Violence and Health

World Health Organization

(Compiled by Joám Evans Pim)

Center *for* Global **Nonkilling**

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"Violence is a preventable disease."

Charter for a World without Violence
8th World Summit of Nobel Peace Laureates
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Note

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Presentation

Glenn D. Paige
Chair, Governing Council
Center for Global Nonkilling

Two unique publications in 2002 arrived at the same conclusion. The World Health Organization's *World Report on Violence and Health* concluded that human violence is a "preventable disease." *Nonkilling Global Political Science* concluded that "nonkilling societies are possible." Both identified the main obstacle to progress in belief that violence is inevitable in the human condition. Both grounded confidence for change in provision of contrary science-based knowledge, education, and recommendations for action by decision makers and the public in all sectors of local, national, and global society. The Center for Global Nonkilling is grateful to the World Health Organization for making the presentation of this book possible, reaching out to an ever widening circle of readers and leaders who can join in taking steps toward a killing-free world. The measurable goal, open to utmost human creativity, is a world in which "everyone has the right not to be killed and the responsibility not to kill others" (Nobel Peace Laureates, *Charter for a World without Violence* (2007).

We are especially grateful to Dr. James A. Mercy, pioneering co-editor of the WHO *World Report on Violence and Health*, for continuing to contribute his extraordinary knowledge here and for generous service as Vice-Chair of the Governing Council, Center for Global Nonkilling.

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Introduction

Nonkilling Public Health

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A nonkilling society, through the unique lens of the public health approach, is one in which the threat of violent death has been effectively eliminated. Indeed, with violence increasingly recognized as a major public health problem, the prevention of violent death and injury has moved to the forefront of international efforts in this field. As with other serious health threats, the eradication of violence, and thus the creation of nonkilling communities, is the ultimate goal of the public health approach.

Violence is a critical threat to the health of individuals and a leading cause of death worldwide. In 1996, the World Health Assembly adopted a resolution recognizing violence as a serious and urgent public health problem. This was followed by the World Health Organization (WHO)'s first *World Report on Violence and Health* (Krug; Dahlberg; Mercy; Zwi; Lozano, 2002) documenting the nature and scope of violence globally. This report revealed that, in 2000 alone, more than 1.6 million people worldwide lost their lives to violence (Krug, et al., 2002). Homicide accounted for almost one-third (31.3%) of these deaths, with a global rate of 8.8 people per 100,000. Another 18.6% of violent deaths were war-related, affecting 5.2 people per 100,000. The largest proportion of fatal violence was self-inflicted, with suicide accounting for almost half (49.1%) of these deaths at a rate of 14.5 fatalities per 100,000. These rates vary considerably by region with the highest rates of homicide found in Africa and the Americas, and the highest rates of suicide identified in Europe and the Western Pacific. The risk of violent death also varied significantly by age, and between racial and ethnic groups, rural and urban populations, and rich and poor countries. For example, in the United States (US) in 2006, African-Americans between the

* The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

ages of 10 and 24 were 5 times more likely to die from homicide than White youths (Centers for Disease Control and Prevention, 2006). Further, in 2000, the rate of violent death was more than twice as high in low- to middle-income countries than in high-income countries. Overall, males accounted for the majority of perpetrators and victims worldwide, including 77% of all homicide victims and 60% of suicide deaths (Krug et al., 2002).

