Part I – Background
INTERPERSONAL VIOLENCE – A UNIVERSAL CHALLENGE

Interpersonal violence and its consequences

More than 1.3 million people worldwide die each year as a result of violence in all its forms (self-directed, interpersonal and collective), accounting for 2.5% of global mortality. For people aged 15–44 years, violence is the fourth leading cause of death worldwide (1). In addition, tens of thousands of people around the world are victims of non-fatal violence every day. These include victims of assault who sustain physical injuries requiring treatment in emergency departments and those who suffer other physical, sexual and psychological abuse, but may not bring it to the attention of health or other authorities. This report focuses on interpersonal violence, which is violence that occurs between family members, intimate partners, friends, acquaintances and strangers, and includes child maltreatment, youth violence (including that associated with gangs), violence against women (for example, intimate partner violence and sexual violence) and elder abuse (2). It is distinct from self-directed violence and collective violence, which are not covered in this report. Self-directed violence is that which people inflict upon themselves, such as suicidal behaviour and self-mutilation (2). Collective violence refers to instrumental violence inflicted by larger groups such as nation states, militia groups and terrorist organizations in order to achieve political, economic or social objectives (2).

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


Since 2000, about 6 million people globally have been killed in acts of interpersonal violence, making homicide a more frequent cause of death than all wars combined during this period. Non-fatal interpersonal violence is more common than homicide and has serious and lifelong health and social consequences.

Beyond physical injuries, the health effects of violence include disabilities, depression, reproductive and physical health problems, smoking, high-risk sexual behaviours and alcohol and drug misuse – behaviours that link experiences of violence to heart disease, stroke, cancer, HIV/AIDS and a host of other chronic and infectious diseases and early death. Violence places a heavy strain on health and criminal justice systems, and social and welfare services. Violence also erodes the economic fabric of communities as local economies are impacted by workforce absenteeism, lost productivity, loss of human capital, and face disincentives for investment and economic development.

Calls to action

Violence has long been recognized as a problem for the criminal justice and defence sectors and has been taken up in various United Nations (UN) resolutions dating back to 1986 (see Box 1). It was put on the international health agenda when the World Health Assembly, at its meeting in Geneva in 1996, adopted a resolution declaring violence a leading worldwide public health problem (WHA49.25). The World Health Assembly called upon Member States to give urgent consideration to the problem of violence and requested the Director-General of the World Health Organization (WHO) to develop a science-based approach to understanding and preventing violence.

WHO responded to the resolution in part with the World report on violence and health – the first comprehensive review of violence as a global public health problem (2). The report covered a broad spectrum of violence, from highly visible forms such as youth violence and collective violence, to more hidden forms that occur against women, children and elderly people, as well as self-directed violence. For each, the report described what was known about the magnitude and impact of the problem, the factors

that increase or protect against the risk of violence, the different intervention and policy responses that have been tried and what is known about their effectiveness. It also made recommendations for action at local, national and international levels. In short, the report recommended that governments:

1. create, implement and monitor a national action plan for violence prevention;
2. enhance capacity for collecting data on violence;
3. define priorities for, and support research on, the causes, consequences, costs and prevention of violence;
4. promote primary prevention responses;
5. strengthen responses for victims of violence;
6. integrate violence prevention into social and educational policies, and thereby promote gender and social equality;
7. increase collaboration and exchange of information on violence prevention;
8. promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights;
9. seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

Box 1: Examples of United Nations actions on interpersonal violence

While crime prevention has been on the agenda of international organizations since 1872, when the First International Congress on the Prevention and Repression of Crime was held in London, interest in preventing interpersonal violence increased around 30 years ago. In 1986 the UN Educational, Scientific and Cultural Organization (UNESCO) asserted in the *Seville statement on violence* that violent behaviour is not genetically programmed into human nature and is therefore preventable (8), and in 1990 the United Nations Guidelines for the Prevention of Juvenile Delinquency were adopted (9). In 1997, the United Nations Office on Drugs and Crime (UNODC) was established and mandated to assist Member States in addressing the interrelated issues of drug control, crime prevention and international terrorism in the context of sustainable development and human security. In 2002, the UN Economic and Social Council adopted the *Guidelines for the prevention of crime* (10), which set out basic principles and methods for crime prevention and provide guidance for international action.

In 1989, the General Assembly of the United Nations adopted the Convention on the Rights of the Child (UNCRC) which obliges governments, “to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation” (11). The Committee on the Rights of the Child, which oversees implementation of this convention, has held several thematic discussions on violence against children and called for the UN *Study on violence against children* (12, 13) which was published in 2006. This report has been followed by several regional reports and by the appointment in 2009 of the UN Secretary General’s Special Representative on Violence against Children, who in 2013 developed the *Global survey on violence against children* (14).

Violence against women has also received considerable attention from UN agencies. In 1993 the UN General Assembly adopted the Declaration on the Elimination of Violence against Women (15). Since 1994 there has been a UN Special Rapporteur on Violence against Women, its causes and consequences. In 1996 the United Nations Development Fund for Women established its Trust Fund to Eliminate Violence against Women, and in 2006 the UN Secretary General’s *In-depth study on all forms of violence against women* was published. In 2010, the UN General Assembly adopted the *Updated model strategies and practical measures on the elimination of violence against women in the field of crime prevention and criminal justice* (16). On its establishment as an organization in 2010, the UN Entity for Gender Equality and the Empowerment of Women (otherwise known as UN Women) prioritized the prevention of and response to violence against women and works closely with other agencies such as UNODC, the UN Population Fund (UNFPA), UNAIDS and WHO to empower women, prevent violence against them, and mitigate its consequences.
The report became a catalyst for stimulating awareness and action. WHO regional committees for Africa, the Americas, Europe, and the Western Pacific adopted resolutions endorsing the report’s recommendations and encouraged their Member States to implement them. Heads of state in the African Union and the Council of Europe endorsed the report, as did international nongovernmental organizations such as International Physicians for the Prevention of Nuclear War, Médecins Sans Frontières and the World Medical Association. At a national level, uptake of the World report on violence and health was reflected in the convening of over 50 policy discussions on the report, and the publication of 25 national reports on violence and health that were modelled on the global report.

WHO also developed the methodology for and conducted the WHO multi-country study on women’s health and domestic violence. The report of this study (5) presented the first comparable data on the prevalence of different forms of violence against women, their consequences and risk factors, and the coping strategies that women develop in the face of intimate partner violence. In 2013, WHO published the first Global and regional estimates of violence against women: prevalence and health burden of intimate partner violence and non-partner sexual violence (6), and Clinical and policy guidelines for responding to intimate partner violence and sexual violence against women (7). These guidelines have been widely disseminated and nearly 35 countries have participated in related capacity-building workshops.

In 2003 the World Health Assembly adopted resolution WHA56.24, which called upon Member States to appoint a focal point within their ministries of health and actively make use of the conclusions and recommendations of the World report on violence and health. 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 WHO’s 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 (WHA67.15).
Aims of this report

The Global status report on violence prevention 2014 represents the progress countries have made in implementing the recommendations of the World report on violence and health (2). The specific aims of the report are to:

- describe the current state of the problem around the world and the extent to which countries are collecting data on fatal and non-fatal violence to inform planning and action;
- assess the current status of programmatic, policy and legislative measures to prevent violence;
- evaluate the status of health, social and legal services for victims of violence;
- identify gaps and stimulate national action to address them.

By providing an assessment of violence prevention efforts at the global level and a snapshot of the state of violence prevention efforts in each country, the report is a starting point to track future progress and offers a benchmark that countries can use to assess their own progress.

Method

In November 2010 WHO, in collaboration with the United Nations Development Programme (UNDP) and the United Nations Office on Drugs and Crime (UNODC), began developing the Global status report on violence prevention 2014. The method for data collection was modelled on that used in WHO’s first Global status report on road safety (17). It involved systematically gathering data and other information from each country, led by a government-appointed National Data Coordinator. Within each country, individual respondents from ministries of health, justice, education, gender and women, law enforcement and police, children and social development, interior, and (where relevant) nongovernmental organizations, completed a self-administered questionnaire. The questionnaire focused on interpersonal violence including child maltreatment, elder abuse, intimate partner violence, sexual violence, youth violence, gang violence and armed violence,2 and included questions covering the following areas:

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2 Armed violence is, “the use or threatened use of weapons to inflict injury, death or psychosocial harm, which undermines development” (18). It is estimated that 90% of armed violence victims die as a result of homicide or from deaths occurring during legal interventions in non-conflict countries (19).
• national plans of action for the prevention of violence overall, and by type of violence;
• agencies/departments responsible for overseeing or coordinating violence prevention activities, as well as mechanisms for collaboration and exchange of information on violence prevention;
• data on homicide from police and civil or vital registration systems;
• data on non-fatal violence from national population-based surveys;
• social and educational policies relevant to multiple types of violence (e.g. incentives for youth at high-risk of violence to complete schooling, policies to reduce poverty in specific areas);
• other policies and laws relevant to multiple types of violence (e.g. alcohol, policing strategies, firearms legislation);
• prevention policies, programmes and laws by type of violence;
• health, social and legal services for victims of violence.

A multisectoral group of national counterparts working on violence prevention was then asked to reach a consensus on the data that best represented their country. The final data submitted for each country were then validated by WHO regional and global violence prevention technical staff by checking them against independent databases and other sources. Permission to include the final data in the status report was then obtained from country government officials. More details on the method can be found in Part V, Explanatory notes (page 57).

The narrative section of this report presents an analysis of information aggregated across countries, including estimated rates of homicide based on homicide data reported by countries and from international datasets. Part VI, At a glance, provides an overview of the findings for the five main types of violence covered by the report, namely child maltreatment, youth violence, intimate partner violence, sexual violence and elder abuse. Part VIII, Country profiles, describes the main indicators reported by each participating country using a standard template. Part IX, the Statistical annex, includes country-by-country results across several indicators.

This report highlights data from 133 countries covering 6.1 billion people and representing 88% of the world’s population. Response rates by region covered 63% of the population in the Eastern Mediterranean Region (16 countries), 70% in the African Region (27 countries), 83% in the European Region (41 countries), 88% in the Region of the Americas (21 countries) and 97% in both the South-East Asia (8 countries) and Western Pacific Regions (20 countries) (see Explanatory notes, Table 7, page 61).
Part II – State of the problem
DEATHS AND INJURIES ARE ONLY A FRACTION OF THE BURDEN

Violence is a major contributor to death, disease and disability, and a host of other health and social consequences worldwide. The magnitude of the problem is best represented by a pyramid. Violent deaths are the most visible outcome of violent behaviour recorded in official statistics, yet represent only the apex of the pyramid. Next are victims of violence that come to the attention of health authorities and receive some form of emergency medical, medico-legal or other care. The third, much broader layer at the base of the pyramid includes acts of violence captured in population-based surveys – acts that may never be reported to health or other authorities. These surveys are critical to documenting the prevalence and consequences of violence against women and girls, child maltreatment and elder abuse. Of course, not all victims of violence are willing to disclose their experiences of violence even in a confidential interview, and the base of the pyramid also comprises the many victims of violence who suffer in silence.

As evident from the information presented in this report on fatal and non-fatal violence, the patterns and consequences of violence are not evenly distributed among countries, regions, or by sex and age. Whereas males are disproportionally represented among victims of violent death and physical injuries treated in emergency departments, women and girls, children and elderly people disproportionately bear the burden of the non-fatal consequences of physical, sexual and psychological abuse, and neglect, worldwide. They also suffer a host of negative health and social consequences from these acts of violence that often last a lifetime and that are not captured in official statistics.

