SUMMARY

Unlike the MDGs, the SDGs include targets for reductions in injuries and violence, which are associated with more than 5 million deaths, or one in 11 deaths. This chapter focuses on road traffic injuries, violence, war and conflict, and natural disasters.

There is an explicit SDG target on road traffic deaths under the health goal and a target on access to safe transport systems which includes improving road safety. Currently about 1.25 million deaths annually are due to road traffic crashes and collisions, which is 23% higher than in 2000. The past decade has shown that implementing a range of interventions, from legislation and driver behaviour change to vehicle design, reduces the risk of injury and death due to road traffic accidents. But because of the increase in numbers of vehicles (90% increase since 2000 to over 1.5 billion and a further 47% increase expected by 2030), halting further increases in road traffic deaths will, in itself, be a major achievement. Further, major reductions in the numbers of road traffic deaths will require an extraordinary effort in all countries.

There are also 1.5 million deaths and many more nonfatal injuries due to other unintentional injuries, including falls, drowning, burns and poisonings, which should be addressed to reach the overall health SDGs.

The SDGs have four targets on reducing deaths and injuries due to violence in goals other than health. Nearly half a million people died from interpersonal violence in 2012, mostly men, with half of murders committed with firearms. Compared to the global rate, homicide rates are four times higher in the low- and middle-income countries of the Americas and more than three times lower in the low- and middle-income countries of the Western Pacific Region. Globally, homicide rates have declined by nearly 17% since 2000.

Physical or sexual violence against women, harmful practices such as child marriage and female genital mutilation, and violence against children, are common in many countries and specific SDG targets to address these issues have been set for 2030. Preventing homicide and nonfatal violence requires a multisectoral approach that addresses underlying causes, such as gender, social and economic inequalities, cultural norms that support violence, easy access and misuse of alcohol, drugs and firearms.

SDG 16 promotes peaceful and inclusive societies for sustainable development, which cuts across all sectors, including health. There has been a long-term decline in the number and intensity of wars and conflict since the end of the Second World War. Since 2011, however, there has been an upturn in conflict deaths, notably due to the increased level of conflict in the Middle East, putting many populations at additional health risk due to increased transmission of infectious diseases, poor nutrition and deteriorating health services, and jeopardizing global efforts to eradicate diseases such has polio.

The SDGs also include several targets that aim to reduce exposure, vulnerability, resilience and adaptive capacity in relation to disasters. Between 2000 and 2014 there were on average 865 000 deaths due to natural and technological disasters. Since 2000, three major disasters that were associated with more than 100 000 deaths have dominated the mortality trend, the Indian Ocean tsunami in 2004, the Myanmar cyclone in 2008 and the Haiti earthquake in 2010. The global numbers of forcibly displaced people as a result of persecution, conflict, generalized violence or human rights violations have reached unprecedented numbers (almost 60 million) in 2014, with further increases in 2015.
Injuries, whether sustained accidentally or as a result of intentional acts of violence, kill more than 5 million people worldwide annually, accounting for 9% of global mortality, which is nearly 1.7 times the number of fatalities that result from HIV/AIDS, tuberculosis and malaria combined. In addition, tens of millions of people suffer nonfatal injuries that require treatment and may result in temporary or permanent disability. For many injuries and some types of violence, there exist effective, evidence-based initiatives that can help reduce incidence and mitigate impact. There is thus a strong case for including injuries in the SDGs, both in terms of the burden of disease they represent and the solutions available to tackle them.

The leading cause of injury deaths is road traffic injury, followed by suicide, falls and interpersonal violence. Other important causes of injuries include drowning,1 fires and burns, poisonings, and war and conflict (Figure 8.1). This chapter focuses on fatal and nonfatal injuries resulting from road traffic accidents, interpersonal violence, conflict and natural disasters. Injuries related to self-harm are addressed in Chapter 7, which deals with mental health disorders.

Every year, 1.25 million people die from road traffic injuries, and another 20–50 million people sustain nonfatal injuries as a result of road traffic collisions or crashes.3 Road traffic injuries are a top 10 cause of death globally, and the leading cause of death for people age 15–29. A significant cause of suffering and death, road crashes also impose a heavy economic burden, costing more than US$ 1800 billion or 3% of GDP globally, with low- and middle-income countries losing around 5% of their GDP.4

Homicide and collective violence account for around 10% of global, injury-related death. In 2012, there were an estimated 475 000 murders. Four fifths of homicide victims are men, and 60% of victims, males age 15–44.5 The low- and middle-income countries of the Western Pacific Region. One of the main drivers of homicide rates is access to guns, with approximately half of all homicides committed with a firearm. Among women, intimate partner homicide accounts for almost 38% of all murders as compared to 6% of murders of men. While homicide grabs headlines, far more people suffer severe health consequences as a result of nonfatal assaults, often sustaining serious injuries requiring emergency care and in some cases resulting in lifelong disability.

