

A new model of masculinity to stop violence against girls and women¹

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The Problem

For too many women and girls, the family and the home are not safe. More and more studies from countries all over the world show this to be true. Fortunately, advocacy to stop domestic violence is increasing. For example, on 8 March 1999 International Women's Day was marked in the United Nations by a special teleconference on ending violence against women and girls.

Why so much violence at home?

Many men believe that women, especially wives and daughters, can and should be beaten. These men also believe that they can even kill women with relative impunity because women are men's property. For them, culture and custom prescribe that women should be killed under certain conditions. And what a man does in his family, they say, is a domestic matter; the state is unlikely to and should not interfere.

For example, I was recently told that an immigrant to Sweden killed his wife and children. When brought for trial, he refused to cooperate on the grounds that the state had no right to question his culture. He had killed his wife because he suspected her of relations with another man. For him, his "culture" justified, even demanded, that he kill her for the sake of his honour. As for killing the children, he said he did so because he couldn't imagine children without their mother. His own potential role as a loving father did not seem to come to mind.

In Sweden itself the problem of domestic violence is also coming to the fore, and men's roles are being re-examined along with the "culture of masculinity". A national campaign calls for men to be more responsible for their behaviour and their treatment of family members. Similar campaigns are going on in different parts of the world, from the White Ribbon Campaign in Canada to a call from the Deputy President of South Africa for men to isolate those men who still regard women as objects and abuse them.

Towards a new model of masculinity

Many men are trying to stop various forms of violence against women. There are men who challenge the definition of women as men's property, men who challenge the patriarchy and the kind of masculinity that supports it. These are the men we need to learn more about, to recognize and work with. These are the men we need to raise our sons to be like. If violence against women and girls is to stop, men as well as women must work against it.

To look for men as well as women who are active against such violence, to find out what

5. National Crime Prevention. *Pathways to prevention: developmental and early intervention approaches to crime in Australia: national crime prevention*. Canberra, Attorney-General's Department, 1999.
6. National Crime Prevention. *Ending domestic violence? Programs for perpetrators*. Canberra, Attorney-General's Department, 1999.
7. Department of Health and Family Service. *Youth suicide in Australia: a background monograph*. Canberra, Department of Health and Family Service, 1997.
8. United Nations. *Prevention of suicide: guideline for the formulation and implementation of national strategies*. New York, United Nations, 1996.
9. Department of Health and Family Service. *Youth suicide in Australia: the national youth suicide prevention strategy*. Canberra, Department of Health and Family Service, 1997.
10. Australian Institute of Family Studies. *Youth prevention suicide bulletin*, 1999, 2. Melbourne, Australian Institute of Family Studies.
11. Tomison A. *Valuing parent education: a cornerstone of child abuse prevention*. Canberra, Australian Institute of Family Studies, 1999 (Issues in Child Abuse Prevention Series, No.10).
12. Osofsky JD, ed. *Children in a violent society*. New York, The Guilford Press, 1997.
13. McCain MN, Mustard JF. *Reversing the real brain drain. Early years study*. Toronto, Report to the Government of Ontario, 1999.
14. Weatherburn D, Lind B. *Social and economic stress, child neglect and juvenile delinquency*. Canberra, Attorney General's Department, 1997.
15. Loeber R, Farington D. Never too early, never too late: risk factors and successful interventions for serious and violent juvenile offenders. *Studies on Crime and Crime Prevention*, 1998, 7(1).
16. Victoria Department of Human Services. *The re-development of Victoria's youth and family services: purchasing specifications*. Melbourne, Department of Human Services, 1999.
17. Steering Committee for the Review of Commonwealth/State Government Service Provision. *Report on Government Services Provision*. Melbourne: Productivity Commission, 1999.

Endnote

- ¹ The views expressed in this paper are not necessarily those of the Australian Institute of Health and Welfare .

they do and why, to try to bring them together to revitalise the movements against violence, the UNICEF/Regional Office for South Asia (ROSA) in 1997 supported some 160 interviews³ with "activists", each of whom was doing something to stop some form of violence against girls and women in South Asia. Over one-third (57) of the activists were men, from Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka. Their examples can help guide us towards new models of masculinity and can stimulate thinking about what is needed for more boys and men to say "no" to beating and killing women as part of what a supposedly "real man" does.

Men's actions to stop violence against women

Take the case of Bharat Joshi*, a young lawyer in Nepal. He works against girl trafficking, particularly from an area where it is known that parents often sell their daughters into prostitution, for the sake of a tin roof, a television, or less. Bharat Joshi encourages the men not to regard a daughter as a commodity that will go to another family, at a cost to the parents. Seen in that light, selling a daughter into prostitution allows the parents to gain, not lose, economically. But Mr Joshi wants to address the root cause of girl trafficking. He says the cause is not poverty, but greed and a lack of affection for girls in the family.

He asks men in the village, "Who treats little females better, animals or people? Which are better parents?" He points to a mother dog nursing both male and female pups, and notes that father and uncle dogs don't kill female pups. The men get the point and start to discuss their attitudes and behaviour.

On one visit to the village, Mr Joshi saw a man beating his wife. He asked the man to stop. The man said that he could beat his wife as he liked, because she was his property. "Are you stronger?" the lawyer asked. "Yes," was the answer. "Then what kind of man are you if you beat someone weaker?" asked Mr Joshi. The man said, "OK, I see what you mean," and stopped beating his wife. Mr Joshi was questioning the model of masculinity in the village, getting the men to think about it in a new light.

Also in Nepal, Ram Thapa* has committed himself to work against domestic violence in the community. He did this because he vowed to be a good father and husband. He decided that for a good family life, community values should support harmony at home. Once he tied up a drunk man who was beating his wife. The husband said, "She's my property, I can beat her if I want." But Ram countered, "But she is like my sister, so you can't do whatever you want."

Another time he took a pregnant woman facing a difficult delivery to the hospital even though the village disagreed. It should be up to the husband to decide to do this, everyone said. When she didn't die after all, they agreed with his action. Then he started a community group of men and women working together to stop various forms of violence against women.

In a Bombay slum, Sanjay*, a self-identified Harijan (an untouchable, the lowest stratum of Hindu society), started telling other men not to harass women. He threatened them if they did. One day he saw a policeman harassing a woman neighbour. The policeman hit her when she did not respond to his advances. Sanjay* and his friends beat up the policeman – a risky thing to do! Then he and the men insisted that the woman go to the police station to register the

case. They would accompany her. She went. Eventually, it is said, she won the case.

In Pakistan, Salim Khan* is one of many men who have joined War Against Rape and similar organizations to help women victims of rape through counselling and legal assistance. Their activism is a testimony to the need for a new law that will recognize and punish rape without the four presently required male Muslim witnesses to penetration. Without this unlikely condition being met, a girl or women who registers a case of rape is at risk of being sentenced for fornication or adultery. She becomes the perpetrator in the eye of the present law.

In Afghanistan, one male interviewee is doing research and writing about women's contributions to the history of Afghanistan. He wants to promote the status of women as human beings to help prevent violence against them.

In Sri Lanka, Mr Fernandes*, a pediatrician, decided that he would be what he called a "passive perpetrator of child abuse" if he didn't publicly recognize that child abuse was the actual cause of some injuries of child patients brought to him. He saw that he needed to try to build a support system for child abuse victims to bring the issue into the open, and work to prevent it. His subsequent research suggests that there may be five times as much sexual abuse of boys as girls in the family in Sri Lanka. This could in part be due to the value placed on girls' virginity. Still, it is not unusual to read in the Sri Lankan newspapers of men who sexually abuse young girls in the family, particularly when the mother is away. Perhaps girls are more reluctant than boys are to report sexual abuse.

Men's inspiration to stop violence against girls and women

What inspired these men and others like them to question cultural values and norms that are patriarchal, and to intervene publicly to stop violence against girls and women? Why do they try to change their own lives? What inspired them to become the kind of husband, father, or man who would deny rather than defend a man's supposed right to abuse women? Why do these men stand so courageously for women's and girls' human rights? Why do they want others to follow their examples?

Most who talked about their own early life said they were inspired by their mother's or sister's words and examples, or by the injustices women faced compared to the men in the family.

For instance, Naseer M* from India said, "I am greatly influenced by my mother. My mother taught me to share with people and to reach out to others and help. She taught me that I am a human being first and a man second. And that as a man, I should help the women publicly and privately to build their lives."

Bharat Joshi* from Nepal described his family as one in which his mother was strong and respected. Thus, when he later saw violence against women, it disturbed him.

Another Nepali, Suman*, said that he was from a scholarly family, yet his sisters did not go to school. He was angry that the women in his family were left out. He considered his

mother's and sisters' illiteracy as an injustice to them. He later helped start a "Send Your Girls to School Programme".

An Indian man, Manoj Patel*, farmer and social worker, said he did not like the way his mother had been treated. She was not allowed to socialize and could not even talk to him in public. He said, "I realized that the most important issue in the family was the husband and wife moving slowly [forward], like a bullock cart with two wheels. I realized that just as both wheels are important for the bullock cart, so they are for the family, but one wheel is stuck. Both men and women are important in the family".

Jamil* from Pakistan said that his mother faced many kinds of violence, and because of this he wanted to change things for other women.

Another man from Pakistan said his mother had been emotionally neglected although his grandmother had been assertive, vocal, and resourceful. "I invariably liked being the gallant hero joining hands with the losing side, he said. Later he met both men and women who also inspired him to work with women as partners.

From Nepal, Bhim Karki's* sister had been married off when she was 15, without his even knowing it. This sad incident encouraged him to bring issues about women's rights into the open and to work for the prevention of gender violence.