Homicide claimed the lives of an estimated 475 000 people worldwide in 2012

In 2012 an estimated 475 000 people worldwide were victims of homicide, for an overall rate of 6.7 per 100 000 population (see Table 1 and Box 2). Rates in high-income countries from all regions were generally lower than rates in low- and middle-income countries, and there were an estimated 3.8 homicides per 100 000 in all high-income countries combined.

Table 1: Estimated numbers and rates of homicide per 100 000 population, by WHO region and country income status, 2012

<table>
<thead>
<tr>
<th>WHO region and country income level</th>
<th>Number of homicides</th>
<th>Homicide rate per 100 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Region, low- and middle-income</td>
<td>98 081</td>
<td>10.9</td>
</tr>
<tr>
<td>Region of the Americas, low- and middle-income</td>
<td>165 617</td>
<td>28.5</td>
</tr>
<tr>
<td>Eastern Mediterranean Region, low- and middle-income</td>
<td>38 447</td>
<td>7.0</td>
</tr>
<tr>
<td>European Region, low- and middle-income</td>
<td>10 277</td>
<td>3.8</td>
</tr>
<tr>
<td>South-East Asia Region, low- and middle-income</td>
<td>78 331</td>
<td>4.3</td>
</tr>
<tr>
<td>Western Pacific Region, low- and middle-income</td>
<td>34 328</td>
<td>2.1</td>
</tr>
<tr>
<td>All regions, high-income</td>
<td>48 245</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Global</strong></td>
<td><strong>474 937</strong>[^a]</td>
<td><strong>6.7</strong></td>
</tr>
</tbody>
</table>

[^a]: Includes 1604 homicides estimated for non-member states.
For low- and middle-income countries, the highest estimated rates of homicide are in the Region of the Americas, with an annual rate of 28.5 deaths per 100,000 population, followed by the African Region with a rate of 10.7 per 100,000 population. The lowest estimated rates of homicide are in the low- and middle-income countries of the Western Pacific Region (2.1 per 100,000) with an annual rate that is three times lower than the global rate of homicide, and just under two times lower than the rate for all high-income countries combined and that for the European Region (see Table 1).

**Young males bear the burden of homicide**

Fatal violence is not distributed evenly among sex and age groups. Males account for 82% of all homicide victims and have estimated rates of homicide that are more than four times those of females (10.8 and 2.5, respectively, per 100,000) (see Table 2). The highest estimated rates of homicide in the world are found among males aged 15–29 years (18.2 per 100,000), followed closely by males aged 30–44 years (15.7 per 100,000). Estimated rates of homicide among females range from 1.2 per 100,000 in ages 5–14 years, to 3.2 per 100,000 in the age group 15–29 years.

### Table 2: Estimated homicide rate per 100,000 population by age group and sex, 2012, world

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>2.8</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>5–14</td>
<td>1.7</td>
<td>1.2</td>
<td>1.5</td>
</tr>
<tr>
<td>15–29</td>
<td>18.2</td>
<td>3.2</td>
<td>10.9</td>
</tr>
<tr>
<td>30–44</td>
<td>15.7</td>
<td>2.7</td>
<td>9.3</td>
</tr>
<tr>
<td>45–59</td>
<td>10.2</td>
<td>2.0</td>
<td>6.1</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>6.7</td>
<td>2.7</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10.8</td>
<td>2.5</td>
<td>6.7</td>
</tr>
</tbody>
</table>
The disproportionate impact of homicide on youth is a consistent pattern across all levels of country income (see Figure 1). It is however much more pronounced in low- and upper middle-income countries than in lower middle- and high-income countries. Furthermore, the effects of country income on homicide rates differ by age group.

In the age ranges 0–4 and 5–14 years, homicide rates increase progressively from high- to low-income countries (see Figure 1). By contrast, homicide rates in the 15–29 and 30–44 year age ranges are highest in upper middle-income countries, followed by low-income countries. This may reflect the influence of factors other than income and which may be specific to upper middle-income countries in the Region of the Americas.

**For women, homicide is often at the hands of partners**

When women are killed, it is often their partner who is responsible. In 2013 WHO and others estimated that as many as 38% of female homicides globally were committed by male partners while the corresponding figure for men was 6% (6, 22). Of the statistics on these female homicide victims, 20% were lacking data on perpetrator-victim relationship (22).

**One in every two homicides is committed with a firearm — although this varies markedly by region**

Approximately one in every two homicides is committed with a firearm, and one in four with a sharp instrument such as a knife (see Figure 2), although the mechanism of homicide varies markedly by region. While firearm homicides account for 75% of all homicides in the low- and middle-income countries of the Region of the Americas, they account for...
only 25% of homicides in the low- and middle-income countries of the European Region, where 37% of homicides involve sharp instruments (see Figure 3). Homicides by sharp force are estimated to comprise 35% of homicides in the African Region, 26% in the Eastern Mediterranean Region, and 38% in the South-East Asia Region.

Figure 3: Proportion of homicides by mechanism and WHO region, 2012
Cultural factors, whether an incident involves child maltreatment, youth violence, intimate partner violence or sexual violence against women or elder abuse, and the availability of weapons often determine how weapons are used in interpersonal violence (2). Firearms are highly prevalent in the Region of the Americas and are the predominant weapon used in violent encounters, including intimate partner homicides. In other regions, weapons such as knives and beatings with fists, feet or objects are more common. The weapons used in interpersonal violence also differ substantially from one type of violence to another. Blunt trauma and suffocation, for instance, are more common in cases of fatal child maltreatment. In contrast, cases of youth violence are more likely to feature lethal weapons such as firearms or knives (2). In some countries, so-called honour killings and death by fire account for a significant number of reported cases of lethal intimate partner violence against women.

Homicides are declining fast in high-income countries but more slowly elsewhere

Over the period 2000–2012, homicide rates are estimated to have declined by just over 16% globally (from 8.0 to 6.7 per 100 000 population), and, in high-income countries, by 39% (from 6.2 to 3.8 per 100 000 population, see Figure 4). By contrast, homicide rates in low- and middle-income countries have shown less decline over the same period. For both upper and lower middle-income countries the reported decline was 13%, and for low-income countries it was 10%.

Hundreds of thousands of victims of violence receive emergency medical care each year

For every violence-related death there are many more individuals who seek emergency treatment for an injury sustained from an act of interpersonal violence. For example, in a nationally representative study of violence-related injury cases presenting at emergency departments during a 1-month period in Brazil, there were 4835 cases of violence-related injury, of which 91% were victims of interpersonal violence and 9% were the result of self-directed violence. More than half of the victims (55%) were also young, aged 10–29 years (23). In the United States of America, 1 723 515 people were treated in emergency departments in 2012 for injuries sustained in an assault; 37% were aged 10–24 (24). In Cape Town, South Africa, analysis of 9236 consecutive trauma centre admissions from October 2010 to September 2011 showed that assault with a sharp instrument (21%) or blunt object (17%) were the two most common mechanisms of injury, that over 70% of all cases were males, and 42% were aged 18–30 years (25).

Globally, an estimated 42% of women who have been physically and/or sexually abused by a partner have experienced injuries as a result of that violence (6). Estimates from some countries indicate that more than
one in four women injured by an intimate partner requires medical care (26). Blunt-force injuries by an intimate partner are most commonly inflicted on the head, face and neck, followed by musculoskeletal and genital injuries (6, 27).

Children who suffer physical abuse may manifest a variety of internal and external injuries that can be life threatening (28). Abusive head trauma is a common cause of injuries in very young children. Skull fractures, retinal haemorrhaging, subdural haematomas, neurological disabilities, cortical blindness and seizures are some of the common injuries related to abusive head trauma (28). Injuries that are unexplained or inconsistent with the history provided by the child or a caregiver may also suggest abuse.

Elder abuse can also lead to physical injuries ranging from minor scratches and bruises to broken bones and head injuries that lead to lasting disabilities. For older people, the consequences of abuse can be especially serious because their bones are more brittle and convalescence takes longer. Even relatively minor injuries can cause serious and permanent damage, or death (29).

**Women, children and elderly people bear the burden of the non-fatal consequences of physical, sexual and psychological abuse**

Violence against women, against children, and elder abuse are particularly prone to underreporting in official death statistics, police reports and data on injuries treated in hospital emergency departments. In the case of violent deaths, there can be significant levels of misclassification of deaths from intimate partner violence, with deaths often being attributed to another cause (for example, a kitchen accident or a fall). Furthermore, information about the victim-perpetrator relationship is often missing from official homicide statistics. Many child and elderly deaths are also not routinely investigated or subject to post-mortem examination, which makes it difficult to establish the precise numbers of fatalities from abuse. In the case of police reports of non-fatal violence and injuries treated in hospital emergency departments, factors such as the severity of the violence, the age of the victim, whether the perpetrator was known to the victim and lack of access or distrust in health or police authorities impact the likelihood of a victim coming forward to report their assault.

Much of what is known about violence against women, children and older adults comes from population-based surveys and special studies. These studies indicate that physical, sexual and psychological abuse are widespread and undermine the health and well-being of millions of women, children and older adults worldwide. These studies also underscore the fact that a reliance on routinely collected data from police and health services is inadequate for the design and monitoring of comprehensive prevention plans addressing these forms of violence. For example, population-based surveys of intimate partner violence against women show that 20% to 60% of women have told no one about the violence and few have sought institutional help, including from health care services. Of women who were injured due to violence, 48% reported needing health care for the injury, but only 36% actually sought it (5).
About 30% of ever-partnered women throughout the world have experienced physical and/or sexual violence by an intimate partner at some point in their lives

Global estimates of intimate partner violence perpetrated by men against women indicate that 30% of ever-partnered women (about one in three) worldwide have experienced physical and/or sexual violence by an intimate partner at some point in their lives (see Figure 5) (6). In the African, Eastern Mediterranean and South-East Asia Regions, approximately 37% of ever-partnered women report experiencing physical and/or sexual violence by an intimate partner in their lives, followed by the Region of the Americas, with approximately 29.8% of women reporting lifetime exposure. Globally, 7.2% of women also report experiencing sexual violence by other perpetrators (6).

One in five girls has been sexually abused during childhood, with estimates from some countries placing that proportion closer to one in three

Estimates of child maltreatment indicate that nearly a quarter of adults (22.6%) worldwide suffered physical abuse as a child, 36.3% experienced emotional abuse and 16.3% experienced physical neglect, with no significant differences between boys and girls (30–32). However, the lifetime prevalence rate of childhood sexual abuse indicates more marked differences by sex – 18% for girls and 7.6% for boys (33). National surveys of violence against children conducted in Africa reveal much higher rates of childhood physical, sexual and emotional abuse than the global rates.
Part II – State of the problem

60 years  For instance, reported rates of abuse among older adults in the past year among adults aged over 60 years in rates of abuse in the past month shows that 6% of older adults reported significant abuse. Elder abuse has not been studied to the same extent as children’s abuse. In South-East Asia Region, low- and middle-income countries find wide variation in the reported prevalence of childhood physical abuse of girls in Swaziland and Zimbabwe, with somewhat higher rates of childhood physical abuse experienced by boys than girls. The reported prevalence of childhood physical abuse was between 22% and 24% in Kenya, the Republic of Tanzania, and Zimbabwe, for instance, indicate that about one in three girls experienced sexual abuse during their childhood. For boys, the reported prevalence of childhood sexual abuse ranged from 9% in Zimbabwe to 18% in Kenya (see Figure 6). The reported prevalence of childhood physical abuse was between 53% and 76% in Kenya, the Republic of Tanzania, and Zimbabwe, with somewhat higher rates of childhood physical abuse experienced by boys than girls. The reported prevalence of childhood physical abuse of girls in Swaziland was 22%. The reported prevalence of emotional abuse during childhood for the four countries was between 24% and 38%, with similar rates indicated by boys and girls (34–37).