There are substantial regional differences in injury burden (Figure 8.2). The African Region and the Eastern Mediterranean Region have the highest per capita burdens, but the Region of the Americas, excluding high-income OECD countries, has the highest injury burden as a proportion of total disease burden (15%), largely due to the very high levels of interpersonal violence and homicide. Unlike the MDGs, the SDGs have several targets for injuries and violence, including an explicit target for road traffic deaths in the health goal (Target 3.6: “By 2020, halve the number of global deaths and injuries from road traffic accidents”) and Target 11.2 regarding access to safe, affordable, accessible and sustainable transport systems for all and improving road safety. The four SDG targets addressing the issue of interpersonal violence range from loosely defined targets (Target 16.1: Significantly reduce all forms of violence and related death rates everywhere) to specific targets on elimination of violence against all women and girls (Target 5.2, discussed in Chapter 4), elimination of harmful practices such as child marriage and female genital mutilation (Target 5.3, discussed in Chapter 4) and violence against children (Target 16.2).

Four fifths of deaths from homicide, and nine tenths of deaths from war impact men.7 That said, there is clearly a case for highlighting violence experienced by women and children, which is often hidden, stigmatized and...
perpetrated by someone known to the victim. For example, based on data from 79 countries and two territories, one in three women worldwide have experienced physical and or sexual violence by an intimate partner or sexual violence by perpetrators other than partners. This form of violence appears to be common in all regions. With regard to children, physical violence and abuse is experienced by both boys and girls. One quarter of all adults report having been physically abused as children, and around 20% of women and 5–10% of men report having been sexually abused as a child. Older people are also victims of violence, as indicated by some studies reporting that 6% of older adults report abuse in the past month. However, data are limited on the prevalence of elder abuse, particularly from low- and middle-income countries.

Natural disasters were not mentioned in the MDGs, but are referred to several times in the SDGs (Targets 1.5, 3.d, 11.5 and 13.1). As part of the goal on cities and human settlements, Target 11.5 states: “By 2030, significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations.” Target 13.1 refers to climate-related disasters: “Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters in all countries.”

Annually, there were an average 656 reported disasters and 86 500 deaths during 2000–2014, excluding epidemics. Overall, the largest numbers of deaths are associated with earthquakes and tsunamis, but storms also take a heavy toll. The economic losses of disasters vary considerably and, in absolute terms, are usually much higher in high-income countries. However, expressed as a percentage of GDP, the direct economic losses from natural disasters in low-income countries between 1980 and 2011 were found to be more than 14 times higher than in high-income countries.

During 2000–2012, homicide rates are estimated to have dropped by almost 17% globally and by an impressive 39% in high-income countries. In the low- and middle-income countries of the European Region, homicide rates have seen an even steeper decline, falling by more than 50% since 2000. In other low- and middle-income countries, progress has been less pronounced; the rate falling 13% in middle-income countries and 10% in low-income countries. Whether this decline is fully reflected in broader violence statistics is unclear.

It is not yet possible to establish global or regional trends for the incidence of violence against women and children.

Globally, mortality rates due to all major cause groups of injuries have fallen since 2000, but, because the world population is growing, this has not translated into fewer annual deaths (Figure 8.3). Since 2000, global road traffic deaths have increased by 23%, and are currently running at an annual rate of about 1.25 million deaths. Recent estimates suggest a lower rise of 13% over the period 2000–2013. One of the main drivers of this trend is the increase in traffic, the number of registered vehicles having grown by 90% since 2000. It is encouraging to note, however, that the mortality rate has remained fairly flat in recent years, despite the increase in traffic.
due to limited data. However, the surveys that have been undertaken – usually collecting data from adults on past violence and abuse – often show very high rates.

WHO estimates of global direct conflict deaths (injury deaths) vary substantially by year, but there has been a statistically significant decline during 1990–2010 of 2% per year, if the Rwandan genocide of 1994 is excluded. There has also been a long-term decline in the number and intensity of wars and conflict since the end of the Second World War. Since 2011, however, there has been an upturn in conflict deaths, notably due to the increased level of conflict in the Middle East.

According to estimates of mortality directly associated with disasters produced by the Centre for Research on Epidemiology of Disasters (CRED), during 2000–2014, an annual average of about 86 500 people were killed by natural and technological disasters. Since 2000, three major natural disasters that were associated with more than 100 000 deaths have dominated the picture: the Indian Ocean tsunami in 2004; the Myanmar cyclone in 2008; and the Haiti earthquake in 2010 (Figure 8.4). The number of disasters has been declining in the last decade and the number of people affected reached its lowest levels since 2000 in 2012 and 2013.

Figure 8.4
Number of people reported killed in disasters, 2000–2014

Several factors have contributed to these positive trends:

- **Effective, enforceable legislation**: The introduction of enforceable legislation, coupled with social marketing, regarding speed, seat belts and child restraints, motorcycle helmets, and drinking and driving has already made a difference in a number of countries.

- **Safer roads**: The same is true of improvements in the construction of new roads, with increased emphasis on the needs of vulnerable road users, including pedestrians, motorcyclists and cyclists.

- **Safer vehicles**: Vehicles too have been made much safer and continuing improvements in vehicle design and safety, such as strengthened front-end design, air bags and computerized braking systems, will be essential components of any post-2015 campaign to bring about a drop in road traffic injuries and deaths.

