Violence Prevention Alliance

Building global commitment for violence prevention

World Health Organization

GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION
CAMPAGNE MONDIALE POUR LA PRÉVENTION DE LA VIOLENCE
VIOLENCE PREVENTION ALLIANCE / ALLIANCE POUR LA PRÉVENTION DE LA VIOLENCE

Contents

Violence is preventable

Interpersonal violence – violence between individuals in families and communities – is a public health problem. Each year, around 520 000 people die due to interpersonal violence, and millions more suffer the effects of non-fatal violence. In response, many governments, nongovernmental organizations and communities are supporting the development and implementation of prevention strategies.

Many governments and non-governmental organizations have already taken steps to prevent violence. Their efforts have not been coordinated or linked with the shared vision of using data-driven planning and evidence-based programming and prevention methods. The World Health Organization's *World report on violence and health* (WRVH) and Global Campaign for Violence Prevention have inspired an effort to combine interests in preventing violence.

The Violence Prevention Alliance is a network of institutions linked by their voluntary adoption of shared violence prevention principles and policies derived from the WRVH. Participation is open to WHO Member State governments, nongovernmental and community-based organizations, and private, international and intergovernmental agencies working to prevent violence. The Violence Prevention Alliance activities will expand the number of agencies that apply a public health approach to implementing violence prevention programmes and services. They will enhance the impact of individual programmes on national and local policy and practice. The Alliance is part of an ongoing effort to integrate more countries into the Global Campaign for Violence Prevention, while connecting similar groups at regional and local levels to facilitate better sharing of knowledge.

The Violence Prevention Alliance was launched in January 2004 and builds upon the evidence-based principles and recommendations described in the WRVH. The Report details a public health approach to violence prevention based on an ecological framework, and provides nine recommendations for building violence prevention capacity. These principles and recommendations have been endorsed and adopted in resolutions by the World Health Assembly, the African Union and the World Medical Association. Concrete steps towards their implementation have already commenced in nearly 50 countries. The Violence Prevention Alliance will encourage mutually supportive and coordinated programmes, strategies and policy decisions that are consistent with the latest knowledge on violence prevention.

Each year, around 520 000 people die due to interpersonal violence, and millions more suffer the effects of non-fatal violence.

This policy paper sets out the conceptual framework, structure and goals that guide the Violence Prevention Alliance. It is divided into two sections: *Introducing the Violence Prevention Alliance,* and *Preventing violence before it occurs*. The first section presents the basics of the Alliance, including the reasons behind its creation, the contribution of the health sector, and its scope, goals and working methods. The second section describes the global magnitude of interpersonal violence, discusses its known causes, risk factors and consequences, and presents theoretical tools to organize our understanding of interpersonal violence.

Interpersonal violence causes death and illness to millions each year, but it can be prevented. The agencies, organizations and governments who make up the Violence Prevention Alliance recognize this and are using public health methods to prevent death and destruction. As a coordinated and informed group, they demonstrate their global commitment to violence prevention by engaging a common approach that enhances each individual effort and creates a worldwide impact. As this common approach becomes even more widely shared, the global impact can be intensified to bring us closer to a world free from violence.

Why not join us in this crucial endeavour?

Etienne Krug
Director
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World Health Organization

Introducing the Violence Prevention Alliance

The power of an alliance

The Violence Prevention Alliance was formed at the first Milestones of a Global Campaign for Violence Prevention *meeting in January 2004. Built around the science-based principles set out in the World report on violence and health (WRVH), the Violence Prevention Alliance is a systematic but informal mechanism through which participant organizations can jointly conceive, implement and evaluate violence prevention activities. Participants in the Violence Prevention Alliance agree upon common principles to guide their actions with respect to advocacy, funding, training and policy for interpersonal violence prevention. The power of the Alliance will be to act from shared principles.*

Given the magnitude of the violence problem and the number and scope of factors that influence its occurrence, no single agency can solve the violence problem alone. The Alliance establishes mutually supportive violence prevention strategies across agencies to ensure that independent efforts reinforce each other. The Alliance will provide high-level exposure and a multisectoral, international voice that can help its local-, regional-, and national-level participants achieve policy-level change and implement effective interventions to address social and political risk factors.

The adoption of a common approach across many agencies that work at different levels and focus on different sub-types of violence has the potential to shape the practices of hundreds of community, provincial, national, regional and international programmes. These programmes will be mutually supportive and will together promote a widespread paradigm for violence prevention based on systematic and scientifically testable programmes in communities, cities and countries around the world. The support provided by such a coordinated and systematic approach, and the Alliance structure itself, will enable each agency to progress better towards its own mission and achieve its objectives.