Some men cited positive examples of their fathers, older brothers, or a famous man that inspired them to help women. A few had been arrested and had learned more about human rights, and violence against women, when in prison.

"Since childhood," Selim* from Pakistan said, "I hated any form of cruelty. Father helped women in the family and other women with problems. I worked against injustice since childhood with the support of parents. In jail as a political activist I came to know about violence against women in prisons."

Shakil*, also from Pakistan, said, "I was detained many times as a political prisoner, because of harassment by police and security forces and because of my conscience. In prison, I read a lot about human rights, and women's rights in particular."

Shankar*, an Indian, said that his father had received better medical treatment than his mother did. "As children we resented this," he explained. "Also, I felt badly for my younger sister when she was removed from college because she was a girl."

What do these men have in common in their background that cuts across caste, class, and national boundaries? They saw injustice and recognized it, whether it was in their own families or outside, or in the contrast between the two. Many had a model of women or men which contradicted stereotypical norms about relations between men and women based on dominance and submission. They saw justice as more important than domination, and worked for this consciously as men who wanted to be better individuals and partners with women. For them, women outside their family were like sisters, mothers, daughters, friends and colleagues, and

they were like brothers, sons, fathers, friends and colleagues. In short, they opened themselves to the feminine in their lives and in themselves, as something that did not need to be suppressed, overcome or denied. For too long, the stereotypical "masculine" has been idealized and the stereotypical "feminine" denigrated, except with reference to the woman in a home controlled by a man.

Fathers may inspire their daughters

What about the women activists in the study, and the role of their fathers? Their stories are another source of information about models of masculinity that can support action to stop violence against girls and women.

Although a detailed analysis of this part of the study remains to be done, I have a strong impression of women who were their fathers' favourites, for whom the father often broke rules about what girls should receive and should be. The girls' strong identifications with the father's perceived strength sometimes prompted them to take bold measures, even if the mother's and father's support failed.

For example, Savitri*, a woman lawyer from Nepal, said she was brought up like a boy with her brothers in a well-to-do family. She did not understand that she was different until she had her first menstruation. When her father and mother wanted her to stop her education and marry, she was shocked and went on a hunger strike. Her mother was willing to sell her jewellery so that Savitri could continue in school. A family friend, a man, intervened and paid some costs. Later Savitri got a scholarship. Her father admitted he had been wrong.

An Indian woman activist, Sarala*, doted on and indulged by her father when she was young, was convinced that he would not force her to marry a man she did not choose. When her father instead lamented, "Will you be a liability to me all your life," she vowed to leave home quietly. She did so to work as a volunteer in an ashram. Her father found her and later supported a marriage she planned herself. He also supported her plan to go to Europe to study on a scholarship, although others in her family and community strongly disapproved.

Another Indian woman, Renu*, simply stopped talking to her mother when she was two years old. She communicated with her mother only through her father, who supported and encouraged her in every way until she became a medical doctor.

An Afghani woman activist remembers her inspirational grandfather like this: "My grandfather was a big mullah. He had a good mind. He was the one who wanted us to go to school, to go to the faculty and to go walking outside the house. He was an old man when the mujaheddin came. They announced that a woman could not be a mullah. And when I went to see grandfather, he was sad. I asked him, 'What is the matter?' And he laughed and said, 'It is not good, it is not right. These things are from another time. Now it is different. Women must have education and must work.'"

Commonalities and partnerships between men and women activists

The injustice of violence against women seems to have struck those, both men and women, who are not locked into gender role stereotypes and unequal relations from childhood. They likely have a close relationship with and concern for the parent of the opposite sex, and they go beyond stereotypical identities of male and female in their own character and action. They lay the groundwork for an active partnership between men and women for stopping violence against girls and women.

To date, however, there has been more emphasis on women's action to stop violence against women than on women's cooperation with men or on the need for a complementary men's movement. Meetings on violence against women rarely address men's roles. But just as the women's movement appeals for a new model for women – empowered actors not victims – new models of masculinity are needed that neither include nor depend on dominance over women but feature partnership with them. To be sure, training of men about gender is under way in South Asia, but there is a need to look deeper at what masculinity can mean.

Rahul Roy, a filmmaker in India whose work focuses on new masculinities, has called for men to take time and create space for men's groups to discuss their gender roles. He wants men to find new choices they can make for themselves and to benefit the next generation. Rahul is filming a group of male youth, in a slum area near Delhi, who are doing just that. He is one of a group of South Asian male film-makers who are completing a series of videos, for use in schools, on alternate masculinities.

In addition to the prospect of having men's and boys' groups, there is still the question of partnership between women and men against gender violence. What do some of the voices of men activists tell us about this possibility?

Narendra*, from Musoori, India, said: "All gender-related training must have both male and female trainers and participants. The trainers and trainees need to be convinced that the training is about empowerment of both males and females. It is not empowerment of women at the cost of disempowering men ... true empowerment lies in interdependence. This must be the foundation of any further training on gender issues."

Dr Mohan Shah*, also from India, said : "It is important to discuss the topic of existing violence against women in all village groups, women's groups, men's groups and youth groups. It is important to bring out that women and men are equal, that they have equal rights. I believe that with the help of such groups, it is possible to change society."

Javed Khan* from Pakistan pointed out: "There cannot be two opinions about the importance of this issue. Crimes like rape, sexual exploitation, acid throwing and stove-burning are all important [to take up] in their own place, but as a whole, society cannot develop where women are oppressed. Women are not only half of the population, but they are the major influence for future generations of the nation. A mother who is subjected to domestic violence can only give to this society children who are timid and shy or are dangerously violent."

Umer Shiekh*, also from Pakistan: "Oppression has a series of faces. It can only be eliminated if we change the values our society. ... We are going to the people telling them they are responsible. He [a man who does not believe in equality] will not be able to have a relationship with his wife. He can't make his children human beings. We are interdependent. Both man and woman have to liberate each other. We should at least be able to love each other."

Ramesh Bastola* from Nepal said: "In preventing violence, crime, rape and so on, we need to involve the men and say, 'Let us do this together and this is our project'. This will be more successful and there will be little opposition. It is much better than doing things by women, to women, for women ... because if men don't know what's happening, there are going to be problems."

Mahesh Mehara*, from India: "Just as the bullock cart will move when both wheels are in balance, the family too will develop when both men and women have equality."

The men activists question the value of the stereotypical masculine model. In the past, when the economic base for society was different and communities were less inter-dependent, control, power, domination and physical strength were more useful for human survival than they seem to be today. Now we face the possible destruction of the planet by the unchecked growth of the military and by exploitation of the environment. The growth of poverty, exploitation and violence threatens human security. Now, caring, sharing, conservation and cooperation are the attributes that can save the earth and its people from self-destruction. These attributes are more stereotypically feminine than masculine. The greater role of technology and communication in the economy today also does not favour physical strength and the stereotypical masculine traits. The feminine is being re-assessed for its strategic contribution for the human future.

For all these reasons, it can be both exhilarating and upsetting to look at new definitions of masculinity and femininity. Still, as the voices of South Asian activists tell us, we need to re-examine and even redefine what our cultures may have set as standards for masculine and feminine behaviour. Those who derive power from the past resist change. Those who care about the human future look to new ways to ensure it. They understand culture as a tool for human adaptation to new situations, not as something stuck in the past. I join the voices of the men and women activists from South Asia, as in other parts of the world, who are calling for a concerted effort to involve more men in the movement to stop violence against women and girls.

In 1997 at a regional meeting on "Ending Violence against Women and Girls in South Asia" sponsored UNICEF, UNIFEM and UNDP, the men in the group added this statement to the Kathmandu Commitment which was issued:

We, men, realizing that no sustainable change can take place unless we give up the entrenched ideas of male superiority, commit ourselves to devising new role models of masculinity. We shall endeavour to "take off the armour" and move forwards becoming a more developed and complete being. We urge international bodies to focus on and explore the destructive consequences of patriarchy .

The women's movement has not been good at appealing to male solidarity. This can change. In Bangladesh, for example, profiles of men active against violence to women and girls have been collected for UNICEF. The material is intended to be used for discussions with men. An advocacy kit, featuring men calling on other men to know and follow laws about violence against women and girls, is being field-tested.

New models of masculinity are being defined, just as new models for women have been developed. Changes within the family are clearly needed – changes that support non-discrimination and human rights for children and women as well as men. All this helps to ensure human future.

One of the best ways to end patriarchal exploitation and abuse of girls and women and their human rights is to bring up boys and girls to honour both the "masculine" and "feminine" that are within themselves and society. Parent education about child development in the context of human rights will be crucial. More involvement of men in parenting can help open the way. In this regard, UNICEF Nepal has conducted a study on parenting and child rearing in Nepal which shows that men would increase their roles as caretakers for children of both sexes if they understood the benefits.

A re-examination of patriarchy, as called for in the Kathmandu Commitment, is under way. No less a scholar and activist than Amartya Sen, 1998 Nobel laureate in economics, is one of the leaders in this effort. Some indicators of patriarchy can already be identified and monitored as part of the effort to decrease its force.

In the ideal future the immigrant mentioned earlier would not kill his wife and children because he would respect and value them as human beings with equal rights. He would understand and honour his own role to nurture and love, just as other men would. Love and nurture should be the prerogative and basis of honour for both men and women. That is the goal of our collective effort to stop violence against girls and women, which otherwise dehumanizes all of us.

Bibliography

Dreze J, Sen A. *India, economic development and social opportunity*. Oxford, Clarendon Press, 1995.

Hayward RF. *Breaking the earthenware jar: lessons from South Asia to end violence against women and girls*. Kathmandu, UNICEF/ROSA (forthcoming).

Kaufman M. *Cracking the armour: power, pain and the lives of men*. Toronto, Penguin Books, 1993.