Drops in homicide may be associated with improvements in country policies and strategies to reduce violence and its consequences. Roughly one third of countries are currently implementing such strategies, including support for safe, stable and nurturing relationships between children and parents or caregivers, reducing the availability and harmful use of alcohol, reducing access to guns, and knives, and promoting gender equality. It is, however, unknown to
what extent these strategies have been a factor in the estimated decrease in the homicide rate.

During 2005–2015, the Hyogo Framework for Action 2005–2015 promoted a strategic and systematic approach to reducing disaster risks, and underscored the need for building the resilience of nations and communities to disasters. The Hyogo Framework was instrumental in stimulating countries, development partners and other agencies to take action to reduce disaster risk, and may have helped decrease mortality rates in the case of some hazards, such as floods, for example, which, despite increasing frequency, are killing fewer people. Many countries (85%) have a national emergency preparedness and response policy and two thirds of countries have a policy in place for health sector emergency preparedness and response.*

### Challenges

*Increase in vehicles:* Based on current trends, and unless urgent action is taken, road traffic death is expected to rise on the list of leading causes of death. The main challenge is to bring road traffic deaths down at a time of rapidly increasing motorization, especially in low- and middle-income countries. A matter of particular concern is the rapid increase in traffic volume without a concomitant investment in road safety strategies.

*Access to guns:* One of the main drivers of homicide incidence is access to guns, approximately half of all homicides being committed with a firearm. It appears unlikely that access to firearms will decline in the coming years in most countries.

*Gender inequality:* Violence against women and children is embedded in gender inequality and discrimination against women and girls. Increased and sustained efforts are needed to bring about changes in gender norms to: (i) empower women and girls, notably through improved access to education and safe, adequately remunerated employment; (ii) mobilize communities and institutions to reduce the acceptability of violence, promote egalitarian gender norms and (iii) reform and effectively enforce laws to address sexual violence and intimate partner violence against women, as well as other laws that limit women’s rights regarding marriage, divorce, child custody and property and inheritance.

*Increasing risks for some types of disasters:* Natural hazards such as hydrometeorological disasters may increase in frequency and intensity as a result of climate change, significantly impeding progress towards sustainable development (see Chapter 2). These risks may be exacerbated by population growth and unsustainable use of natural resources.

---

*Disabilities:* Millions of people who do not die as a result of injuries and violence suffer serious injuries and, in some cases, lifelong disabilities as well as mental trauma. Greater investment for the prevention, treatment and rehabilitation of functioning loss due to injuries is critical.

*Other injuries – falls:* The SDGs focus on road traffic injury and violence, but other key injury areas are also of concern. An estimated 693,000 fatal falls occurred in 2012, making it the second leading cause of unintentional injury death, after road traffic injuries. There are also tens of millions of falls that, while not fatal, are severe enough to require medical attention. Older people who suffer falls are also at risk for subsequent long-term care and institutionalization.

*Other injuries – burns:* Fire-related injuries are another concern, with the majority occurring in low- and middle-income countries. They are often associated with unsafe cooking methods, including cooking with open fires, and with violence against women. Women and children are particularly at risk. Largely preventable, in high-income OECD countries burns have been reduced to almost negligible levels.

*Other injuries – drowning:* An estimated 372,000 people died from drowning in 2012, and over half of the world’s drowning occurs in the South-East Asia Region and the Western Pacific Region. Many deaths due to drowning could be averted by barriers to control access to water, ensuring constant adult supervision for preschool children, teaching school children basic swimming and safe rescue skills as well as improving flood risk reduction strategies.

*Conflict:* As noted in the SDG declaration spiralling conflict, violent extremism, terrorism and related humanitarian crises and forced displacement of people threaten to reverse much of the development progress made in recent decades. It will be a major challenge to reverse current trends and provide more effective support to conflict and post-conflict countries in all sectors including health.

### Strategic Priorities

Given the complexity of the determinants of injuries and violence, establishing development targets that are both simple and compelling enough to focus attention, but also specific enough to facilitate the drawing up and implementation of effective policy, is fraught with difficulty. However, certain targets look promising. Road traffic deaths, for instance, are an example of a specific target that is relevant to all countries, a serious problem that is easily defined and measured, while also being something that we can make progress on, using well-established, evidence-based interventions. The target of halving the global number of road traffic deaths by 2020 is much more ambitious than the target set at the Decade of Action for Road Safety 2011–2020, which was endorsed by the UN General Assembly in 2010.
aiming to stop the predicted increase at about current levels. Given the projected increase in road vehicles (47% by 2030), it will be a substantial achievement to hold global road traffic deaths to the current level, let alone achieve a decrease. The key strategies are to roll out and implement effective behaviour change interventions such as legislation, enforcement and social marketing; improve road infrastructure, bearing in mind vulnerable road users; and encourage the uptake of good vehicle design measures.