Globally, 6% of older adults report significant abuse in the past month

Elder abuse has not been studied to the same extent as other types of violence. The only available global estimate shows that 6% of older adults reported significant abuse in the past month (38). National surveys conducted in predominately high-income countries find wide variation in rates of abuse in the past year among adults aged over 60 years. For instance, reported rates of abuse among older adults living in private households range from 0.8% in Spain and 2.6% in the United Kingdom to upwards of 18% in Israel, 23.8% in Austria and 32% in Belgium (38–40). In studies of vulnerable elders (for example, those suffering dementia or living in a residential institution for older adults), nearly 25% reported significant levels of psychological abuse (41). With a rapidly ageing population in countries around the world, the number of elderly adults vulnerable to abuse, neglect and exploitation is expected to grow.

Violence contributes to lifelong ill health, particularly for women and children

The non-fatal consequences of violence are by far the greatest part of the social and health burden arising from violence (see Figure 7). Physical injuries themselves are outweighed by the wide spectrum of negative behavioural, cognitive, mental health, sexual and reproductive health problems, chronic diseases and social effects that arise from exposure to violence. All types of violence have been strongly linked to negative health consequences across the lifespan, but violence against women and children contributes disproportionately to the health burden. The available evidence shows that victims of child maltreatment and women who have experienced intimate partner and sexual violence have more health problems, incur significantly higher health care costs, make more visits to health providers over their lifetimes and have more hospital stays (and longer duration of hospital stays) than those who have not experienced violence (2, 27).
Violence against women and girls is an important risk factor for HIV, other sexually transmitted diseases, unwanted pregnancies and other reproductive health problems. For example, women who have experienced intimate partner violence have a 16% greater chance of having a low birth weight baby and are more than twice as likely to have an induced abortion (6). In certain regions of the world, women who have experienced intimate partner violence are 1.5 times more likely to acquire HIV and 1.6 times more likely to have syphilis (6). Violence against women and children has also been strongly linked to many other adverse health outcomes affecting the brain and nervous system, gastrointestinal and genitourinary systems, and immune and endocrine function (endocrine glands secrete hormones that control and coordinate activities throughout the body) (27, 28).

Figure 7: Behavioural and health consequences of violence
Exposure to violence is also strongly associated with high-risk behaviours such as alcohol and drug abuse and smoking, which in turn are key risk factors for several leading causes of death, including cardiovascular disease, cancer, chronic lung disease, liver disease and other noncommunicable diseases (42–44). Victims of violence are also at higher risk of depression, anxiety, post-traumatic stress disorder and suicidal behaviour (27, 28, 45, 46). Both exposure to violence and men’s perpetration of violence against women have been shown to be associated with high-risk sexual behaviours (47, 48). For example, findings from a multi-country study in Eastern Europe found a substantially greater risk of problem drinking (10 times) and drug use (six times) among young adults who had four or more adverse experiences in childhood compared to young adults without these experiences (42). Young adults who experienced adverse events in their childhood also had a 2.4 times increased risk of cancer, 5.8 times risk of stroke and 49-fold increased risk of attempting suicide compared to those without adverse child experiences (42).

Women exposed to intimate partner violence are almost twice as likely to have an alcohol use disorder, twice as likely to experience depression, and have a 4.5-fold increased risk of suicide attempts compared to women who have not been exposed to partner violence (6). Women who have experienced non-partner sexual violence are also 2.3 times more likely to have alcohol use disorders and 2.6 times more likely to have depression or anxiety than women who have not (6).

**Violence has high economic costs – preventing violence can promote economic growth**

The health and social consequences of violence take an economic toll on countries too, although the precise burden is unknown, particularly in developing countries where economic losses and impact tend to be underestimated. The provision of treatment, mental health services, emergency care and criminal justice responses are some of the direct costs associated with violence. There are also a wide range of indirect costs. Victims of violence are more likely to experience spells of unemployment, absenteeism, and to suffer health problems that affect job performance (49). Other indirect costs include those related to lost productivity because of premature death; long-term disability; the provision of places of safety for children and women; disruptions to daily life because of fears for personal safety; and disincentives to investment and tourism (49).
Findings from various cost studies show that most countries expend a significant amount of resources in responding to violence. It was estimated in 2004 that direct and indirect economic costs of violence were equivalent to 0.4% of gross domestic product (GDP) in Thailand, 1.2% of GDP in Brazil and 4% of GDP in Jamaica (49). In the United States, the total lifetime economic burden resulting from new cases of fatal and non-fatal child maltreatment is approximately US$ 124 billion annually (in 2010 dollars) (50). The annual economic cost of violence against women is estimated to be US$ 5.8 billion in the United States for the year 2003 (51).

A few efforts have been made to estimate the potential benefits of violence prevention to national economies. Comparison of data from Costa Rica (with a homicide rate of 8.1 per 100,000 population) with four nearby countries (Guyana with 16.1; Dominican Republic with 16.5; Jamaica with 33.8; and Haiti with 33.9) suggests significant gains could be made by these four countries if violence could be reduced to Costa Rica’s level. Guyana and the Dominican Republic would benefit from growth rate increases of 1.7 and 1.8% respectively, while Haiti and Jamaica could both increase annual economic growth per capita by an estimated 5.4% (52).

This section has shown that violence is a significant public health problem in its own right, and a major risk factor for lifelong ill health and other social problems that in combination can lead to substantial economic costs. It is against this backdrop that Part III, Findings, describes what countries are doing to prevent violence and mitigate its consequences, as indicated by their survey responses.
Part III – Findings
KNOWLEDGE OF THE TRUE EXTENT OF THE PROBLEM IS HINDERED BY GAPS IN DATA

Reliable data on the nature and extent of violence, the populations at risk and the causes and consequences of violence are essential to developing well-informed national plans of action and policies, programmes and services to prevent and respond to violence. Data on both fatal and non-fatal violence are necessary to inform these efforts. Countries were asked to provide information on deaths as well as on national population-based surveys that capture information on victimization which may or may not have been reported to police or other authorities.

For deaths, countries were asked to provide information on homicide from police data and from civil or vital registration data. Both sources of data have their strengths and weaknesses. Strengths of police data include the detailed nature of the information included, their comprehensiveness (compared to other crimes, homicide data suffer much less from underreporting), and their validity and consistency. Weaknesses of police data include the fact that within and between countries there can be wide variation in homicide information collected by law enforcement authorities because of varying legal thresholds for classifying a death as an intentional homicide, and because of varying police and law enforcement capacity to identify and record homicide events (53). For instance, infanticide leading to death or so-called “honour killings” may not be recorded as intentional homicides in police statistics (53).

Civil or vital registration systems, on the other hand, typically record homicides using the International Classification of Disease (ICD) external cause of injury codes (see ICD-10, chapter 20) (54). The manner (or intent) of death is determined by a medical professional (for example, a coroner or medical examiner) along with the underlying cause (the way in which the person sustained the fatal injury – for example, gunshot, strangulation). For a death to be classified as homicide, there must be a preponderance of evidence indicating that the injuries were inflicted by another person with the intent to injure or kill. In general, civil or vital registration systems are not subject to legal thresholds for classifying a death as a homicide. Thus, some cases may fall in the so-called undetermined intent category because of insufficient evidence to determine the manner of death. However, unlike criminal justice data, these systems...
record all causes of death, which facilitates adjustments to correct for incompleteness when computing national totals. Nonetheless, the quality of public health data on homicides is influenced by factors similar to police data, including insufficient professional health staff (especially in developing countries), problems of undercounting when not all deaths are properly examined and certified, and the possibility that cause of death assessments are changed by coroners after statistics are produced (20).

**Fully 60% of countries do not have usable data on homicide from civil or vital registration sources**

The findings from the survey show substantial gaps in data across the two sources of homicide information. The majority of countries (88%) report having data on homicide from police sources. However, fully 60% of countries do not have usable data on homicide from civil or vital registration sources, while about 9% of countries report having neither police nor vital registration data on homicide. Within certain WHO regions, the availability of data on fatal violence is even more limited. For instance, in the Eastern Mediterranean Region some 30% of countries report missing homicide data from police sources, and in the African and South-East Asia Regions, 70%–75% of countries indicate they are missing homicide data from civil or vital registration sources (see Figure 8). Data on homicides also remain insufficiently detailed in many countries to guide and monitor prevention and response efforts. For instance, 36% of countries report being unable to provide a breakdown of homicide by sex in their police data and more than half (54%) are not able to provide this breakdown in their civil or vital registration data. In addition, 13% of countries (over one third in the Eastern Mediterranean Region) say they lack annual data on homicide for the period 2001–2010 to track trends. Countries were not asked about information on victim-perpetrator relationships or about the circumstances surrounding the violent death. However, other studies (20,21) have found that few systems collect such information, making it difficult to classify homicides by type of violence (for example, those resulting from child maltreatment, elder abuse or from intimate partner violence). Without more detailed data, the measures countries are taking to prevent homicide run the risk of being poorly targeted and less effective than they could be.

Approximately 43% of countries reporting the availability of police homicide data do not use a standard definition to classify homicides (e.g. UNODC’s International Classification of Crime for Statistical Purposes) (55); for countries reporting homicide data from civil or vital registration sources, about 14% are not using a standard definition (e.g. ICD-10 external cause of injury codes) (54). Countries should identify ways to strengthen data from both sources and should also look for ways to link data from these and other sources to provide more complete and comprehensive information to target prevention efforts.
For most types of violence, under half of countries reported having conducted nationally representative population-based surveys

While the majority of countries say they have data on fatal violence from either police or vital registration sources, for most types of violence less than half of countries surveyed report having conducted nationally representative prevalence surveys (see Figure 9).

Even though gang violence and armed violence are highly visible types of violence, few countries have gathered systematic data to determine the prevalence and characteristics of these types of violence at a national level. Only 6% of countries report the conducting of national surveys on gang violence and 11% of countries report the conducting of surveys on armed violence, including in countries where smaller-scale studies indicate serious problems with gangs and gun violence. Further, only 26% indicate that they have surveyed youth violence, including 29% of countries in the Region of the Americas and 43% of countries in the European Region. Where conducted, such surveys have typically gathered population-based data on bullying, physical fighting and school violence.

Intimate partner violence is the most extensively surveyed of all types of violence

Approximately 57% of countries indicated that they had conducted national surveys on violence against women which focused on intimate partner violence, making this type of violence the most extensively surveyed of all, followed closely by population-based surveys that include sexual violence (see Figure 9). Data on intimate partner and sexual violence have typically been collected either in dedicated surveys of violence against women, or as part of demographic and health or reproductive health surveys. About two thirds of countries in the European Region and Region of the Americas (68% and 67% respectively) indicated that they have conducted surveys on intimate partner violence compared to 52% of countries in the African Region, 38% of countries in the Eastern Mediterranean Region and 25% of countries in the South-East Asia Region. About half (52%) of countries indicated that they have conducted national surveys that included questions on sexual violence, including many countries in Africa (67%), and between 25% and 62% in other WHO regions.