The shared approach will also help organizations plan their programming based on scientific principles and evidence. An introduction to these principles begins on page 8. The increased numbers of programmes that follow these principles and the linking of organizations through the Alliance framework will allow more intervention models to be evaluated in a scientifically rigorous manner, leading to a broader base of information about what works to prevent violence in different settings. In addition, interventions could be scaled up and tested in a variety of settings more easily, increasing the certainty of consistent findings with every subsequent evaluation.

The Violence Prevention Alliance is a network of WHO Member State governments, nongovernmental and community-based organizations, and private, international and intergovernmental agencies working to prevent violence. Violence Prevention Alliance participants share a public health approach that targets the root causes and risk factors underlying the likelihood of an individual becoming involved in violence and recognizes the need for improved services to mitigate the harmful effects of violence when it does occur.

Violence Prevention Alliance activities aim to facilitate the development of policies, programmes and tools to implement the recommendations of the World report on violence and health in communities, countries, and regions around the world, and attempt to strengthen sustained, multisectoral cooperation around this shared vision for violence prevention.

Ultimately, this will give individual programmes the breadth and certainty of information they need to implement interventions of known effectiveness and to replace those found to be ineffective.

Scope of the Violence Prevention Alliance

The Violence Prevention Alliance attempts to address the problem of violence as defined in the WRVH, namely:

the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.[1]

The typology of violence introduced in the WRVH, while not a rigid categorization of its sub-types, is a useful tool for understanding violence (Figure one). This typology first divides the general definition of violence into three types according to the relationship between the victim and the perpetrator, then further divides each of these into more specific sub-types of violence.

• Self-directed violence refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicidal behaviour.

• Interpersonal violence refers to violence between individuals, and distinguishes family violence from community violence. The former occurs mainly between family members and intimate partners and usually, though not exclusively, takes place in the home. This category includes child maltreatment, intimate partner violence and elder abuse.[2] Community violence generally takes place outside the home between individuals who are not related and who may or may not know each other. This

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1 Krug EG et.al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002, pg. 5.
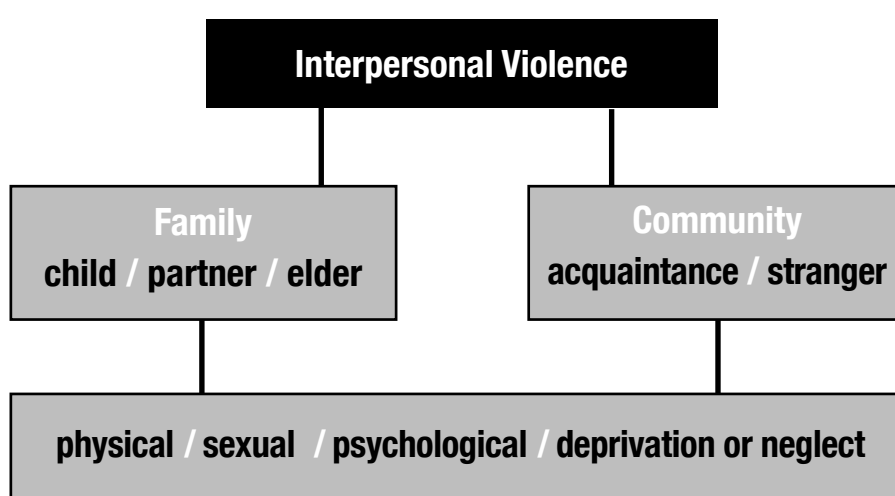
2 Throughout this document, standard WHO terminology is used to refer to the various sub-types of violence. It is recognized that this terminology is not universally accepted and that other terminologies are favoured in some settings.

includes youth violence, assault by strangers, violence related to property crimes and violence in workplaces and other institutions.

• Collective violence is used by members of a group against another group or set of individuals and can be socially, politically or economically motivated.

The typology also illustrates the nature of violence, which can be physical, sexual, psychological or involve deprivation or neglect.