SCA and UNICEF. *Workshop on Alternate Masculinities in South Asia* (video). Kathmandu, Save the Children (UK) and UNICEF Regional Office for South Asia, 1998.

Steps Towards Development. Profiles of men active against violence to women and girls,

Decca, UNICEF, 1998.

UNICEF. Ending violence against women and girls in South Asia: meeting report, 21-24 October 1997, Kathmandu, *ROSA Reports*, No. 23 (March). Kathmandu, UNICEF Regional Office for South Asia, 1998.

UNICEF Nepal. *Parenting and child-rearing in Nepal: a study of knowledge, attitude and practice*. Kathmandu, UNICEF Nepal, 1998.

UNICEF. *Transforming private rage into public action: strategy meetings on gender and violence against women and girls – perspectives on the future role of UNICEF in South Asia*. Kathmandu, UNICEF/ROSA, 1999.

Endnote

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- ² The views of the author are not necessarily those of UNICEF. The author is Senior Advisor of the Special Project on Ending Violence Against Women and Girls, UNICEF.
- ³ Number as of July. Over 180 interviews were finally collected.
- ⁴ All names indicated in the text with* are pseudonyms.

Managing violence and health: strategies, solutions, research and methodological issues

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Abstract. This paper envisages a variety of models for the provision of health services which might limit the extent and impact of violence. The appropriate services, and institutions for their delivery, will vary within and between nations depending on needs and capacity. Following a discussion of risk and protective factors for violence, the paper specifies the properties of a national or regional setting which will determine the appropriate institution(s) to be used, then discusses a variety of institutional forms which may serve as the basis for service delivery. Strategic analysis should precede any programme design. Programmes should be piloted and tested before being introduced on a wider scale or transplanted to a different cultural setting.

Introduction

Violence is deeply entrenched in human behaviour. In many respects, the state of the world during our lifetime has been a depressing one. Technologies of collective violence have contributed to the deaths of hundreds of millions of people during the 20th century. Interpersonal or individual violence also appears widespread, if not endemic.

On the other hand, historians will suggest that in many respects the world is a less violent place than it used to be. The earliest available statistics on homicide suggest that, in western societies at least, the "good old days" were much worse (*1*).

The prevention and control of violence in the modern era has thus far been primarily the province of criminal justice agencies. However, many institutions of social control lie outside the criminal justice system and the link between violence and health has become increasingly apparent. A number of adverse health experiences enhance the likelihood that an individual will become the perpetrator, and/or the victim, of violence. Conversely, the impact of violence may produce adverse health consequences for victims, and for society more generally.

This paper envisages a variety of models for the provision of services which address risk factors for interpersonal violence, or which serve to mitigate the effects of violence on its victims. It reviews major factors which, singly or in interactive combination, may influence the risk of violent behaviour; it explores alternative institutional configurations for the delivery of services; and it concludes that programmes which show promise should be piloted and tested on a large scale.

Risk factors for violence

Many factors contribute to the risk that an individual will behave aggressively or become the target of aggression (*2, 3, 4*). These factors interact, and may operate in a cumulative manner. They vary in their impact over time and place. Among them are:

- culture (the value placed on violence) (3);
- location context (the appearance that no one is in control) (5);
- social context (aggressive peers) (6, 7);
- economic conditions (poverty and inequality) (8);
- biology (adverse perinatal experiences; brain injury; alcohol, drug and other substance abuse; gender differences) (9, 10);
- personality (lack of empathy; impulsiveness) (11);
- family influences (maternal rejection; parental use of physical punishment and threat) (12, 13).

There are, in addition, protective factors which may neutralize or reduce the adverse impact of risk factors, and may thereby contribute to violence prevention. These might include:

- educational opportunities;
- employment opportunities;
- support for potentially abusive parents;
- educating young people in media viewing habits;
- nonviolent means of conflict resolution;
- restricting access of young males to lethal weapons.

Models for violence prevention

Human societies differ so widely that there can be no "one size fits all" recipe for the design and delivery of interventions for violence prevention. Initiatives introduced with the best of intentions may founder if they are culturally inappropriate. The capacity of institutions, whether they be governmental, commercial or nonprofit, to achieve effective outcomes will vary over time and space (14).

Some of the basic properties of societies which can determine the most appropriate configuration of programmes for violence prevention, include:

- overall wealth;
- distribution of wealth;
- the traditional role of the state;
- the country's epidemiological profile;
- orientation of the public towards state institutions;
- orientation of the public towards individual responsibility;
- the nature of civil society;
- the structure and strength of families;
- the legal and cultural status of women;
- racial/ethnic or cultural heterogeneity;
- population density/dispersion;
- cultural salience of alcohol use.

From the risk factors reviewed above, it seems that in many societies the most productive investment for violence prevention would be in the area of maternal and child health, and other measures to enhance the well-being of families with young children. These investments can be made directly, or indirectly, by reducing socioeconomic and gender inequality.

Accumulating evidence suggests that adverse perinatal experiences can have an indelible harmful impact on a child, and the first three years of life may have lasting influences on a person's physical or mental health. Irreparable damage can be done to a child's nervous system, *in utero* and in early childhood, by trauma or stress (15, 16). This suggests that attention to the following areas might have beneficial consequences for violence prevention:

- maternal and child nutrition;
- perinatal substance abuse;
- trauma prevention in early childhood;
- parenting skills.

Of course, these four areas are hardly exhaustive of strategies for violence prevention. One might add the control of substance abuse, limiting media depictions of aggressive behaviour, providing nonviolent means of conflict resolution, promoting nonviolent and pro-social values, the control of lethal weapons, and enhancing educational and economic opportunities for women generally.

There are many good reasons other than violence prevention to promote maternal and child health. A person's overall well-being and economic potential, and that of society as a whole, are to a great extent dependent on good health.

What institutions might contribute to violence prevention?

Economic development and a reduction of inequality within and between societies may be expected to have a positive impact on preventing violence. But until this is achieved, what is the most productive way to proceed?

Various institutions exist in society whose resources and energies might be harnessed to further violence prevention. Not all are equally and universally appropriate. First, an institution must be able to deliver the desired outcome. Second, even if it can do so, the institution must be compatible with the culture in which it operates. Indigenous minorities, indeed any target audience, may be less receptive to messages emanating from what they perceive to be a "foreign" source. And some institutions may be suited to certain functions, but not others. For example, some religious organizations may be very good at delivering services aimed at meeting the nutritional needs of infants and children, but not very good at fostering the reproductive self-determination of women.

In general, the source of information of service should be culturally resonant with the target audience. In some settings, a revered leader or trusted local institution will be most appropriate; in others, peer-to-peer education will be preferred.

The following list is offered with the caveat that the potential usefulness of institutions listed will be context-specific. The reader is invited to contemplate new institutional forms and types that may be applicable to local settings.

The military

In some nations, the military might be regarded as an occupying army, to be avoided whenever possible. And the militarization of many societies, accompanied by the widespread availability of weapons, may increase the likelihood that civilian disputes will be settled by violent means. But in those nations where the armed forces enjoys a degree of legitimacy in the eyes of the public, they may well be in a position to contribute to health services: (17, 18). They possess a degree of mobility and logistical capacity which often exceeds that of any other institution. In Australia, members of the defence forces have contributed to the development of housing and sanitation infrastructure in remote indigenous communities. The model of military medical assistance for disaster relief or in peacekeeping settings may also be instructive (19).

The police

As with the military, the police in some societies may be regarded as agents of repression. But where they are not, they may well be in a position to provide basic services. In some remote locations, the police officer may be the only representative of the state, and may be called upon to play a number of roles, including that of health promoter. Even in modern urban societies, police have an important role to play in mitigating the impact of violence on its victims. Collaboration and liaison with mental health services may contribute to violence prevention (20). In Australia, the South Australian Police Service has 50 officers dedicated to assisting victims of crime, whose role in part is to reduce the impact of post-traumatic stress (21).

Prisons

Many violent offenders end up in prison. For better or worse, most return eventually to the community. Good prison programmes can help reduce the likelihood of their reoffending. Moreover, prison health services can diagnose a variety of health conditions, from previous head injury to mental illness, which might contribute to further aggressive behaviour. These services can provide appropriate therapeutic intervention.

Educational institutions

Most nations provide at least an elementary education for their children. However, some provide only limited educational opportunities for girls. The inverse relationship between female literacy and infant mortality ($r = -.79$) is not spurious. The school can make an important contribution to the health of girls, and to the health of their eventual offspring.

The school is thus a point of contact for children where their physical and mental health problems can be diagnosed, and where nutritional needs may be met. The International School Health Initiative (ISHI), a collaborative programme involving the World Bank, WHO, individual donor nations and international NGOs such as Save the Children and the Partnership

for Child Development, focuses specifically on promoting the quality of school health and nutrition programmes.

Similarly, the WHO Global School Health Initiative is an ambitious programme to foster health promotion in schools around the world. In addition, school programmes have been developed for the identification and control of aggressive student behaviour such as bullying (22, 23).

Private enterprise

Businesses may contribute to health promotion for their own employees or for the general public. Partnerships for Health Promotion, an initiative of the Prince of Wales Business Leaders Forum and WHO, involves a number of large businesses who finance projects around the world. The Indian company, Sakal Papers Limited, sponsors community health posts in remote villages and training for local women in health care, among other activities.

Small businesses may lack the capacity to deliver services on a large scale, but they often have the benefit of widespread contact at the grassroots. As such, with appropriate guidance they may be ideally situated to provide basic health information to customers. In some communities, pharmacists can also provide valuable advice on a range of health issues (24).¹ Hairdressers may be in a position to impart basic health information to their female customers. Bartenders too may be in a position to impart health information, not only limited to alcohol consumption (26). I recall hailing a taxi in a large Southeast Asian city a few years ago and, having asked where I could find the best local satay, was reminded by the taxi driver that one should watch one's cholesterol levels.