Countries reported that sexual violence was the predominant type of violence surveyed across all levels of country income status, with 52% indicating that they have conducted a national prevalence survey on sexual violence (see Table 3). While the proportion of countries reporting that they have conducted national surveys on various types of violence was consistently lower in low-income countries relative to middle- and high-income countries, this was not the case with sexual violence. More low-income countries reported conducting population-based surveys that included questions on sexual violence than high-income countries.

Approximately four in 10 countries (41%) report that they have conducted national surveys on child maltreatment (see
Figure 9), with 60% of countries in the European Region having done so compared with 43% in the Region of the Americas, 33% in the African Region and 13% of countries in the South-East Asia Region. These differences are also evident when looking at country income status. Only 14% of low-income countries report having conducted surveys on child maltreatment compared to nearly half of high- and middle-income countries (47% and 45% respectively) (see Table 3).

About one in six (17%) countries reports having conducted a survey on elder abuse (see Figure 9), including 32% of countries in the European Region, 19% of countries in the Region of the Americas and between 7%–13% in other regions, with the exception of the South-East Asia Region where no country indicates having conducted such a survey. Elder abuse was reportedly also the least surveyed of the different types of violence in low-income countries.

It is important to note that survey respondents were not always aware that national prevalence surveys had been conducted in their countries. Where this was the case, information about the existence of relevant surveys was shared with countries during the validation process. It is nonetheless possible that existing surveys have been missed. In addition, countries may have categorized a single survey as providing information on several different forms of violence (for example, intimate partner violence, sexual violence, child maltreatment) or have incorrectly categorized a small-scale survey as a national survey.

Table 3: Population-based surveys by type of violence and country income status (n = 133 reporting countries)*

<table>
<thead>
<tr>
<th>Type of violence</th>
<th>High-income</th>
<th>Middle-income</th>
<th>Low-income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed violence</td>
<td>13%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>Child maltreatment</td>
<td>47%</td>
<td>45%</td>
<td>14%</td>
</tr>
<tr>
<td>Elder abuse</td>
<td>34%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>58%</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>47%</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Youth violence</td>
<td>47%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Survey covering all types</td>
<td>45%</td>
<td>27%</td>
<td>14%</td>
</tr>
</tbody>
</table>

* There were too few reported surveys of gang violence for inclusion in this table.
NATIONAL ACTION PLANNING IS UNDERWAY IN MANY COUNTRIES

Developing a national action plan is a key step towards effective violence prevention. It is a way for countries to articulate how violence impacts the health, economic viability and safety and security of a nation. It also provides direction to policy-makers and others about what needs to be done and how best to achieve sustainable reductions in violence. As outlined in the recommendations of the World report on violence and health (2), a national action plan should include: objectives; priorities; strategies; assigned responsibilities; a timetable and evaluation mechanism; and adequate financial resources for implementation. The plan should also be based on input from a wide range of governmental and nongovernmental actors, and feature coordinating mechanisms at local and national levels to enable collaboration between sectors, with a specific organization mandated to monitor and report periodically on progress. Formulating a national action plan therefore involves considerable time and resources, and the existence of such a plan can thus be assumed to indicate a firm commitment to addressing the problem.

Plans that encompass all types of interpersonal violence are less common than those for specific types of violence

The different types of violence share many underlying risk factors and are related to each other in important ways. For example, children who suffer rejection, neglect, harsh physical punishment and sexual abuse – or witness violence at home or in the community – are at greater risk of engaging in aggressive and antisocial behaviour at later stages in their development, including engaging in violent behaviour as adults (56, 57). About half (51%) of countries surveyed indicated that they had integrated plans that address multiple types of violence (see Table 4). This suggests that in about half of countries, planning may be driven more by efforts to address specific types of violence than efforts to create synergies across types of violence. Integrated plans addressing all types of violence were far more frequent in the Region of the Americas (76%) than in other regions.

Many countries include intimate partner violence and sexual violence in their national plans to address violence against women. Approximately three out of every four countries reported having national action plans for child maltreatment (71%), followed by national action plans for intimate partner violence (68%) and sexual violence (65%), and youth violence (53%). Less than half of the surveyed countries reported plans to address elder abuse (41%), armed violence (40%) or gang violence (37%) (see Table 4).

Table 4: National action plans by type of violence and WHO region (n = 133 reporting countries)

<table>
<thead>
<tr>
<th>Type of violence</th>
<th>African region</th>
<th>Region of the Americas</th>
<th>Eastern Mediterranean Region</th>
<th>European Region</th>
<th>South-East Asia Region</th>
<th>Western Pacific Region</th>
<th>All countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed violence</td>
<td>41%</td>
<td>62%</td>
<td>44%</td>
<td>32%</td>
<td>50%</td>
<td>25%</td>
<td>40%</td>
</tr>
<tr>
<td>Gang violence</td>
<td>30%</td>
<td>62%</td>
<td>44%</td>
<td>33%</td>
<td>38%</td>
<td>25%</td>
<td>37%</td>
</tr>
<tr>
<td>Youth violence</td>
<td>41%</td>
<td>71%</td>
<td>44%</td>
<td>63%</td>
<td>38%</td>
<td>45%</td>
<td>53%</td>
</tr>
<tr>
<td>Child maltreatment</td>
<td>56%</td>
<td>91%</td>
<td>69%</td>
<td>78%</td>
<td>88%</td>
<td>55%</td>
<td>71%</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>63%</td>
<td>86%</td>
<td>44%</td>
<td>78%</td>
<td>75%</td>
<td>55%</td>
<td>68%</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>70%</td>
<td>86%</td>
<td>38%</td>
<td>63%</td>
<td>75%</td>
<td>60%</td>
<td>65%</td>
</tr>
<tr>
<td>Elder abuse</td>
<td>33%</td>
<td>86%</td>
<td>50%</td>
<td>39%</td>
<td>50%</td>
<td>35%</td>
<td>41%</td>
</tr>
<tr>
<td>Plan covering all types</td>
<td>41%</td>
<td>76%</td>
<td>50%</td>
<td>46%</td>
<td>50%</td>
<td>50%</td>
<td>51%</td>
</tr>
</tbody>
</table>
The Eastern Mediterranean Region reported the lowest frequency of national action plans to address intimate partner violence (44%) and sexual violence (38%). In the African Region, plans to address sexual violence, intimate partner violence and child maltreatment were reported by more than half of countries (70%, 63%, 56% respectively), whereas for youth, armed, and gang violence, only 30%–41% of countries in the region reported plans of action to address these types of violence. Plans of action to address elder abuse were indicated in fewer than half of all countries in the African, European and Western Pacific Regions.

**National plans are not always informed by data**

National action plans and information from data systems should be mutually reinforcing since good epidemiological data are needed to discern where violence is occurring, the groups at greatest risk and to track and monitor progress. Without an understanding of the extent and causes of violence it is difficult to formulate effective national plans of action or other policy frameworks for violence prevention. Ideally, the collection and analysis of data on the prevalence of — and risk factors for — fatal and non-fatal violence should therefore precede the formulation of national plans of action. However, where no such data collection systems and survey findings are available, it is also logical for authorities to develop a national plan of action that calls for improvements in the capacity to collect data. Comparing the extent to which national plans of action coincide with the availability of national population-based surveys for non-fatal violence thus provides insight into the relationship between data, policy and planning.

Globally, many more countries reported that they had plans of action to reduce violence than population-based surveys (see Figure 10). This was less the case for intimate partner and sexual violence against women, with the number of countries reporting national action plans on these types of violence 11–13 percentage points higher than the number of countries reporting surveys. Many countries include both intimate partner and sexual violence in their national plans to address violence against women and often include both intimate partner violence and sexual violence in population-based surveys. The most frequently reported plans of action were for child maltreatment (71% of countries), which was 30 percentage points more than the percentage of countries reporting surveys on child maltreatment. Similar gaps between plans of action and available survey data were seen for armed and gang violence and elder abuse, with about three times as many countries reporting plans of action for these types of violence than countries with survey data on them.
Regionally, the African Region had the largest gap between plans of action and available survey data across most types of violence. Consistency between action between action plans and the availability of survey data was highest in the European Region.

The reported predominance of national action plans over the availability of national survey data in general, and for the African Region in particular, suggests that much planning and policy-making is being done in the absence of data. While for some countries this may reflect a lag between calls for data collection and actual data collection improvements, future work should prioritize the filling of this gap by ensuring that national plans of action are firmly anchored in representative data on the magnitude and causes of different types of violence.

**Violence prevention activities are often addressed by multiple agencies without a lead agency for coordination**

The public health approach to violence prevention is a multisectoral one involving the public and private sectors (for example, health, education, criminal justice, social services and business) and civil society. In addition to adopting a multisectoral approach, it is also important to have leadership and mechanisms in place to coordinate the activities of different sectors and ensure fruitful collaboration between them.

Around 96% of countries reported having multiple agencies or departments that take responsibility for violence prevention and response efforts, with an average of five agencies listed per country. By sector, agencies responsible for gender and women’s affairs were the most frequently mentioned (54%), followed by the interior (41%), health (38%), police (32%) and social welfare (30%). The existence of lead agencies to coordinate the activities of different sectors and report periodically on progress in preventing all forms of violence, however, was rare. The absence of clear leadership and a mandate to ensure coordination of prevention activities that cover all forms of violence within countries makes it more challenging for agencies or departments to invest resources strategically, avoid duplication of effort and ensure accountability.

About three quarters (77%) of countries reported having a system in place for the regular exchange of information between different agencies and sectors involved in violence prevention. This suggests that at least the information exchange component of such a multisectoral coordinating mechanism very often exists, although the effectiveness of such systems remains unclear.
COUNTRIES ARE INVESTING IN PREVENTION BUT NOT ON A LEVEL COMMENSURATE WITH THE SCALE AND SEVERITY OF THE PROBLEM

Violence is a multifaceted problem with biological, psychological, social and environmental roots. Efforts geared towards preventing violence should therefore be comprehensive, tackling the range of factors that increase the risk of violence, including larger social determinants such as economic and gender inequality, and should be sustained over time. Violence prevention efforts can be targeted at individuals, relationships, communities and whole societies, and delivered in collaboration with the different sectors of society such as schools, workplaces, nongovernmental organizations and the criminal justice system.

Although there is no simple or single solution to the problem of violence, there is a growing body of knowledge on how to prevent violence, and countries and donor agencies seem to be investing more in prevention. However, there is considerable unevenness in the extent to which different strategies are being supported, and violence prevention has yet to attract political and financial support commensurate with the scale and severity of the problem.

A growing number of scientific studies demonstrate the preventability of violence. The evidence supporting certain prevention strategies is stronger and the prevention gains shown so far are greater for some types of violence than for others (for example, to address child maltreatment and youth violence). With some exceptions, most of the existing evidence for effective violence prevention programming also comes from studies in high-income countries, and may not easily be adapted to low- and middle-income settings where economic and social conditions, and the epidemiology of the different forms of violence, are very different (2, 56, 58).