Figure one: Violence taxonomy

Interpersonal Violence	
Family child / partner / elder	**Community** acquaintance / stranger

physical / sexual / psychological / deprivation or neglect

Violence is complex and multifaceted. Achieving a coordinated, population-level response to all three types of violence (self-directed, interpersonal and collective) is currently beyond the scope of the Violence Prevention Alliance. Interpersonal violence alone causes a significant proportion of worldwide violence-related deaths and disabilities, and its many sub-types are closely related to self-directed and collective violence. Initial Alliance efforts have concentrated on the issues surrounding interpersonal violence, while at the same time acknowledging its links with other forms of violence. More specifically, the work within the Violence Prevention Alliance focuses on the information systems, risk factors, prevention strategies and support services for victims that are common to all sub-types of interpersonal violence and are often linked to self-directed and collective violence.

Alliance participants are committed to adopting a public health approach to interpersonal violence prevention. They participate in consensus-determined activities to promote and implement the recommendations of the WRVH and to actively encourage the widespread adoption of the Violence Prevention Alliance's guiding principles. The Alliance is not a grant-making organization; there are no costs associated with participation and participants are not remunerated.

Goals of the Violence Prevention Alliance

The Violence Prevention Alliance serves to bring together agencies working at all levels of intervention, including donor agencies; international, regional and intergovernmental bodies; local and community-based groups; policy-makers; programme developers; researchers and service providers. The agencies will be committed to using a public health approach based upon the ecological framework (Figure four, p13)

The aims of the Alliance are to:

- Increase capacity for information-gathering on the epidemiology of violence;

- Broaden the evidence base on what works and what does not work in violence prevention policy and programming by testing promising programmes in a variety of settings and evaluating intervention models that have not yet been tested;

- Encourage widespread implementation of programmes that are known to be effective and discontinuation of programmes that are not.

The short-term goals of the Violence Prevention Alliance are to:

- Attract a large and diverse group of participating organizations that have endorsed the Violence Prevention Alliance Principles and adopted the public health approach to violence prevention in their related activities;

- Encourage international donor agencies to:
  - adopt the public health approach to violence prevention in their policy documents;
  - prioritize funding for violence prevention programmes that are based on the public health approach; and
  - work closely with promising programmes to help them conduct rigorous scientific evaluations;

- Encourage countries and organizations to adopt the public health approach to violence prevention in their work and to evaluate their programmes scientifically;

- Create a high level of visibility and awareness of the Violence Prevention Alliance, of the activities of its participant organizations and of the benefits of the public health approach to violence prevention;

- Provide a forum for donors, recipients and other agencies working to prevent violence to interact in a way that will increase worldwide capacity to reduce violence.

Long-term goals include:

- Increase the number of population-based programmes that engage in the primary prevention of violence through a public health, science-based approach, and work towards the implementation of the recommendations of the WRVH (Annex).
- Increase the support – financial and technical – provided to such programmes.
- Affect policy-level changes in countries with participant organizations in accordance with the WRVH recommendations.

Activities of the Violence Prevention Alliance

The Violence Prevention Alliance facilitates implementation of the WRVH recommendations and uptake of the public health approach to violence prevention by:

- Providing strategy-level guidance to participant organizations and others on how to draw upon the WRVH recommendations and the public health approach to become more effective and systematic in the violence prevention activities that they support and implement.
- Sharing best practices for data collection, prevention programmes and support services for victims between and within participant institutions and groups that focus on the different sub-types of violence.
- Sharing information, experiences and expertise between participants through the development of technical partnerships and other collaborative projects.
- Publishing advocacy materials for a variety of audiences that explain and promote the public health approach.
- Supporting Alliance participants in the creation of national reports on violence and national action plans for violence prevention.
- Convening a Violence Prevention Alliance Annual Meeting as a platform for information-sharing, increasing participation and evaluating the effects of Alliance principles in the field.
- Identifying and recruiting individuals to champion the cause of violence prevention in their countries and regions, to help raise the profile of the violence problem globally and to act as violence prevention advocates.
- Implementing an annual award system to acknowledge innovative research and programming for the primary prevention of interpersonal violence.
- Monitoring the impact of the work of the Violence Prevention Alliance and developments in the field of violence prevention overall.

Preventing violence before it occurs

Violence is a public health problem

The *World report on violence and health* highlighted the importance of viewing violence through a public health lens and made nine recommendations (see Annex) to promote the primary prevention of violence and strengthen support services for its victims.[1] The 2002 launch of the WRVH was followed by the beginning of the Global Campaign for Violence Prevention, an ongoing set of activities to promote the systematic and coordinated approach to violence prevention introduced in the WRVH.