Community groups

Depending on the quantity and quality of organizational life in a community, there may be many local associations in a position to contribute to violence prevention. Civic organizations and service clubs may contribute to health promotion by sponsoring screening programmes and health fairs (27), as well as a variety of violence prevention projects (28). The Sporting Shooters' Association of Australia conducts training programmes in the safe handling and use of firearms. Some indigenous communities in Australia develop their own institutions of social control and provide for coordination with formal institutions of criminal justice (29).

Religious organizations

The first hospitals were religious organizations. In the 18th century, private philanthropic associations, such as those established by the Quakers, established mental hospitals (30). In many communities, the strongest institutions are religious organizations. In many places around the world, ministers of religion are among the most highly respected members of the community. Where this is in fact the case, they are strategically placed to communicate basic information, and indeed assist in the provision of services, to their parishioners. In at least one North American city, church-based health fairs have provided free health screenings and services to thousands (31). In Thailand, a Buddhist temple provides drug rehabilitation services

(32). Religious institutions may provide important media for health education and promotion in areas as diverse as smoking cessation and malaria control (33, 34, 35).

Of course, one may imagine a variety of hybrid organizational forms. In Indonesia, religious-based women's organizations promote maternal and infant health through a variety of initiatives (36).

One must acknowledge, however, that religious organizations are not universally suited to promote health or prevent violence. Some religious sects foster violence. The implementation of religious teachings within some cultural traditions tends to subordinate women to an extent that limits their access to health services. In contexts such as these, one must look to other institutions.

Women's organizations

In most western societies, the issue of violence against women was first placed on the public agenda not by governments but by women themselves. Women's organizations have provided emergency accommodation and counselling services to victims of sexual assault and domestic violence. Beginning in the 1970s in western industrial societies, alternative women's health groups began to offer information and primary care at the neighbourhood level. In some less affluent countries, women's organizations are also active and effective. The National Council of Women in Papua New Guinea has been instrumental in drawing attention to violence as a major social issue and in establishing services for women and children who are victims of violence.

Traditional health practitioners

In some cultures, basic health services can be provided in a culturally compatible manner by traditional healers (37). These traditional health practitioners may be trained in primary health care to complement their traditional knowledge. They may be in a position to communicate nontraditional knowledge in furtherance of violence prevention; traditional birth attendants come immediately to mind. But not all services provided by traditional healers are beneficial. Some may engage in practices which are injurious rather than curative. Even when they do make a positive contribution, they may be resisted by the medical profession.

Paraprofessionals

The "barefoot doctors" of Mao's China caught the attention of much of the world by bringing primary health care to rural settings which were previously underserved. This basic model exists in many places today. In some settings, the large-scale recruitment, training and deployment of village health workers may serve as an effective vehicle for health promotion and as the interface between the formal health care system and the community (38).

In urban industrial societies, community health workers who share the same ethnic, linguistic and socioeconomic backgrounds as the communities they serve can play an important role in health promotion, especially in relation to maternal and child health (39).

Volunteers

The earliest initiatives in support of women victims of crime and violence were the work of volunteers. But the potential for volunteer contributions to public health and violence prevention are much wider. Johnson et al (40) and Schaefer et al (41) describe volunteer peer counselling programmes that provide low-income women with role models, information, support and encouragement, and which thus contribute to healthier infants.

The medical profession

Historically, medical practitioners have tended to focus on repairing the injury rather than the cause. Members of the British medical profession were slow to recognize the sexual abuse of girls in the first decades of the 20th century (42). The physical abuse of children is hardly a uniquely modern phenomenon, but battered child syndrome only became widely recognized in the West during the 1960s. More recently, medical practitioners have been slow to respond more comprehensively to domestic violence. More enlightened members of the medical profession are now able to recognize symptoms of violence against women, and to refer women victims to appropriate counselling. Hospitals have begun screening their emergency department patients for signs of domestic violence (43, 44, 45). The American Academy of Pediatrics is advocating that violence prevention and the promotion of nonviolence be thoroughly integrated into the education, clinical practice and community activities of pediatricians (46).

Some of the more promising interventions involve home visits to young expectant mothers by professional visiting nurses (47). The visiting professionals provide information about nutrition and parenting skills. The programme follows up with postnatal visits and child care services. One such programme, Hawaii Healthy Start, targeted high-risk families and found that subsequent rates of child abuse and neglect were 62% lower than rates among a control group (48).

Whatever the model or combination of models that are introduced in a given setting, the likelihood of success will be greater if the recipients are able to identify with the source of the message. An initiative is likely to meet with greater success if it is seen by the beneficiaries to belong to them. Ideally, the prospective beneficiaries will have a role in defining the problem and devising the solution. A community whose members have a sense of ownership of a programme or a message will be more receptive than if a programme is simply imposed on them from above.

The imperative of evaluation

Programmes and policies for the prevention and control of violence, whether under the auspices of state health authorities or anyone else, should first be justified by a thorough needs analysis. Following implementation, they should be subject to rigorous independent evaluation. Provision for this evaluation should be incorporated in the design and budget of the programme in question. Measures which are identified as working in one jurisdiction should not be blindly embraced elsewhere. There is ample precedence for rigorous evaluation of violence prevention initiatives (49).

While the good standard for evaluation remains the randomized controlled trial, other designs are appropriate, particular for those interventions which take place at community or regional level (50).

Future direction

I should like to make three suggestions for future work in the area of violence prevention. First, there is need for a systematic overview of initiatives to differentiate between those which have been demonstrated to work, those which haven't, and those on which the jury is still out. Second, national or regional strategic analyses are needed to identify the main manifestations of violence, the factors that give rise to them, and the most appropriate institutions and solutions for their prevention and control. Third, some thinking is needed about how community resources may be harnessed to further violence prevention.

Identify what works

An inventory of what has been demonstrated to work, what has been demonstrated not to work, and what appears promising, if not yet tested definitively, would make a significant contribution to health promotion and violence prevention. One must also be mindful that an intervention may have undesirable unintended consequences (51, 52).

A model for such an undertaking already exists in the work of Sherman and colleagues on crime prevention (53). Their comprehensive overview of crime prevention initiatives graded the evaluations according to the scientific rigour with which they were conducted:

- level 1 (correlations between interventions and a measure of crime or crime risk factors);
- level 2 (temporal sequence between the programme and the crime or risk outcome clearly observed, or a comparison group present without demonstrated comparability to the treatment group);
- level 3 (comparison between two or more units of analysis, one with and one without the programme);
- level 4 (comparison between multiple units with and without the programme, controlling for other factors, or a non-equivalent comparison group having only minor differences evident);
- level 5 (random assignment and analysis of comparable units to programme and comparison groups) (53).

Systematic overviews of health promotion programmes, with special attention to the strength of study design, already exist (54, 55).

National or local strategic analyses

Individual nations, or regional groups of similarly situated nations, could engage in a national or regional overview to determine the level and distribution of violence, the risk and protective factors that are present, and policy opportunities most appropriate to the culture and

national conditions. Australia did this 10 years ago, producing a comprehensive report containing 138 recommendations for governments and institutions across all sectors of Australian society (2). Similar studies have been undertaken in the United States (3). Such national intersectoral commissions have been urged by the Pan American Health Organization, among others.

Harnessing resources for violence prevention and control

The prevention and control of interpersonal violence is beyond the capacity of governments alone. Precisely what kinds of activities governments can do and should do to reduce violence will vary from place to place. But their resources and capacities are limited.

A major challenge faced by governments in the 21st century will be to achieve new efficiencies in the conduct of public affairs. One means of accomplishing this is to harness resources from outside the public sector in furtherance of public policy. For the provision of services related to violence prevention, this can entail a number of strategies which can be implemented either singly or in combination (56).

Conscription

Just as citizens may be conscripted for military service, so too can they be conscripted for community service. This may entail work in hospitals, health centres, schools or the community.

Required record-keeping and disclosure

As Foucault and his followers remind us, the simple process of enumeration and record-keeping has a regulatory function (57, 58). When disclosed, these accounts provide not only a record of performance and a vehicle for accountability but also a mirror for self-scrutiny. Many nations have yet to develop statistical systems that might serve as the basis for public policy. The lack of reliable data and under-reporting of intentionally inflicted injuries inhibits the identification of high-risk groups and the development of injury prevention programmes. Compulsory notification of certain diseases and injuries is common practice in some nations.

Cooption of organized interests

Institutions of civil society may be invited to collaborate in solving social problems. In many western nations, organizations of concerned parents campaign against media depictions of violence, and other groups promote nonviolent means of conflict resolution.

Incentives

The state, or indeed the private sector or nonprofit institutions, may offer incentives or inducements to engage in a particular course of action. Heads of government in Australia offer annual violence prevention awards to recognize the most promising initiatives in violence prevention. Such recognition of grassroots solutions encourages creative thinking and

commitment to reduce violence in Australian society. One such programme is the Julalikari Night Patrol in the Northern Territory, in which members of the Aboriginal community assist those who are incapacitated by alcohol.

In other nations, award programmes explicitly recognize exemplary innovations in the provision of health services. The Innovations in American Government Program, a joint initiative of the Ford Foundation and Harvard University, seeks to celebrate outstanding examples of creative problem-solving in the public sector. One recipient, the Monroe Maternity Center, provides certified nurse/midwife care for low-risk deliveries, comprehensive women's health care, and community perinatal education for disadvantaged rural residents.

