



Interpersonal violence prevention in the Eastern Mediterranean Region: Facts from the *Global status report on violence prevention 2014*

Introduction

The *Global status report on violence prevention 2014* is jointly published by the World Health Organization (WHO), the United Nations Development Programme (UNDP) and the United Nations Office on Drugs and Crime (UNODC). For the first time ever, it assesses national efforts, globally and by WHO regions, including the Eastern Mediterranean Region, to address interpersonal violence. Interpersonal violence includes child maltreatment, youth violence, intimate partner violence¹, sexual violence and elder abuse. Interpersonal violence is a risk factor for lifelong health and social problems. It is both predictable and preventable and responsibility for addressing it rests clearly with national governments.

The report aims to assess countries' progress in implementing the recommendations of the 2002 *World report on violence and health* (Box 1) and the related World Health Assembly resolution WHA56.24. The resolution encouraged Member States to consider adopting the recommendations of the *World report on violence and health* and to prepare their own reports on violence prevention addressing the magnitude of the problem, the risk factors, existing prevention efforts and future action enhancing a multisectoral response. It also requested WHO to promote research to support evidence-based approaches for the prevention of violence and the mitigation of its consequences.

¹ According to WHO, intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Box 1. Recommendations of the 2002 World report on violence and health

- Create, implement and monitor a national action plan for violence prevention
- Enhance capacity for collecting data on violence
- Define priorities for, and support research on, the causes, consequences, costs and prevention of violence
- Promote primary prevention responses
- Strengthen responses for victims of violence
- Integrate violence prevention into social and educational policies, and thereby promote gender and social equality
- Increase collaboration and exchange of information on violence prevention
- Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights
- Seek practical, internationally agreed responses to the global drug trade and the global arms trade.

The specific aims of the *Global status report on violence prevention 2014* are to:

- describe the state of the problem of interpersonal violence worldwide and the extent to which countries are collecting data on fatal and non-fatal violence to inform planning and action;
- describe the current status of programme, policy and legislative measures to prevent violence;
- describe the status of health care, social and legal services for victims of violence;
- identify gaps in tackling the problem of interpersonal violence and stimulate national action to address them.

By giving an assessment of violence prevention efforts globally and a snapshot of these efforts by country, the *Global status report on violence prevention 2014* provides a starting point for tracking future progress and offers a benchmark that countries can use to assess their own progress.

The *Global status report on violence prevention 2014* highlights data from 133 countries, covering 6.1 billion people and representing 88% of the world's population. Sixteen² out of the 22 countries of the Eastern Mediterranean Region participated in the report. Of these, six are high-income and 10 are low- and middle-income countries.

² Afghanistan, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Morocco, occupied Palestinian territory, Oman, Qatar, Saudi Arabia, Sudan, Tunisia, United Arab Emirates and Yemen.

Findings

The current state of the problem of interpersonal violence in the Eastern Mediterranean Region

Of the estimated 475 000 homicides in the world in 2012, 38 447 (8%) occurred in the low- and middle-income countries of the Eastern Mediterranean Region. In terms of homicide rate, the Region's low- and middle-income countries rank third (7 per 100 000 population) among low- and middle-income countries in all WHO regions (Table 1).

In countries of the Region, firearms account for the largest proportion of homicides (48%), followed by sharp force trauma (26%). Among all homicide victims, males and those aged 15–44 years account for the largest proportion.

Violence-related deaths are only the tip of the iceberg. For every death due to violence, there are many more non-fatal and hidden cases of violence, a disproportionate number of whom are women, children and older people. There is, however, a paucity of data on non-fatal violence, suggesting that much planning and policy-making is being conducted in the absence of data.

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

WHO region and country income level	Number of homicides	Homicide rate per 100 000 population
African Region, low- and middle-income	90 081	10.9
Region of the Americas, low- and middle-income	165 617	28.5
Eastern Mediterranean Region, low- and middle-income	38 447	7.0
European Region, low- and middle-income	10 277	3.8
South-East Asia Region, low- and middle-income	78 331	4.3
Western Pacific Region, low- and middle-income	34 328	2.1
All regions, high-income	48 245	3.8
Global	474 931*	6.7

*Includes 1604 homicides estimated for non-Member States.

Knowledge of the true extent of the problem is hindered by gaps in data

Out of the 16 participating countries from the Eastern Mediterranean Region, 12 countries have data on homicide from police sources, while only four countries have data on homicide from civil or vital registration systems. All participating regional high-income countries, and 60% of the low- and middle-income countries, are missing data on homicide from civil or vital registration systems.