In 2000, an estimated 1.6 million people worldwide lost their lives to violence. Approximately half of these deaths were suicides, nearly one-third were homicides, and about one-fifth were casualties of armed conflict. These deaths are only 'the tip of the iceberg' of the consequences of violence. In addition to the more than 500 000 deaths each year from interpersonal violence, thousands more people suffer the physical and psychological effects of non-fatal violence.[2]

The prevention of interpersonal violence at a population level has implications well beyond the individuals directly involved. It has the potential to revive communities and improve people's lives across their whole life-course, from childhood through adulthood and old age. Violence harms the social fabric of families and communities in innumerable ways. Both the physical and psychological consequences of violence can permanently alter the quality of life of those directly affected and of their families and friends. Death, severe injuries, long-term disability, psychological disorders and incarceration are common consequences of violence that incapacitate people during their most productive years of life. In communities where violence is particularly prevalent, such consequences are so common that they can drastically alter the ability of the entire community to function socially and economically.

Moreover, childhood experiences of violent situations can negatively affect child and adolescent development and psychology in ways that frequently lead to high-risk behaviours later in life (Box one). These behaviours increase the risk that, as adults, childhood victims or witnesses of violence will suffer from some

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1 The use of the term "victim" to describe an individual who has been subjected to violence and its consequences (or to any negative health outcome) is the subject of an ongoing debate concerning the degree to which such terms are disempowering in themselves. The use of this term in the current document is intended to reflect the full scope of the effects of victimization, from mild short-term effects, through severe and chronic disability, to death. No implications relating to issues such as personal resilience are intended or should be assumed.

2 A list of further reading is available upon request from violenceprevention@who.int

of the other leading causes of death and disability, including ischaemic heart disease, alcoholism or other substance abuse, mental illness, chronic lung disease and sexually transmitted infections.

Violence is also both a cause and a consequence of poverty, inequality and social inequity, political instability and scarcity of resources (Box Two). Such conditions are known to contribute to high levels of both interpersonal and collective violence. Interpersonal violence may also be viewed as a potentially valuable warning sign of impending collective violence resulting from a volatile social, political or economic situation. Strengthening the systems, services and policies needed to prevent interpersonal violence may therefore be an important means of preventing collective violence.

Box 2

The role of interpersonal violence prevention in reducing poverty and fostering development

While all social classes experience violence, research consistently suggests that people with the lowest socioeconomic status are at greatest risk. The mechanisms are complex and not well understood, but evidence indicates that both absolute poverty and income inequality are related to levels of violence. Studies have shown that homicide is more prevalent in low-income communities and countries than high-income communities and countries, and the economic and social burden of its consequences are often more devastating for poorer people, communities and countries. In addition, countries with a larger gap between rich and poor experience more violence than countries in which there is more income equality, regardless of the absolute income level of the nation.

Absolute poverty and income inequality may foment violence in societies through many mechanisms. For instance, lack of educational and economic opportunities may compel young people who have few prospects for gainful employment to participate in local drugs trades, which are frequently sources of violence at community and societal levels. Women and girls in rural and economically depressed areas are often at increased risk of sexual violence as they carryout everyday tasks such as collecting water or working in fields, and poverty is also a leading factor that pushes women into prostitution. Poorer people have less leisure time as they work long hours or far from home, leaving children unsupervised and therefore at higher risk.