Another recipient, the Illinois "Parents Too Soon" Program, provided health, social and educational services to teenagers at risk of pregnancy. The programme achieved an 18% decrease in births to Illinois teenagers of 15-19 years between 1982 and 1987, improved the health of babies born to young mothers, and improved the employability of teenage parents.

Incentives can also be provided to encourage individual behaviour. One incentive-based educational programme to encourage breastfeeding produced positive changes in breastfeeding knowledge and attitudes, and encouraged more women to breastfeed (59).

Delegation or deference to private parties

In some settings, private interests may be allowed to operate, with or without government subsidy. Governments subsidies to mission hospitals is common in sub-Saharan Africa. In some cases, these may involve explicit contracts specifying function and objectives (14).

Contracting out

Governments may achieve efficiencies by contracting some or all of their health services to private interests. Bennett, Russell and Mills (14) describe how a mining company's hospital provides clinical services to a local community under contract to the government.

Conclusion

Even though cultural diversity precludes a "onesize fits all" model of violence prevention, and what succeeds in Boston may not work in Bangladesh, one should always be alert for new ideas. By thinking laterally and strategically, one can learn from other cultures without trying to mimic them. One can also learn from other domains of social life and public policy. Consider, for example, the Dutch institution of neighbourhood wardens. These are ordinary individuals who are employed by government to keep an eye on their neighbourhoods or on public transport facilities with a view to preventing crime (60). Significant achievements in the prevention and control of violence can still be realized, but not without three ingredients: creative thinking, strategic planning, and evidence-based policy.

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References

1. Gurr TR. Historical trends in violent crime: a critical review of the evidence. In: Tonry M, Moore M, eds. *Crime and justice: an annual review of research*. Chicago, University of Chicago Press, 1981:295-353.
2. National Committee on Violence, *Violence directions for Australia*. Canberra, Australian Institute of Criminology, 1990.
3. Reiss AJ, Jr, Roth J. *Understanding and preventing violence*, vol I. Washington, DC, National Academy Press, 1993.
4. McDonald D, Brown M. *Indicators of aggressive behaviour*. Research and Public Policy Series, No. 8. Canberra, Australian Institute of Criminology, 1997.
5. Wilson JQ, Kelling G. Broken windows. *Atlantic Monthly*, 1982, 249(3):29-38.
6. Farrington D. Predictors, causes and correlates of male youth violence. In: Tonry M, Moore M, eds. *Youth violence (Crime and justice: an annual review of research*, vol. 24) Chicago, University of Chicago Press, 1998.
7. Sampson RJ, Lauritsen JL. Violent victimization and offending: individual, situational, and community-level risk factors. In: Reiss AJ, Jr, Roth JA, eds. *Understanding and preventing violence*, vol. 3. Social influences. Washington, DC, National Academy Press, 1993:1-114.
8. Braithwaite J, Braithwaite V. The effects of income inequality and social democracy on homicide. *British Journal of Criminology*, 1980, 20:45-53.
9. Reiss AJ, Jr, Miczek K, Roth J. Understanding and preventing violence. In: *Biobehavioral Influences*, vol. 2. Washington, DC, National Academy Press, 1993.
10. Moffitt TE. Neuropsychology, antisocial behavior, and neighborhood context. In: McCord J, ed. *Violence and childhood in the inner city* Cambridge, Cambridge University Press, 1997:116-170.
11. Wilson JQ, Hernstein R. *Crime and human nature*. New York, Simon and Schuster, 1985.
12. Widom C. The cycle of violence. *Science*, 1989, 244:160-166.
13. Farrington D. Childhood aggression and adult violence: early precursors and later life outcomes. In: Pepler DJ, Rubin KH, eds. *The development and treatment of childhood aggression*. Hillsdale, NJ, Erlbaum, 1991:5-29.
14. Bennett S, Russell S, Mills A. The role government in adjusting economies. Paper 4 in *Institutional and economic perspectives on government capacity to assume new roles in the health sector: a review of experience*. London, London School of Hygiene and Tropical Medicine, 1995.
15. Perry B et al. Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: how states become traits. *Infant Mental Health Journal*, 1995, 16(4):271-291.

16. Perry B. Incubated in terror: neurodevelopmental factors in the cycle of violence. In: Osofsky J, ed. *Children, youth and violence: the search for solutions*. New York, Guilford Press, 1997:124-148.
17. Kemmer T, Podojil R, Sweet LE. U.S. army dietitians deploy in support of Cobra Gold: a humanitarian mission. *Military Medicine*, 1999, 164(7):488-494.
18. Wittich AC. The military gynaecologist in low-intensity conflict environment. *Military Medicine*, 1993, 158(4):275-277.
19. Hawley A. Rwanda 1994: a study of medical support in military humanitarian operations. *Journal of the Royal Army Medical Corps*, 1997, 143(2):75-82.
20. Marans S, Berkowitz SJ, Cohen DJ. Police and mental health professionals: collaborative responses to the impact of violence on children and families. *Child and Adolescent Psychiatric Clinics of North America*, 1998, 7(3):635-651.
21. Cook B, David F, Grant A. Victims' needs, victims' rights: policies and programs for victims of crime in Australia. Canberra, Australian Institute of Criminology, 1999.
22. Olweus D. *Bullying at school: what we know, and what we can do*. Oxford, Blackwell, 1993.
23. Dusenbury L et al. Nine critical elements of promising violence prevention programs. *Journal of School Health*, 1997, 67(10):409-414.
24. Sinclair HK et al. Training pharmacists and pharmacy assistants in the stage-of-change model of smoking cessation: a randomised controlled trial in Scotland. *Tobacco Control*, 1998, 7(3):253-261.
25. Braithwaite J. *Corporate crime in the pharmaceutical industry*. London, Routledge and Kegan Paul, 1984.
26. Bissonette R. The role of the clergy in community mental health service: a critical assessment. *Psychiatric Quarterly*, 1979, 51(4):294-299.
27. Boon DA. Medical adventure in Nepal. *Journal of Otolaryngology*, 1980, 9(6):526-533.
28. Mugford J, Nelson D. *Violence prevention in practice*. Canberra, Australian Institute of Criminology, 1996.
29. Chantrill P. *The Kowanyama Justice Group: a study of the achievements and constraints on local justice administration in a remote Aboriginal community*. Seminar paper presented at the Australian Institute of Criminology, 11 September 1997. See: <<http://www.aic.gov.au/conferences/occasional/chantrill.html#abstract>>.
30. Rothman D. *The discovery of the asylum: social order and disorder in the new republic*. Boston, Little Brown, 1971.
31. Tuggle MB. New insights and challenges about churches as intervention sites to reach the African-American community with health information. *Journal of the National Medical Association*, 1995, 87: Suppl. 635-637.
32. Barrett ME. Wat Thamkrabok: a Buddhist drug rehabilitation program in Thailand. *Substance Use and Misuse*, 1997, 32(4):435-459.
33. Spencer C, Heggenhougen H, Navaratnam V. Traditional therapies and the treatment of drug dependence in Southeast Asia. *American Journal of Chinese Medicine*, 1980, 8(3):230-238.
34. Mfaume MS et al. Mosques against malaria. *World Health Forum*, 1997, 18(1):35-38.
35. Schorling JB et al. A trial of church-based smoking cessation interventions for rural African Americans. *Preventive Medicine*, 1997, 26(1):92-101.

36. Munir LZ. The role of religious women's NGOs in promoting child survival and development in Indonesia. *Pacific Journal of Public Health*, 1990, 4(4):274-276.
37. Kale R. Traditional healers in South Africa: a parallel health care system. *British Medical Journal*, 1995, 310:1182-1185.
38. Werner D. *Donde No Hay Doctor/Where there is no doctor: a village health care handbook*. Palo Alto, CA, Hesperian Foundation, 1978.
39. Love MB, Gardner K, Legion V. Community health workers: who they are and what they do. *Health Education and Behavior*, 1997, 24(4):510-522.
40. Johnson Z, Howell F, Molloy B. Community mothers' programme: randomised controlled trial of non-professional intervention in parenting. *British Medical Journal*, 1993, 306(6890):1449-1452.
41. Schafer E et al. Volunteer peer counselors increase breastfeeding duration among rural low-income women. *Birth*, 1998, 25(2):101-106.
42. Smart C. A history of ambivalence and conflict in the discursive construction of the 'child victim' of sexual abuse. *Social and Legal Studies*, 1999, 8(3).
43. Roberts G. Domestic violence victims in emergency departments. In: Chappell D, Egger S, eds. *Australian violence: contemporary perspective's II*. Canberra, Australian Institute of Criminology, 1995:87-104.
44. Roberts GL et al. Prevalence study of domestic violence victims in an emergency department. *Annals of Emergency Medicine*, 1996, 27(6):741-753.
45. Jezierski M. Partners against violence: two Minnesota hospitals join community-wide effort. *Health Progress*, 1996, 77(2):38-40.
46. Mercy JA. Advocating for children: the pediatrician's role in violence prevention. *Pediatrics*, 1999, 103(1):157.
47. Olds D et al. Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. *Journal of the American Medical Association*, 1998, 280(14):1238-1244.
48. Duggan A et al. Evaluation of Hawaii's Healthy Start Program. *Future Child*, 1999, 9(1):66-90.
49. Powell KE, Hawkins DF, eds. Youth violence prevention: descriptions and baseline data from 13 evaluation projects. *American Journal of Preventive Medicine*, 1996, 12(5): Suppl.
50. Okoumunne O et al. Methods for evaluating area-wide and organisation-based interventions in health and health care: a systematic review. *Health Technology Assessment*, 1999, 3(5):1-99.
51. Grabosky PN. Counterproductive regulation. *International Journal of the Sociology of Law*, 1995, 23:347-369.
52. Tenner E. *Why things bite back: technology and the revenge effect*. London, Fourth Estate, 1997.
53. Sherman LW et al. *Preventing crime: what works, what doesn't, what's promising*. Washington, DC, National Institute of Justice, 1997.
See: <<http://www.preventingcrime.org/report/index.htm>>.
54. Bruvold WH. A meta-analysis of adolescent smoking prevention programs. *American Journal of Public Health*, 1993, 83(6):872-880.
55. Grossman D, Garcia C. Effectiveness of health promotion programs to increase motor vehicle occupant restraint use among young children. *American Journal of Preventive*

