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Prevention of Child Abuse and Neglect  
Making the links between human rights and public health

## **PREVENTION OF CHILD ABUSE AND NEGLECT**

### **Making the links between human rights and public health**

Child abuse and neglect are problems of epidemic proportions. Despite many barriers to reliably estimating the amount of child abuse and neglect, there is no doubt as to the significance of the resulting social damage. It is estimated that up to 40 million children could be the victims of child abuse every year around the world (WHO, 1999, p.17). In fact, child abuse and neglect are doubly damaging, inflicting a first wave of destruction at the time of abuse, and a second wave years later in the form of increased risk among previously abused adolescents and young adults for becoming perpetrators and victims of both interpersonal and self-directed violence.

Child abuse and neglect are therefore significant problems in their own right, and manifestations of an even larger challenge: violence itself. It is this recognition that underlies the public health approach to the prevention of violence, which the World Health Organization (WHO) as one among other public health agencies is committed to implementing at global, national and local level. This paper will provide an overview of the global profile of violence, and within it, the problem of violence against children. It will present the public health approach to violence prevention, highlighting its application in the area of child abuse and neglect. The paper will also discuss the added value of adopting a health and human rights perspective, describe WHO activities in the prevention of interpersonal violence, and suggest areas for future action in the prevention of violence and the promotion of human rights.

### **Defining and Classifying Violence**

WHO defines violence as:

The intentional use of physical force or power, threatened or actual, against another person or against oneself or a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (WHO, 1995).

The relevance of this definition to implementing the United Nations Convention of the Rights of the Child (CRC) is discussed in more detail below. At this point, however, it is important to reflect on a number of salient points within the definition. Firstly, inclusion of the term 'power' broadens the nature of violent acts beyond the direct use of physical force to include those that result from a power relationship, such as threats and intimidation, and wilful acts of deprivation, neglect, or other acts of omission. Secondly, the definition is not restricted to the individual as the target of violence. Thirdly, the outcomes include physical injury and developmental harms in the areas of psychological, emotional and social functioning.

This overall definition of violence is complemented by a typology of violence developed for the *World Report on Violence and Health* (due for publication in 2002, see below).

The typology classifies violence into three broad categories: 1) Self-directed violence, (2) Interpersonal violence; (3) Collective violence. Interpersonal violence, which is the focus of WHO violence prevention efforts, includes:

- a) Family and partner violence occurring between family members and intimates;
- b) Violence between acquaintances and strangers that is not intended to further the aims of any formally defined group or cause.

Family and partner violence includes child abuse, intimate partner violence, and elder abuse. Acquaintance and stranger violence includes stranger rape or sexual assault, youth violence, violence occurring during property crimes, and violence in institutional settings such as schools, workplaces, and nursing homes.

### **Fatal and Non-Fatal Outcomes of Violence**

According to global burden of disease projections, approximately 2.3 million people died in 1998 as a result of violence, which is equivalent to four percent of all deaths. Of these deaths, 42% were due to suicide, 32% resulted from homicides, and 26% were due to war. Among persons aged 15 to 44 years, homicides, suicide and war-related fatalities all ranked among the top ten causes of death worldwide (Krug, 1999).

These manners of death show marked socio-economic variations. Suicides are most frequent in the wealthier countries, and homicides predominate in the poorer countries (Krug, Powell & Dahlberg, 1998). There are also clear gender- and age-related patterns. Up to four years of age, the proportion of male and female victims of homicide is roughly equal. From five years onward, male victims begin to outnumber female victims, and between the ages of 15 and 34 males outnumber female homicide victims by around 10 to one. While older perpetrators kill most infants and young children, from age 10 onwards the victims and perpetrators of homicide tend to be of equivalent age groups.

Indications are that the incidence and severity of preventable violence are increasing. According to global burden of disease projections comparing the years 1990 and 2020, interpersonal violence will rise from 19 to 12 in the top 30 contributors to the global disease burden; self-inflicted injuries from 17 to 14, and war-related injuries from 16 to 8 (Murray & Lopez, 1996).

Deaths, of course, represent only the tip of the violence iceberg. For each fatality there are multiple victims that sustain non-fatal physical and psychosocial damage. The severity of these non-fatal consequences varies widely between physical injuries resulting in emergency medical care, and insidious psychological effects. This creates enormous challenges for the identification and counting of non-fatal violent incidents. These challenges are especially great in the case of family and partner violence since they are closely tied to cultural norms around gender- and age-specific power relationships. Consequently, the best available figures on the magnitude of child abuse and neglect are likely to suffer from a high level of under-reporting.

Globally, an estimated 40 million children are subjected to child abuse each year (WHO, 1999, p.17). Cross-country comparisons are problematic because different studies have used different definitions of child abuse and neglect, different methodologies and different time frames. For instance, surveys suggest that between 3% and 29% of all male

children are have been sexually abused, and from 7% to 36% of all female children (Finkelhor, 1994). An estimated one out of every three women in the world is subject to some form of domestic violence.

Violence has great consequences on child health and development, including varying levels of physical disability; mental health and behavioural sequelae; functional impairments; transmission of fatal sexually transmitted diseases, such as HIV/AIDS, and other damages to reproductive health. In this sense, violence has an impact on the child's enjoyment of all other human rights, and in particular the right to development of the child, including physical, psychological and social development in a manner compatible with human dignity. Almost all of these consequences bear upon the health care sector, and so in addition to its human costs violence exerts a crippling economic burden on health systems.

