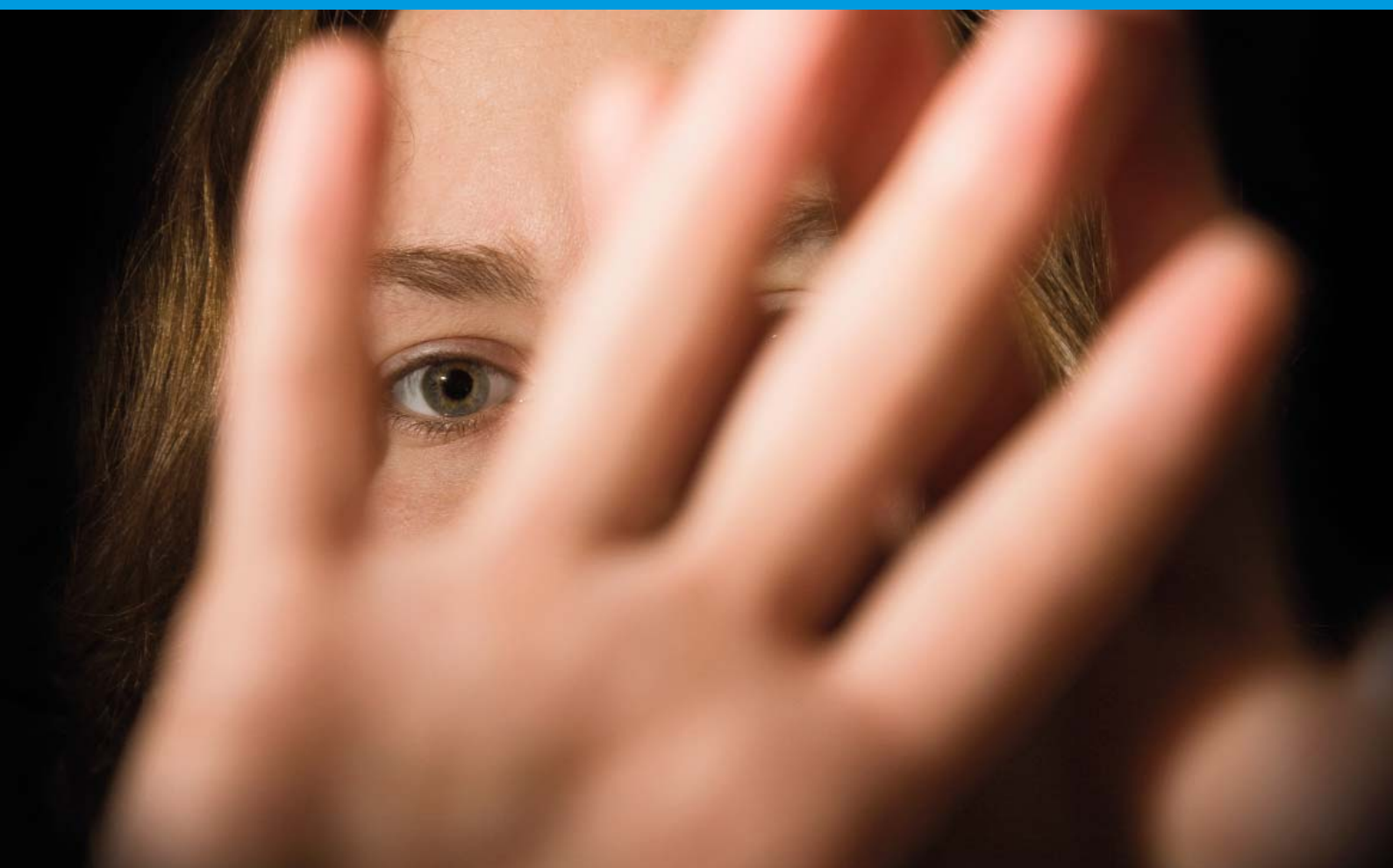


The role of public health in the prevention of violence



A statement from the UK
Faculty of Public Health

The role of public health in the prevention of violence: a statement from the United Kingdom Faculty of Public Health

Executive summary: Ten points on the role of public health in violence prevention

1. The epidemiology of violence: The public health community has a key role monitoring violence as major health threats. In England, increasingly, as part of partnership working, local areas are adopting information sharing approaches to tackling violence, particularly in adult and children's safeguarding and in city centre crime involving alcohol.

2. Evidence-based violence prevention: Good scientific evidence is an essential part of a public health approach to violence prevention. There is a rich evidence base for primary prevention of violence, particularly in developed countries. This includes extensive evidence for the effectiveness of early years and young people's interventions, parenting training and control of violent and addictive behaviours. Preventive measures analogous to the prevention of an infectious agent, an addiction, and measures at different points in the life course are also important.

3. Asset based community development and international development: We need an asset-based approach, recognising all the strengths and resources – natural, human, educational, economic and environmental – available to a community to improve its security and health. This favours human development over pre-occupation with economic growth, which may increase inequalities, and fail to grow social and educational support or improve health.

4. Primary prevention: The key role and responsibility of the public health community in this area is to prevent violence. Public health practitioners and policy makers are uniquely placed to address inequalities and root causes of conflict in local, community and international situations. Primary prevention of conditions for violence should be our main objective.

5. Secondary prevention – early intervention: Where it is not possible to prevent violence, early intervention should be undertaken to mitigate further escalation. This involves early warning and intervention, de-escalation and conflict handling, alongside effective planning.

6. Tertiary prevention of violence – mitigation and response: Faculty of Public Health (FPH) systems and public health professionals must be effectively mobilised in response to violent conflicts. Tertiary prevention involves response, treatment and rehabilitation, as well as reconstruction and resolution.

7. New public mental health and conflict resolution: New learning from brain science, psychology and public mental health fields needs to be applied in developing violence prevention strategies, humanitarian aid and conflict resolution. Discussion of power differences is important and can be part of recognising our common human and civil rights.

8. The role of public health in conflict resolution: Public health is neutral territory in which enemies can come together. As a professional body with a respected membership throughout the world, our first response to violent conflict should be to behave as honest broker. We should seek to bring together public health specialists on different sides of a conflict to create a dialogue aimed at influencing peaceful resolution and rapprochement.

9. The Faculty of Public Health role as an educational body: FPH will review educational materials on violence for our curriculum and look to accredit relevant interdisciplinary resources and courses on violence as a public health problem. FPH special interest groups are encouraged to take forward the prevention agenda from local to international levels. Our Global Health Committee will play a role and developing ethics and values work will be vital.

10. The leadership role of public health: FPH professionals need to take up leadership roles in prevention, control and response to violence, at local, national and international level. Public health professionals should be actively involved in the measurement and surveillance of all forms of violence, in advocating for effective interventions and monitoring of outcomes and in partnerships to promote safeguarding and crime and disorder.

The role of public health in the prevention of violence: a statement from the United Kingdom Faculty of Public Health

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.

As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With 3,300 members based in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

Introduction

Public health and health services communities around the globe have a long tradition of working for health improvement, transcending narrow economic and political concerns and the self-interest of individuals, ethnic groups, religions or countries. The need to reaffirm this global and collective ethic has never been stronger.

Public health has brought together humankind in a spirit of co-operation and mutual support. The eradication of small pox and the near eradication of polio are perhaps the best examples of this spirit. The all-embracing world health strategies of 'Health for all by the year 2000',¹ 'Health 21',² and now 'Health 2020'³ have expressed wider aspirations, including solidarity between nations and reducing inequalities in economic status, health experience and life chances.

'Health promotion is peace promotion'⁴ – the activity of improving population health inherently strives to reduce inequalities, to achieve fairness, and tackle environmental, economic and social causes of ill health.^{5, 6, 7} There is also a need to strengthen national and international public health networks, as shown by the Ebola crisis.⁸

Violence is a major public health problem. We believe it has been given insufficient attention and priority in the arena of public health policy, partnerships and interventions. A public health approach to violence prevention involves, measuring health needs arising from violence, determining causes and solutions to problems, advocating effective interventions and mobilising partnerships to improve health and prevent or control the harmful effects of violence.

These functions, in respect to violence prevention, mitigation and control, apply to all levels of violence – in domestic and local situations, with conflicts between communities, within countries and international violence.^{9, 10} This paper sets out the roles of public health practitioners and the role of the public health system in preventing, mitigating and responding to violence.

Violence – Some definitions

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. ¹¹

Intimate partner violence can be defined as ‘any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship’, including violence within same sex relationships. ¹²

Sexual violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances directed, against a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. It includes trafficking for sexual exploitation. ¹³

Gender based violence: acknowledging the power imbalances which gives rise, specifically, to violence against women. ¹⁴

Terrorism is politically motivated violence or the threat of violence, especially against civilians, with the intent to instill fear. Terrorism is intended to have psychological effects that reach beyond the immediate victims to intimidate a wider population, such as rival ethnic or religious groups, a national government or political party, or an entire country. ¹⁵

Genocide was defined by the United Nations in 1948 to mean *»any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group as such: killing members of the group, causing serious bodily or mental harm to members of the group, deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part, imposing measures intended to prevent births within the group, forcible transferring children of the group to another group«* More people were killed because of genocide in the 20th century than through any other cause (approximately N=174 million). ¹⁶

Primary violence prevention:

Preventing violence before it occurs. Looking at and focusing on root causes and using an upstream approach for prevention methods.