Reducing interpersonal violence, particularly against women and children, is also a priority with considerable global support, notably among UN agencies, including the UN General Assembly, the UNESCO, the United Nations Development Programme (UNDP), the UNICEF, United Nations Entity for Gender Equality and Women’s Empowerment (UN Women) and WHO. In 2014, the World Health Assembly drew attention to the important role of health systems in addressing violence, in particular against women and girls and against children, and called upon the WHO Director-General to develop a global plan of action to strengthen the role of the health system in addressing interpersonal violence.

The global violence prevention field’s vision for the post-2015 era is one of cutting worldwide levels of interpersonal violence by half within the next 30 years. While not as ambitious as the SDG targets, which aim to eliminate several forms of violence in the next 15 years, this vision aligns well with SDGs 5 and 16 that explicitly target violence reduction. A 15-year global plan of action on strengthening the role of the health sector in addressing interpersonal violence, in particular against women and children, will be considered by WHO Member States at the May 2016 World Health Assembly.

To date, few countries have implemented the social, economic and educational policy measures needed to address important risk factors for violence. This is a particular matter of concern in regard to violence against women, which is an issue for all regions and countries, and is worse in settings where familial violence against women and against children is considered socially acceptable. As noted above, access to guns is another major concern, and while nearly all countries have national laws to regulate firearm possession and use, there is wide variation in the adequacy and enforcement of these laws.

The SDGs provide a framework for the focus on preventing conflict and more effective assistance to conflict and post-conflict countries. Better integration of humanitarian and development assistance is essential. Health will have to continue and strengthen working closely with other sectors to reduce the impact of conflict on people’s health and
well-being. In each area of concern, from intimate partner and other family violence, sexual violence to human trafficking, policy responses and effective interventions already exist. The SDGs are an important opportunity to steer decision-makers towards them, as part of global, regional and country efforts to address these pressing issues.

The main strategy for managing the health risks associated with disasters in the post-2015 era is supported by the Sendai Framework for Disaster Risk Reduction 2015–2030.

The Framework identifies four priorities for action that involve national, regional and global participation:

1. Understanding disaster risk: in all its dimensions of vulnerability, capacity, exposure of persons and assets, hazard characteristics, and the environment.

2. Strengthening disaster risk governance to manage disaster risk: for prevention, mitigation, preparedness, response, recovery and rehabilitation.

3. Investing in disaster risk reduction for resilience: for the enhancement of the economic, social, health and cultural resilience of people, communities, countries and their assets as well as the environment.

4. Enhancing disaster preparedness for effective response and to “build back better” in recovery, rehabilitation and reconstruction.

WHO’s Six-year Strategic Plan to Minimize the Health Impact of Emergencies and Disasters 2014–2019 outlines the policies and programmatic implications for the health sector.

Effective emergency and disaster risk management health policies and programmes should be guided by a comprehensive approach across the emergency management cycle: prevention/mitigation; preparedness; response and recovery. Policies and programmes should also be designed to address common issues and build essential capacities in an “all-hazard approach”, supplemented by hazard-specific elements such as outbreaks, floods, earthquakes, radiological hazards and conflict.

While the health sector will lead in managing the risk of infectious diseases (chapters 3 and 5), for most types of hazards and events other sectors will play a key role. Intersectoral collaboration is thus crucial to building health security capacity. It should also be remembered that community members are central to effective emergency and disaster risk management, as they are the primary responders – and victims – of any emergency. The resilience of communities can be strengthened by helping them identify relevant hazards and vulnerabilities, and by building their capacities to mitigate, prepare for, respond to and recover from emergencies.
ROAD TRAFFIC INJURIES

Every year, approximately 1.25 million people die, and another 20–50 million people sustain nonfatal injuries, as a result of road traffic collisions. Road traffic injuries are the ninth leading cause of death globally, and the leading cause of death for people age 15–29. Almost 60% of road traffic deaths are among people age 15–44. Based on current trends, and unless urgent action is taken, road traffic deaths will become the fifth leading cause of death by 2030.

TRENDS

While the number of registered vehicles increased by no less than 90% between 2000 and 2012, the increase in numbers of deaths due to road traffic injuries was much less dramatic (Figure 8.5), suggesting that interventions to improve global road safety have had some impact on mortality statistics. Indeed, 76 countries reduced the number of deaths on their roads between 2000 and 2013, showing that improvements are possible, and that many more lives could be saved if countries took further action.

POSITIVE DEVELOPMENTS

There are positive developments for several interventions from legislation to vehicle design that contribute to positive trends, such as:

- Comprehensive legislation: While considerable effort is still needed to bring legislation into line with best practice, progress is being made. Between 2011 and 2014, 17 countries, representing 409 million people; amended their road safety laws on one or more behaviour risk factors to make them comprehensive. Criteria used to assess comprehensive legislation are being refined and made stricter as the epidemiological evidence relating to particular risk factors evolves.

- Speed limit laws: 26% of countries have adopted comprehensive urban speed laws.

- Comprehensive seat belt laws: Covering occupants in both front and rear seats; 58% of countries have passed this kind of legislation.

- Drinking and driving laws: Almost 20% of countries have such laws in place, based on blood alcohol concentration, with a limit of 0.05 g/dl or less for the general population 0.02 g/dl for young drivers, which is in line with best practice.

- Motorcycle helmet laws: Comprehensive laws are in place in a quarter of countries.