Depending on the type of violence surveyed, only 2–6 of the 16 participating countries from the Region have conducted nationally-representative population-based surveys (see Fig. 1).

National action planning is not always informed by data

Half of the countries report that they do not have integrated national action plans that address multiple

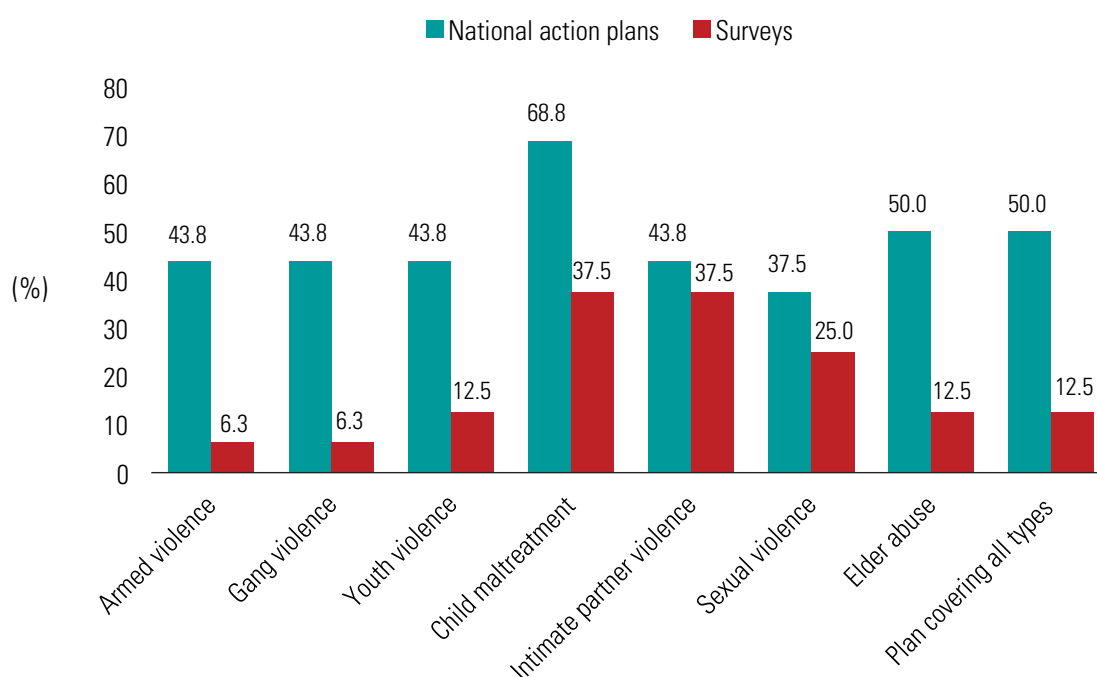


Fig. 1. Proportion of participating countries in the Eastern Mediterranean Region with national action plans and national survey data, by type of violence

types of violence. The proportion of countries with national action plans varies by type of violence, with the highest being for child maltreatment (69%) and lowest for sexual violence (38%). Furthermore, most of the national action plans that countries reported are not supported by national survey data except in the case of plans for intimate partner and sexual violence (see Fig. 1). Additionally, violence prevention activities are often addressed by multiple agencies without a lead agency for coordination.

