2002, accompanied by a summary document for policy makers.
6. The report describes how a complicated web of factors at individual, family, community and societal levels contributes to causing violence. Some of these factors include harsh discipline, poor monitoring

and supervision of children, witnessing violence, drug trafficking, access to firearms, alcohol and substance abuse, inequalities between the sexes and in income, and norms that support violence as a way of resolving conflicts.

7. Violence is preventable. The wide variation in rates of violence between and within nations and over time confirms that violence results from social and environmental factors that can be changed (e.g. its social acceptability). In addition, there is increasing evidence that specially designed and carefully implemented interventions (e.g. home visitation and parent training) can prevent violence and are cost-effective.
8. Knowledge about the magnitude and the causes of violence is steadily increasing, but much remains to be done in both developed and developing countries. By assisting countries to implement epidemiological surveillance programmes and research, public health can provide the scientific base, and, through its research into understanding the root causes of violence and evaluating preventive measures, it can stimulate the growth of effective interventions.
9. WHO will guide global public health efforts to prevent violence. On the basis of the evidence presented in the world report on violence and health it will create a framework to facilitate the implementation and coordination of multidisciplinary activities for the prevention of violence and the treatment and care of victims. The task of WHO is as follows:
 - in surveillance, to set standards for and facilitate collection of data on all types of violence and their physical and psychosocial consequences;
 - in research, to commission and conduct research important for policy making, such as analysis of the economic dimensions of violence and its prevention, population-based research on risk and protective factors at societal and community levels, the effectiveness of violence prevention efforts, and the documentation of good practices;
 - in prevention, to define clearly what works, to disseminate this knowledge as widely as possible, and to stimulate multisectoral involvement in prevention activities;
 - in treating and caring for victims of violence, to strengthen services and support, and to promote the reconstruction of health services where these have been destroyed by armed conflicts or economic failure;
 - in advocating for the prevention of violence, to create increased awareness about the impact of violence on public health, its preventability, and the need for greater political and financial support for primary, secondary and tertiary prevention.
10. Coordination of activities across nations and regions can greatly accelerate efforts to identify and implement effective strategies to prevent violence. Creating safe communities around the world requires commitment by many different sectors at international, national and community levels to documenting the problem, building the evidence base, promoting the design and testing of prevention programmes, and disseminating the lessons learned.
11. The contribution of WHO to the provision of global guidance and coordination for the prevention of violence was acknowledged at the first meeting on United Nations collaboration for the prevention of interpersonal violence (Geneva, 15-16 November 2001). Eleven United Nations bodies were represented at the meeting, which aimed to develop a mutual understanding of the violence-prevention activities within the different United Nations organizations and to identify areas for collaboration. A joint invited WHO to act as facilitator of the initial follow-up activities.

Action by the Executive Board

12. The Executive Board is invited to note the above report.

APPENDIX III: OVERVIEW OF THE WHO PLAN OF ACTION ON VIOLENCE PREVENTION AND HEALTH

In 1997, the Fiftieth World Health Assembly passed resolution WHA50.19 which endorsed the WHO plan of action on violence prevention and health. The plan of action provides an overview of the main elements of the public health approach to violence prevention, and the following text is the WHO Plan of Action:

WHO integrated plan of action on violence and health

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

Objective 1. To describe the problem (first priority)

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

Activities:

- to survey the capacities of current data collection systems to obtain, analyse and use information about violence; and to develop accurate, affordable and valid measures for collecting information about non-fatal violence and its costs and consequences;
- to develop a typology and definitions of different types of violence, related risk behaviour and consequences;
- to collect data on deaths from all external causes in order to assess the accuracy of classification, and to collect accurate demographic data for calculation of rates;
- in collaboration with other sectors concerned, to improve baseline data on suicide and homicide, especially those coming to the attention of the health sector, including information on sex, age, relationship of victim/perpetrator, and circumstances;
- to facilitate the development and adaptation of research methodology to describe and measure violence better in its different forms, with its determinants and physical, psychological and social consequences;
- to promote and provide technical support for the compilation of local and national analyses of data on different types of violence, and for international comparisons (the analyses must be informed by a gender and equity perspective);
- to carry out district- or community-based surveys of violence in order to determine the nature and extent of interpersonal violence, especially in relation to women, children and adolescents;

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

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

Activities:

- to strengthen and support research related to violence in all appropriate WHO programmes;
- to advocate the development of research on violence through the global ACHR and its regional committees;
- to use available mechanisms and resources to promote research "networking" among WHO collaborating centres, nongovernmental organizations and other institutions as a priority, confirming the need for a public health approach to violence and health;
- to promote research on the costs of violence;
- to create an inventory of research activities on health-related violence in order to facilitate "networking" and the exchange of data and information;
- to organize and disseminate the results of such research so that they can be effectively used for policy formulation and programming.

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

Activities:

- to identify and document existing activities for preventing different forms of violence and for managing their consequences;
- to foster the development and evaluation of demonstration projects, promoting innovative, challenging and non-traditional responses, in order to determine which methods are effective and why, and what are the impediments to effective action, with special attention to community-based interventions;
- to assess curricula for conflict resolution and promote their inclusion in the training of health workers and teachers dealing with children and adolescents, and to promote the adaptation of such materials for health education of parents and children.

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

Activities:

- to provide technical support and guidance to the health sector in improving the quality, effectiveness, equity and efficiency of services for those affected by violence, and in particular to devote attention to the coordination and interfaces of the health sector with other sectors, in order to ensure that secondary victimization does not occur;
- to promote, as part of the curriculum for training and the continuing professional development of health professionals at all levels, the incorporation of an understanding of violence and its health consequences, as well as the requirements for the provision of sensitive services;
- to adapt and evaluate methods of preventing violence and managing its health consequences that facilitate the involvement of families, communities, women and young people, the health sector and other appropriate sectors, in the analysis, formulation, implementation and evaluation of locally suitable strategies;
- to promote and support community-based approaches in the prevention of violence, and the management of the consequences, through coordinated regional and national intersectoral policies, legislation and services that strengthen the related capacity of communities;
- to promote greater intersectoral involvement in the prevention and management of violence;
- to promote the integration of violence prevention into local development programmes and efforts to empower communities; to promote joint projects of developed and developing countries, given the increased importance of violence as a public health issue in both North and South, and considering the potential for each to learn from the other;
- to disseminate information and new knowledge generated by data collection and the results of research as a basis for policy development and action at all levels.

Resources and means of implementation

If WHO is to respond to the challenge of violence prevention as a public health priority, complementary and more efficient use of its resources will be necessary, maximizing its expertise and experience. WHO will also have to strengthen the role and responsibilities of its networks of collaborating centres, as well as to increase its cooperation with competent national institutions and nongovernmental organizations.

Furthermore, WHO will have to mobilize additional extrabudgetary resources, giving priority to the need for investment in monitoring and surveillance as the foundation for appropriate policies and cost-effective and efficient programmes. The Organization will take a lead in mobilizing and coordinating action to prevent and control violence. In this global endeavour the task force will continue to monitor the whole process, working in close collaboration with all interested parties. It will make every effort to develop this new initiative for violence prevention and health in the framework of the renewed health-for-all strategy.

Evaluation

At the end of the first three years of activity sufficient data and experience should have been accumulated to allow for the formulation of precise goals and quantifiable

targets to evaluate the programme in subsequent years. By that time it should also be possible to establish operational targets based on the concept of "best practices". Furthermore, it is likely that authorities will be better able to determine the areas and circumstances amenable to public health interventions, either to prevent violence or to mitigate its effects. Indicators for such an evaluation should have been selected by then.