Secondary violence prevention:

Early identification of potential offenders/situations where violence may occur and seeking to intervene.

Tertiary violence prevention:

Long-term response to violence, violent incidents and conflict, including conflict resolution. ¹⁷

Resilience, in the UK, has come to mean the overall ability of public services and communities to respond to and deal with ‘all-risks’ of civil, environmental, communicable disease disasters and breaches of security. ¹⁸

The World Health Organization considers violence a major threat to public health and divides violence into three broad categories according to characteristics of those committing the violent act: self-directed violence, interpersonal violence and collective violence. Collective violence is subdivided into social, political and economic violence. Political violence in this definition of the WHO includes war and violent conflicts, including, among others, state violence and terrorist acts.

The WHO definition of violence recognises that violence may not always be physical and visible but includes coercion, economic deprivation and more subtle threatening relationships. This subjugation may be against individuals in domestic situations, between communities or social groups, or between political factions, ethnic groups, religions or countries.¹⁹

FPH draws attention to the recent World Health Assembly resolution on addressing violence, to which the UK is a signatory. The resolution asks nations to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs, and child development, in order to promote and develop an effective, comprehensive, national multi-sectoral response to interpersonal violence.

It is in particular concerned with violence against women and girls, and against children, by, inter alia, adequately addressing violence in health and development plans, establishing and adequately financing national multi-sectoral strategies on violence prevention and response including protection, as well as promoting inclusive participation of relevant stakeholders.²⁰

Any approach to violence prevention should be grounded in respect for human rights.^{21, 22, 23, 24} In this context, we note the importance of the Global Strategy for Women's and Children's Health (2010), which emphasises "participatory decision making processes, non-discrimination, and accountability."²⁵

FPH further draws attention to the Sustainable Development Goals, which pledges to "significantly reduce all forms of violence and related death rates everywhere" and affirms that "there can be no sustainable development without peace and no peace without sustainable development."²⁶

The Office of the UN High Commissioner for Human Rights note the importance of human rights in the new global strategy in relation to women's, children's, and adolescents' Health:

- Providing access to affordable, acceptable, good quality healthcare and services for all women, children, and adolescents on an equal footing;
- Empowering women, children, and adolescents to claim their rights and participate in decision making;
- Putting in place the necessary policy and legal frameworks to ensure the accountability of all actors involved in health service delivery;
- Adopting comprehensive strategies, working together with other sectors that affect health, to respond to the full range of health challenges faced;
- Engaging multiple stakeholders, including children and adolescents, in policy formulation, implementation and review and supporting consistent participation;
- Improving health outcomes for marginalised, excluded, and vulnerable women, children, and adolescents.²⁷

We recognize that violence is one of the most important threats to public health. This may be the extreme violence being experienced in places such as Syria, the Ukraine, Nigeria, Gaza and other areas of the world, where the lives of children and civilians are being lost daily through bombs and lack of basic amenities. But it is also the sort of violence experienced in developed countries who do not consider themselves to be 'at war'- the emotional violence of bullying in workplaces, schools, the internet and domestic violence and child and elder abuse with its life-long impact, particularly on mental health.²⁸

Violence has a major negative impact on a global level. It has direct and indirect costs on peoples' long-term physical, mental and sexual health. The strain and costs to resources make violence a major public health issue. Violence appears in many forms across society, and as well as injury and death, the consequences of it range from child abuse and neglect, to human trafficking, as well as non-communicable diseases, mental distress and long term mental illness.

Globally it is estimated that 1.3million deaths occur annually due to violence in different forms.²⁹ However, this number would grow considerably if one were to include deaths and the health consequences that result indirectly as a result of violence e.g. deaths from alcohol, tobacco and other drugs used as coping mechanisms. In England and Wales there are 2.5 million violent incidents a year.

These result in 300,000 emergency department attendances 35,000 emergency admissions and cost the NHS an estimated £2.9 billion a year. The overall economic cost to the country has been estimated at between £29.9billion³⁰ and £41 billion³¹. In different parts of the world violence is occurring within conflict zones. This causes death and injuries but also creates long-term consequences for health and adverse social and environmental consequences.³²

The World Health Organisation says that 'almost all violence is predictable and therefore preventable'.³³ Early identification and interventions are key to preventing violence. This requires a holistic, multi-systems approach. Such an approach includes good communication and sharing of relevant information between schools, workplaces, hospitals, in general practice, criminal justice institutions, non-governmental organisations and communities.³⁴

Further in-depth community and situational research and development are needed, with the consideration of how public spaces and living environments can have an effect on violent behaviour. Perpetrator and victim relationships need to be reassessed. We need to promote independence and inter-dependence, the resilience of individuals and communities, and we must encourage non-violent resolution of problems and mobilisation of assets within communities.

Violent behaviour shows similar features to infectious diseases - being capable of being learned from one generation to the next, from one community to another. Therefore major aspects of violence prevention should be interruption of the cycle of violence and reduction in tolerance of violence as a way of settling differences.³⁵

1. The epidemiology of violence

The public health community has a key role in monitoring violence as major health threats.^{36, 37} The World Health Organization and its collaborating centres are major repositories of health data on violence globally.³⁸ In England, the VIPER system offers local authorities profiles of the health and social consequences of violence.³⁹
40

Local areas are increasingly adopting information sharing approaches to tackling violence as part of partnership working, particularly in adult and children's safeguarding⁴¹ and in city centre crime – particularly crime involving alcohol.^{42, 43, 44} Standardisation of approaches to data definition and data collection are needed, particularly using the Information sharing to tackle violence (ISStV standard, both in the NHS and internationally.^{45, 46}

After traumatic events such as terrorist attacks and mass shootings it is important to document health impacts. An example was the study showing the psychological resilience of Londoners after the 7-7 bombings.⁴⁷ Data on violence can also serve an important documentation function for reconciliation.⁴⁸ Root cause analysis or reviews of individual incidents are important in learning lessons for the prevention of future incidents. The major function of the epidemiology of violence is to determine prevention strategies.⁴⁹ Office of National Statistics data shows that in 2013/14, 1.4 million women and 700,000 men in England and Wales experienced domestic abuse.⁵⁰

2. Evidence-based violence prevention

A major aspect of a public health approach to violence prevention is the search for good quality scientific evidence. The hierarchy of evidence describes levels of evidence from multiple good quality randomized trials, through single controlled studies to observational studies to the opinions of experts.⁵¹

Much policy action in this area uses the latter category of 'opinions of experts' backing the hunches of politicians, so would not be regarded as having a strong evidence base. Indeed, politicians and policy makers should recognize that plausible ideas for interventions could cause harm.⁵²

There is a surprisingly rich evidence base for the primary prevention of violence, particularly in developed countries, which do not consider themselves at war, much of it summarized in the *Preventing Violence, Promoting Health* report of the North West WHO Collaborating Centre for Violence prevention.^{53 54}

Using the life course approach, it is apparent that interventions in early years lead to better development of children and young people better able to communicate effectively and without violence. Parenting skills can be taught particularly to assist children and young people with mild to moderate behaviour problems. Mentoring and peer education services supporting young people and young adults can also be effective. Cochrane collaboration and the social science sister body, the Campbell collaboration, are major resources for evidence based approaches to violence prevention.⁵⁵

Many systematic reviews conclude with the view that more research is needed. Often there is a need to act to tackle violence and randomised trial models may be difficult to undertake or be inappropriate. However, policy makers should strive to use the good evidence that exists to inform policies, programmes and investment decisions.^{56,57,58, 59} Where there is inadequate evidence of effectiveness, policy

makers should invest in high quality research and evaluation using the most rigorous research methods.

3. Asset based community development and international development

We believe communities have assets of their own which should be built on in order to address problems of security and health.⁶⁰ This applies at local levels, within countries and between countries. Much of our assessment of needs and service planning is deficit-based: recognising all the faults, weaknesses and deprivations of communities.

Instead we need an asset-based approach, which recognises all the strengths and resources - natural, human, educational, economic, environmental - available to a community. Such a route to development would major on human resources such as education, training and health and the protection of economic, natural and environmental resources for the local people rather than wealthy elites. It would favour human development over the current pre-occupation with economic growth, which may increase inequalities, fail to grow social and educational support and fail to improve health.⁶¹

An asset-based approach can apply to prevention, control and response to violence in communities within countries and between countries.

4. Primary prevention of violence

We believe that with respect to violence, the principal role and responsibility of the public health community is to prevent it.^{62,63,64,65,66} Indeed, public health practitioners and policy makers are uniquely placed to address inequalities and tackle the root causes of conflict in local, community and international situations. Primary prevention of the conditions for violence should be our main objective.

Violence shows the strongest inequalities gradient within countries and internationally.^{67,68} The most deprived communities within the UK have five times the rates of violent death and admissions to hospital compared to wealthier areas. The inequalities in violence and consequences of violent conflict such as refugee and environmental burdens are many times worse for the poorest countries than for wealthy nations. Increasing social inequality has been linked to increases in violent crime across a range of countries.⁶⁹

However, it is important to recognise that most people in deprived communities are not violent. Increasingly, evidence suggests that those exposed to abuse, neglect and stress in childhood are more likely to turn to violence to attempt to solve their own problems. This requires action to target child abuse, neglect, domestic violence (including recognition of the gender imbalance in domestic violence) and other adverse childhood experiences. Such activities need to be disproportionately targeted at communities (such as some deprived ones) where need is greatest.