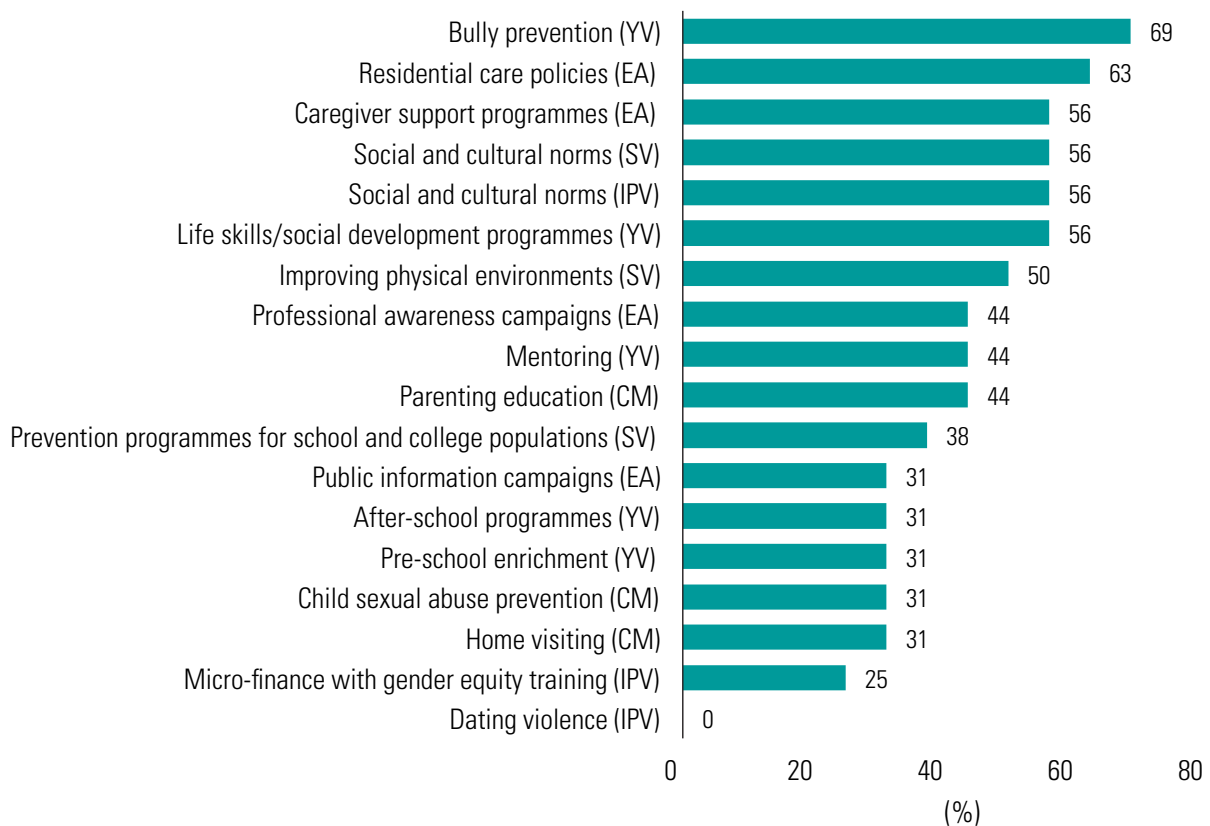
Countries are investing in prevention, but not at a level commensurate with the scale and severity of the problem

Countries are not simply reacting to violence but are also investing in prevention. On average, 42% of countries

reported larger scale implementation of each of the prevention programmes surveyed (i.e. implementation across many schools and communities or with a reach out over 30% of the intended target population) (Fig. 2).

Uptake of prevention programmes varies by type of violence. It is greatest for elder abuse and lowest for intimate partner violence. The prevention programmes surveyed were more often implemented on a larger scale in high-income countries except in the case of bullying prevention, social and cultural norms change and improving the physical environment.³

Social and cultural norm change strategies represent the most common approach used to address partner violence and sexual violence, while caregiver support programmes and residential care policies represent the



Key: YV = youth violence; EA = elder abuse; SV = sexual violence; CM = child maltreatment; IPV = intimate partner violence; While each programme is shown as relevant to a particular type of violence, some of the programmes listed in the figure have shown preventive effects on several types of violence.

Fig. 2. Proportion of participating countries in the Eastern Mediterranean Region that reported larger scale implementation of surveyed violence prevention programmes

³ Physical environment improvement involves efforts to reduce the likelihood of sexual assault by, for instance, improving the safety of trains or buses through the provision of special seating areas and/or compartments for women and girls, and ensuring that streets and parking areas have adequate street lighting.