- Child restraints: A third of all countries have comprehensive laws for child restraints.

- Attention to all road users: Increased attention to the needs of all road users when constructing new roads, with increased emphasis on the needs of vulnerable road users (pedestrians, cyclists and motorcyclists). Safety ratings are available that rate roads according to different categories of road users.

- Vehicle safety: Continuing improvements in vehicle design and safety, such as strengthened front-end design, electronic stability control, ensuring seat belt fixture and anchorage points. These offer huge potential to reduce the likelihood of crashes and the severity of injury from road crashes.
**CHALLENGES**

*Elevated mortality rates in low-, middle- and non-OECD high-income countries:* Over 90% of road traffic deaths occur in low-, middle- and non-OECD high-income countries, which account for 85% of the world’s population, but only 56% of the world’s registered vehicles. Several factors are at work, including: poor or poorly implemented regulations; inadequate road and vehicle quality; a higher proportion of vulnerable road users; and increasing vehicle numbers.

*Increasing road traffic death rates in some regions:* This is partly attributable to the rapid rate of motorization in many developing countries that has occurred without a concomitant investment in road safety strategies (Figure 8.6).

*High mortality among younger adult men:* More than one third of all road traffic deaths are among men age 15–44, the group that is often least likely to pay attention to public health messages (Figure 8.7).

*Vulnerable road users:* Half of the world’s road traffic deaths occur among motorcyclists (23%), pedestrians (22%) and cyclists (4%). In most low- and middle-income countries, a much higher proportion of road users are pedestrians, cyclists and users of motorized two- or three-wheeled vehicles than in high-income countries.

*Lack of legislation meeting best practice on key behavioural risk factors:* As indicated above, many countries lag behind on adopting best practice legislation relating to speed and drink-driving, and the use of motorcycle helmets, seat belts and child restraints.

*Lack of law enforcement:* While an increasing number of countries have enacted laws relating to key risk factors for road traffic injuries, in the vast majority of countries the enforcement is lacking. For example, only one quarter of countries rate their enforcement of seat belt laws as good.

---

**STRATEGIC PRIORITIES**

SDG Target 3.6 aims to halve the global number of road traffic deaths by 2020. This is much more ambitious than the target set at the Decade of Action for Road Safety 2011–2020, which was endorsed by the UN General Assembly in 2010, aiming to stop the predicted increase at about current levels. Given the projected increase in road vehicles (47% by 2030), it will be a substantial achievement to hold global road traffic deaths to the current level, let alone achieve a decrease.

If current trends continue, and nothing is done to address the various challenges faced, then global road traffic deaths may increase to around 1.5 million per year. Under an optimistic scenario, where increases in vehicles per capita are associated with fatality rates falling to those observed in high-income countries over the last two decades, global deaths will decrease to around 1 million per year by 2030. Substantial additional efforts will be required to make progress towards the SDG target of 625 000. There is a strong evidence base on the kinds of interventions and government actions that are effective; the key is to ensure their implementation. The most recent UN General Assembly resolution, which acknowledges the coordinating role of WHO for the UN system, and the Decade of Action for Road Safety 2011–2020 outline the strategic priorities for making progress towards the SDG targets on road safety as the following:

- **Enacting and enforcing comprehensive legislation on key risk factors:** Laws to address speeding and drink-driving and to ensure the use of motorcycle helmets, seat belts and child restraints need to be enacted and enforced, supported by government commitment and funding.

- **Making road infrastructure safer for pedestrians and cyclists:** The needs of road users must be taken into consideration in road safety policy, transport planning and land use. In particular, governments need to consider how non-motorized forms of transport can be integrated into more sustainable and safer transport systems.

- **Improving vehicle standards:** Governments should focus on ensuring that vehicles in circulation are well maintained and meet international standards, including crash-testing standards.

- **Improving post crash care:** The way victims of road traffic crashes are dealt with following a crash determines their chances and quality of survival. Prompt communication and activation of the response system, prompt response and effective assessment, treatment and transport of injured people to formal health-care facilities (where necessary) are essential.
VIOLENCE AND HOMICIDE

There were an estimated 475 000 deaths globally in 2012 as a result of interpersonal violence (homicide). Four out of five homicide deaths were men, most of them age 15–44, which makes homicide the third leading cause of death in this age group. Globally, as many as 38% of homicides occurring in women are committed by their male partners; by comparison, only 6% of homicides in men are committed by their female partners. There is very large variation in homicide rates between regions.

Victims of nonfatal violence far outnumber victims of homicide. While young to middle-aged men generally experience higher rates of nonfatal violence than others, women, children and elderly people also suffer from the nonfatal consequences of physical violence and sexual and psychological abuse. Nearly one quarter of all adults report having been physically abused as children, while 18% of women report having been sexually abused as children. Violence against women is all too common and takes many forms, including violence committed by an intimate partner, sexual violence by any perpetrator, trafficking for purposes of sex, murders in the name of honour or dowry, and early child and forced marriage (see also Chapter 4). About one in three women report having been a victim of physical or sexual violence by an intimate partner at some point in their lives.