FPH believes that health promotion is peace promotion: the actions of improving health and reducing inequalities and perceived injustices can enable people to achieve better health and quality of life. Preventing the root causes of violent conflict is essential if global health is to improve in a violence-free world.

The Faculty's global health strategy calls for the new sustainable development goals (SDGs) to address fundamental societal problems which prevent people from achieving their full potential and create the conditions for inequality, unfair distribution

of resources, poor health, conflict and violence.⁷⁰ The SDGs also set targets to "significantly reduce all forms of violence and related death rates everywhere" and to "end abuse, exploitation, trafficking and all forms of violence against children"; and further states that "there can be no sustainable development without peace and no peace without sustainable development."⁷¹

But we also consider that sustainable development goals must embrace asset-based community development approaches in rich and poor worlds alike, and we must expect more transformational change from wealthy countries, towards sustainable growth and energy use, and in their relationship to poor countries.⁷²

Primary prevention of violence requires actions to tackle alcohol since alcohol is strongly linked to all types of violence. Fiscal measures are particularly effective, and minimum unit pricing per unit of alcohol is likely to reduce such violence. FPH strongly supports the introduction of this measure.^{73, 74}

FPH also notes the recent World Health Assembly resolution on addressing violence to which the UK is a signatory, and which asks nations to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs and child development.

The resolution aims to promote and develop an effective, comprehensive, national multi-sectoral response to interpersonal violence. This is of particular importance in relation to violence against women children. For example, we should be adequately addressing violence in health and development plans, establishing and adequately financing national multi-sectoral strategies on violence prevention and response including protection, as well as promoting inclusive participation of relevant stakeholders.⁷⁵

5. Secondary prevention of violence – early intervention

Where it is not possible to prevent violence, early intervention should be undertaken to mitigate against the escalation of violence. Secondary prevention involves early warning and early intervention, de-escalation and conflict handling. It also requires a high degree of planning, preparedness and resilience, to deal with the threat of violence.⁷⁶

Public health infrastructure needs to be strengthened to increase the ability to identify, respond to, and prevent problems of public health importance. This includes public health aspects of specific terrorist attacks, such as chemical, biological and nuclear weapons and environmental threats. Systems development includes workforce, laboratory and information systems and other components of the public health system, including education, research and community involvement.

Public health professionals need to be educated and informed to better identify, respond to, and prevent the health consequences of terrorism, and promote the visibility and availability of public health services in the communities that they serve.

Public health services need to address the mental health needs of populations that are directly or indirectly threatened with violence.

Public health professionals and services need to play their part in assuring roles are clear and that relationships and actions are understood among public health agencies, law enforcement and first responders.^{77, 78}

6. Tertiary prevention of violence – mitigation and response

Where there are violent conflicts, public health systems and public health professionals must be effectively mobilised in response. Tertiary prevention involves responses to violence and to the consequences of violence. It therefore includes response, treatment and rehabilitation. But it goes on to embrace reconstruction, resolution and reconciliation.^{79, 80}

Public health professionals are involved in providing humanitarian assistance to, and protecting the human rights of, the civilian populations that are directly or indirectly affected by violence.

The public health system must ensure availability of, and accessibility to, health care, including medications and vaccines, for individuals exposed, infected, made ill, or injured in violent attacks. The public health system should address mental health needs of populations that are directly or indirectly affected by violence or terror threats.

The public health system must assure the protection of the environment, the food and water supply, and the health and safety of rescue and recovery professionals.

Public health professionals should be involved in building and sustaining the public health systems to collect data about the health and mental health consequences of violence and other disasters, on victims, responders, and communities, and develop uniform definitions and standardised data-classification systems of death and injury resulting from violence and other disasters.

Public health professionals should promote sustainable development in order to enhance resilience in the event of violent actions.⁸¹

7. New public mental health and conflict resolution.

We believe that new learning from the fields of public mental health, brain science and from psychology needs to be taken into account in formulating positions and strategies for humanitarian aid and for conflict resolution.^{82, 83, 84} Our responses to conflict and all forms of violence (particularly in the areas of women and children) are often based on the victim-perpetrator-rescuer relationship, which only succeeds in rendering the victim dependent, and gives the perpetrator more enemies to fight. In this, the victim is seen as 'good', the perpetrator as 'bad'.⁸⁵

Research and experience in psychology suggests that this attitude is unhelpful. This may be the only way to help when babies and young children are involved but it is rarely helpful when the conflict is between adults. It disempowers the victims by teaching them that they need help to stand up for themselves and empowers the aggressors who now have a second enemy to fight.

Discussion of a situation in the context of power differences – and recognising when a group of people has been disempowered – is important and can be part of a constructive process and discourse which recognises our common human and civil rights. We accept that greater efforts are needed to understand the motivation, behaviors and experiences of all parties involved in a conflict, in order to reach non-violent solutions. This also applies in local violence prevention and control with regard to perpetrators of violence in domestic and community situations.^{86, 87, 88, 89, 90}

8. The role of public health in conflict resolution

FPH believes public health is neutral territory in which enemies can come together. As a professional body with a respected membership throughout the world we believe our first response to violent conflict should be to behave as honest broker. We should seek to bring together public health specialists on different sides of a conflict to create a dialogue aimed at influencing peaceful resolution and rapprochement. Through joint approaches to public health problems in conflict zones, the professions of public health can demonstrate the potential of cooperation.^{91, 92, 93}

FPH will seek to be active in supporting professional activities on all sides of conflict – for instance providing technical expertise, mentoring and support for relevant health surveys, providing networking and partnership approaches to secure humanitarian aid and health protection programmes such as immunization. We will offer relevant expertise in health protection, public mental health, analytical support and partnership development.^{94, 95}

FPH, as a body exercising medical, nursing and other clinical and public health professional codes of conduct should always advocate, where possible, non-violent conduct and responses to conflict.

We believe it is necessary to pursue high-level dialogue between professionals (and politicians) for violence prevention, but we also recognise that there are circumstances where there is overwhelming evidence of injustice and inequity in healthcare access due to conflict. Being silent or doing nothing is not a neutral act, but is compounding the problems. In such circumstances we believe it is necessary for public health professionals to speak out collectively, and as individuals, based on the evidence.

FPH recognises the need for public health practitioners to develop partnerships with agencies and experts in the fields of criminal justice, law enforcement, the military, political scientists and international lawyers.^{96, 97, 98, 99, 100}

9. The Faculty of Public Health role as an educational body.

FPH will review the role of public health professionals in relation to violence prevention, control and response in its educational materials and in its curriculum. FPH will look to accredit or recommend relevant interdisciplinary materials, resources and courses which contribute to the prevention and control of violence as a public health problem.

Special interest groups of FPH members will be encouraged to take forward the agenda of violence prevention from local to international levels. Our Global health committee will play a key role and our developing work on ethics and values will also be vital. We will work with recognised authorities in other disciplines such as international law, ethics, political science and emergency health and environmental agencies, to enhance the knowledge and evidence base and create effective policies for prevention and intervention.

10. The leadership role of public health.

We recognise the need for public health professionals to take up leadership roles in prevention, control and response to violence, at local national and international level. In the UK we recognise a need for a public health approach to violence and for the

involvement of local public health professionals in partnership forums to prevent and control inner city violence, domestic violence and to safeguard children and vulnerable adults. In national and international forums there is the same need for involvement of public health professionals, in measurement and surveillance of all forms of violence, in advocating for effective interventions and in monitoring the outcomes.

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EVIDENCE

Impacts of violence

The consequences of violence situations affect the lives of those involved directly and indirectly. Violent injury and death is the extreme manifestation of the pervasive ill health caused by living in fear and the threat of violence. Violence, and the threat of violence, can cause physical injury, mental and behavioural costs, sexual and reproductive health costs and chronic disease.^{101, 102}

The impact of violence on mental health and wellbeing is widespread. A clear demonstration of the impact of witnessing violence is within combat zones. In villages and camps in Northern Uganda, 74.3% of respondents met Post Traumatic Stress Disorder symptom criteria, while 44.5% met the depression symptom criteria (68). Those that have witnessed violence can have differing emotions including regret, shame, anger, humiliation, and inadequacy.¹⁰³

Violence can also result in health-harming behaviours. For instance, a study looking at alcohol and bullying found that victims of bullying were drinking partly as a coping behavioural mechanism.¹⁰⁴ There is also evidence to suggest harmful implications for people that have suffered from adverse childhood experiences (ACE) including abuse, neglect and household dysfunction.

In a study conducted by the World Health Organization looking at ACEs in Eastern Europe, people with four or more ACEs compared to those with no ACEs were three times more likely to be a current smoker, 10 times more likely to be a problem drinker and 49 times more likely to have ever attempted suicide.¹⁰⁵

The most prevalent factors for chronic, non-communicable disease are use of tobacco and alcohol, poor diet and lack of physical activity. These behaviours are likely to be more prevalent in communities under threat of violence or in conflict situations and consequently chronic diseases are more likely to be associated with life under the threat of violence.