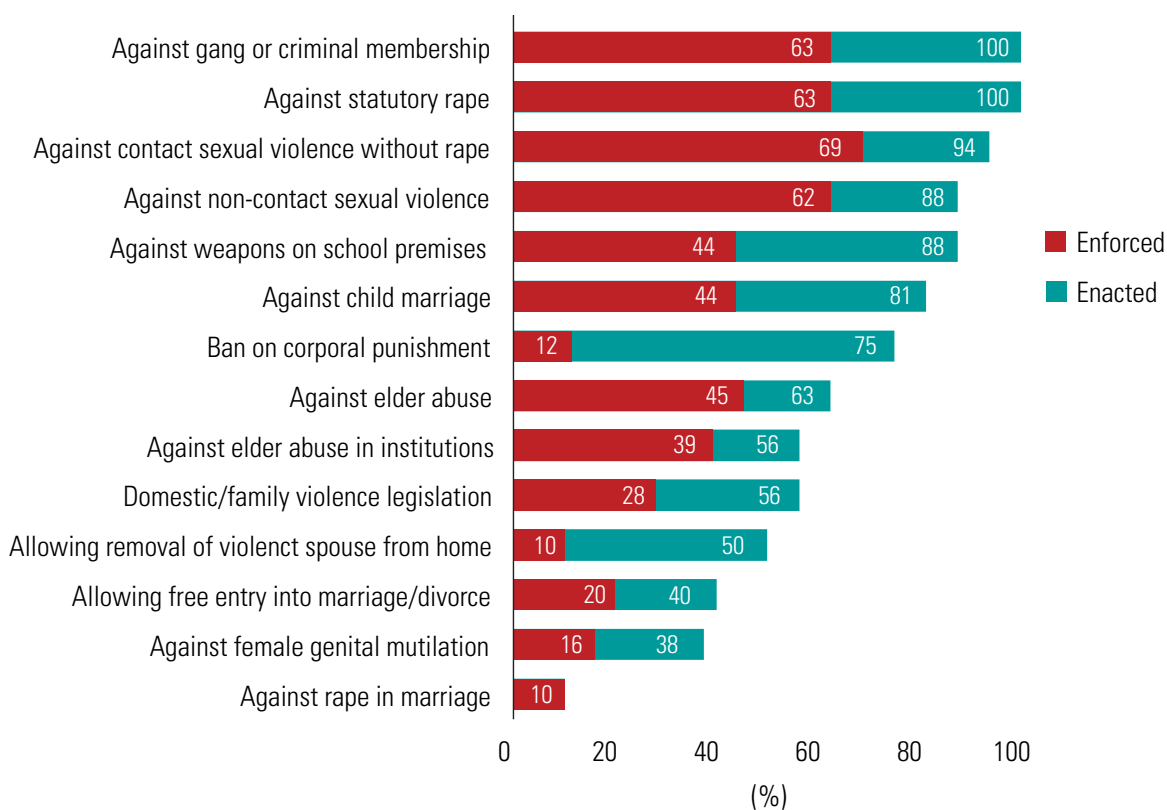


Fig. 3. Proportion of participating countries in the Eastern Mediterranean Region with laws to prevent violence and the extent to which countries report these laws as being fully enforced

most commonly reported strategies to prevent elder abuse. None of the countries in the Region addressed school-based dating violence prevention, probably due to the cultural context. Efforts are being made to begin prevention activities at younger ages in many countries.

Countries can do more to address key risk factors for violence through policy and other measures

Policing strategies, including improving community-police relations and problem-oriented policing,⁴ are widely used in almost all countries. However, few countries are implementing social and educational policy measures to mitigate some of the key risk factors for violence. For example, only half of the countries are implementing housing policies to de-concentrate poverty, while incentives for high-risk youth to complete schooling are available in only 17% of high-income countries and just 5% of low- and middle-income countries. All countries have laws to regulate civilian

access to firearms. However, the laws themselves and the populations covered vary widely.

Laws relevant to violence have been widely enacted but reported enforcement is inadequate

While the majority of laws surveyed relevant to different types of violence were reported to have been enacted in the Region, not all enacted laws were reported to be fully enforced. The smallest gaps between enactment and enforcement were reported for laws against rape in marriage (noting that just 10% of countries in the Region enacted such laws), laws against rape (forced sexual intercourse) and laws against elder abuse in institutions. The largest gaps between enactment and enforcement were reported for laws banning corporal punishment, laws against weapons on school premises and laws allowing removal of violent spouse from the home (Fig. 3).

⁴ Problem-orientated policing integrates daily police practice with criminological theory and research methods to enhance prevention and reduce crime and disorder, and emphasizes the use of systematic data analysis and assessment methods.

Availability of services to protect victims and address their needs varies markedly

Child protection services and medico-legal services for victims of sexual violence are the most widely available of all victim services surveyed, while adult protective services are the least available (see Fig. 4). Out of the 16 countries that participated in the survey, 10 countries do not have adult protective services in place to assist vulnerable older adults.

Identification and referral services for victims of intimate partner violence are available in 69% of the Region's countries. Despite strong evidence linking experiences of violence to mental health problems, mental health services are reported to be available in just over half of the countries. The quality of services and their availability to victims was not assessed in the report.

Conclusions and actions

The findings of the *Global status report on violence 2014* offer an opportunity for all violence prevention stakeholders in the Eastern Mediterranean Region to come together and step up their activities and