TRENDS

During 2000–2012, there has been a marked decline in homicide rates (Figure 8.8), which are estimated to have fallen by around 17% globally (from 8.0 to 6.7 per 100 000 population), and by an impressive 39% in high-income countries (from 6.2 to 3.8 per 100 000 population). In the low- and middle-income countries of the European Region, homicide rates have seen an even steeper decline, falling by more than one half since 2000. In several other regions, modest declines were observed with the exception of the low- and middle-income countries of the Region of the Americas, where homicide rates continue to be very high.

The differences in levels between regions are striking. The low- and middle-income countries of the Region of the Americas has 28.5 homicides per 100 000 population. This is four times higher than the global average and almost 14 times higher than in the low- and middle-income countries in the low- and middle-income countries of the Western Pacific Region, where murders occur at a rate of 2.1 per 100 000 population per year. Organized criminal violence and violence related to illicit drugs have been important contributors to rising homicide rates in some countries of Latin and Central America.

Globally, approximately half of homicides are committed with a firearm, but murder methods vary markedly by region. For example, firearm homicides account for 75% of all homicides in the low- and middle-income countries of the Region of the Americas, but only 23% in the low- and middle-income countries of the Western Pacific Region.

POSITIVE DEVELOPMENTS

Roughly one third of countries are undertaking steps to implement promising strategies to reduce violence, including:

- increasing safe, stable and nurturing relationships between children and their parents and caregivers;
- developing life skills in children and adolescents;
- reducing availability and harmful use of alcohol;
- reducing access to guns, knives and poisons (particularly pesticides);
- promoting gender equality and the empowerment of women;
- changing cultural norms that support violence;
- victim identification, care and support;
- identification and prosecution of perpetrators in order to reduce the “culture of impunity”.

It is unknown to what extent interventions such as these have contributed to the observed declines in homicide since 2000. Homicide as well as most forms of interpersonal violence are strongly associated with social determinants such as social norms, gender inequality, poverty and unemployment, and other cross-cutting risk factors.
**CHALLENGES**

The Global Status Report on Violence Prevention 2014 and the Report on Global and Regional Estimates of Violence Against Women 2013 identified several core concerns:

- Continued extremely high homicide rates in the low- and middle-income countries of the Region of the Americas;
- Few countries are implementing social, economic and educational policy measures to address the social, cultural and economic risk factors for violence;
- Violence prevention laws are widely enacted, but enforcement is often inadequate;
- While nearly all countries have national laws to regulate firearms, enforcement is often inadequate, and few countries report having special firearms control programmes such as gun buy-backs and firearms collection and destruction programmes;
- Availability of services to identify, refer, protect and support victims varies markedly;
- Prevalence estimates for intimate partner violence are substantially higher in the low- and middle-income countries of the African Region, the Eastern Mediterranean Region and the South-East Asia Region, compared to other regions of the world (Figure 8.9), but only half of countries in these regions are implementing wide-scale social and cultural norm-change strategies to address sexual and intimate partner violence;
- In many settings, intimate partner violence against women and child maltreatment are considered socially acceptable and are often condoned;
- Discrimination against women and girls, including in legislation, continues to detract from efforts to address violence against women and girls;
- National surveys of violence against children conducted in Africa have documented high rates of childhood physical, sexual and emotional abuse;
- Violence prevention requires a multisectoral response, but few countries report the existence of lead agencies to coordinate the activities of different sectors and report periodically on progress.

**STRATEGIC PRIORITIES**

The global violence prevention field’s vision for the post-2015 era is to cut worldwide levels of interpersonal violence by half within the next 30 years. While not as ambitious as the SDG targets, which aim to eliminate several forms of violence in the next 15 years, this vision aligns well with SDGs 5 and 16, that explicitly target violence reduction.

Several UN agencies have focussed on violence reduction as a priority, including WHO, UNESCO, UNODC, UNDP, UNICEF and UN Women as well as the UN General Assembly.

In 2014, the World Health Assembly drew attention to the important role of health systems in addressing violence, in particular against women and girls and against children, and called upon the WHO Director-General to develop a global plan of action to strengthen the role of the health system in addressing interpersonal violence, in particular against women and girls and against children.

A 15-year global plan of action on strengthening the role of the health system in addressing interpersonal violence, in particular against women and girls and against children, will be considered by WHO Member States at the May 2016 World Health Assembly. It will include actions to address four strategic directions to address violence, in particular against women and girls and against children:

- strengthening leadership and governance of the health system;
- strengthening health service delivery and the capacity of health workers to respond to violence;
- strengthening programming for prevention;
- improving research and information.
WAR AND CONFLICT

In 2012, an estimated 164,000 people died related to war and conflict, corresponding with about 3% of global deaths, and increasing to over 200,000 conflict deaths in 2014.2,26 These estimates do not include deaths due to the indirect effects of war and conflict on the spread of diseases, poor nutrition and collapse of health services.