Based on systematic reviews of the scientific evidence for prevention, WHO and its partners have identified seven “best buy” strategies – six that focus on the prevention of violence and one that focuses on response efforts. These strategies can potentially impact multiple forms of violence, help reduce the likelihood of both perpetrating violence and becoming a victim, and represent areas where developing countries and funding agencies can make reasonable investments. These strategies are:

1. developing safe, stable and nurturing relationships between children and their parents and caregivers (59);
2. developing life skills in children and adolescents (60);
3. reducing the availability and harmful use of alcohol (61);
4. reducing access to guns and knives (62);
5. promoting gender equality to prevent violence against women (63);
6. changing cultural and social norms that support violence (64);
7. victim identification, care and support programmes (65).

To assess how far programmes representing the six prevention strategies are being implemented, the survey asked whether the 18 prevention programmes listed in Figure 11 existed in each surveyed country and whether they were: not implemented; implemented once or a few times; or implemented on a larger scale (for example, across many schools or communities or with a reach to over 30% of the intended target population). The 18 programmes are further defined in Part VII, Glossary. Findings relating to alcohol and other policies and victim support programmes are covered in later sections of this report.

The findings from the survey indicate that many countries are investing in prevention, yet none of the 18 prevention programmes is being implemented on a level necessary to achieve significant and sustainable reductions in violence (see Figure 11). Across the 18 programmes, many are being implemented on a larger scale by fewer than 40% of surveyed countries. It is also important to note that implementation on a larger scale does not necessarily mean implementation of a particular programme with documented evidence of effectiveness.
Social and cultural norm-change strategies are the most common approach used by countries to address violence against women

About half of surveyed countries reported implementing social and cultural norm-change strategies to address sexual violence and intimate partner violence against women (see Figure 11). This is in contrast to microfinance combined with gender equity training programmes and school-based dating violence prevention programmes, where 21% and 22% of countries (respectively) reported implementing these types of approaches. Social and cultural norm-change strategies were also one of the few types of strategies reportedly implemented by more than 40% of countries in all regions (except in the South-East Asia Region) (see Table 5). Based on other evidence, many countries use these types of strategies to raise awareness about violence against women. Although rigorous evaluations of social and cultural norm-change strategies are still needed to assess their impact, they can be an important strategy to inform and create cultural shifts in what is acceptable and unacceptable behaviour, and in promoting norms supportive of healthy, non-violent and gender equitable relationships.

It is not surprising that fewer countries reported implementing school-based dating violence prevention programmes. Although the practice of dating may not take place or be recognized as acceptable by governments in some countries, only a handful of school-based dating violence prevention programmes have been developed to help young people address relationship violence and learn
healthy and positive relationship skills that can be carried into adulthood. Evaluations of these programmes in mostly high-income countries show some positive changes in knowledge and attitudes toward relationship violence, and limited reductions in certain forms of abusive behaviours (66–71).

While few countries reported implementing the specific intervention of microfinance combined with gender equity training, it is one of the few interventions with documented evidence showing reductions in intimate partner violence (72–74). More countries may wish to consider strategies that economically empower women and promote gender equality. Efforts that empower women both socially and economically are important for violence prevention.

Table 5: Proportion of countries implementing different types of programmes on a larger scale, by type of programme and WHO region (n = 133 reporting countries)

<table>
<thead>
<tr>
<th></th>
<th>African Region</th>
<th>Region of the Americas</th>
<th>Eastern Mediterranean Region</th>
<th>European Region</th>
<th>South-East Asia Region</th>
<th>Western Pacific Region</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child maltreatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visiting</td>
<td>7%</td>
<td>52%</td>
<td>31%</td>
<td>51%</td>
<td>13%</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>Parenting education</td>
<td>11%</td>
<td>57%</td>
<td>44%</td>
<td>46%</td>
<td>13%</td>
<td>40%</td>
<td>38%</td>
</tr>
<tr>
<td>Child sexual abuse prevention</td>
<td>44%</td>
<td>62%</td>
<td>31%</td>
<td>29%</td>
<td>0%</td>
<td>35%</td>
<td>37%</td>
</tr>
<tr>
<td><strong>Youth violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-school enrichment</td>
<td>22%</td>
<td>67%</td>
<td>31%</td>
<td>54%</td>
<td>13%</td>
<td>15%</td>
<td>38%</td>
</tr>
<tr>
<td>Life skills/social development programmes</td>
<td>33%</td>
<td>71%</td>
<td>56%</td>
<td>63%</td>
<td>38%</td>
<td>30%</td>
<td>51%</td>
</tr>
<tr>
<td>Bullying prevention</td>
<td>30%</td>
<td>52%</td>
<td>69%</td>
<td>59%</td>
<td>25%</td>
<td>35%</td>
<td>47%</td>
</tr>
<tr>
<td>Mentoring</td>
<td>15%</td>
<td>29%</td>
<td>44%</td>
<td>27%</td>
<td>13%</td>
<td>10%</td>
<td>23%</td>
</tr>
<tr>
<td>After-school programmes</td>
<td>7%</td>
<td>43%</td>
<td>31%</td>
<td>59%</td>
<td>25%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Intimate partner violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dating violence prevention programmes</td>
<td>22%</td>
<td>38%</td>
<td>0%</td>
<td>27%</td>
<td>13%</td>
<td>15%</td>
<td>22%</td>
</tr>
<tr>
<td>Microfinance with gender equity training</td>
<td>19%</td>
<td>33%</td>
<td>25%</td>
<td>12%</td>
<td>0%</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td>Social and cultural norm-change programmes</td>
<td>41%</td>
<td>67%</td>
<td>56%</td>
<td>48%</td>
<td>25%</td>
<td>50%</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Sexual violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention programmes for school and college populations</td>
<td>30%</td>
<td>52%</td>
<td>38%</td>
<td>37%</td>
<td>25%</td>
<td>25%</td>
<td>35%</td>
</tr>
<tr>
<td>Improving physical environments</td>
<td>15%</td>
<td>24%</td>
<td>50%</td>
<td>29%</td>
<td>25%</td>
<td>40%</td>
<td>29%</td>
</tr>
<tr>
<td>Social and cultural norm-change programmes</td>
<td>56%</td>
<td>62%</td>
<td>56%</td>
<td>42%</td>
<td>38%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Elder abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional awareness campaigns</td>
<td>11%</td>
<td>24%</td>
<td>44%</td>
<td>37%</td>
<td>0%</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>Public information campaigns</td>
<td>15%</td>
<td>19%</td>
<td>31%</td>
<td>27%</td>
<td>0%</td>
<td>30%</td>
<td>23%</td>
</tr>
<tr>
<td>Caregiver support programmes</td>
<td>15%</td>
<td>43%</td>
<td>56%</td>
<td>51%</td>
<td>25%</td>
<td>35%</td>
<td>39%</td>
</tr>
<tr>
<td>Residential care policies</td>
<td>11%</td>
<td>52%</td>
<td>63%</td>
<td>40%</td>
<td>13%</td>
<td>30%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Life skills training and bullying prevention are the most common approaches implemented to address youth violence

Life skills and social development programmes were the most common youth violence prevention approach that countries reported implementing. These types of programmes are designed to help children and adolescents manage anger, resolve conflicts in a non-violent way and develop social problem-solving skills. Systematic reviews of the evidence show that these types of programmes can result in a 15% reduction in violent behaviour in students across all school years and a 29% reduction among students in secondary school (75, 76). Half of surveyed countries reported implementing these types of programmes (see Figure 11), with substantially more countries in the Region of the Americas (71%) and the European Region (63%) implementing these programmes on a larger scale than elsewhere (see Table 5). Bullying prevention programmes were also commonly mentioned, with 47% of countries indicating that they have implemented such programmes.

Efforts are being made to address parent-child relationships and the developmental pathways toward later violent behaviour

It is worth noting that countries reported implementing a number of programmes to promote positive and nurturing relationships between children and their caregivers, and strategies aimed at getting children off to a good start to ensure greater success in school (see Figure 11). There is a strong and growing body of evidence showing the impact of early relationships between children and their caregivers on the structural and functional development of the brain and the subsequent cognitive, emotional and social development of children (77, 78). Children growing up in environments without the benefit of safe, stable and nurturing relationships with parents or other caregivers have difficulty forming relationships with peers and others, lack empathy for others in distress and are at much greater risk of experiencing depression and anxiety, developing poor communication skills and adopting antisocial behaviours. They also have poorer educational attainment and economic productivity over their lifetimes and are more likely to be a perpetrator or victim of violence (59).
There are a number of evidence-based programmes designed to help strengthen early relationships and interactions between children and their caregivers, promote healthy development and improve child behaviour. These include home visiting programmes, which have been shown to reduce child maltreatment by as much as 39%, and other parenting education and parent and child programmes, which have also demonstrated short- and longer-term positive outcomes for children (79–81). About 35% of countries reported implementing home visiting programmes and 38% reported implementing parenting education programmes and pre-school enrichment programmes, although this varied by region (see Table 5). For instance, more countries in the Region of the Americas and in the European Region reported implementing home visiting programmes on a larger scale than countries in other regions (see Figure 12).

**Caregiver support programmes are the most commonly reported strategy to prevent elder abuse**

Nearly 40% of countries reported implementing caregiver support programmes to prevent abuse of older adults (see Table 5). These types of programme help caregivers deal with the emotional demands and stresses involved in providing care. More than half of Eastern Mediterranean Region countries (56%) and 51% of European Region countries indicated implementing caregiver support programmes on a larger scale. However, this was reportedly the case in only 15% of countries in the African Region, and between 25% and 43% of countries in the other regions.

Programmes to improve standards of care within nursing and other residential care homes to reduce the chances of elder abuse were reported by about 36% of countries. Whereas 63% of Eastern Mediterranean Region countries and 52% of countries in the Region of the Americas reported larger scale implementation of residential care policies to prevent elder abuse, this was not the case elsewhere. In the African Region, only 11% of countries reported having implemented these types of policies and procedures on a larger scale, and less than 20% had implemented such programmes only once or a few times.

Implementation of other strategies to prevent elder abuse was limited at best. A quarter of countries (26%) reported having implemented campaigns aimed at educating professionals to recognize the signs and symptoms of elder abuse and improve their problem-solving and case management skills on a larger scale (mostly in the Eastern Mediterranean and European Regions); 23% report having implemented public information campaigns (see Figure 13). In the African Region, the Region of the Americas and South-East Asia Region, most countries reported implementing public information campaigns on a one-off or occasional basis.
Community and problem-orientated policing strategies are widely used

Countries were also asked about policing strategies to prevent violence. Community policing and problem-orientated policing have become important law enforcement strategies to strengthen relationships with communities and address crime, disorderly behaviour and other situations that contribute to fear and insecurity in urban neighbourhoods. A growing evidence base (82) supports their effectiveness in preventing several types of violence (for example, alcohol- and drug-related youth violence), although most studies of community-based and problem-orientated policing are from high-income countries where informal social controls are stronger and the rule of law is intact.

Almost all countries reported using strategies to improve community-police relations such as community policing (99% of countries), and routinely using directed or problem-orientated policing strategies (94%) which require analysis, assessment and community involvement to address crime and disorder problems. Globally, around nine out of ten countries report that police use these two types of strategy.
COUNTRIES CAN DO MORE TO ADDRESS KEY RISK FACTORS FOR VIOLENCE THROUGH POLICY AND OTHER MEASURES

Violence of all types is strongly associated with social determinants such as weak governance; poor rule of law; cultural, social and gender norms; unemployment; income and gender inequality; rapid social change; and limited educational opportunities. Cross-cutting risk factors such as ease of access to firearms and other weapons and excessive alcohol use are also strongly associated with multiple types of violence. Together these factors create a social climate that is conducive to violence and in the absence of efforts to address them, sustained violence prevention gains are difficult to achieve. Any comprehensive violence prevention strategy must therefore identify ways to mitigate or provide a buffer against these risks, including through policy and other measures.