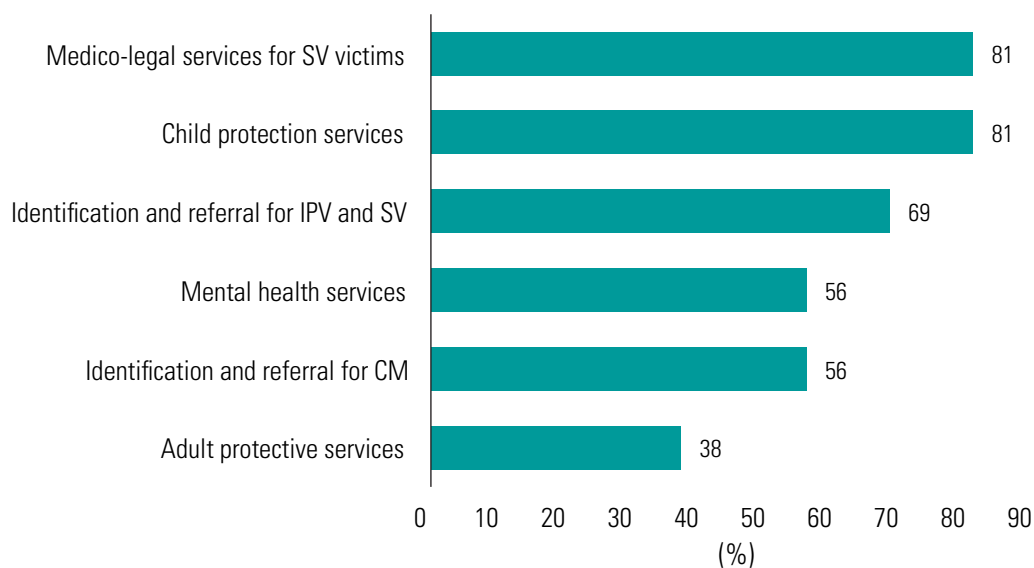
investments to match the burden and severity of the problem in the Region.

For instance, by showing the extent to which national action plans are often not driven by data, the findings provide pointers for governments and regional bodies on how they should steer national planning exercises in a more data-driven direction. By highlighting gaps in prevention programming and service delivery by type of violence, stakeholders at the national, regional and global levels have an opportunity to correct existing imbalances. Perhaps most important, the findings represent a set of indicators and a baseline that will help countries to measure and track future progress based on clearly set targets.

The following actions at the national level are suggested in order to address the gaps identified in the report. However, countries' specific cultural and social contexts need to be taken into account to ensure that the measures taken are appropriate.

Strengthen the collection and use of data on violence and its prevention

- Strengthen the vital registration and police data collection systems and ensure that the systems classify violence based on international classifications (ICD-10)



Key: CM = child maltreatment; IPV = intimate partner violence; SV = sexual violence.

Fig. 4. Proportion of participating countries in the Eastern Mediterranean Region that reported availability of surveyed services for victims of violence

and UNOCD classifications) with disaggregation of data by age, sex, homicide mechanism and victim-perpetrator relationship.

- Improve data on non-fatal violence through data collection in hospital emergency departments and victim care delivery services, as well as through national population-based surveys.
- Develop/strengthen mechanisms for cross-validation between different sources of data, including police records and vital registration systems.
- Strengthen support for outcome evaluation studies of violence prevention programmes and victim services in low- and middle-income countries.
- Ensure that data are disseminated to all concerned sectors and appropriately used for planning and monitoring purposes.

Make sure national action plans are based on evidence

- Review existing national action plans for comprehensiveness, whether they address all forms of violence and the extent to which they are informed by data on violence, as well as risk and protective factors.
- Set national baselines and targets for violence prevention and control plans and activities to track progress.

Scale up prevention programmes

- Scale up prevention programmes for all types of violence and ensure they are comprehensive, well-coordinated and informed by evidence and best practice.
- Integrate violence prevention into existing health programmes and services, such as reproductive and maternal health, child health, school health and mental health.

Ensure that victim services are widely available, acceptable and accessible

- Evaluate existing victim services to ensure effectiveness, accessibility, acceptability and sensitivity.
- Develop standardized protocols in health care, social protection and other sectors, including identification, care and referral of violence victims.
- Build the capacity of staff delivering victim services using best practice-based approaches.

Strengthen multisectoral coordination, policies and legislation

- Develop/strengthen leadership and coordination mechanisms across different sectors and across different forms of violence.
- Scale up action on policies addressing multiple types of violence (such as incentives for youth to complete schooling) with provision of required resources.
- Review/improve existing laws against different forms of violence and ensure their full enforcement.

Build capacity for violence prevention and control

- Develop/strengthen human and institutional capacity on different aspects of violence prevention and control, from prevention to delivery of victim services.
- Integrate violence prevention and control in medical curricula, on-the-job training, and continuous education programmes, particularly in closely-related specialties, such as reproductive and maternal health, child health, emergency medicine and trauma care and mental health.

This project has been funded by the UBS Optimus Foundation, as well as the Government of Belgium; the Bernard van Leer Foundation; the United Nations Development Programme, and the United States Centers for Disease Control and Prevention.



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WHO-EM/HLP/087/E