TRENDS

Between 1990 and 2011 there was a decline in the number and intensity of wars and conflicts.11,12 According to the Human Security Report 2013, the total number of conflicts dropped 40% from 1992 to 2011. High-intensity conflicts declined by more than half after the end of the Cold War, while terrorism, genocide and homicide numbers were also down.12

WHO estimates of global direct conflict deaths (injury deaths) vary substantially by year, but there is a statistically significant average decline during 1990–2010 of 2% per year, if the Rwandan genocide of 1994 is excluded (Figure 8.10).

Since 2011, however, there has been an upturn in conflict deaths, notably due to the increased level of conflict in the Middle East (Figure 8.11).13,26 It appears likely that conflict mortality levels for 2015 may be similar to or exceed those for 1990. It is estimated that in 2014, there were at least 17 conflicts that killed more than 1000 people each, compared to 15 in 2013.26 Ongoing conflict in Afghanistan, Iraq and the Syrian Arab Republic accounts for significant numbers of conflict-related deaths, with these three countries accounting for an estimated two thirds of global conflict deaths in 2014. Nigeria’s ongoing conflicts were the fourth deadliest, doubling on the previous year as the conflict with a militant group, Boko Haram, intensified. Sudan and South Sudan are also suffering from conflict as are an increased number of African countries. There is increasing documentation and evidence on high rates of sexual violence against women in conflict situations.27
POSITIVE DEVELOPMENTS
Notwithstanding the recent increase in violent conflict, it is possible to point to a number of reasons for the long-term decline in the numbers of wars and the level of conflict-related violence since the end of the Second World War.11

- **Global partnership:** The strong normative proscription against the use of military force – except in self-defence, or sanctioned by the UN Security Council. This also includes more emphasis on peacekeeping, peace-building and peace-making initiatives.

- **Economic factors:** Increased economic interdependence (globalization) and increased economic development.

- **Increased democratization:** This may be associated with reduced national willingness to wage wars of offence.

- **Enhanced state capacity:** This means access to greater resources to address grievances and deter violence.

- **Fewer conflicts of global scale:** Examples include the Second World War, anti-colonialism and the Cold War.

CHALLENGES
**Fragile and conflict/post-conflict situations:** These situations present the most profound challenges to development in the world today. In both fragile and conflict-affected states, poverty levels are usually high and welfare levels low. The stability and social cohesion necessary for development are frequently lacking. And often there are no strong and legitimate institutions to address poverty and manage conflict. Violent conflict is more likely to re-emerge in such areas, leading to further impoverishment, undercutting social cohesion and eroding institutions.28,29 Each conflict is slightly different, but important factors include the longstanding and intractable Middle East crisis, remnants of the Cold War and sectarian religious divisions. Many conflicts are also driven by underlying causes, including poverty, poor governance and neglect, and local grievances.

- **Sociopolitical factors:** These include the upturn in the number and intensity of conflicts in the last five years, both in the African Region and the Eastern Mediterranean Region. It also involves the religious extremist component in many of the conflicts, including the transnational upsurge of belligerence associated with certain manifestations of Islam, which may in turn be in part stimulated by economic stagnation and unemployment, along with increased globalization. Risks of nuclear or chemical terrorism are likely to have increased.

- **Adverse impact on disease control and nutrition:** War and conflict impede the maintenance of public health interventions and health services and are major obstacles in efforts to eradicate, eliminate or control diseases such as malaria and HIV. Polio is a particularly telling example: the battle against the virus has become entirely focused on conflict zones such as in Afghanistan and Pakistan. War and conflict also adversely affect the economy and people’s livelihoods and may cause serious malnutrition and famines.

STRATEGIC PRIORITIES
SDG 16 is to “Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels”. Its first two targets are to:

- significantly reduce all forms of violence and related death rates everywhere;
- end abuse, exploitations, trafficking and all forms of violence against and torture of children.

To break cycles of insecurity and reduce the risk of their recurrence, national reformers and their international partners need to build legitimate institutions that can provide a sustained level of citizen security, justice and jobs – offering a stake in society to groups that may otherwise receive more respect and recognition from engaging in armed violence than in lawful activities, and punishing infractions capably and fairly.29

In May 1998, the Fifty-first World Health Assembly accepted the role of WHO in *health as a bridge for peace* in the Health for All in the 21st century strategies. In fragile and conflict-affected settings, health can serve as an important entry point around which all stakeholders can unite. Health investments can potentially contribute to state-building and, perhaps, to enhanced national and local legitimacy. It is essential to work with local communities and with non-state actors in order to rebuild or preserve the functioning of the health system, ensure disease control, address the needs of affected groups such as women and children, provide access to comprehensive services, including sexual and reproductive health and mental health and psychosocial care, maintain health financing and protect health-care workers.

The SDGs provide a global framework for greater focus and action in conflict and post-conflict countries. This requires greater integration efforts of health and other sectors, and of humanitarian and development support.
Disasters are often associated with hazards that include hydrological (floods and landslides), meteorological (extreme temperatures and storms), climatological (droughts and wildfires) and geophysical phenomena (earthquakes/tsunamis, volcanic eruptions and dry mass movements). Hydrological and meteorological disasters accounted for 47% and 36%, respectively, of all natural disasters in 2014. Globally, 324 natural disasters were registered in 2014, which were associated with 141 million victims and 7,823 deaths. Technological disasters, including industrial and transport disasters, accounted for almost 40% of all types of disasters in 2014, but affect smaller numbers of people as they tend to be more localized.