Compounding the loss of human life, violence also results in significant economic costs to nations around the world. Violence-related health care, law enforcement and judicial services, lost work days, and reduced productivity cost the global economy billions of US dollars per year (Krug et al., 2002). For example, suicide deaths cost Canada almost US$ 80 million in 1999 alone, at a rate of more than US$ 849,000 per suicide (Clayton; Barcel, 1999). The costs of interpersonal and collective violence in Latin American countries ranged from 5.1% of the gross domestic product (GDP) in Peru to 24.9% of the GDP during a conflict period in El Salvador during the 1990s (Buvinic; Morrison; Shifter, 1999). The estimated cost *per* homicide is US$ 15,319 in South Africa, US$ 602,000 in Australia, US$ 829,000 in New Zealand, and more than US$ 1.3 million in the U.S. (Corso; Mercy; Simon; Finkelstein; Miller, 2007; Fanslow, 1997; Phillips, 1998; Walker, 1997; Waters et al., 2004). Some of this variability in cost estimates is due to differences in the methods used, including the types of costs included and the year the estimates were calculated. Violent deaths exact disproportionate costs on society; victims tend to be younger than those who die from internal causes, thus increasing the years of potential life lost and decreasing a nation's average life expectancy (Pridemore, 2003). Inclusion of life expectancy as one of only three indicators in the United Nation's human development index suggests that these premature deaths may have important consequences for the development of nations (Pridemore, 2003; United Nations Development Programme, 2001).

Of course, fatal violence represents only a small fraction of the physical and sexual violence perpetrated across the world. Available national surveys have reported lifetime prevalence rates of 10% to 34.4% for physical assault and 15.3% to 25% for sexual assault (Krug et al., 2002). However, reliable estimates of nonfatal violence and related injuries are more difficult to obtain due to the necessary reliance on self-report surveys for these data. It is likely that these methods underestimate the full scope of the problem, especially under cultural conditions that discourage disclosure. As an extreme example of such conditions, data from Alexandria, Egypt indicate that 47% of female homicide victims were killed by a family member after being

raped by someone else (Mercy; Abdel Megid; Salem; Lofti, 1993). More subtle pressures to maintain silence about victimization affect men, women, and children exposed to violence around the world.

Despite difficulties in estimating the extent of nonfatal violence, attention to the full spectrum of violent behavior and intentional injury is necessary in any conceptualization of violent death prevention. In many instances, violent behaviors that are not intended to kill, such as fighting, deliberate self-injury, or shaking an infant, can result in severe and lethal injuries (Dahlberg; Krug, 2002). Further, victims of homicide or suicide attempts may ultimately survive if prompt and effective treatment for injuries is available. Indeed, recent research suggests that advancements in emergency medicine account, in large part, for the stability of US homicide rates between 1931 and 1999, despite a 700% increase in rates of aggravated assault (Harris; Thomas; Fisher; Hirsh, 2002). These authors reported that, between 1960 and 1999, mortality rates among assault victims were reduced by nearly 70% in the US, with only 1.67% of aggravated assaults in 1999 ending in death. Interventions that prevent the lethality of violence may significantly reduce the number of violent deaths in a community. However, interventions aimed only at preventing violent deaths or reducing mortality among victims will ultimately be ineffective at creating societies free from violent victimization. For this reason, a core focus and contribution of the public health approach to violent death prevention is an emphasis on *primary* prevention—that is, preventing violent behavior *before* it occurs. If effective primary prevention strategies for reducing interpersonal, self-directed, and collective violence can be identified and implemented in combination with complementary *secondary* and *tertiary* prevention efforts that aim to reduce the short- and long-term effects of fatal and nonfatal violence, the movement toward a nonkilling society could be importantly advanced.

The Public Health Model and Violence Prevention

The public health approach to violence prevention is unique in several ways. First, as noted above, the public health approach emphasizes *primary prevention* efforts aimed at preventing violence before it occurs. This stands in contrast to what has been the predominant, more reactive approach to violence, in which the majority of resources are focused on responding to violent offenders with deterrence, investigation, and incarceration efforts (Mercy; Hammond, 1998). The primary prevention efforts of public health complement criminal justice, mental health, or medical inter-

ventions that serve to reduce recidivism or ameliorate the negative consequences of violence. With a focus on identifying risk and protective factors that increase or reduce the risk of violent behavior and developing interventions that address these factors, the public health model starts "upstream" in order to prevent the cascade of circumstances and behaviors that may result in violent injury and death in the future.