There were an estimated 36 million deaths that occurred globally in 2008 as a result of non-communicable diseases e.g. cardiovascular disease, cancers, chronic respiratory disease and diabetes.¹⁰⁶ For the year 2014, the Crime Survey for England and Wales reported that 46% of violence resulted in injury.¹⁰⁷

The physical injuries inflicted by violence and conflict can be devastating to the development of a country. In the war in Afghanistan civilian casualties in 2014 were 3,699 deaths (up 25 per cent) and 6,849 civilian injuries (up 21 per cent) for a 22 per cent rise in total civilian casualties over 2013. Since 2009, the armed conflict in Afghanistan has caused 47,745 civilian casualties with 17,774 Afghan civilians killed and 29,971 injured.¹⁰⁸ In the UK in 2013, violent incidents that resulted in either wounding or a minor injury were 632,000.¹⁰⁹

The threat of violence or violent behaviour can have a damaging and long-lasting effect on communities. It can produce a place of fear, which in turn reinforces the necessity, and presence of violence. This can create an uninviting environment and can prevent development in these areas.

Financial cost

In England and Wales in 2008/9, the annual cost of violence to society was estimated at £29.9 billion and the cost of violence to health services was 2£.9 billion and £41 billion.¹¹⁰ In the Criminal Justice system the cost of violent crimes amounted to £4.3 billion (2008/2009).¹¹¹

Taking action to prevent violence is cost effective. An economic evaluation in Cardiff concluded that “an effective information-sharing partnership between health services, police and local government led to substantial cost savings for the health service and the criminal justice system compared with 14 other cities in England and Wales designated as similar by the UK government where this intervention was not implemented.”¹¹²

Who is most at risk of violence?¹¹³

- Those in vulnerable populations that rely on other people for basic care e.g. elderly, children, disabled populations
- In populations where a disability may result in communication barriers
- Those living within communities where the threat of violence has a constant presence
- In population groups where individuals easily go unnoticed/are not identified as at risk and they ‘slip under the radar’.
- In families where intergenerational or domestic violence occurs
- In situations where individuals are not aware of or do not have outside support and do not know of referral systems or resources
- In areas of greater economic and social deprivation
- Areas where there is high alcohol or drug consumption
- One in four women experience domestic abuse or violence at some point in their lives. This may be physical, sexual, emotional or psychological abuse¹¹⁴
- 30% of this abuse starts in pregnancy, and existing abuse may get worse during pregnancy or after giving birth.
- Sex workers both female and male are at particularly high risk of physical and sexual violence¹¹⁵.

Who is at risk of being involved with perpetrating violence?¹¹⁶

- Those who were subject to neglect or violence or treated with force as a child
- Individuals who viewed domestic violence within the home
- Being subject to a number of adverse childhood experiences
- Having a negative or fractured relationship with the primary caregiver
- Delinquent friends
- Those involved with gangs
- Those with high alcohol consumption from a young age
- Those with alcohol dependence, causing neglect of care
- Alcohol environments that are poorly managed and controlled
- Areas where there is increased availability and accessibility to alcohol
- In cultures where violence is a social norm or certain harmful traditional practices are maintained
- In areas of greater economic and social deprivation
- Individuals with adult psychiatric disorders or childhood conduct disorder
- Not exclusively, but more common in men.

Different types of violence and evidence-based prevention and interventions

Preventive approaches need to begin with intervention in the early years. The relationship between parents and infants begins at conception and the first 1001 critical days, from conception to end of the first two years, are profoundly important in the prevention of violence.^{117, 118, 119, 120} New evidence from the field of brain science illustrates the mechanisms underpinning findings from previous social and behavioral research and reinforces the need for early intervention in the form of parenting support.

This is not to condone violent behaviors or to suggest that behaviors cannot be controlled or modified depending on subsequent influences as a child grows up. But early years' influences are vital in setting the best possible circumstances for individuals as effective communicators, capable of creating caring and respectful, non-violent relationships.^{121, 122, 123}

1. Child maltreatment

Child maltreatment, as defined by the World health organization, refers to '*the physical and emotional mistreatment, sexual abuse, neglect and negligent treatment of children, as well as to their commercial or other exploitation*'.

Those children who are most dependent are most at risk of child maltreatment specially the 0-4 years age range.¹²⁴ On a worldwide scale nearly 25% of adults reported having suffered physical abuse as a child, with 36.3% having experienced emotional abuse and 16.3% suffering from physical neglect.¹²⁵

Globally 1 in 5 girls have been sexually abused during childhood with some countries estimating it at closer to one in three.⁹ In the case of child mortality, homicide accounted for 31,000 deaths of children under 15 years of age.¹²⁶

On a national scale child maltreatment is widespread, in a study by NSPCC the results revealed that during childhood 1 in 5 had experienced severe maltreatment (11-17 year olds).¹²⁷

Primary prevention

As outlined in the '1001 critical days report', from conception until eighteen months is a crucial time for development.¹²⁸ This finding supports 'the earlier the better' approach for a primary violence prevention strategy for child maltreatment. Support of parents is crucial to ensure that children are given the best start to life in a supportive and caring environment void of violence and conflict.

Early years interventions can focus on development of parenting skills or by offering support to families. Parenting programmes such as Triple P, Incredible years and home visiting programmes such as the Family Nurse Partnership and the Early Start Programme, have had positive results.

The Family Nurse Partnership is a home visiting programme, from pregnancy up until two years old. It has a strong positive evidence base from three large US clinical trials results including; reductions in verified child abuse and neglect.¹²⁹ At the pre-school age there are also primary interventions that are used to develop emotional, social and developmental skills before a child enters the school system. Some examples of these programmes from the U.S are the Perry Pre-school programme and the Chicago Child-Parent Centre. The Perry Pre-school program

had long-term evaluation. One study followed participants to the age of 40 and had results that showed that those that participated in the program had committed fewer crimes than a comparison group that did not complete the program.¹³⁰

Secondary prevention

It is important in the case of child maltreatment to closely monitor potential violent situations and intervene if necessary. This form of secondary prevention can be seen in resources offered for parents and safeguarding of children. For instance; '*Parents Anonymous*' offers programs and a helpline to support and assist parents to offer a positive home environment.¹³¹

Tertiary prevention

In the cases where child maltreatment has occurred and the child is in need of help tertiary prevention comes into play. There are different organisations worldwide involved in the rehabilitation of the child, helping them to deal with and recover from the situation they have been in. One example of this is the Kidz Clinic in Johannesburg, South Africa. It works with children that have been victims of abuse by offering a psychological assessment, counselling and therapy to abused children.¹³²

Children safeguarding is an essential element of both secondary and tertiary prevention of harm to children. After some years of national reports in the UK which emphasised process and procedures for child protection, The Munro report signalled a shift in emphasis towards evidence-based prevention and early intervention and early help, professionalisation of social work, and less bureaucratic approaches to child protection. It called for a child-centred approach to care and stressed *safeguarding* as a wider activity than simply protection as a holistic approach embracing multi-agency support including housing, educational and voluntary sector interventions.

More research would also be needed into more effective intervention in the safeguarding process.¹³³

2. Youth Violence

This form of violence refers to those aged 10-29 years, it often occurs outside of the home and between people that are not related to each other¹³⁴. It includes bullying and gang violence.

In 43 conflict affected states roughly 60% of the population is under 25. Without properly guiding and using the resources of these young people, violence can have a major effect on the labour market and economic stagnation as well as potentially causing youth to feel excluded and vulnerable to exploitation.¹³⁵

Every year there are 200,000 estimated homicides worldwide among 10-29 years old that account for 43% of total global homicides.¹³⁶ Youth violence is also perpetrated by young men.¹³⁷

With regards to bullying, one study on bullying and victimization of 40 developing countries, found that exposure to bullying ranged from 8.6%-45.2% in boys and from 4.8-35.8% in girls.¹³⁸

Primary prevention

Youth violence, as with other manifestations of violence, can be prevented through effective early years interventions and also through peer mentoring and effective youth programmes in adolescence. The same core 'sound trials' appear in papers addressing risks for teenage pregnancy, for substance misuse and for violent behaviour.^{139, 140, 141, 142}

Other specific programmes offer guidance to young people to deal with situations in a non-violent way. The UNICEF 'Rights Respecting in Schools award' is one way in which the United Nations Convention on the Rights of the Child is promoted and encouraged in children in formal education in the United Kingdom.¹⁴³

Secondary prevention

Where violence or the threat of violence is present, secondary prevention is vital to prevent escalation. The Olweus Bullying Prevention Programme is used in schools to reduce bullying within schools. This begins with a questionnaire for the pupils so the severity of the situation can be assessed. A committee is then set up where strategies are laid out on how to deal with issues – both classroom-based and individual activities.¹⁴⁴ In terms of other interventions, talking therapies, multi-systemic therapy, family interventions and mentoring programs have been used.¹⁴⁵

Gang-related violence is a complex problem. There are few well-conducted trials of intervention either using therapeutic tools or diversionary interventions such as training and jobs. However, elements which have been shown to address gang violence include coordinated multi-agency, multi-modal strategies, specific to one city or locality, using civil injunctions, peer mentoring and school based learning.

Effective interventions adopted a problem-solving approach and analysed the local problem rather than simply importing an intervention. They had a strong management structure with clear leadership of the intervention, supported by partnership working, adopting a collaborative approach among front line staff. They targeted behaviour (gang violence) rather than affiliation (gang membership) and they offered both a 'carrot' by providing opportunities out of gang activity through employment, training, treatment and family support, and a 'stick' through enforcement, prohibitions and sanctions.