Similarly, poverty results from violence in many ways. For example, at the individual and family levels, catastrophic health and long-term care costs to treat violent injuries push families into insurmountable debt. Disability from violent injuries, as with all disabilities, can socially marginalize victims and push a formerly productive person out of the labour force, plunging the individual and the family into poverty. At the societal level, high levels of interpersonal violence result in large-scale disinvestment in communities and countries.
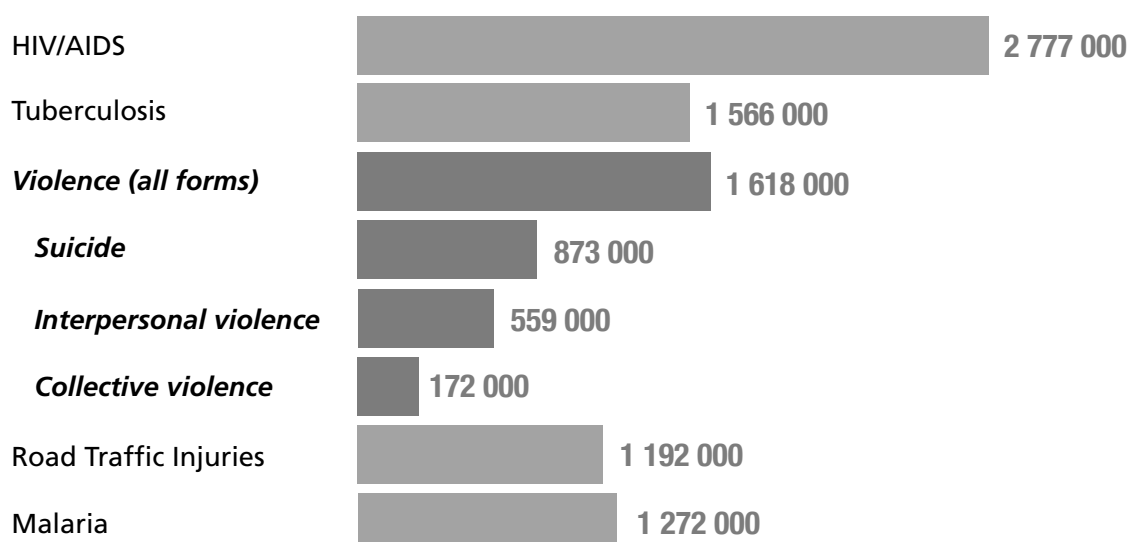
The economic and social consequences of violence are also obstacles to development. Exploring the relationship of violence to the Millennium Development Goals (MDGs) highlights the important contribution that violence prevention can make to positive social and economic development. The MDGs provide a framework for development that includes indicators for reducing poverty and promoting health; violence relates directly and indirectly to several of them. For instance, Recommendation 6 of the World report on violence and health, which encourages the promotion of gender and social equity and equality, is directly linked to MDG 3: Promote gender equality and empower women. Gender-based violence is a form of discrimination against women that perpetuates women's unequal status, thus inhibiting gender equality. As the Beijing Declaration and Platform for Action have articulated, gender equality cannot be achieved without addressing violence.

Violence also relates directly to MDG 6: Combat HIV/AIDS, malaria and other diseases. Links between violence and HIV/AIDS suggest that efforts to eliminate sexual violence and intimate partner violence can make a significant contribution to reducing the spread of HIV/AIDS, and that violence prevention measures can improve the lives of people living with the disease. Lastly, as outlined above, preventing violence and its negative long-term consequences can contribute greatly to the achievement of MDG 1: Eradicate extreme poverty and hunger by helping families avoid debt from catastrophic health care costs and preventing the lost wages and rehabilitation expenses that often accompany disability.

Poverty and inequality have implications for violence and violence prevention at all levels: primary prevention, service delivery, pre-hospital, emergency and long-term care. Poverty acts as a risk factor for violence at all levels of the ecological model, and is modifiable through social and economic policy intervention at community, national and international levels. Policies to alleviate poverty are likely to reduce violence as a secondary positive outcome, while policies aimed at preventing violence and strengthening the systems that support those who have experienced violence are also likely to reduce poverty and foster environments that are conducive to development.

Public health is concerned with providing the maximum health benefits at a population level, that is, for the greatest number of people. Given the magnitude of its occurrence and the extent of its consequences, violence is a global public health issue. It is a leading cause of death for people aged 10 – 44 years, and results in annual death rates comparable to those of other major public health threats, such as tuberculosis, road traffic injuries and malaria (Figure two). Moreover, violence can be analysed using standard epidemiological research methods. Repeated studies in many different settings show that it occurs in predictable patterns and is mediated by modifiable risk and protective factors. As with infectious diseases and other public health problems, these characteristics allow violence to be prevented through interventions that change individual behaviours, small-group and community dynamics, and broader social and physical environments.

Figure two: Estimated annual deaths from major public health problems
(millions of people, worldwide)