Because risk and protective factors associated with violence have been identified by researchers across various fields of scientific inquiry, including psychology, sociology, criminology, law, medicine, and education, an interdisciplinary approach is considered integral to the public health approach. By integrating multiple disciplines through a *cross-cutting perspective*, the public health model can more effectively address complex, multifactor problems, such as violence. Indeed, not only do the predictors of violence overlap multiple fields, but the various forms of violent behavior often co-occur, have shared risk factors, and are linked to a variety of other health problems. Thus, the use of a cross-cutting approach allows public health to address the complexities inherent in preventing behaviors as multi-faceted and intertwined with other aspects of social and political life as violence.

Another unique aspect of the public health model involves commitment to the creation of a *rigorous science base* to illuminate and identify ways of confronting these complex relationships and systems. The public health model is focused on the development and use of high-quality research to understand and act upon the threat of violence at multiple stages, often concurrently. These include: monitoring trends in perpetration and victimization; identifying risk and protective factors to reveal high-risk populations and targets for prevention efforts; rigorously evaluating the effects of interventions, programs, and policies; and developing methods for disseminating and implementing effective approaches to encourage widespread adoption. Thus, public health provides a multidisciplinary scientific approach with explicit attention to the development of effective prevention strategies (Mercy; Hammond, 1998).

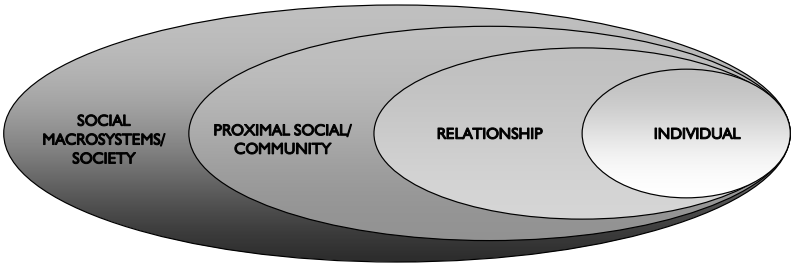
Finally, the field of public health can be differentiated from other disciplines by its attention to improved outcomes *population-wide*, rather than at the individual level. While the likelihood that an individual will be victimized by or perpetrate fatal violence can be reduced through medical care, incarceration, mental health treatment, or skills-training, for example, the goal of public health is to identify solutions that can reduce the risk for an entire population, as evidenced by lower overall prevalence rates. The potential for achieving change at the broadest level can be increased by moving beyond approaches that address *only* individual-level factors to incorporate risk and protective

factors at multiple levels of influence, from individual risk characteristics to the cultural and social determinants of violent behavior.

The Social Ecological Model

One way of conceptualizing the broad spectrum of risk and protective factors influencing violence perpetration is within the framework of the social-ecological model (Bronfenbrenner, 1979; Figure 1). This model organizes risk and protective factors for violence within four overlapping levels of influence affecting the development of human behavior. As shown in Figure 1, factors at the inner levels of the social ecology include those with the most immediate and direct influence on behavior.

Figure 1. The Social-Ecological Model



At the *Individual* level are biological and personal history characteristics, such as personality traits, attitudes and beliefs, or life experiences that function to increase or decrease risk for violence.

At the *Relationship* level, family members, friends, and peers can also have important effects on an individual's risk for violence, through parenting behaviors, socialization efforts, or behavior modeling, for example. At the outer levels, the model captures factors that have a broader, and perhaps less direct, influence on the risk levels of individuals and populations.

Community level factors include aspects of the physical and social contexts in which relationships occur (e.g., schools, workplaces, neighborhoods) that can influence violent behavior, such as institutional policies, availability of weapons, local law enforcement resources, or employment rates.

Factors at the *Societal* level include those which foster a larger climate or culture in which violence is either promoted or restrained. Such factors might include the presence and enforcement of laws, social or political con-

flict between social groups, social disorganization or inequality, and social or cultural norms about violence.

The arrangement of these levels in concentric circles (see Figure 1) highlights the interactive nature of the relationships between factors across the social ecology, and points to the critical importance, recognized by the public health model, of addressing factors at multiple levels concurrently in order to improve the health and safety of entire populations of people.