Additional efforts must also be made to strengthen and support relevant institutions to ensure that prevention strategies are effective in achieving their desired aims within the context of these various social determinants. As part of a multisectoral approach to violence prevention, this support may be useful in both justice and security sectors, as well as in the health, education and social sectors, among others.

Few countries are implementing social and educational policy measures to mitigate key risk factors for violence

About 40% of countries surveyed reported national policies providing incentives for youth at risk of violence to complete secondary schooling, with the lowest percentage (13%) of countries in the South-East Asia Region and the highest (71%) in the European Region (see Figure 14). Poor academic achievement has consistently been linked with delinquency and school failure (83). Students with lower grades are more likely to be involved in physical fighting and other problem behaviour. Weak connections to school, and school dropout, also increase the risk of involvement in violence (83). Conversely, academic enrichment can increase achievement and school attendance, improve literacy and numeracy and enhance social integration (84, 85)—all of which can protect against violence.

Figure 14: Proportion of countries with schooling and housing policies to reduce the risk of violence, by WHO region (n = 133 reporting countries)
Housing policies at national level to reduce the concentration of poverty in urban areas which were explicitly aimed at reducing violence were rare – only 24% of countries reported having such policies. South-East Asia Region reported none, while 7% of countries in the African Region, 43% in the Region of the Americas and 50% in the Eastern Mediterranean Region reportedly did have such policies. Concentrated poverty is a visible aspect of disadvantage. Communities with high concentrations of poor and unemployed people also tend to have high levels of residential instability, making it difficult for people to establish common values and norms and to develop strong social ties and support networks. There is also a level of disorganization that compromises community participation and makes it difficult to exercise effective social control. These levels of economic and social disadvantage create the conditions for high rates of violence. They exacerbate social marginalization and also contribute to poor physical and mental health.

More countries are tackling the harmful use of alcohol, although patterns of risky drinking behaviour remain very high in several countries

Although levels of alcohol consumption, patterns of drinking and rates of violence differ between countries, there are important links between alcohol and violence across all cultures (61). For instance, harmful alcohol use directly affects physical and cognitive function, leading to reduced self-control, which may make some drinkers more likely to resort to violence in confrontations. Experiencing or witnessing violence can lead to the harmful use of alcohol as a way of coping or self-medicating. Alcohol and violence may also be related through common risk factors (for example, antisocial personality disorder) that contribute to the risk of both heavy drinking and violent behaviour.

Policy measures to reduce the harmful use of alcohol include restrictions on the sale and serving of alcohol – for example, through excise taxes on beer, wine and spirits; reduced hours or days of sale of alcoholic beverages; minimum age for the purchase of alcohol; and regulations on the
density of alcohol outlets (86).

At least 80% of countries reported having excise taxes on beer, wine and spirits, with no significant differences between income levels. The only exception was excise tax on wine, which almost 29% of high-income countries reported not levying. Several studies have used economic modelling to estimate the effects of alcohol price increases on the incidence of violence. For instance, findings from the United States suggest that a 1% increase in the price of an ounce of pure alcohol would reduce the probability of intimate partner violence against women by 5.3% (87), and a 10% increase in the price of beer would reduce the number of college students involved in violence each year by 4% (88).

There were no large differences by region or income level for the legal minimum age for on- and off-premise alcohol sales. On average, countries reported the legal minimum age for both on- and off-premise sales of alcohol as 18 years.

For decision-makers, acknowledging the importance of implementing policy measures to mitigate school dropout, concentrated poverty and the harmful use of alcohol, alongside other prevention strategies to address the key risk factors for violence, is an essential prerequisite to achieve societies and communities that are both safe and healthy.

Nearly all countries include measures to regulate access to firearms, although laws themselves and populations covered vary widely

Firearms increase the likelihood of death and serious injury when used in acts of violence and are frequently used to threaten individuals in violent encounters. Several case-control studies, ecological time-series and cross-sectional studies across countries indicate that gun availability is a risk factor for homicide, particularly firearms homicide (20, 89).

Measures to prevent firearms-related injuries include those addressing access, supply and use of firearms, and restrictions on the secondary trading of firearms. They include, for example, bans on specified firearms or ammunition, background checks, waiting periods and other licencing requirements, laws to prevent child access, and restrictions for certain settings (for example, school premises, carrying guns in public places, etc.). Internationally, the Firearms Protocol of the UN Convention on Organized Crime (90) provides a framework for states to control and regulate licit arms and arms flows, prevent their diversion into the illegal circuit and facilitate the investigation and prosecution of related offences without hampering legitimate firearm transfers (90).

Nearly all countries in the survey (99%) across all regions reported having national laws to regulate firearms, including: mandatory background checks before issuing a licence to purchase or own a firearm (96%); laws restricting access to handguns, shotguns and automatic firearms (95%, 96% and 96% respectively); and laws restricting the carrying of firearms in public (98%). Fewer countries – about two thirds – report having special firearms control programmes such as gun buy-backs and firearms collection and destruction programmes, with about 60%–63% of countries in the Western Pacific Region, the Region of the Americas and the European Region having such programmes. The nature of the restrictions, the populations covered (for example, all citizens or certain age groups), licencing agents and the processes for implementing the requirements, however,
vary across countries. Examples of restrictions from various countries are presented in Table 6.

Two systematic reviews and one meta-analysis summarize the effects of various strategies to prevent firearm-related violence. One systematic review (92) concluded that there is insufficient evidence to determine whether firearm laws have any effect on violence. A recent meta-analysis (93) suggests that bans on the sale of firearms had small effects and law enforcement strategies had moderate effects in reducing gun violence. Another systematic review (94) finds that directed police patrols focusing on illegal gun carrying can prevent gun crimes (including murders, shootings, gun robberies and gun assaults). These studies conclude that more research is needed to determine the effectiveness of waiting periods, background checks, zero-tolerance policies in schools and other measures to limit firearms use in settings where they are already widely available. With one exception (92), these reviews also conclude that strategies addressing access to firearms, such as bans on firearms, and the enactment and enforcement of laws against the illegal possession and carrying of firearms, show promise. Subsequent to these reviews, a new study from South Africa finds that stricter licensing and reduced circulation of firearms accounted for an estimated 4585 lives saved across five major cities between 2001–2005 (95).
Table 6: Firearm restrictions in selected countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Background check</th>
<th>Minimum age for purchase</th>
<th>Licence denied or revoked where family violence is present</th>
<th>Limits on ammunition</th>
<th>Private sales permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Yes, criminal and mental health</td>
<td>18 years; 21 years for handguns</td>
<td>No</td>
<td>Only allowed to possess ammunition for intended weapon</td>
<td>Yes</td>
</tr>
<tr>
<td>Brazil</td>
<td>Yes, criminal, mental health and employment</td>
<td>25 years, with a few exceptions</td>
<td>No</td>
<td>Any quantity permitted</td>
<td>Yes</td>
</tr>
<tr>
<td>China</td>
<td>No civilian may lawfully acquire, possess or transfer a firearm or ammunition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>Yes, criminal and mental health</td>
<td>18 years</td>
<td>Yes</td>
<td>Information not available</td>
<td>Information not available</td>
</tr>
<tr>
<td>Finland</td>
<td>Yes, criminal and mental health</td>
<td>18 years (15 with parental consent)</td>
<td>No</td>
<td>Any quantity permitted</td>
<td>Yes</td>
</tr>
<tr>
<td>Japan</td>
<td>Yes, criminal and mental health</td>
<td>18 years</td>
<td>No</td>
<td>Any quantity permitted</td>
<td>No</td>
</tr>
<tr>
<td>Mexico</td>
<td>Yes, criminal, mental health, physical and addiction</td>
<td>18 years</td>
<td>No</td>
<td>500 .22 cartridges, 1000 shotgun cartridges, 200 cartridges for other weapons</td>
<td>No</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Yes, criminal, mental health and addiction</td>
<td>17 years</td>
<td>No</td>
<td>Only as much as prescribed by licence</td>
<td>No</td>
</tr>
<tr>
<td>South Africa</td>
<td>Criminal, mental, medical, domestic violence, addiction, employment, previous gun licences</td>
<td>21 years, with some exceptions</td>
<td>Yes</td>
<td>Up to 2400 primers or 200 cartridges per firearm</td>
<td>No</td>
</tr>
<tr>
<td>Sweden</td>
<td>Yes, criminal and mental health</td>
<td>18 years</td>
<td>Yes</td>
<td>Only allowed to possess ammunition for intended weapon</td>
<td>No</td>
</tr>
<tr>
<td>United States of America</td>
<td>Yes, criminal, mental health, addiction, domestic violence (only when purchasing through a federally licenced dealer). Some states impose further restrictions</td>
<td>18 years for shotguns and rifles; 21 years for handguns and other weapons</td>
<td>Yes</td>
<td>Restrictions based on age and for certain types of ammunition (e.g. armour piercing)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Source: GunPolicy.org [website] hosted by the University of Sydney (http://www.gunpolicy.org/, accessed 20 August 2014) (91)
The enactment and enforcement of legislation on crime and violence are critical for establishing norms of acceptable and unacceptable behaviour, and creating safe and peaceful societies. Of particular importance are strategies to enable safe reporting of interpersonal violence and ensuring that legal protection and support are available to all citizens. In certain circumstances, the threat of criminal sanctions can have a deterrent effect, for instance on people with strong social ties or when the certainty — but not necessarily the severity — of sanctions is high. An important objective for violence prevention is therefore to strengthen collaboration between public health, the criminal justice sector and key security institutions such as the police in order to increase the chance that potential perpetrators of violence will be deterred and prevented from committing crime in the first place (and if not, at least held accountable for their actions). Where necessary, support to strengthen the relevant institutions in these sectors can help to improve enforcement levels.

Legislation is a key component of any violence prevention policy or plan. For instance, appropriate legislation can encourage parents to move away from using harsh physical discipline toward their children, and can help to promote attitudes and beliefs that reject violence against women. Where social convictions or deeply entrenched traditions fuel harmful practices (such as child marriage or female genital mutilation) legal reform can mobilize key actors and institutions in efforts to end such practices. Accordingly, in the most successful cases where the law has led to a change in attitudes and behaviour, adoption of the law has been accompanied by wide awareness-raising initiatives, public information and education campaigns, capacity-building for relevant professionals, and the social mobilization of a wide range of strategic actors including opinion leaders, religious and local leaders.

Countries were asked about the existence and enforcement of laws relating to various forms of violence, including laws that address several forms of violence against women (for example, sexual violence). The findings from the survey indicate that laws relevant to violence have been widely enacted. On average, about 80% of countries have enacted each of the violence prevention laws surveyed. However, this ranges from a low of 40% for the existence of laws to prevent elder abuse in institutions to a high of 98% for laws on rape (see Figure 15).