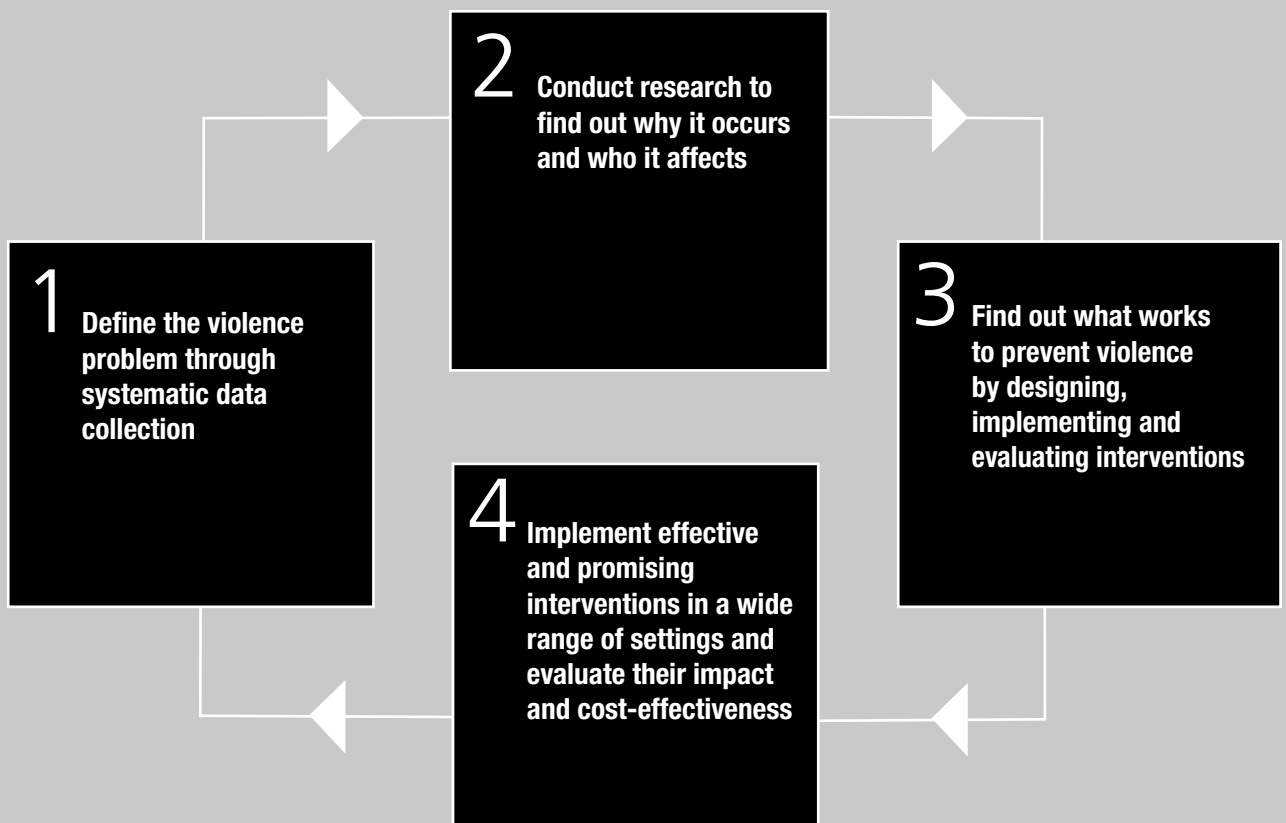|	
HIV/AIDS	2 777 000
Tuberculosis	1 566 000
Violence (all forms)	1 618 000
Suicide	873 000
Interpersonal violence	559 000
Collective violence	172 000
Road Traffic Injuries	1 192 000
Malaria	1 272 000

Not everyone is equally at risk of being involved in violence either as a perpetrator or as a victim. The risk of involvement in some types of violence differs markedly by gender (men are more often victims and perpetrators of homicide, while women are more commonly the victims of intimate partner and sexual violence); and by age (rates of severe physical violence rise sharply at age 15 and remain high to age 44). In addition, environmental and community characteristics (such as high unemployment rates) influence levels of violence, and countries with higher levels of income inequality also tend to experience higher levels of homicide. Scientific evidence has shown that the different sub-types of interpersonal violence are interrelated and one may lead to another – for example, victims of child abuse may be more likely to engage in violence as adolescents. Preventing one sub-type can therefore help to prevent other types of interpersonal violence. Moreover, while some risk factors and consequences may be specific to a single sub-type of interpersonal violence, many causes and risk factors are common to all forms. Interventions that target these shared causes and risk factors are likely to be effective at preventing all sub-types.

Making decisions based on science

The *World report on violence and health* set out a number of scientifically tested and proven principles and recommendations based upon a public health perspective (see Annex). A public health approach to violence prevention strives to implement interventions that will have a population-level effect by influencing modifiable risk factors that act before violence occurs (Figure three). This type of intervention, called primary prevention, focuses on the conditions that may lead to an individual becoming involved in violence rather than on victims or perpetrators. The public health approach is based upon an ecological framework that provides a mechanism for understanding the levels at which different risk factors exist and therefore the levels at which primary prevention interventions might effectively act (Figure four).