Primary Prevention Strategies across the Social Ecology

Violence and killing are multifaceted problems resulting from the complex interaction of biological, psychological, environmental, and social factors. Ultimately, therefore, substantial progress in reducing rates of violence is possible through an array of interventions targeting potent risk and protective factors at each level of the social ecology. These approaches may take many forms and the most promising interventions may be those that address multiple levels simultaneously. Table 1 provides examples of prevention efforts at each level of the social ecology.

Table 1. Examples of Possible Strategies to Prevent Violence and Promote Nonkilling

	Homicide	Suicide	Armed Conflict
Individual	Provide social development training to children in primary and secondary schools in anger management, social skills, and problem-solving. Provide enriched preschool education for all children. Provide therapy for children who have been exposed to violence.	Screen for depression and suicidality in schools, hospitals and clinics. Provide school-based, skills-based training in coping skills, suicide warning signs, and helping friends or acquaintances who are mentally distressed.	Provide social and economic transition for child soldiers back into productive roles in society. Provide mental health care for individuals affected by conflict who may be at an increased risk for suicide or interpersonal violence perpetration.

Relationship	Provide social support and training in parenting skills to new parents. Teach adolescents how to form healthy relationships. Provide adult mentors for high-risk youth. Visit homes of families at high risk of child abuse during infancy to provide professional support and skill-building for parents. Improve parent management strategies and parent-child bonding in the families of aggressive children.	Train gatekeepers or community members likely to come into contact with those at high risk of suicide (e.g., coaches, bartenders, school counselors, etc.) in suicide warning signs and referring those at risk to appropriate services. Educate parents of youth with risk or history of depression and/or suicidality about controlling access to lethal means of committing suicide.	Decrease risk for family separation during conflict and displacement. Provide adequate services for children who lose or are separated from caregivers to reduce their risk of becoming involved in the fighting as combatants.
Proximal Social/Community	Initiate after-school programs to extend adult supervision of youth. Create safe havens for children in homes and businesses on high-risk routes to and from school. Establish violence prevention coalitions in high-risk neighborhoods. Provide adequate shelter space for battered women. Disrupt illegal gun markets in communities. Train health care professionals in identification and referral of family violence victims. Improve emergency response and trauma care. Promote interventions by bystanders to prevent or interrupt violence.	Implement community-based approaches to increase connectedness between individuals and their families, schools, and workplaces. Improve emergency response and trauma care. Promotion of safe storage of firearms and other lethal methods. Train primary care physicians to identify risk factors for suicide in patients.	Create integrated community associations to encourage interdependence and cooperation between conflicting groups. Disseminate public health information to high-risk communities on ways to prevent injury from implements of war such as landmines and unexploded ordinance.

Social Macrosystems/Society	Reduce media messages supporting violence and enhance messages supporting nonviolence. Reduce income inequality. Promote gender equality. Deconcentrate lower-income housing. Establish meaningful job creation programs for inner-city youth. Increase enforcement and severity of penalties for sexual and intimate forms of violence. Utilize diversion or alternative sentencing approaches to provide preventive services to high-risk populations. Public information campaigns to promote prosocial norms.	Reduce access to the lethal means of committing suicide (e.g., fencing high bridges, requiring monitoring of prescriptions by doctors, controlling access to poison, reducing firearm access among high risk groups for suicide, etc.). Use public health communication strategies to reduce stigma of mental health treatment.	Identify and monitor risk factors for armed conflict to permit advance preparation for diplomatic prevention efforts and humanitarian aid responses for high-risk settings. Provide assistance to governments in political transition to encourage peaceful transfer of power and institutional development. Reduce income inequality within nations. Reduce access to biological, chemical, and nuclear weapons.

Note: The strategies presented here include those with proven effectiveness, as well as some that are promising or untested.