- Medicine*, 1999, 16(1):Suppl.12-22.
56. Grabosky PN. Using non-governmental resources to foster regulatory compliance. *Governance*, 1995, 8(4):527-550.
 57. Miller P. On the interrelations between accounting and the state. *Accounting, Organization and Society*, 1990, 15:315-338.
 58. Rose N, Miller P. Political power beyond the state: problematics of government. *British Journal of Sociology*, 1992, 43(2):173-201.
 59. Sciacca JP et al. A breast feeding education and promotion program: effects on knowledge, attitudes and support for breast feeding. *Journal of Community Health*, 1995, 20(6):473-490.
 60. Hesselting R. Functional surveillance in the Netherlands: exemplary projects. *Security Journal*, 1995, 6(2):1-25.
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Endnote

- ¹ Braithwaite (25) notes that pharmacists in some developing nations have been known to encourage inappropriate medication.

ANNEXES



Global Symposium on Violence and Health
12-15 October 1999, Kobe, Japan

PROGRAMME

12 October 1999, Tuesday

0830 - 0930 **Registration**
0930 - 1015 **Opening Session**

Welcome Remarks

Yuji Kawaguchi, Director of WHO Centre for Health Development in Kobe, Japan
Hideo Shinozaki, Director-General of Health Service Bureau, Ministry of Health and Welfare, Japan
Toshizo Ido, Vice-Governor of Hyogo Prefecture, Japan
Kazutoshi Sasayama, Mayor of Kobe City, Japan

Special Messages

Director-General, World Health Organization, Geneva
Secretary-General, United Nations, New York

1015 - 1020 **Group Photo**
1020 - 1050 **Coffee Break**

1050 - 1120 **Introduction to the WHO Kobe Centre and Global Symposium on Violence and Health**
Yuji Kawaguchi, Director of WHO Kobe Centre

1120 -1200 **Keynote Address**
Chair: Ataollah Amini, Senior Advisor to Director of WHO Kobe Centre

Violence and health: an overview

Hazel McCallion, Mayor of the City of Mississauga, Ontario, Canada

1200 - 1300 **Lunch Break**
1300 - 1800 **Plenary Session 1:**
What Do We Know about Global Health Problems Related to Violence?

Moderator: Rudolph Jackson, Morehouse School of Medicine, USA
Rapporteur: Maurice Apprey, University of Virginia, USA

Global health problems of violence
Claude Romer, World Health Organization, Geneva

Suicide as a form of violence and its implications for public health: the case of Sri Lanka
Kalinga Tudor Silva, University of Peradeniya, Sri Lanka

The impact of family violence on girls in South Asia
Ruth Finney Hayward, UNICEF, New York

Domestic violence and abuse against children and women in Japan
Natsuko Yoshimoto, Kobe, Japan

1500 - 1530 **Coffee Break**
1530 - 1730 **Plenary Session 1 (continued)**

Violence against older people and its health consequences: experience from Africa and Asia
Todd Petersen, HelpAge International, United Kingdom

Review of 16 cases of honour killings in Jordan
Hani Jahshan, National Institute of Forensic Medicine, Jordan

An introduction to the Global Atlas on Violence and Health
George Benwell, Otago University, New Zealand

Projections of global trends and patterns of violence and health
Joanna Mary Barker, Curtin University of Technology, Australia

The public health model for violence prevention: the CDC perspective
W. Rodney Hammond, Centers for Disease Control and Prevention, USA

1730 - 1800 **Discussion**

Chair: Joanna Mary Barker, Australia
Moderator: Rudolph Jackson, Morehouse School of Medicine, USA

13 October 1999, Wednesday

0900 - 1230 **Plenary Session 2:**
Policy and Management of Violence and Health: Where Are We?

Moderator: Hazel McCallion, Mayor of Mississauga, Canada
Rapporteur: Ruth Finney Hayward, UNICEF, New York

Violence breeds violence
Jeremy Harris, Mayor of Honolulu, USA

Policy and management of gender-based violence and health in the Asia-Pacific region
Lorraine Corner, UNIFEM, Thailand

Violence and health in Mongolia with special reference to policy implications for action
Udval Natsag, Ministry of Health and Social Welfare, Mongolia

Violence and health in Mongolia: issues on management, resource allocation and education
Tserendorjiin Sodnompil, Ministry of Health and Social Welfare, Mongolia

1030 - 1100 **Coffee Break**
1100 - 1200 **Plenary Session 2 (continued)**

Managing violence, drugs and health in Papua New Guinea: an effort of community participation and integration
Mathew Nelson, National Narcotics Bureau, Papua New Guinea

Violence prevention and health development: experiences from Indonesian cities
Charles Surjadi, Atma Jaya Catholic University, Indonesia

Determinants of social violence among youth and their risky health behaviour: policy implications
Tetsuji Yamada, The State University of New Jersey, USA and Tadashi Yamada, University of Tsukuba, Japan

1200 - 1230 **Discussion**

Chair: Lorraine Corner, UNIFEM, Thailand
Moderator: Hazel McCallion, Mayor of Mississauga, Canada

1230 - 1330 **Lunch Break**
1330 - 1730 **Plenary Session 3:**
What Do We Know about Determinants of Violence and Health?

Moderator: Lorraine Corner, UNIFEM, Thailand
Rapporteur: Ntombodidi Zodidi Tshotsho, Ministry of Health, South Africa

Guest speech: Policy and management of violence and health in Japan
Keizo Takemi, Member, House of Councilors, Japan

Ethnonational conflict resolution: from basic assumptions to praxis
Maurice Apprey, University of Virginia, USA

Determinants of violence and health: first results of a WHO Kobe Centre research programme
Klaus Peter Strohmeier and Götz Köhler, Ruhr-Universität, Germany

Psychosocial assessment of children exposed to war-related violence in Kabul
Suraya Dalil and Niloufar Pourzand, UNICEF, Afghanistan

Violence, women's health and society: the situation in Viet Nam
Le Thi Phuong Mai, Population Council, Viet Nam

1520 - 1540 **Coffee Break**
1540 - 1700 **Plenary Session 3 (continued)**

Structural violence and women's health: work in the beedi industry of India
Rekha Pande, University of Hyderabad, India

The victim of violence in Nepal
Rudra Mani Paudel, Himalayan Association for Human Rights, Environment and Development, Nepal

Violence at home: experience from the Eastern Mediterranean
Ahmed Abdullatif, WHO/EMRO, Egypt

Social support, domestic violence, and depressive mood among immigrant women in Japanese communities: a pilot study
Kaname Tsutsumi, Kyushu International University, Japan

1700 - 1730 **Discussion**

Moderator: Lorraine Corner, UNIFEM, Thailand

1730 - 1745 **Tea and Refreshments**
1745 - 1900 **Special Seminar Session:**
Health and Violence Concerning Women and Children: Indian and Japanese Experience

Moderator: Asma Fozia Qureshi, Aga Khan University, Pakistan
Rapporteur: Ruth Finney Hayward, UNICEF, New York

Victims of sexual assaults in Japan
Miwa Kojimoto, Tokyo Gakugei University, Japan

Health issues related to child labour, gender and domestic violence in India
Rekha Pande, University of Hyderabad, India

Understanding domestic violence, child abuse and its care
Hiroko Tomoda, Osaka City University, College of Nursing, Japan

A covert form of aggression against women entering conjugal union
Tomo Matsuo, Kobe University and Emma Tamaian, Babes-Bolyai University of Cluj-Napoca

14 October 1999, Thursday

0900 - 1230 **Plenary Session 4:
Services and Interventions: What Has Been Practiced and What Are The
Unmet Needs?**

Moderator: Larry Chavez, Sacramento Police Department, USA

Rapporteur: Peter Grabosky, Australian Institute of Criminology, Australia

Youth violence and the violent world of children – school shootings in the United States,
1997-1999

Rudolph Jackson, Morehouse School of Medicine, USA

The health care response to domestic violence

Janet Carter, Family Violence Prevention Fund, USA

Incivility and ignorance: the American experience of violence in the workplace and
schools

Larry Chavez, Sacramento Police Department, USA

A population health approach to family violence programming: Health Canada's
experience

David Allen, Family Violence Prevention Unit, Canada

1040 - 1100 **Coffee Break**
1100 -1230 **Plenary Session 4 (continued)**

Maximizing human potential – violence prevention for teens and the role of senior
citizens in San Diego

Marcia A. Petrini, Yamaguchi Prefectural University, Japan

Experience as a gynecologist in supporting victims of sexual violence

Ikuko S. Moriyama, Nara Medical University, College of Nursing, Japan

Violence against chronically ill patients

N.P. Napalkov, Petrov Institute of Oncology, Russia

Female genital mutilation: an extreme form of violence

Berhane Ras-work, Inter-African Committee, Switzerland

The connection between childhood sexual abuse and relationship health: a comparison of
heterosexual and homosexual long-term sexual relationships