TRENDS

During 2000–2014, an average 86,500 people were killed each year by natural disasters (not including biological hazards). Since 2000, there have been on average 656 natural and technological disasters each year, with slightly lower figures during 2012–2014. In 2013, the number of people affected reached its lowest point since 1997 (Figure 8.12).

The number of total deaths was the lowest in 2014, but the long-term mortality trend is dominated by major events (Figure 8.13). Several major natural disasters stood out, each killing more than 50,000 people in a single year: the Indian Ocean tsunami in 2004 and the Haiti earthquake in 2010, the cyclone in Myanmar in 2008, and the extreme temperatures in Europe in 2003 and 2010.

Out of over one million disaster-related deaths during 2000–2014, 61% occurred in Asia where 60% of the global population live, and 20% in the Americas. Africa (6%) and Oceania (less than 1% of deaths) had much smaller proportions.
POSITIVE DEVELOPMENTS

Global framework for action: The Hyogo Framework for Action 2005–2015 provided the basis for risk management embedded inside health systems that ensured a greater focus on prevention, including exposure and vulnerability reduction, while also addressing preparedness, response and recovery. International mechanisms for strategic advice, coordination and partnership development for disaster risk reduction, such as the Global Platform for Disaster Risk Reduction and the regional platforms for disaster risk reduction, as well as other relevant international and regional forums for cooperation, have been instrumental in the development of country policies and strategies and the advancement of knowledge and mutual learning.

Country action: Many countries (85%) have a national emergency preparedness and response policy and two thirds of countries have a policy in place for health sector emergency preparedness and response.16 In their reporting to WHO, 130 Member States indicated that they have “emergency preparedness and response programmes” in place.

Globally 79 countries have reported they are implementing the Safe Hospital Initiative, which provides concrete actions towards the implementation of the Sendai Framework for Disaster Risk Reduction 2015–2030. WHO has been promoting safer hospitals for more than 20 years31 and there is evidence of success. For instance, the hospitals in the Kathmandu valley were functioning immediately after the earthquake in Nepal (April and May 2015), helping to save lives. While the number of floods has been increasing, mortality has fallen. This likely reflects improvements in development conditions in low- and middle-income countries and better early warning, disaster preparedness and response in health and other sectors.32

CHALLENGES

Disasters occur frequently: On average there is about one major disaster recorded on the global databases every day on earth, and intensity may be increasing, in some cases as a result of climate change.

Large economic impact: Many countries – especially low- and middle-income countries, where the mortality and economic losses from disasters are disproportionately higher – are struggling to meet the financial, logistical and humanitarian needs for recovery from disasters.

Lack of country policies and poor emergency care services: One third of countries do not have any type of policy in place for health sector emergency preparedness and response.19

Tackle disaster risk drivers: Further efforts are needed to reduce exposure and vulnerability and to tackle underlying disaster risk drivers, such as the consequences of poverty and inequality, climate change and variability, unplanned and rapid urbanization, and poor land management.

STRATEGIC PRIORITIES

The post-2015 development agenda provides the international community with a unique opportunity to enhance coherence across policies, institutions, goals, indicators and measurement systems for implementation. SDG Target 3.d calls for strengthening of country capacity for early warning, risk reduction and management of national and global health risks, which aligns with the application of a comprehensive all-hazards approach to the development of country capacities for emergency and disaster risk management for health. This links with several WHO resolutions that called for Member States to strengthen national emergency prevention, preparedness, response and recovery programmes, and the resilience of health systems.33,34

The Sendai Framework for Disaster Risk Reduction 2015–2030, as part of the post-2015 development agenda, aims to substantially reduce disaster risk and loss through integrated and multisectoral actions to prevent new disasters, mitigate existing disaster risk, reduce hazard exposure and enhance preparedness for response and recovery.21 The Framework puts health at the centre of global policy and action to reduce disaster risks20,26 and takes an all-hazards approach, including epidemics and pandemics within its scope as well.

To enhance the resilience of national health systems, the Sendai Framework recommends that disaster risk reduction strategies be integrated into all aspects of health-care provision (primary, secondary and tertiary), WHO has worked with Member States and stakeholders on the development of an Emergency Disaster Risk Management for Health (EDRM-H) policy framework, based on a comprehensive and integrated risk management approach, referring to a series of closely interrelated steps of prevention/mitigation, preparedness, response and recovery.24 It is intended to serve as an overarching policy across all types of hazards.
NOTES AND REFERENCES


6 Graph uses WHO regional grouping with high-income OECD countries separated out (see Annex 1).


25 Includes contact and noncontact sexual violence (unwanted advances, harassment involving coercion).


35 The substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries.

36 Prevent new and reduce existing disaster risk through the implementation of integrated and inclusive economic, structural, legal, social, health, cultural, educational, environmental, technological, political and institutional measures that prevent and reduce hazard exposure and human vulnerability to disaster, increase preparedness for response and recovery, and thus strengthen resilience.