Successful projects focussed both on reducing incidence and reducing lethality. Exchange of information both formally and informally, engaging community groups and voluntary groups via existing networks, and effective marketing were also key elements. The enforcement elements of the strategy should be implemented consistently and as advertised.¹⁴⁷

Tertiary prevention

In cases where violence does occur it is important to effectively collect data surrounding the violent incident to inform future cases. The Cardiff model uses anonymised data that has been collected from emergency departments with information such as use of weapon and where violence has occurred to inform future cases. This approach is being used for the South East London Violence Prevention Model which is an emergency department programme focused on high-risk youth to deal with violence by data sharing.¹⁴⁸

In relation to alcohol-related violence, the Cardiff programme also records 'last drink survey' which informs alcohol licensing decisions and responsible beverage serving schemes in local pubs and clubs.

3. Online threats

Organisations and individuals use the Internet to manipulate, intimidate and even coerce vulnerable individuals. This type of violence includes social media bullying and ideological and emotional grooming. A recent meta-analysis found a strong correlation between cyber bullying and traditional bullying. Further evidence is needed for understanding effective programs to reduce victimisation that occurs on and offline.¹⁴⁹

Child exploitation and online protection command, reported 1,145 public reports of online grooming in 2012.¹⁵⁰ In 2013, Childline reported an 87% rise in young people contacting them with problems concerning online bullying.¹⁵¹ The NSPCC has also raised concerns in relation to the impact of online pornography on children aged 11-17.¹⁵²

Online violence is a fast developing area and FPH will update this statement with the best available and latest evidence base as it is available. FPH strongly endorses statutory Personal Social, Health and Economic Education for all children.

Primary prevention

To prevent online threats it is important to raise awareness amongst anyone using the Internet. The 'thinkuknow' website offers e-learning and face-to-face resources and training for professionals and young people to be up to date with the risks on the Internet.¹⁵³

Tertiary prevention

In the case where a child has been harmed by an online case e.g. cyber bullying, the child must be helped. Reporting the case to Child Exploitation and Online Protection command (CEOP) and the police this could prevent future similar abuse by the perpetrator. There are also a number of help lines for children, for instance, NSPCC and Childline.

4. 'Self-directed' violence

This refers to violence that an individual inflicts upon themselves such as self-harm and suicide.¹⁵⁴ In the year 2000, approximately 815,000 people killed themselves globally.¹⁵⁵ Within the UK and Republic of Ireland in 2013, there were 6708 suicides.¹⁵⁶ Suicide rates amongst men in 2013 were the highest since 2001. The highest rate of suicide was within the age group of 45-59.^{67, 157} Research suggests that in the UK between 1 in 15 and 1 in 12 young people self-harm.¹⁵⁸

Primary prevention

To prevent 'self-directed violence' the root causes of the situation need to be addressed. This may be improving one's mental wellbeing or working on particular mental health issues. Mindfulness is a technique aimed at reducing stress and anxiety by reconnecting with our bodies and an awareness of thoughts, and more research is required into the evidence base for this as a primary prevention

technique.¹⁵⁹ The risk of suicide and self-harm are greatly increased where alcohol and other substances are involved.

One of the key strategies for violence prevention as outlined by the World Health Organization is 'Reducing the availability and abuse of alcohol'.¹⁶⁰ Examples of controls by governments on obtaining the means by which suicide can be conducted include legislation on '*restricting pack sizes of paracetamol and salicylates on self-poisoning*' in the UK¹⁶¹ and imposing restrictions of hazardous pesticides in Sri Lanka used in self-poisoning.¹⁶² Useful resources for primary prevention include suicide helplines such as the Samaritans, Childline, Papyrus and the Campaign against Living Miserably.

Secondary prevention

Where someone is identified as at risk of suicide, collaborations can be used in order to effectively work together to support those in need. The 'Zero Suicide Collaborative' is working to '*bring together people with lived experience, cross-system care providers and other stakeholders to reduce suicides to Zero across the South-West of England by October 2018*'.¹⁶³

Tertiary prevention

After someone has attempted suicide, long-term prevention needs to be considered. In Vienna, the Austrian Association for Suicide Prevention instigated media guidelines and launched a media campaign to stop the sensationalist reporting of subway suicide, which was thought to have caused cases of copycat suicides.¹⁶⁴

In 1994 in the U.S.A, the Brady Handgun Violence Prevention Act, created a mandatory 5-day waiting period for buying arms.¹⁶⁵ This has the potential of preventing some impulsive suicide attempts with a deadly weapon. One prevention method in Italy focused on elderly individuals with a high risk of suicide. Each individual was provided with a portable alarm device, the results showed that there were significantly fewer suicide deaths within this group.¹⁶⁶

5. Domestic violence

The most common type of violence in the UK is domestic (intimate partner) violence. Domestic abuse has long been recognised as a major public health issue. Violence arising from rape and sexual assault, sexual exploitation and female genital mutilation are also important UK public health issues –as is violence arising from modern slavery, human trafficking and hate crime.

Many of these issues come under the remit of safeguarding boards for children and adults and directors of public health, and their teams have an opportunity through these Boards to discharge their duties in relation to violence prevention in the promotion and protection of health.

In addition directors of public health may wish to take an active interest in the role of their local Community Safety Partnership and Domestic Abuse Forums by providing public health support to these partnerships, ensuring that Community Safety and Domestic Abuse issues are appropriately reflected in Joint Strategic Needs Assessments; and that violence prevention work is closely aligned to Health and Wellbeing Boards, strategies and work programmes. Ensuring that there is good local intelligence and providing appropriate advocacy for violence prevention are significant contributions that public health can make.

Intimate partner violence can be defined as “any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.”¹⁶⁷

In England and Wales in 2011, 900,000 women and 600,000 were estimated to have suffered abuse from an intimate partner.¹⁶⁸ In a World Health Organization review, it was found that on a global scale, ever-partnered women reported 30% physical and/or sexual intimate partner violence. The prevalence of intimate partner violence was highest in WHO regions of Africa, Eastern Mediterranean and South East Asia.

An exposure to violence is high among 15-19 year olds and reaches its peak in the age range of 40-44 years.¹⁶⁹ Of all types of violence the World Health Organization found that the most surveyed type was intimate partner violence.¹⁷⁰

Primary prevention

Domestic violence can have a profound and long-lasting effect on all involved so primary prevention where possible is fundamental. One tool for raising awareness about domestic violence and the resources that are available is large-scale public information and awareness campaigns. For domestic violence the ‘Strength to Change’ campaign was launched by the NHS in Hull. The campaign reached a large number of men and a third of those that saw it commented that ‘*it had changed the way they thought about domestic violence*’.¹⁷¹

FPH also notes the Council of Europe’s Convention on Preventing and Combating Violence against Women and Domestic Violence, to which the UK is a signatory. This landmark treaty opens a path for creating a legal framework at pan-European level to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence. The Convention also establishes a specific monitoring mechanism (“GREVIO”) in order to ensure effective implementation of its provisions by the parties.¹⁷²

Another major campaign is the United Nations ‘UNiTE Campaign to End Violence against women’. It is a global initiative to end violence against women and girls by increasing political will and raising awareness.¹⁷³ A resource for pre-school and primary school age children is an educational reading book created by the Minnesota Coalition for Battered Women, called ‘Hands are not for hitting’.¹⁷⁴ The book is aimed at teaching children that violence is not acceptable and uses the hands to demonstrate what the children can do with their hands. It also includes a section for suggested activities and discussion for the teacher.

Secondary prevention

Multi-agency risk assessment conferences bring together representatives from different fields – including the Police and Children’s Services – to discuss people at high risk of domestic abuse.¹⁷⁵ A service used in general practices to help with interventions is the Identification and Referral to Improve Safety (IRIS). The service provides electronic prompts to health practitioners of a potential high-risk case. Training and support for the clinical and administration staff is provided to improve the recording and response to cases.¹⁷⁶

There are clear guidelines in relation to the critical role of health services and in particular routine enquiry into domestic abuse. Maternity services and sexual health services should be undertaking routine enquiry of domestic abuse of all clients, and,

in particular women, and high quality training should be in place. Gynaecology, general practice and A&E are other services where staff should be trained to be aware and able to deal with disclosures. The health visiting workforce is particularly important in both primary and secondary prevention.^{177, 178}

The availability of housing for women, men and families in particular who become homeless as a result of abuse is important.^{179, 180} CEDAR is an example of a programme relating to children who have witnessed domestic abuse to mitigate long lasting negative effects.

Tertiary prevention

For dealing with a domestic violence situation tertiary prevention interventions are required. In cases where the law is involved there are criminal justice interventions – including restraining orders and specialist domestic violence courts.¹⁸¹ For victims there are educational programmes and services, ‘*Kahrmel Wellness*’ offers a programme to help victims rebuild their lives and another for professionals to understand domestic abuse and how they can assist victims. ‘*Kahrmel Wellness*’ also offers services such as long-term accommodation services.¹⁸²

Survivors of domestic or child abuse may have increased likelihood of mental health problems, addiction and interaction with the criminal justice system – and those services should have capacity to address recovery.