Figure three: The public health approach outlines four steps for preventing violence:

2 **Conduct research to find out why it occurs and who it affects**

1 **Define the violence problem through systematic data collection**

3 **Find out what works to prevent violence by designing, implementing and evaluating interventions**

4 **Implement effective and promising interventions in a wide range of settings and evaluate their impact and cost-effectiveness**

This ecological framework characterizes interpersonal violence as the outcome of interactions between factors at four levels: individuals, close relationships, communities and society.

a At the individual level, personal history and biological factors influence how individuals behave and affect their likelihood of becoming a victim or a perpetrator of violence. Risk factors at this level include psychological or personality disorders, alcohol and/or substance abuse and a history of behaving aggressively or having experienced abuse.

b Close relationships such as those between family, friends, intimate partners and peers may also influence the risks of becoming a victim or a perpetrator of violence. For example, experiencing poor parenting, having witnessed violence conflict between parents or having violent friends may influence whether or not a young person engages in or becomes a victim of violence.

c Community contexts in which relationships occur, such as schools, neighbourhoods and workplaces, form surroundings that are favourable or unfavourable to violence. Risk factors at this level may include level of unemployment, population density, mobility and the existence of a local drug or firearm trade.

d Societal factors influence whether violence is encouraged or inhibited. These factors include poverty, levels of social, economic and gender inequalities, weak economic safety nets, poor rule of law and social and cultural norms around violence.
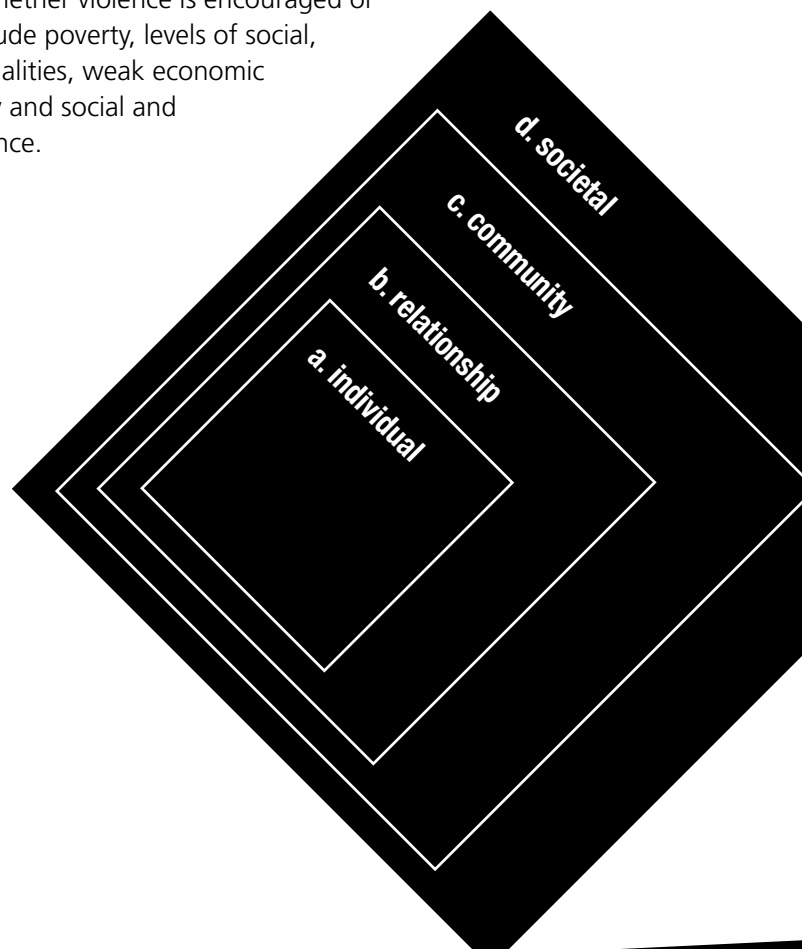
d. societal

c. community

b. relationship

a. individual

Figure four: the ecological model

The principles of public health provide a useful framework for continuing to investigate and understand the causes and consequences of violence, and for preventing violence from occurring through primary prevention programmes, policy interventions and advocacy. In addition, while far more research and evaluation is needed to determine what works and what does not among the numerous interventions that have been tried, there are several programmes that have been shown to be both effective in preventing violence and cost-effective in the long term (Box three).