There were no significant differences by income level in the proportion of countries with laws in place to prevent various forms of violence: the average proportion of countries reporting laws to prevent violence was 76%, 77% and 82% for low-, middle- and high-income countries respectively. The only exception to this related to laws preventing elder abuse, where the average proportion of high-, middle- and low-income countries with each of the laws to prevent elder abuse was reported as 33%, 62% and 69% respectively. There were, however, many more regional differences. For example, the proportion of countries in the African Region (52%) and Western Pacific Region (50%) with laws recognizing rape within marriage as a crime was reportedly much lower than in the Region of the Americas (91%) or the European Region (98%).
Figure 15: The proportion of countries with laws to prevent violence and the extent to which countries report these laws as being fully enforced (n = 133 reporting countries)

For all laws, levels of reported enforcement were usually much lower than the enactment of legislation

Overall, the average proportion of countries in which each of the laws was reported to have been enacted was 80%, while the average proportion of countries in which each of the laws was reportedly enacted and fully enforced was 57%. The biggest gaps between the reported existence and enforcement of laws – a difference of 46 and 43 percentage points respectively – related to bans on corporal punishment and to domestic/family violence legislation. Focusing on better enforcement of existing laws is likely to lead to significant violence prevention gains. This should include attending to institutional mechanisms and resources, and increasing human capacity to ensure that enacted legislation is doing what it is intended to do – protect people from violence, hold perpetrators accountable and create environments that are safe for all citizens.

With the exception of countries in the European Region, less than half of countries reported that bans on corporal punishment were fully enforced. There is some evidence to suggest that enactment of a ban may be sufficient to change attitudes and behaviour around the use of corporal punishment. For instance, findings from a multi-country study conducted in five European countries (three with bans on corporal punishment and two without) found that nearly all forms of corporal punishment were used less in countries with bans than in those in which corporal punishment was lawful (97). Parents in countries with bans in place were also less accepting of corporal punishment and stated that their knowledge of the ban was one of four factors that most affected whether or not they used corporal punishment. Other factors influencing them included the parent’s definition of physical violence, personal approval of corporal punishment, and their own experience of childhood violence.
AVAILABILITY OF SERVICES TO IDENTIFY, REFER, PROTECT AND SUPPORT VICTIMS VARIES MARKEDLY

Providing high-quality care and support services to victims is important for reducing trauma, helping victims heal and preventing repeat victimization and perpetration. There are many services for victims of violence, including: emergency response services for injured victims; other health services to identify and address the longer-term impact of violence on health; community services related to housing; victim advocacy; substance abuse and mental health services; and legal and social support services.

Countries were asked about a subset of these services. These included: the availability of mental health services; the extent to which child and adult protective services were available; whether mechanisms were in place to identify and provide referral services for victims; whether medico-legal services were available for victims of sexual violence; and the availability of legal services relating to victim compensation and representation in criminal courts.

Mental health services are not widely available in several regions even though the need for them may be very high

Despite strong evidence linking experiences of violence to mental health problems, less than half of countries (49%) reported the availability of mental health services to address the needs of victims. However, this varied widely across regions: two thirds of countries in the Region of the Americas and the European Region reported that these services were available to assist victims, compared to only 15% in African Region countries (see Figure 16). This suggests a critical gap, particularly in countries where the need for such services may be especially high based on what we know about rates of physical, sexual and other forms of violence across the different WHO regions. Addressing the needs of victims with trauma-focused care, cognitive behavioural therapy or other low-intensity psychological interventions and other mental health services can potentially mitigate the serious mental health outcomes of abuse.

Figure 16: Proportion of countries reporting implementation of mental health services for victims of violence at larger scale (n = 133 reporting countries)
Child protection services are the most widely available of all services

Child protection services were the most widely reported of all services (69%), followed by medico-legal services for victims of sexual violence (see Figure 17). About eight out of every 10 countries in the Region of the Americas and in the Eastern Mediterranean and European Regions reported having systems in place to identify and investigate potential cases of child maltreatment. This was also the case for three quarters of countries in the South-East Asia Region. Other types of screening and referral services (for example, through maternal and child health programmes) to identify and support potential victims of child maltreatment were also reported by 59% of countries. However, in both instances, these services were more commonly reported by high-income countries (80%) than low-income countries (33%).

Although child protection services are present in many countries, these services are often dispersed, fragmented and poorly resourced, and may in fact have a detrimental impact on the protection of child victims of violence (14). As a result, even when such services are available, child victims and their families may fail to use them and a lack of information about existing services, the fear of seeing confidentiality broken, and concerns about reprisals can further undermine the quality of child protection services (14).

Two thirds of countries indicated that they do not have adult protective services in place to assist vulnerable older adults

Of all the services included in the survey, adult protective services were the least reported by countries. Only one third of countries indicated that they have adult protective services in place to investigate potential cases of elder abuse and assist vulnerable older adults. The lack of adult protective services, particularly in contrast to child protection services, was consistent across all regions (see Figure 18). Countries furthest along in efforts to protect and support older adults include these services as part of their national policy (29, 98). The United States, for example, has a fully developed system for reporting and treating cases of elder abuse. Services are designed to provide elder abuse victims with a coordinated, interdisciplinary system of social and health services which enable them to continue living independently at home and to protect them against further abuse.

With a rapidly ageing population, the need to strengthen the system of adult protection is important. By 2030, older adults are projected to comprise 13% of the world population – one in eight people will be aged 65 years or older (99). While low- and middle-income countries will experience the most rapid growth in ageing, with increases of up to 140%, high-income countries are expected to experience increases averaging 51% (99).
Referral and support services for violence against women are available in half of the world’s countries, but information is lacking on the quality, coverage and uptake of these services

WHO recommends asking women about exposure to intimate partner violence when assessing conditions that may have been caused or complicated by intimate partner violence in order to provide appropriate follow-up care and support. Asking all women about their experiences with intimate partner violence is not recommended in all settings. Women who disclose violence should be provided with immediate support and care that is responsive to their concerns, and which helps them access information, resources and further support (7). Comprehensive care (including emergency contraception, prophylaxis for HIV and other sexually transmitted infections and psychological support) should be provided to survivors of rape and sexual assault.

About half of countries (53%) reported the availability of identification, referral and support services for women who have experienced intimate partner violence or sexual violence (see Figure 17), with more high-income countries reporting the availability of such services (61%) than middle- (53%) or low-income countries (38%). Two-thirds of countries, on the other hand, indicated availability of medico-legal services for victims of sexual assault, making these services the most frequently reported services available to victims after child protective services. Countries were not asked about the nature, coverage and quality of such services or about the consistency with which these services are offered to victims, or how many victims make use of them. Victims of sexual assault require comprehensive and gender-sensitive services from trained health care providers to help them recover from the traumatic event and lessen both short- and long-term health consequences (7). Medico-legal services, in particular, are important for women who may wish to pursue legal action (100, 101). National health systems as a whole need to address violence against women by providing high-quality care and services that are timely, effective, sensitive to the needs of victims and their safety, and provided by well-trained professionals.

Victim support services often extend beyond medical and other care. Legal representation in criminal courts and receiving compensation from the state are important for all types of interpersonal violence as well. While the majority of countries (86%) report having laws providing victims with legal representation and participation in criminal courts,
only 52% report victim compensation legislation. Both the existence of such laws and the extent to which they are reportedly enforced also varies by country income level, with the existence and enforcement of such laws being much greater in high-income countries than in low- and middle-income countries.
Part IV – The way forward
CONCLUSIONS

This *Global status report on violence prevention 2014* uses a standardized method to assess the measures countries are taking to prevent and respond to interpersonal violence. It includes 133 countries, accounting for 88% of the world’s population. The report brings violence prevention in line with other issues such as alcohol and health, climate change, mental health, road safety, tobacco, and tuberculosis, where regularly repeated assessments along the lines of this report allow countries to set baselines and targets and monitor progress over time.

The *Global status report on violence prevention 2014* for the first time provides a detailed picture of the global violence prevention landscape some 12 years after the *World report on violence and health* was launched, with its nine recommendations for action. The results show that there are many efforts under way around the world to prevent and respond to violence:

- Two thirds of the countries report national action plans to address child maltreatment and violence against women compared to around half reporting plans for youth violence prevention; just 40% report plans for elder abuse, armed violence and gang violence prevention.
- Prevention activity is under way, with about half of surveyed countries reporting implementing primary prevention programmes such as life skills training and bullying prevention programmes to prevent youth violence, and social and cultural norm-change strategies to address violence against women; more than one third of countries also reported implementing programmes addressing parent-child relationships and some of the early developmental pathways toward later violent behaviour.
- Over half of the countries have each of the services surveyed in place to identify, refer, protect and support victims of violence.
- Almost 80% of countries have enacted each of the violence prevention laws surveyed.
- Problem-orientated and community-based policing are in place in most of the countries that participated in the survey.

The *Global status report on violence prevention 2014* also uncovers many gaps in global violence prevention that need to be filled. Knowledge about the true extent of the problem of interpersonal violence in many countries is hindered by a lack of data. Without such data it is difficult to develop effective national plans of action and policies, prevention programmes and services for victims. National action plans for all types of violence are frequently formulated in the absence of data and too often fail to address elder abuse, armed violence and gang violence. Mechanisms or lead agencies to coordinate multisectoral work addressing all forms of violence are exceedingly rare, in spite of being recognized as a cornerstone of the public health approach to violence prevention. Uptake of prevention programmes is highly uneven, with consistent gaps in the African, South-East Asia and much of the Western Pacific Regions. Prevention programmes are also not being implemented in a manner and on a level necessary to achieve significant and sustainable reductions in violence. While countries are implementing strategies to change sociocultural norms, much more needs to be done to implement effective strategies to promote gender equitable norms and empower women in order to prevent intimate partner violence and sexual violence. Elder abuse remains one of the most neglected types of violence.

While globally there is more attention given to victim services than to prevention, important services such as mental health and adult protective services are nonetheless lacking in half or more of surveyed countries. Globally, enforcement of laws relevant to all types of violence remains weak: on average, each of the laws surveyed was reported to be fully enforced by just over half of the countries. Key social and educational policies addressing multiple types of violence, such as incentives for youth to complete schooling, and housing policies to alleviate poverty, remain too rare across much of the world. Filling these gaps should be a priority.

**Strengths and limitations of the report**

The *Global status report on violence prevention 2014* has four notable strengths. Its main strength is the comprehensiveness of its coverage. It is comprehensive in the types of measures it covers – national action plans, agencies responsible for violence prevention, information systems, data collection capacity, policies, prevention
programmes, laws and victim services. In relation to most of these measures it also includes a subnational assessment, i.e. at provincial or state level. It is comprehensive in the types of interpersonal violence it covers — armed violence, gang violence, child maltreatment, youth violence, intimate partner violence, sexual violence and elder abuse. Given the sensitivity of the issue of interpersonal violence in many countries, and that this is the first attempt at conducting such a survey, its geographical coverage can also be viewed as comprehensive — 133 of WHO’s 196 Member States are included, accounting for 88% of the world’s population; this ranges from 63% of the population of the Eastern Mediterranean Region to 97% of the populations of the South-East Asia and Western Pacific Regions.

A second strength is the standardized method used. The method was designed to increase the accuracy and completeness of data submitted to WHO by requiring respondents from multiple sectors to take part in consensus meetings and reach agreement on the final answers, drawing on all relevant documents available in the country. An additional benefit of this method was that it helped to build bridges between sectors by linking individuals and institutions working on violence in the same country. Several National Data Coordinators observed that the consensus group meeting was the first time that practitioners from different sectors had met to discuss violence prevention and victim services. Furthermore, the nomination and training of National Data Coordinators, followed by close collaboration with them throughout the data collection and validation process, has sown the seeds of regional violence prevention networks.