6. Sexual violence

This covers rape, sexual assault, sexual exploitation and trafficking. In England and Wales in 2011-2012 the police recorded a total of 53,700 sexual offences. Rape accounted for 16,000 offences and sexual assault for 22,100 offences.¹⁸³ Approximately one in five women, globally, during her lifetime, will be a victim of rape or attempted rape.¹⁸⁴ The International Labour Organisation stated that, worldwide, 4.5 million people were victims of forced sexual exploitation.¹⁸⁵

Primary and secondary prevention

By teaching young people about well-functioning and acceptable behaviour in relationships, it may be possible to reduce sexual violence. Peer-led sex education programmes such as Apause (Added Power and Understanding in Sex Education) teach negotiated sexual behaviours and mutual respect. Peer education has also been found to be effective in relation to drug and alcohol education and to be a key element of successful youth programmes.¹⁸⁶ ‘Safe Dates’ is a program for 11-18 year olds around preventing dating violence by focusing on changing negative social norms.¹⁸⁷

High quality Personal Social Health and Economic Education should be a statutory requirement in all schools, and should include understanding of consent. FPH notes that prevalence of violence within teenage relationships is high.¹⁸⁸

We further note the importance of the findings and learning from the Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013).¹⁸⁹

In the UK, students can take part in a ‘Bystander intervention’ training. It aims to give students the confidence to take action when witnessing domestic and sexual violence in peers and question certain social attitudes surrounding sexual violence victims.¹⁹⁰ There are other programs aimed at raising awareness of sexual violence

and promoting non-violent solutions in relationships such as: 'Shifting boundaries'¹⁹¹ for 11-14 year olds and 'Coaching boys into men' for school athletes.¹⁹²

Tertiary prevention

In the cases where sexual violence has occurred sexual assault referral centres (SARC) are available across the UK with assistance. SARCs act as an immediate health and care response to victims of sexual assault and rape. They are open access and can also assist with criminal justice and safeguarding services.¹⁹³ Some organisations also offer follow-up care including counselling for rape and sexual assault victims.

7. Disabled person abuse

This type of violence refers to abuse against individuals with either a physical or mental disability and can be committed by someone unknown to the individual or someone in a position of expected trust.

A survey conducted by Mind in London found that in 2013 45% of people with severe mental illness had been victims of crime within the past year. It also reported 40% of women had been a victim of rape or attempted rape in adulthood, with 10% victims of sexual assault.¹⁹⁴ In Orissa India, a survey from 2004 reported that 25% of learning disabled women had been raped and 6% of disabled women had been forcibly sterilised.¹⁹⁵

8. Elder abuse

Elder abuse can be defined as harm or distress being brought on to an older person through either particular actions or lack of appropriate action within a relationship where there is an expectation of trust.¹⁹⁶ Elder abuse is a problem for both individual carers and local statutory agencies to address and much has been done in the UK already but there is more to do and specific actions and training implications for all those charged with caring for older people.¹⁹⁷

In a World Health Organisation survey, 6% of older adults, globally, had reported significant abuse within the past month of the survey.¹⁹⁸

A collaborative report from Kings College London and NatCen in 2007, found that, in that past year those aged 65 and older living in a private household reported a rate of 2.6% of mistreatment by either a relative, close friend or care worker. When this definition was broadened to neighbours and acquaintances this figure increased to 40%.¹⁹⁹

A 2014 Health and Social Care Information Centre report provides key findings from Abuse of Vulnerable Adults data collected between 2012-2013. The data shows that of 108,000 current safeguarding referrals, and 87,000 completed referrals made to 152 councils with adult social services responsibilities, physical abuse and neglect were the most common types of abuse reported, accounting for 28% and 27% respectively of all allegations.

Alleged abuse was more likely to occur in the vulnerable adult's own home (39 per cent of all locations) or a care home (36%). The perpetrators of harm were commonly reported to be social care worker (32%) or a family member (a combination of the Partner and Other Family Member categories, 23%)²⁰⁰

International: The Madrid International Plan of Action acknowledges that “Older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women. Some harmful traditional practices and customs result in abuse and violence directed at older women, often exacerbated by poverty and lack of access to legal protection.”²⁰¹

For example in countries like Tanzania, in conjunction with the limited rights older women have, traditional beliefs in witchcraft resulted in the deaths of 505 older women in 2013.²⁰²

In 2009 the UN special rapporteur on extrajudicial, summary or arbitrary executions recognised that in countries like Nepal, elderly women and widows are vulnerable to violence and abuse during traditional practices like exorcism ceremonies.²⁰³

The UN recognises that in at least 41 African and Asian countries witchcraft accusations are used with impunity to justify extreme violence against older women.²⁰⁴

The extent to which older people face violence and abuse is hard to know due to the fact that demographic and health (DHS) surveys (used by countries to inform development interventions) only collect data on people between the ages of 15 and 49. This leaves the UN, nation states and most NGOs with a knowledge gap regarding the issues fundamental to older people²⁰⁵

Primary prevention

To prevent elder abuse one of the key aspects is raising awareness. This includes among family members and even elderly people themselves. One way to do this is through the use of public awareness campaigns. The ‘Dignity in Care’ campaign is focussed on improving the quality of care in services with respects to the dignity of patients. Outside support for instance day care centres, respite care and befriending programs may help decrease stress of a carer and increase social interactions.²⁰⁶

Secondary prevention

Where someone may be at risk of abuse or in a potentially abusive situation screening programmes can be used. Some screening tools are: Hwalek-Sengstock, Elder Abuse Screening test, Brief Abuse Screen for the elderly and Elder Abuse suspicion index.²⁰⁷ It is important for carers to receive support in the form of peer-support groups and support helplines. In some cases there are also interventions for carers including psycho-educational skill building and psychotherapy counselling.²⁰⁸

Tertiary prevention

There are services available for those that have been affected by elder abuse. These include counselling and legal assistance for someone to become independent again.

9. Hate crime

A hate crime can be defined as ‘any hate incident, which constitutes a criminal offence, perceived by the victim or any other person, as being motivated by prejudice and hate.’²⁰⁹ The Lesbian Gay Bisexual and Transgender (LGBT) community is a group of people that have been the target of many hate-crimes. In the last three years, 48% of lesbian, gay and bisexual people have been victims of a crime or incident.²¹⁰ In 2013/14 84% of hate crimes in England and Wales, recorded by the police were racial hate crimes.²¹¹ Between January 2008 and December 2012 there have been 1123 reported murders of transsexual people in 57 countries globally.²¹²

10. Situational/environmental/public space violence

Aspects of the environment, such as poor street lighting, may increase the risk of violence. Public spaces can be understood as roads, parks, transport systems, streets, and public buildings and shared housing.

Primary prevention

The 'design disadvantage study' conducted by Alice Coleman in 1985 explored housing situations and environments specifically in post-war public housing projects. One finding of the study was that the greater the number of households using an entrance, the more vandalism, graffiti and litter there was.²¹³ The defensible space theories of Coleman²¹⁴ and Newman²¹⁵ have informed 'planning out crime' and the Home Office 'Safer Places' approaches.²¹⁶

Another prevention tool is creating positive public spaces. A US-based charity, 'Project for Public Spaces', strives to help communities to improve public spaces so they cater for the needs of the area and create safe and positive environments.²¹⁷ The UN is heading up two programmes to focus on creating safe public spaces for women. The 'Safe cities free of violence against women and girls' initiative is focused on developing and implementing tools and policies and creating a strong prevention and response strategy for women and girls in different public settings.²¹⁸

The other programme 'Safe and Sustainable cities for all' has created positive results through working in partnerships with local authorities. Improving and creating more green space particularly in urban environments is another preventative tool. It promotes physical activity and can create a safe environment in which to be outdoors. In terms of improving outdoor environments increasing street lighting and CCTV surveillance can reduce the risk of violence.²¹⁹

A number of strategies can be undertaken to reduce the prevalence of violence and create a more harmonious environment. If drinking environments such as bars and pubs are effectively managed, the risk of violence can be reduced. Some examples of this are targeted police enforcement and bars to develop codes of practice.²²⁰ The community trials study in California demonstrated success in reducing alcohol-related harms through responsible beverage server training, policing of drinking and driving, community alcohol education programmes, restriction on sales to minors and restrictions on point of sales advertising.²²¹

Secondary prevention

Multi agency approaches to crime reduction in city centres have been found to be effective where they involve a high degree of information sharing and specific interventions to reduce alcohol related harms.^{222, 223}

Policing strategies which have been found to be effective in controlling violence and addressing crime include hot-spots policing which targets areas of highest crime for regular police presence,²²⁴ and problem-based policing which enables the police to adopt and advocate wider multi-agency approaches to preventing crime.²²⁵ Neighbourhood watch has also been shown to have favourable outcomes in reducing crime.²²⁶

Asset based community development and international development

Communities have assets of their own which should be built on to address problems of security and health. This applies at local levels, within countries and between

countries. Much of our assessment of needs and service planning is deficit-based: recognising all the faults, weaknesses and deprivations of communities. Instead we need an asset-based approach which recognises all the strengths and resources - natural, human, educational, economic, environmental available to a community.²²⁷

Such a route to development would major on human resources such as education, training and health and the protection of economic, natural and environmental resources for the local people rather than wealthy elites. It would favour human development over the current pre-occupation with economic growth, which may increase inequalities, fail to grow social and educational support and fail to improve health.²²⁸

11. Inter-communal violence

This type of violence occurs when there is tension within communities between groups. It can best be explained in terms of intergroup relations and behaviour. 'Intergroup relations refer to relations between two or more groups. Whenever individuals belonging to one group interact, collectively or individually, with another group or its members in terms of their group identification we have an instance of intergroup behaviour.'²²⁹ Inter-communal conflict is conflict that occurs between competing groups within a state.