The prevention strategies in Table 1 fall into two general categories. The first category includes those approaches that attempt to prevent violence from occurring in the first place. These strategies promote nonkilling by reducing the likelihood that violence will be expressed. These types of strategies include, for example, social development training which has the potential to reduce homicide by providing children and adolescents with skills intended to reduce aggressive or violent behavior that can underlie it (e.g., emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work; Hahn, Fuqua-Whitley, Wellington, et al., 2007). The second type of general strategies includes those which reduce the lethality of violence, without necessarily reducing the expression of violent behaviors. These types of strategies include, for example, efforts to improve trauma care and

emergency response for victims of assault, suicide attempt or war. Unless death occurs immediately, the outcome of a violence-related injury depends on its severity and the speed and appropriateness of treatment (Committee on Trauma Research, 1985). The establishment of trauma and emergency response systems designed to more efficiently and effectively treat and manage injured victims is an important factor in reducing the likelihood that an injury will result in death.

The strategies in Table 1 include those with proven effectiveness as well as some that are promising or untested. Home visitation for families at high risk of child maltreatment is among those strategies for which we have strong evidence of effectiveness for the primary prevention of violence. The Nurse-Family Partnership program, for example, which provides home visitation to low-income, first-time mothers from pregnancy through their child's infancy, is designed to systematically engage mothers and other family members in improving prenatal health-related behaviors (e.g., smoking, alcohol use, health access), providing more responsible and competent care of infants and toddlers, and improving parents' economic self-sufficiency (Hill; Uris; Bauer, 2007). Results from several randomized controlled trials have shown this program to effectively reduce child maltreatment and injury (Hill; Uris; Bauer, 2007). A 15-year follow-up study of the program found reduced rates of crime and violent behavior among both children and mothers (Olds et al., 1998). This program, therefore, has the potential to prevent child homicides by reducing maltreatment as well as to reduce the future potential for children to engage in violent behavior that could lead to killing.

Another set of strategies for which we have interventions and policies with evidence of effectiveness includes approaches that reduce the lethality of violence. For example, efforts to reduce access to lethal means of suicide can reduce the likelihood of lethal suicidal behavior. This strategy was applied to the problem of self-poisoning with pesticides, a primary means of attempting and completing suicide in many developing countries. In Samoa, the introduction of paraquat, an agricultural pesticide, was associated with a 367% increase in suicide rates between 1972 and 1981 (Bowles, 1995). Efforts to control access to paraquat began in 1981 and the suicide rate dropped by over two-thirds by 1988. Thus, although levels of suicidal behavior may have been unchanged, deaths due to suicide declined substantially.

A strategy with potential for reducing the likelihood of collective violence between culturally and/or racially distinct groups in geographical proximity involves the process of creating integrated community associations to encourage interdependence and cooperation between potentially

conflicting groups. Hate-motivated violence appears to flourish where racially or ethnically distinct groups cling to negative beliefs and stereotypes about each other (Senechal de la Roche, 1996). A lower frequency of interaction and level of functional interdependence between such groups sustains negative beliefs and stereotypes that contribute to greater frequency and severity of collective violence (Black, 1998; Senechal de la Roche, 2001). In a study of communal violence between Hindus and Muslims in India, cities with strong associational forms of civic engagement, such as integrated business organizations, trade unions, political parties and professional associations were much less likely to experience ethnic violence than those in which Hindus and Muslims were segregated (Varshney, 2002). Interventions and policies that support the creation and maintenance of formal mechanisms of association between social groups, otherwise at odds with one another, may be useful for preventing collective violence that can contribute to killing.

The evidence base supporting the effectiveness of the strategies for preventing violence or killing listed in Table 1 is stronger for some strategies than others. Research is needed to more fully evaluate the effectiveness of the strategies listed in this Table, as well as other potential options. More complete discussions of the evidence base for violence prevention can be found in a number of key sources (e.g., Doll; Bonzo; Mercy; Sleet, 2008; Krug et al., 2002; Pinheiro, 2006; Rosenberg et al., 2006).

Although the evidence base for specific strategies is still developing, it is clear that the problem of violence and killing represents a serious, though not intractable, threat to the health of individuals and nations. Many countries have begun to utilize the public health approach to track the incidence of violence in their communities, to develop and implement prevention programs, and to engage their citizens and governments in action to reduce the impact of violence. These important efforts show promise that, through the development and widespread adoption of effective, multi-dimensional primary prevention approaches for violence prevention, the vision of a nonkilling society may be realized.

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