Rita Weingourt, Sapporo Medical University, Japan

1230 - 1300 **Discussion**

Moderator: Larry Chavez, Sacramento Police Department, USA

1300 - 1400 **Lunch Break**

1400 - 1730 **Plenary Session 5:**

Meeting the Challenge: Future Actions and Strategies

Moderator: Janet Carter, Family Violence Prevention Fund, USA

Rapporteur: Kalinga Tudor Silva, University of Peradeniya, Sri Lanka

Guest speech: Highlights of health and the American child: priority issues for the 21st Century

Louis W. Sullivan, Morehouse School of Medicine, USA

Signs of self-awareness

Jushichiro Naito, Japan Pediatrics Association, Japan

Violence and health: personal, social, national, ethnic and racial issues

Peter Loewenberg, University of California, Los Angeles, USA

Health as a bridge to peace: the role of health professionals in conflict management and community reconciliation

Paula Gutlove, Institute for Resource and Security Studies, USA

Population dynamics, structural changes and resource distribution: violence prevention and health development in cities in the next two decades

Lyndsay Neilson, University of Canberra, Australia

1540 - 1600 **Coffee Break**

1600 - 1730 **Plenary Session 5 (continued)**

The contribution of welfare services to violence prevention and health development: an Australian experience

Ching Choi, Australian Institute of Health and Welfare, Australia

The victim empowerment programme: partnership with the health sector in South Africa

Ntombodidi Zodidi Tshotsho, Ministry of Health, South Africa

A new model of masculinity to stop violence against girls and women

Ruth Finney Hayward, UNICEF, USA

Managing violence and health: strategies, solutions, research and methodological issues

Peter Grabosky, Australian Institute of Criminology, Australia

1730 - 1800 *Panel Discussion*

Chair: Ntombodidi Zodidi Tshotsho, Ministry of Health, South Africa

15 October 1999, Friday

0900 - 1200 *Closing Session*

Moderator: Hazel McCallion, Mayor of Mississauga, Canada

Summary report of Global Symposium on Violence and Health
W. Rodney Hammond, CDC, USA and Fellow Rapporteurs

1030 - 1100 *Coffee Break*

1100 -1200 *Closing Session (continued)*

Recommendations -- Kobe Declaration on Violence and Health

Words from participants

Closing remarks

Yuji Kawaguchi, Director of WHO Kobe Centre

Annex 2

Global Symposium on Violence and Health 12-15 October 1999, Kobe, Japan

SUMMARY REPORT¹

Introduction

The World Health Organization Centre for Health Development (WHO Kobe Centre) held a Global Symposium on Violence and Health at the International Conference Center in Kobe, Japan, from 12 to 15 October 1999.

The present report provides a summary of the symposium. Section 1 provides an introduction to the structure of the report. Section 2 gives background information on the organization of the Global Symposium on Violence and Health. Section 3 describes the documentation used in the process of the symposium. Section 4 focuses on presentations and highlights.

Section 5 includes the Symposium Rapporteur's technical report, which highlights methodological issues concerning violence prevention and health development. It also gives recommendations on unmet needs in policy formulation, programme management, health services and research.

It is emphasized that all documents related to the Global Symposium on Violence and Health are currently available on the WHO Kobe Centre's homepage at <http://www.who.or.jp>.

Background

The Global Symposium on Violence and Health was convened in response to the worldwide situation of violence and health, particularly during recent years. Not only have there been ethnic wars and severe civil unrest in many parts of the world, but increasing levels of self-inflicted and interpersonal violence have been seen in both developed and less developed countries. The health consequences of this rise in violence are believed to be increasingly complex and serious, and therefore require attention.

The Global Symposium on Violence and Health encompassed a broad spectrum of issues related to violence and public health concerns. The symposium was intended to provide a review of the global situation on violence and health, with major emphasis accorded to a review of current management strategies, programme implementation and health services. Accordingly, the programme was based on an integrated framework of five plenary sessions, namely:

1. *What do we know about global human health problems related to violence?*
2. *Policy and management of violence and health: where are we?*
3. *What do we know about determinants of violence and health?*
4. *Services and interventions: what has been practiced and what are the unmet needs?*

5. *Meeting the challenge: future actions and strategies*

Beyond this, the coverage of the meeting was global and the methodology was interdisciplinary. The symposium had some 300 participants from 36 countries and the panelists included ministerial leaders, city mayors, executive managers, leading academics, researchers, professionals and specialists from developed and less developed countries, as well as from international organizations.

The main expected outcome of the meeting was to collect solid facts, to draw insights on global issues of violence and health, and to seek better strategies and solutions to the problems. It was expected that recommendations on public health research, particularly policy, programme and community actions in violence prevention of shared concern would be produced. Those objectives are reflected in the following text.

Symposium documentation

The following list of documentation, numbered 1-11, shows the main process of the Global Symposium on Violence and Health. The list is provided here as a record and reference of this important event.

1. *Summary report of the Global Symposium on Violence and Health*
2. *Symposium brochure (themes, objectives, outcomes and call for papers)*
3. *Programme (Agenda)*
4. *The Director's address*
5. *Special messages from the UN Secretary General and WHO Director-General*
6. *The Kobe Declaration 12-15 October 1999*
7. *Collection of abstracts*
8. *Symposium exhibition: global concern of violence and health*
9. *World Atlas on Violence and Health*
10. *Symposium proceedings*
11. *The list of symposium participants*

Document 1 is the present summary report of the Global Symposium on Violence 12-15 October 1999. Document 2, a pre-symposium brochure, outlined the important themes, objectives and expected outcomes of the meeting. It also served as an introductory document, calling for presentation abstracts for the symposium. Documents 3-9 are the documents used during the symposium, namely the programme, the Director's address, the special messages, the Kobe Declaration on Violence and Health, collection of abstracts, the symposium exhibition on global concern of violence and health, and the publication *World Atlas on Violence and Health*.

Note that Document 4, *The Special Messages*, contains messages from Mr Kofi Annan, Secretary-General of the United Nations, and from Dr Gro Harlem Brundtland, Director-General of the World Health Organization. Document 5, *The Kobe Declaration*, highlights an important outcome of the symposium.

Document 10 is the present book.

Symposium presentations and highlights

Day 1: 12 October 1999, Tuesday

Opening Session and Plenary Session 1: What do we know about global human health problems related to violence?

The symposium commenced at 9:30 a.m. as scheduled. The community leaders of Hyogo Prefecture and Kobe City, where the WHO Centre for Health Development is located, welcomed participants and offered the hospitality of the host community.

The meeting was especially honoured to receive special messages from the United Nations Secretary-General (see Section 2) and the WHO Director-General. Both supported the meeting, confirming that violence is a most complex and far-reaching issue, a principal cause of morbidity and premature mortality worldwide but yet a much-neglected epidemic, particularly with regard to its impact on women.

Dr Yuji Kawaguchi, Director of the WHO Kobe Centre, gave a warm welcome to the symposium participants. He introduced the symposium, the mission of the WHO Kobe Centre and described the organization of the Global Symposium on Violence and Health.

The opening session featured the keynote address delivered by Mayor Hazel McCallion from Mississauga, Canada. The mayor drew particularly on the experience of her own city, discussing issues concerned with policy formulation, programme management, and grassroots implementation, as well as future strategies and actions on violence and health.

Dr Claude Romer from the WHO headquarters in Geneva gave an extensive overview of the efforts undertaken by WHO. In particular he provided the symposium with a public health model in violence prevention and health development.

In addition, Dr Romer:

- noted the importance of using a public health approach;
- presented a definition of violence related to physical and psychological injury;
- presented a taxonomy of violence (i.e. interpersonal, self-inflicted, organized);
- underlined the public health from a retroactive approach to a proactive one.

In a similar vein, Dr W. Rodney Hammond highlighted the role of CDC in violence prevention and introduced to the participants a public health model describing the progression of violence prevention work from surveillance through risk factor research and intervention evaluation to programme implementation. The need to improve surveillance was noted as a primary concern. Best practices to prevent violence were described, including:

- social cognitive programmes;
- parent training;
- mentoring programmes;
- home visits during the first two years by trained nurses.

In this connection, eight presentations at the symposium made clear the relationship between violence and health through community-based experience which encompassed the problems associated with self-inflicted behaviours, violence against women and children, and those against elderly people. WHO's effort in alleviating the importance of violence and health was indicated in the papers.

In all, the day's sessions were attended by almost 300 people including ministerial leaders, city mayors, high-level managers, academics, researchers and professionals from government agencies and nongovernmental and international organizations. The meeting demonstrated community participation and interdisciplinary practice.

Day 2: 13 October 1999, Wednesday

Plenary Session 2 : Policy and management of violence and health: where are we?

Plenary Session 3 : What do we know about determinants of violence and health?

Special Seminar : Concerning women and children: Indian and Japanese experience

Day 2 featured on the inspiring speech delivered by Mayor Jeremy Harris from Honolulu, Hawaii, USA, who described the progress of, and issues related to, policy and management concerning violence prevention and crime control in his city. He emphasized the benefits of an "enhanced" law enforcement response, particularly with regard to domestic violence against women and children.

In addition, the Mayor of Honolulu mentioned several themes, namely:

- resources to strengthen numbers of police and mandatory sentencing of repeat offenders;
- programmes on street gangs, drug abuse and illegal firearms;
- dramatic decreases in violent crimes that were reported;
- how decreases occurred despite worsening local economic conditions.

Also on Day 2, participants welcomed Professor Keizo Takemi, Member, House of Councilors of Japan, who despite severe leg injuries, he travelled from Tokyo to address the meeting. Professor Takemi described Japan's experience in the area of violence and health, particularly in the light of policy and management issues. The address met with an enthusiastic response from symposium participants.