There can be many root causes of conflict within communities, which may be based on economic inequalities and jealousies, religious, ethnic or social differences and prejudices and strained local political relationships. These conditions apply internationally also (please see next section).

In the UK there have been many examples of negative relations between distinctive groups, such as in Luton, where there has been tension between the English Defence League and the Muslim community.²³⁰

FPH draws attention to the analysis of WHO, UNICEF and other organisations which highlight that humanitarian needs are increasing, and the importance of ensuring that that essential healthcare services and lifesaving interventions are available in even the worst of times.²³¹

Sarah Zeid and others have underscored the need for "strategic action to tackle and prioritise support for reproductive, maternal, new-born, child, and adolescent health (as this) is fundamental to human dignity."²³² This action, Zeid affirms, must be more "context sensitive, adapted to and for changing circumstances and across the life course. The health interventions and overall response to crises in humanitarian and fragile settings must be better anticipated, planned and resourced."

Key messages are highlighted in Zeid's research, including:

- Meeting the health needs of women, children, and adolescents in crises and fragile settings is the most fundamental step on the pathway to both sustain the gains of the millennium development goals and achieve the sustainable development goals
- Strategic action to tackle and prioritise support for reproductive, maternal, new-born, child and adolescent health is fundamental to human dignity
- Such action must be more context sensitive, adapted to and for changing circumstances and across the life course

- The health interventions and overall response to crises in humanitarian and fragile settings must be better anticipated, planned, and resourced.²³³

Primary prevention

In order to prevent violence before it occurs within a community a positive and 'better' community needs to be developed. Prejudice can be defined as 'a negative attitude towards people based on their membership in a group'.²³⁴ Poor inter-group relations can result from particular prejudices groups hold about one another. Increased intergroup contact can decrease prejudice where positive interactions between groups occur.

Three types of intergroup contact that could result in reducing tensions are: cross-group friendships (where long-term friendships are formed between different groups), extended contact (where there is knowledge that the in-group has friends in the out-group) and imagined contact (where positive contact can be imagined, prejudice can be reduced).²³⁵

REWIND is a UK-based community interest company that works in anti-racism. It is based on challenging myths surrounding race with practical evidence. Their work has also been used in challenging extremism of many forms. REWIND works with professionals, in schools and universities and has played a prominent role in the PREVENT agenda of successive governments, brought to the fore most recently in response to Islamist extremism, but of equal relevance in relation to the Far Right radicalisation and extreme nationalism.²³⁶

Secondary prevention

Community safety partnerships are a collaboration of police, local authorities and other services to protect the local communities and create a safe environment.²³⁷

One way to improve community relations is to increase dialogue between opposing groups. In 2013, the Quilliam Foundation hosted a talk between regional representatives of the English Defence League and a group of Muslims living or working in the Luton area.²³⁸ At the end of the discussion individuals exchanged contact information with the view of meeting up again.

Tertiary prevention

'Exit' programmes have been successful in Germany and Austria in helping far right individuals 'exit' their social and political groups and rehabilitate from extremist supremacist roles and stances. Similar initiatives are needed in the UK and other countries.²³⁹

12. Conflict-specific violence

This is violence that occurs specifically as a result or consequence of a current conflict situation. As well as deaths and injuries to combatants and civilians, indirect deaths and illness result from lack of essential resources and disruption to basic services. Some 200,000 people a year may die indirectly due to war and conflict.⁶⁶

FPH underscores that sexual violence is an important manifestation of intergroup conflict. It recognises the importance of the Council of Europe Convention on preventing and combating violence against women and domestic violence in

providing clear recommendations to signatories in relation to international humanitarian and criminal law.

Conflict can also lead to mass displacement, which complicates existing health and social problems and generates new ones.^{240, 241}

There can be many root causes of the conflict: for instance, disagreements over access to resources, vastly unequal economic situations, religious, tribal and ethnic differences and strained political conditions. Consideration of the public health role in relation to the prevention, control and response to terrorism falls into this section.

Primary prevention

The public health community has an essential role in creating the conditions which reduce inequalities and create the conditions for harmonious, peaceful and healthy community relationships. Inequalities in resource availability and usage create conditions of perceived injustice, which lead to frustration, anger and violence. Health promotion is peace promoting where it addresses underlying inequalities and creates conditions of equality and justice.^{242, 243, 244, 245}

Religious fundamentalists find a rich harvest of potential martyrs from conditions of abject poverty around the world. But for some, religious totalitarianism and intolerance is the driver. In the USA, religious extremists have bombed abortion clinics. It is difficult for any agency or value system – religious, scientific, cultural, political or economic – to combat any form of fanaticism, which by definition is not open to argument. The greatest chance to diffuse fanaticism is to work with the vast majority of moderates in all the great religions to achieve some common ground.^{246, 247}

Secondary prevention

Secondary prevention involves early warning and early intervention, de-escalation and conflict handling. It also requires a high degree of planning, preparedness and resilience to show firmness and resolve to deal with the threat of violence.

Strengthening public health systems

Skilled resources are needed in epidemiology, surveillance, and microbiological, occupational and environmental science. The effectiveness, safety and availability of vaccines, antimicrobials and antitoxins for bio-terrorist agents need to be intensively researched and supply systems improved.

Public health systems in many countries including England are being systematically weakened, through organisational upheaval and resource constraints. Responses to violence within countries, and preparedness for major terrorist assaults, requires strengthened public health and public safety resilience and emergency planning systems. Public health intelligence can monitor and raise awareness of issues relating to violence in particular groups and the health consequences across sectors.

Any clinical or public health strategies for women and children, men, sexual health, disability or elderly people should prioritise violence on a multi-agency basis. In particular, services for children have a more general preventive role for the next generation. Surveying views and experiences of client groups and engaging them in responses should be part of health improvement activity and service development, as well as developing effective and innovative health service responses.

Mental health capabilities also need to be improved. Better capability for protection of food and water supplies and ambient air is needed. We also need better ways of communicating with the public and better ways of mobilising and co-coordinating the considerable resources of voluntary organizations.

Informed and prepared public health professionals

Public health professionals need to develop their own knowledge and understanding of manifestations of terrorist actions and maintain vigilance – many of the diseases and injuries caused by biological and chemical agents are non-specific and insidious. Health systems need to develop their collective capacity, intelligence and preparedness.

Health professionals and emergency services need to ensure the availability of, and knowledge about, appropriate vaccines and antimicrobials, for the protection of high-risk frontline staff and for the prevention of secondary infection and contamination following a terrorist action.

Public health systems need to be able to support the investigation of an immediate chemical or biological problem and assist with population health surveys for the long-term health consequences. Public health services need to address mental health needs of populations that are directly or indirectly threatened with violence.

Preparedness planning/‘resilience’

Resilience has come to mean ‘the overall ability of public services and communities to respond to and deal with ‘all-risks’ of civil, environmental, communicable disease disasters and breaches of security.’²⁴⁸ Health professionals need to be able to inform their patients about the health consequences of terrorist attacks to enable appropriate levels of preparedness and resilience by the public.

Public health services need to be an integral part of all civil contingencies planning; to be vigilant, informed and test plans regularly. Public health professionals and services need to play their part in assuring roles are clear and that relationships and actions are understood among public health agencies, law enforcement and first responders.

There is a difficult balance between informing and preparedness and creating alarm.²⁴⁹

Advocating for the control, reduction and elimination of availability of weapons at local, national and international levels

It is certainly the case that genocides have been perpetrated, as in Cambodia and Rwanda, without the availability of guns and sophisticated weaponry. However, the easy recourse to violence and the widespread availability of guns has made possible mass shootings and terrorist outrages that would not have been able to kill so many people if they had been knife incidents. Recent atrocities such as the terror attacks in Paris and Tunisian shootings demonstrate how easy it is to get hold of small arms.

There is no situation which justifies the possession of handguns by private citizens in any civilized society. Concern over knife and gun crime in the UK in the 2000s led to concerted local programmes of control, led by police, community safety partnerships and education services. This has resulted in a reduction in knife and shooting incidents in the UK.²⁵⁰ National policies for control of small arms, explosives and incendiaries are needed, particularly in the USA. Public health professionals should

be involved in documenting the adverse health impact of small arms and knives and advocate control.^{251, 252, 253}

National governments must recognize their responsibility in causing and perpetuating armed conflicts through their sales of weapons to warring factions. They must severely restrict their exports of weapons and international agreements on the control of conventional arms sales must be strengthened.^{118, 119, 120} Efforts are needed to diversify armaments industries away from military production towards peaceful socially useful production.²⁵⁴

A serious attempt to prevent international conflict and terrorism must include measures to control and ultimately eliminate weapons of mass destruction. The threat of nuclear war and nuclear winter demonstrated how the best civil defence could never offer protection from truly catastrophic scenarios. Similarly, the best civil defence cannot protect against the worst possible terrorist outrage. Prevention is better than cure when there is no cure. Real security can only come from securing global control over weapons technologies.^{255, 256, 257, 258}

Public health professionals can advocate strengthening international treaties to control, and ultimately eliminate, chemical, biological and nuclear weapons in the same way that they have with specific disease control and eradication programmes.^{259, 260}

Tertiary prevention

Tertiary prevention involves responses to violence and to the consequences of violence. It therefore includes response, treatment and rehabilitation. But it goes on to embrace reconstruction, resolution and reconciliation.^{261, 262, 263, 264}

Public health professionals are involved in providing humanitarian assistance to, and protecting the human rights of, the civilian populations that are directly or indirectly affected by violence.