Box 3

The glass weapons project – applying the public health approach

In 1985, an oral and maxillofacial surgeon in Wales, the United Kingdom, came to the conclusion that many of the violence–related facial injuries he treated could be prevented. He tested his clinical impressions scientifically, recruiting junior doctors and dentists from the local Emergency Department (ED) to help conduct basic research into the magnitude and causes of the violent injuries they routinely treated. This investigation catalysed a project that developed over the next 15 years and significantly reduced the number of injuries resulting from violence in which bar glassware was used as a weapon. The surgeon applied the four steps of the public health approach to this secondary prevention endeavour as follows:

Step 1: Define the problem – Junior doctors and dentists in an urban ED interviewed 500 consecutive patients presenting for violence-related injuries using a questionnaire developed by the oral and maxillofacial surgeon. The questionnaire asked for information on the circumstances leading to the patient's injury, and on the weapons that had been used. Most interviews were conducted at night, when most assault patients attend EDs.

Step 2: Identify risk factors – Bar glassware (glasses and bottles) was identified as the most frequently used weapon category apart from fists and feet. A further four-city survey showed that one-pint lager glasses were the most common type of bar glassware implicated in violent incidents. Laboratory testing showed that toughened bar glasses were harder to break than the non-toughened glasses, and that when the toughened glasses did break, they shattered into blunt rather than sharp fragments.

Step 3: Develop and evaluate interventions – A community-randomized trial showed that toughened pint glasses were associated with fewer injuries than weaker glasses.

Step 4: Implement effective interventions – An advocacy campaign that showed graphic pictures of facial injury was launched through the Welsh Development Agency, the national charity "Alcohol Concern", and the media to encourage pubs, bars and nightclubs across the country to use only toughened pint glasses. The glass industry in the United Kingdom switched to toughened bar glassware in 1997 – 1998, and efforts to create a manufacturing standard to cover domestically produced and imported glasses are under way. The intervention was evaluated through additional questions added to the annual British Crime Survey, which showed that glass injuries decreased substantially with the rise in production of toughened bar glassware.

Conclusion

Historically, violence prevention efforts have been hindered by the lack of political will because policy makers have not believed that violence is preventable. The Violence Prevention Alliance offers the information and methods to change that belief.

While criminal justice responses to violence are necessary and useful, they are not sufficient for the prevention of violence at a population level. The other aspects of a comprehensive response to violence, including efforts for its prevention, have been spread thinly across multiple sectors, such as ministries of welfare, education and employment, and civil-society groups.

The Violence Prevention Alliance provides leadership by offering a forum to participants for information exchange, technical assistance partnerships and policy-level advocacy. The perspective that the Alliance promotes revolves around the three theoretical models described in this paper: the typology of violence; the public health approach; and the ecological framework. These models guide understanding, research and action for violence prevention. The typology is a tool to help organize thinking about the different types of violence and the ways in which violence occurs. The public health approach offers practitioners, policy-makers and researchers a stepwise template that can be applied to planning programmes, policies and research. Finally, the ecological framework bridges these two models, providing a structure for understanding the contexts within which violence occurs, and the interactions between risk factors within and across contexts. The ecological framework shows where and how to apply the public health approach and is useful for categorizing planned or existing interventions to help elucidate the mechanisms by which they might be working.

By promoting a science-based and coordinated approach to interpersonal violence prevention, the Violence Prevention Alliance aims to increase the evidence base on primary prevention programmes that are effective and those that are not. By involving agencies that have historically provided support to interpersonal violence prevention, the Alliance will use the evidence base to increase the number of effective violence prevention programmes that are implemented. The systematic and coordinated approach promoted by the Violence Prevention Alliance will help enhance the effects of individual programmes working around the globe to prevent the different sub-types of interpersonal violence, its root causes and cross-cutting risk factors.
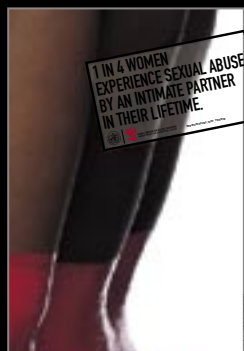
Annex

Recommendations of the *World report on violence and health*

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.

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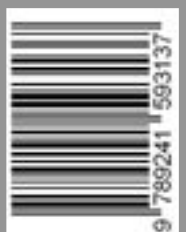VIOLENCE PREVENTION ALLIANCE / ALLIANCE POUR LA PRÉVENTION DE LA VIOLENCE

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Organization

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