Underlying themes in the succeeding presentations included:

- perspectives on gender-based violence which provided a comprehensive overview of efforts to counter violence against women (the development of the policy agenda, especially in developing countries, was emphasized);
- policy implications on social violence among youth (defined as risk behaviours such as drunk driving and use of alcohol and illicit drugs);
- health care structures and management of services in the light of violence, especially domestic violence;
- resource allocation and educational needs for health managers;

- challenges related to increased violence in communities undergoing rapid economic change (e.g. Papua New Guinea).

The determinants of violence were identified in terms of the following:

- the interdependence between violence and institutions (e.g. intergenerational transfer of violence and ethnonational transfer of violence);
- poverty, education and unemployment;
- gender relations and masculinity;
- immigration, settlement and ethnicity;
- limited institutional care and resources;
- responsibility and commitment;
- culture and society;
- advocacy of civil society.

The meeting repeatedly emphasized that institutional violence is a hidden serious issue. The determinants of violence and health cannot be separated from the political, cultural and economic systems of society, although the perpetrator's self-determination also must be addressed. Human and social developments are necessary prerequisites for preventing violence and promoting better health.

Day 3: 14 October 1999, Thursday

Plenary Session 4: Services and interventions: what has been practiced and what are the unmet needs?

Plenary Session 5: Meeting the challenge: future actions and strategies

The activities of Day 3 focused on public health strategy concerning implementation and practice. Key issues of unmet need were addressed, with future strategies and actions being proposed.

In regard to services and interventions, the meeting discussed the high rates of youth violence, the use of firearms, teen pregnancy (a high risk for later violence) and incivility at school and in the workplace. Intervention strategies and actions in conflict resolution should include appropriate school intervention programmes, early recognition of risk behaviour, weapon control measures, mentoring and support groups.

Health problems resulting from family (domestic) violence are serious but are often overlooked by health professionals. Also, the patients themselves may be inhibited from speaking about it to others. Services and interventions should particularly take account of the following:

- a national agenda for health care provision;
- the need for screening and identification;
- the prevalence of sexual violence and its adverse health impact;
- an evidence-based document on partner abuse (medical records of patient pathology);
- multiple and cross-sectoral strategies;

- education for physicians and investigators;
- the need for more female investigators;
- community involvement in public education campaigns.

Strategies to reduce female genital mutilation would in addition include:

- the achievement of more equal power relations between men and women;
- changes in attitude and practice at grassroots, with stronger government support;
- better integrated efforts of governmental and nongovernmental organizations and agencies.

The meeting further discussed the serious unmet need of health care for the elderly, with special reference to emerging issues in connection with marked demographic changes in age structure. Increasing cohorts of elderly populations may increase the incidence of abuse and violence against the aged and chronically ill patients. Better diagnosis and recognition of related symptoms and the training of health care providers were said to be necessary.

To meet the challenge of defining future actions and strategies, Dr Louis W. Sullivan, the guest speaker of Session 5, delivered a paper of critical importance – differentials in mortality and related health problems as a result of violence in different population groups, notably White and Black Americans, their children and younger male adults.

Dr Jushichiro Naito, the keynote speaker of the same session informed the meeting that violence prevention should begin with childbearing, rearing and caring. Protecting the child's self and its psychological development is a way to success.

Other themes in the succeeding presentations included:

- the reduction of abuses and aggression against citizens by the state;
- balancing the structural changes in demographics, settlement and resource distribution;
- creation of appropriate welfare structures (programmes and projects) and provision of care and services;
- men and women working together as partners in minimizing gender-based violence;
- the development of local victim empowerment programmes;
- the enhancement of strategies and solution (the role of culture and sensitivity);
- implementing the principles and ethics of civil society in conflict – management for family and community reconciliation

Day 4: 15 October 1999, Friday

Closing Session

The closing session featured the endorsement of "The Kobe Declaration of Violence and Health, 12-15 October 1999". The Rapporteurs' critical analysis of the symposium and related recommendations on future actions and strategies is shown below.

The meeting closed at midday with the closing remarks by Dr Yuji Kawaguchi on the future activities and development of the WHO Centre for Health Development in Kobe.

Symposium rapporteur's remarks: a technical report

Main points of the meeting (1-4)

1. The meeting agreed that violence is an important public health concern.
2. The meeting discussed and asserted that violence has many forms, including:
 - domestic violence;
 - youth violence;
 - self-inflicted violence;
 - organized civil violence;
 - child abuse;
 - rape and sexual assault;
 - violence against elderly and chronically ill people.
 - female genital mutilation.

Note that different forms of violence may require different strategies and solutions. The key point is the appropriate use of methodology in identification of relevant issues.

3. The meeting believed violence can and must be prevented:
 - Prevention, programmes and policies were discussed;
 - More examples are needed;
 - Prevention services require strong management, strategic planning and wise allocation of resources.
4. Working towards better information, data collection and a good reporting system is both necessary and crucial.

Summary and recommendations

1. Many presentations suggested the need to change the violence that is embedded in the culture. This raises an important question about the mechanism for change, especially in areas related to the status of women.
2. Several presentations highlighted the psychological aspects of violence and the developmental aspects of violence that stem from early childhood. This raises the need for the inclusion of behavioural science expertise, particularly psychology, sociology and other related behavioural sciences, within public health science and practice.
3. There should be an emphasis on sound violence surveillance for purposes of policy and programme development.
4. Programmes should be developed around the actual determinants of violence, i.e. programmes suited to particular locations (such as urban vs rural), populations and specific forms of violence.
5. It is extremely important to improve the availability of data and information. There were notable gaps in the available information in the Atlas on Violence and Health.
6. We should continuously strive for evidence-based prevention policies and programmes.
7. It is clear that violence prevention must include many sectors, such as social service,

Particularly, implementing the complete public health model

- To define and measure the problem (level of surveillance).
- To find the causes (risk factors).
- To find what works (evaluation and intervention).
- To communicate what works (what can be implemented).

Define and measure the problem

- It is argued that building a sustainable surveillance programme at national and local levels is the wisest first investment.
- Surveillance is not as effective for putting an issue onto a political agenda as the anecdotal approach.
- Surveillance is very effective for a sustained commitment to public financed prevention programmes and policies.
- Surveillance make it easier to target resources and helps those who allocate or utilize resources to be accountable.
- The commitment of resources for surveillance is frequently difficult.

There are two possible reasons:

- data collection seems to be a weak and emotionally insensitive response to an urgent and compelling problem like violence;
- resources for data collection and surveillance are assumed to compete with resources for programmes.

However, undertaking programmes need not be incompatible with gathering data. Public health epidemiologists must put a human face on the numbers and should not rely on statistics alone. Furthermore, international lending authorities (e.g. the World Bank) will increasingly require surveillance data on violence and injury risks as a condition for future loans in developing countries.

Evaluate what works

- Different levels of evaluation related to:
 - the extent to which you are reaching a population in need;
 - the extent to which consumers are satisfied;
 - the extent to which programmes are accomplishing their objectives;
 - the extent to which an intervention produces a benefit compared to something different.
- Pay special attention to unintended side-effects because:
 - in some United States youth violence prevention programmes it was found that aggression increases temporarily as a programme is implemented;

- self-esteem enhancement programmes actually increase aggression among at-risk youth who tend to externalize their behaviour;
- youth referred to boot camps were found to be more likely to be subsequently incarcerated.

Communicate what works

- Translate science into clinical practice and policy.
- Increase communication beyond science journals.
- Exploit the long tradition of public health messaging utilizing the media, for example:
 - it is an effective way to change negative social norms and customs;
 - it can change attitudes about violence against women and children;
 - it can increase the responsibility of those who observe violence to engage in action to prevent it;
 - it may be possible to develop self-screening methods to encourage individuals having problems with violence to seek help within themselves.

Two biggest problems with violence and health, and one possible answer

Helping the public to understand that violence is not inevitable. It is a choice!

Public health data already demonstrate that violence changes from place to place, from person to person and over time. The challenge will be whether or not we choose to control it or avoid doing so.

Matching the right response to the right problem

We heard many possible solutions, such as:

- changing the status of women;
- improving health care services;
- more police on the streets;
- parent education;
- social cognitive interventions;
- incarcerating repeat offenders.

Other points stressed by symposium participants included:

- The problem is that violence has multiple causes and therefore many solutions.
- In the future it is likely that violence will be described and clinically prevented according to its many types.
- It may prove more practical to identify and prevent specific types of violence rather than thinking of all violence as the same. This is the experience of public health with respect to many problems, such as hepatitis, diabetes, sexually transmitted diseases, flu immunization and vaccination programmes.

- It will also be true that some interventions will have multiple benefits.
- Violence prevention is likely always to be complicated.
- As always in public health, no important problem is ever simple nor perfectly solved.
- Since, as a practical matter, some interventions may be well suited for one type of violence but not for another, it will be crucial to have a well managed public health system.

In conclusion, we may agree or disagree on how to do it, but it does not matter. The bottom line is that violence can be prevented and controlled if we choose to do so!

Endnote

¹ It is acknowledged that this document, particularly Section 5, is based on the Symposium Rapporteur's remarks delivered at the closing session of the meeting, which represents a synthesis of several plenary session reports contributed by his team of rapporteurs. The Symposium Rapporteur was Dr W. Rodney Hammond, Director, Division of Violence and Injury Prevention, Centers for Disease Control and Prevention in Atlanta, Georgia, USA. Others were Dr Maurice Apprey from the University of Virginia, USA. Dr Ruth Finney Hayward from UNICEF/New York, Dr Ntombodidi Muzzen-Sherra Tshotsho from the Department of Health, South Africa, Dr Peter Grabosky from the Australian Institute of Criminology, and Dr Kalinga Tudor Silva from the University of Peradeniya, Sri Lanka.

Annex 3

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