The public health system must ensure availability of, and accessibility to, health care, including medications and vaccines, for individuals exposed, infected, made ill, or injured in violent attacks. The public health system should address mental health needs of populations that are directly or indirectly affected by violence or terror threats. The public health system must assure the protection of the environment, the food and water supply, and the health and safety of rescue and recovery professionals.

Public health professionals should be involved in building and sustaining the public health systems to collect data about the health and mental health consequences of violence and other disasters, on victims, responders, and communities, and develop uniform definitions and standardised data-classification systems of death and injury resulting from violence and other disasters.

Public health professionals should promote sustainable development in order to enhance resilience in the light of violent actions.^{265, 266}

The role of public health in conflict resolution

FPH believes public health is neutral territory in which enemies can come together. As a professional body with a respected membership throughout the world we believe the first response of our members to violent conflict should be to behave as honest broker. We should seek to bring together public health specialists on different sides of a conflict to create a dialogue aimed at influencing peaceful resolution and rapprochement. Through joint approaches to public health problems in conflict zones, the professions of public health will demonstrate the potential of cooperation to other sectors of conflicting societies including politicians.

FPH will actively support professional activities in all sides in conflict – for instance providing technical expertise, mentoring and support for relevant health surveys providing networking and partnership approaches to secure humanitarian aid and health protection programmes such as immunization. We will seek to offer relevant expertise in health protection, public mental health, needs assessment and analytical support and partnership development. FPH will also seek to address, including through our membership, issues of capacity building and infrastructure in post-conflict zones.^{267, 268}

We believe it is necessary to pursue high-level dialogue between professionals (and politicians) for violence prevention, but we also recognise that there are circumstances where there is overwhelming evidence of injustice and inequity in health experiences due to conflict. Being silent or doing nothing is not a neutral act but is compounding the problems. In such circumstances we believe it is necessary for public health professionals to speak out collectively, and as individuals, based on the evidence.

FPH recognises the need for public health practitioners to develop partnerships with agencies and with experts in the fields of criminal justice and law enforcement, the military, political scientists, conflict resolution specialists and international lawyers.^{269, 270, 271, 272}

Even in highly charged conflict situations, a willingness to understand the other side's viewpoint can prevent violence and sideline extremists.²⁷³ Instant resort to violence only confirms the fanatic in the righteousness of his or her cause and fuels distrust and dehumanisation of 'the other'.^{274, 275, 276}

Elsworthy and Rifkind describe a human security approach to protect human rights and civil society through local and international non-violent, practical and immediate responses. The robust, non-violent mobilisation of the community, with the strong involvement of women, is possible and can be highly effective. They describe local actions which can defuse violence and begin to establish conditions for trust and confidence-building in conflict situations. These are:

- avoid where possible the use of more violence
- show respect
- improve physical conditions
- include all parties in the peace process
- encourage civil society and consult
- set up centres of listening and documentation (CLDs)
- provide trauma counselling
- Train and employ a significant number of women in policing duties;
- train skilled negotiators and mediators
- work with religious leaders

- build bridges
- introduce truth and reconciliation processes²³

The Oxford Research Group²⁷⁷ seeks to provide spaces in which groups who disagree may begin to build dialogue and find common interests. They seek to recognise the need to understand the root causes of a conflict by facilitating an inclusive dialogue. They use conflict resolution methodologies such as strategic scenario planning and managing radical disagreement.²⁷⁸ These methodologies encourage strategic rational calculations that assist in creating a pathway to the end of conflict. Their methods seek to analyse complex systems and get away from habitual short-term or 'linear' thinking that perpetuates the status quo.

The Centre for Nonviolent Communication describes five essential elements in conflict resolution: developing a shared vision of an interdependent and fair society; acknowledging and dealing with the past; building positive relationships; significant cultural and attitudinal change; and seeking substantial social, economic and political change.²⁷⁹

These are only two examples of academic peace building and conflict resolution agencies. Other academic and non-governmental organizations involved in international law and conflict resolution are listed in the resources section.

In post conflict situations, international legal processes have been applied which are broadly restorative or retributive. Both have a role. Restorative justice benefits both victim and perpetrator – it fosters insight and acceptance of responsibility and creates opportunities to make amends to individuals and/or communities as a whole. Examples include the South African Truth and Reconciliation Commission and similar efforts in Ruanda and Northern Ireland. Retributive justice holds perpetrators responsible through punishment to deter further crime, example: the International Criminal Tribunal for the former Yugoslavia.²⁸⁰

Respect for international law

The United Nations has 'become essential before it has become effective'. Now more than ever, there is a need for respect and support for the United Nations and for financial and moral backing from world authorities. Under international law, national dictators are not immune from prosecution for crimes against humanity. A key tenet of international law is that the right to use armed force is limited to situations of self-defense, and then, only when the United Nations Security Council has taken the necessary steps to maintain international peace and security. This is further reinforced by the guidance that the right to use force should only be used where 'the necessity of that self-defense is instant, overwhelming, leaves no choice of means and no moment for deliberation.'²⁸¹

If a new just world order is to be established, our leaders will need to develop greater respect for and commitment to a more democratic and powerful United Nations.^{282,}
²⁸³

Preventing terrorism and its health consequences should be in the curricula of all schools of health. At the same time, health professionals must maintain and promote a balanced perspective that gives terrorism preparedness an appropriate priority amidst the many other health problems people suffer. Sustainable development is necessary for resilience, for robust civil society and for good public health. The pursuit of social justice and securing human rights are essential for improved public health. Visionary leadership by public health professionals will continue to be

critically important in addressing terrorism. Preventing ill-health and reducing global inequalities in health are the central roles of public health, and also happen to be the most important requirements for preventing violence and responding to violence in all its forms.

Useful Resources and Organisations:

Violence Prevention Alliance <http://www.who.int/violenceprevention/en/>

Medical Peace Work <http://www.medicalpeacework.org>

REWIND <http://www.rewind.org.uk>

<http://www.quilliamfoundation.org/about/>

Institute for Strategic Dialogue <http://www.strategicdialogue.org>

WAVES Trust <http://www.wavetrust.org.uk/home.html>

Parent Infant Partnership <http://www.pipuk.org.uk>

ECPAT <http://www.ecpat.org.uk>

TASC <http://tascwheel.com>

Appendix One

Start well, Live better

The Faculty of Public Health's Manifesto, *Start Well, Live Better*,²⁸⁴ features twelve asks of government. Many of these have direct value in our efforts to prevent violence these are:

- Investing in the first 1001 days of a new baby's life
- Introducing a minimum unit price for alcohol
- Introducing 20 mph zones in all residential areas
- Introducing a universal living wage
- Promoting active travel
- Moving towards a zero carbon energy policy to support global efforts to reduce climate change

Appendix Two

Sections of the FPH Global Health Strategy that relate to violence prevention

Values and guiding principles

- Promote social justice-everyone is equal (*less poverty and social segregation, less unequal standpoints, less need for control and power, less violence*).
- Promote equity of access (*more access for all and not just those with unfair amount of power, fair for all, less unrest, less violence*)
- Be respectful –in our participation and our partnerships (*working well with other organisations means more data sharing and cooperation and more holistic based problem solving in relation to tackling violence*)

Strategic goals

Goal 1:

Be a leader in advocating 'Better Health for All'.

1. Advocate public health approaches to global health challenges
3. Form multi-disciplinary alliances with key partners to ensure greater collaboration and coordination of global health activity

Goal 4:

Share and generate knowledge, evidence and information to support global public health action

Support research and knowledge synthesis to maximise the potential and extend the reach of FPH, using a wide range of communication platforms to address global public health challenges.

Case study 10-UK Pakistan Public Health Group

Group of senior public health professionals of Pakistani descent based in the UK who have been working to strengthen public health in Pakistan since 2011

Delivering the strategy: key enablers

Partnership and engagement

Working with a wide range of partners is key to realising our strategic ambitions. This requires a systematic approach to stakeholder engagement with a clear purpose for collaboration.

The role of FPH within a partnership will vary between organisations. In some circumstances FPH may provide the lead (for example on core business such as public health standards) whilst within other partnerships FPH may support, facilitate or endorse the activities of its partner(s).

Delivering the strategy: robust programme management

Prioritisation and management of activity

In order to achieve our goals we need a clear approach to what we do, who we work with, and where we work. This will ensure that we are supporting projects that are aligned to our strategic goals, whilst effectively managing our capacity to engage.²⁵

In order to further develop this approach we will undertake the following:

- Map current and potential stakeholders and their global health priorities to identify which organisations would be a good 'fit' for partnership (also supports goal 1)
- Map current projects to make an assessment of whether they are aligned to our strategic goals
- Identify gaps in our existing scope of activity (e.g. in terms of regions/countries, project type or skills/training needs) where we should seek to provide support
- Identify opportunities for attracting funding and influencing funding programmes for the future.

We will implement an open and robust approach to project development, using good programme management and governance arrangements. This will require a standardised assessment procedure that current activity and new proposals will undergo. Questions used to inform the assessment are set out in Appendix 4.

A guiding principle for all projects is that they are based on countries' needs as identified and expressed by people from within those countries. Activity must also be able to add value and help meet identified needs in a sustainable way.

We will strengthen our approach to monitoring and evaluation by ensuring that all FPH supported projects implement a systematic process for monitoring and evaluating their activity.

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