A third strength of the report is that almost all data included have been endorsed by the governments of the countries concerned. This ensures recognition by government of the problem as described in the report, which is a prerequisite for governments taking responsibility for addressing interpersonal violence.

A final strength is that this report has generated, on the basis of statistical models, comparable homicide estimates across countries for homicide rates, numbers, and breakdown by sex and mechanism. This has been done by drawing on multiple sources — including data reported by countries from public health and criminal justice data sources — which were then combined with other existing datasets. However, as with any study, there are limitations. First, there is the possibility that many responses overestimated the extent and quality of national violence prevention activities. Data collection involved the use of self-administered questionnaires which respondents initially completed by themselves before discussion in the consensus meetings. This can introduce a number of potential biases. In addition, a degree of subjectivity was introduced as respondents were asked to rate their perceptions of the degree to which laws relevant to the different types of violence were enforced, and the extent to which prevention programmes were being implemented. The systematic inclusion of independent experts from academia or civil society to help verify government responses could have helped to reduce these biases.

Second, while the survey method provided an assessment of the existence of national action plans, policies, prevention programmes, laws, and victim services (and in certain cases their level of implementation and reported enforcement), it was not designed to assess their quality. For instance, the survey asked about types of programmes. It did not gather information on the specific programmes implemented in countries or gather details about programmes in order to assess the extent to which delivered programmes were the ones with documented evidence of effectiveness or, at a minimum, whether the programmes implemented include evidence-based principles and practices. With regard to laws, the report did not evaluate the quality of legislation (for example, exact scope, quality of legislative texts, political neutrality, flexibility or enforceability).

Third, not all policies, programmes, victim services and laws relevant to violence prevention were examined in this report. Included were those best supported by evidence and judged by experts to be the most important. Fourth, while the method proved successful in collecting data on levels of fatal violence, it was less successful in gathering prevalence data on non-fatal violence. It will be important to draw lessons from the process of carrying out this first report for any subsequent Global status reports on violence prevention. Overcoming these limitations will, however, require a more time-consuming and labour-intensive data collection method.
RECOMMENDATIONS: NATIONAL, REGIONAL AND INTERNATIONAL

The findings of the *Global status report on violence prevention 2014* are relevant to national, regional and global violence prevention efforts. Across all these levels they offer an unprecedented opportunity for violence prevention stakeholders to come together and step up their activities and investments to a level commensurate with the burden and severity of the problem. For instance, by showing the extent to which national action plans are driven by data, the findings provide pointers for governments, regional bodies and international violence prevention partners on how they should steer national planning exercises in a more data-driven direction. By highlighting gaps in prevention programming and service delivery by type of violence, stakeholders at all three levels have an opportunity to correct imbalances in preventive attention. Perhaps most importantly, whether at national or international level, the findings represent a set of indicators and a baseline measure to track future progress and to help set targets within countries and internationally.

National level

A primary aim of the report is to identify gaps in national violence prevention efforts and to stimulate actions to address them. Accordingly, countries should review the report’s findings for their countries in relation to regional and global findings and in this way develop a roadmap for how their existing violence prevention efforts can be improved. Where necessary, this review could be done by reconvening the intersectoral expert groups that were established during the data collection process. The review should pay particular attention to the following recommendations deriving from the main findings of the report and the gaps it identified.

Strengthen data collection to reveal the true extent of the problem. Vital registration and police systems for collecting data on violence-related deaths should be evaluated for the completeness and accuracy of the data they collect; their use of international classifications of fatal and non-fatal violence (ICD-10 and UNODC international classification of crime); breakdown by age, sex, homicide mechanism and victim-perpetrator relationship; and timeliness of their reporting. Similar efforts should be made to improve data on incidents of violence with non-fatal consequences treated in hospital emergency departments and other victim care facilities. Existing recent population-based national and subnational surveys of the prevalence of all the main types of interpersonal violence should be identified. While police and service-based reporting provides important data on the most severe forms of violence that result in death or serious injury, country specific national population-based surveys play an important role in documenting more hidden forms of violence. Several officials were unaware that high-quality national surveys had been carried out within their borders. Where none exists, conducting such surveys — using instruments that produce valid and cross-culturally comparable findings and with the help of international experts if required — and periodically repeating them to assess changes over time should be made a priority.

Develop comprehensive and data-driven national action plans. All countries should critically review the extent to which national action plans are comprehensive and address all forms of violence, and are informed by nationally representative data on the magnitude and characteristics of violence and the risk and protective factors for violence. Such plans provide a framework that can strengthen efforts to address specific types of violence, and given the strong connections between the different types of violence they have the potential to accelerate overall violence prevention gains.

Integrate violence prevention into other health platforms. Because violence is a risk factor for outcomes such as HIV and sexually transmitted diseases, mental health and substance abuse disorders, and because immunization programmes, early childhood development and school health programmes may already be well developed, countries should integrate violence prevention into other health platforms that already exist.
Strengthen mechanisms for leadership and coordination. Mechanisms for the leadership and coordination of violence prevention activities – including key rule of law institutions – should be established where they are weak or non-existent. Systems for the exchange of information should be reviewed for the extent to which they are focused on preventing violence. Ideally, these mechanisms should be forums that periodically convene representatives of relevant sectors to discuss the latest available data on violence with a view to identifying emerging problems (and their underlying risk factors) so that appropriate interventions can be made in time.

Ensure prevention programmes are comprehensive, integrated and informed by evidence. The extent to which prevention programmes address all types of violence should be reviewed. Greater attention should be given to integrating prevention and response efforts across the different types of violence because programmes that simultaneously address multiple types of violence can help to reduce the costs and complexity of addressing them separately. For instance, programmes to support new parents and promote gender equality and non-violent social and cultural norms, life skills training for children and youth, and policies to reduce access to and the misuse of alcohol all have the potential to prevent several types of violence. Prevention programmes identified through the survey should be qualitatively examined with a view to assessing how far their content and mode of delivery conform to evidence-based best practices, and, where needed, modified so that they more closely approximate evidence-based best practices. More attention must be given to putting in place prevention programmes that go beyond awareness-raising and instead bring about lasting social and cultural changes that move societies towards more egalitarian and non-violent norms.

Ensure that services for victims are comprehensive and informed by evidence. Services to identify, refer and protect victims should be carefully assessed to determine whether they provide comprehensive and sensitive high-quality services and referrals, and how widely they are available and accessible to victims, in particular those who are less likely to seek and access such services and are victims of the most hidden and stigmatized forms of violence (for example, violence against women, child maltreatment and elder abuse). As with prevention programmes, there is a need to ascertain the extent to which they conform to evidence-based best practice. Particular attention should be paid to further developing mental health and adult protective services in the many countries where they remain weak. The development of victim services should be complemented by the scaling up of prevention programmes that can contribute to reducing the need for services.

Strengthen support for outcome-evaluation studies. In relation to prevention programmes and victim services, strengthening support for outcome-evaluation studies should be a priority. The surprisingly large number of violence prevention programmes and services for victims being implemented once or a few times in many low- and middle-income countries suggests that there is great potential to close the current gap in the evidence base between high-income countries (which account for 90% of all published outcome-evaluation studies of violence prevention programmes), and low- and middle-income countries, where the development of such programmes is a priority. National stakeholders should use the report to identify violence prevention programmes and victim services in low- and middle-income countries that could be subject to outcome evaluation, with the help of international partners when required, and facilitate the conduct of such evaluations.

Enforce existing laws and review their quality. That laws against most forms of violence have been enacted in the majority of countries should not breed complacency. Little is known about the quality of these laws, and a careful review of these laws against internationally recognized standards of quality of legislation would be an important step to consider. Just as importantly, with on average only 57% of countries reporting that each of the laws surveyed was fully enforced, this report shows that the enforcement of existing laws should be a priority. Awareness campaigns to publicize the laws, and increase public understanding of and support for them, should be considered. Where necessary, institutions in relevant sectors such as the justice, security, health, education and social sectors should be strengthened and supported to ensure the quality of law and policy-making, as well as enforcement efforts.

Implement and enact policies and laws relevant to multiple types of violence. Policies and laws which address multiple types of violence (such as incentives for youth to complete schooling, and laws designed to reduce access to, and misuse of, alcohol) must be more widely implemented and enacted, and resources to do so developed. The violence prevention potential of these policies and laws should be better harnessed by ensuring that trends in
violence are factored in when any amendments are made to them.

**Build capacity for violence prevention:** Although capacity-building is not explicitly assessed in the Global status report on violence prevention 2014, developing national action plans, coordination mechanisms, information systems, policies, programmes, services and laws to prevent and respond to violence clearly cannot happen without the requisite human and institutional capacity to do so. Thus a key cross-cutting recommendation is the critical importance of training the workforce and building up the institutions and networks over time so that other recommendations listed here can be acted upon effectively.

**Regional and international levels**

**Strengthening the global violence prevention agenda.** International partners should draw upon the findings of the report to enhance their calls for increased investment in global violence prevention efforts. By clearly demonstrating the extent to which violence prevention has been taken up by governments at all levels of development in all regions of the world, the report shows that violence prevention is a topic of widespread concern, and that, if offered, increased financial and technical support for national violence prevention work is likely to be enthusiastically accepted. By changing the nature of such support to fill the gaps in policies, laws, prevention programmes and outcome-evaluation studies highlighted by this report, the global violence prevention agenda can be considerably strengthened.

**Strengthen support for comprehensive and integrated violence prevention programming.** By coming together across the lines of their interests in specific types of violence, international organizations and donors can support a more streamlined approach to prevention that, in addition to providing programmes which focus on specific types of violence, prioritizes integrated prevention policies and programmes to address several types of violence simultaneously.

**Increase collaboration between international organizations and donor agencies.** Many international and regional organizations, such as the UNDP, UNFPA, UNODC, UNICEF, UN Women and WHO, and the African Union, the Inter-American Development Bank, the Caribbean Community, the Council of Europe, and the League of Arab States, have developed policy instruments, funding streams, advocacy platforms and normative guidance materials to support national violence prevention efforts. Greater efforts should be made to foster collaboration and coordinated action between these organizations, particularly in view of the post-2015 agenda on sustainable development, which in all likelihood will prominently include violence prevention. Donor agencies, many of whom have been supporting violence prevention projects, should collaborate more closely to increase coherence and synergy in the field and avoid duplication.

**Set baselines and targets, and track progress.** At international level, the global violence prevention field has lacked the necessary indicators to establish common baselines and shared targets for its efforts to advance national violence prevention efforts. The findings of this report help fill this gap, and along with information from other initiatives (for example, UNODC reports on homicide; Together for Girls Violence Against Children Surveys; WHO’s multi-country study on women’s health and domestic violence against women, and its global and regional estimates of the prevalence of violence against women), lend themselves to the generation of violence prevention baselines and targets on the basis of which countries can monitor their progress.

A growing body of research shows that much interpersonal violence can be effectively prevented and its far-reaching consequences mitigated. This report shows that many countries have begun to implement prevention programmes and victim services, and to develop the national action plans, policies and laws required to support violence prevention programmes and response efforts. At international level, high-level resolutions that commit Member States to tackling interpersonal violence within their countries and through the establishment of networks and partnerships have been adopted. Yet this survey shows that serious gaps remain and that much work is still required before the full potential of the growing violence prevention field is realized. No country can rest on its laurels and assume it has successfully addressed interpersonal violence. The international community must continue to recognize interpersonal violence as an important health, criminal justice, development and gender equality issue, and must step up its support for the prevention of and response to all forms of violence.
REFERENCES