### **The Added Value of Public Health**

Public health and criminal justice share a common goal: the prevention of violence. Where criminal justice works to reduce violence by incapacitating perpetrators and deterring would-be perpetrators, public health operates to remove the root causes of violence and minimise the harm where violence does occur. For public health these aims are known as primary, secondary and tertiary prevention. Primary prevention refers to approaches implemented on a universal scale, that aim to prevent the onset of violence and related risk factors. Secondary prevention refers to approaches implemented on a selected scale, for people at enhanced risk of violence, and are aimed at preventing the onset and reducing the risk of violence. Tertiary prevention refers to strategies implemented on an indicated scale, once the problem is already clearly evident and causing harm; e.g. for individuals or groups that have already demonstrated violent behaviour and/or been victimized by perpetrators of violence.

At the core of public health is its use of scientific methods to answer three key questions about violence and violence prevention (Mercy et al, 1993). These questions are: what is the size and shape of the violence problem; what are its causes; and what works to reduce it? The scientific methods that public health uses to answer these questions are, respectively, surveillance, research and evaluation.

#### *Surveillance*

Surveillance attempts to identify the dimensions of the violence problem by showing who is most affected in terms of age, sex and other demographic markers; what times of the day, week and year are most dangerous; where incidents are most common; what factors may go together with violence (e.g. alcohol abuse), the types of weapons involved, and so on. In this sense, it can help to calculate how children are affected by violence in comparison to other age groups, which types of violence affects them at what age, and who are the primary perpetrators of violence against children. For public health, surveillance is accomplished by attempting to measure these dimensions at places where victims of violence are most likely to be encountered, which, at least for violence leading to physical injuries, are not police stations but rather health facilities. For instance, 50% to 75% of violence victims seen in UK hospital emergency rooms did not report to the police (Shepherd, Shapland & Scully, 1989); in the US 46% of victims seen in hospital were not reported to the police (Houry et al, 1999), and in South Africa 50% to 80% of

victims registered in a household survey received medical treatment only (Kruger et al, 1998). This information helps to target the groups most at risk for violence and most in need of primary prevention, and assists in locating secondary prevention resources where they are most required. A surveillance system may, for example, show that a significant proportion of victims of violence in a selected site are children and adolescents, and that cases of child abuse arise more frequently among children aged 0-5, while cases of interpersonal community violence involve adolescents aged 15-19.

### *Research*

Research attempts to answer questions about the underlying causes of violence by using scientific methods such as the comparison of individuals where certain types of violence have occurred with individuals where they have not occurred. Such research, has, for instance, identified child abuse and neglect as occurring more often in the early history of perpetrators of violence than in control groups of individuals who do not perpetrate violence (e.g. Widom, 1989). This knowledge provides the focus needed for effective primary prevention.

### *Evaluation*

Evaluation attempts to answer questions about what works in respect of prevention strategies. It attempts to do so using methods that compare individuals and groups who have been exposed to some intervention or treatment with those who have not. For example, efforts to evaluate what works in the prevention of child abuse have compared the frequency of abuse in families that have received periodic visits and training in parenting skills from nurses or social workers against the frequency of abuse in families that do not receive such visits and training. A number of studies show that there is a lower frequency of abuse in families that receive this preventive treatment (e.g. Olds et al, 1998; Farrington & Walsh, 1999), suggesting that home visitation and parent training may be an effective child abuse prevention strategy in some settings. This knowledge provides the tools needed to do prevention, and helps to ensure that resources are used on programmes that are certain to work rather than on interventions that may look good but in fact are of little preventive value.

Further arguments for the public health focus on reducing violence by dealing with the root causes is supplied by evidence for the dramatic differences between societies in the amounts of certain kinds of violence. Homicide rates, for example, vary from 0.6 per 100,000 of the population in Japan, through seven per 100,000 in the US and 25 per 100,000 in Estonia (WHO, unpublished data). As a second example, firearm death rates of 0.13 per 100,000 in high- and upper-middle income Asian countries compare to 12 per 100,000 in high- and upper-middle income countries of the Americas (Krug, Powell & Dahlberg, 1998).

The multidisciplinary commitment of public health arises from the recognition that because the risk factors for violence are spread across many different parts of society, prevention will involve drawing together the contributions of the multiple disciplines responsible for each sector. For example, while home visitation to families at high risk for child abuse can reduce the immediate risk of abuse in those families, the additional risks of economic inequality and unemployment indicate that sustainable, population-wide prevention gains would necessitate the addition of wider-scale interventions from local authorities responsible for social welfare and job creation.

## **The Ecological Model of Violence and Violence Prevention**

The public health understanding of what causes violence and how it can be prevented is summarised in the ecological model. The ecological model builds on the assumption that the causes of violence are complex and involve the interaction of factors at many levels of the social system, ranging from the individual through to national and international forces. The model discerns four causal levels, each of which is embedded in the next: 1) Individual; 2) Family; 3) Community; 4) Structural.

The individual level seeks to identify biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. In the case of child abuse, a history of having been abused as a child, being a single parent, and having an early unwanted pregnancy, may increase the probability of perpetrating abusive acts. The family level encompasses the close relationships (e.g. to peers, parents, partners and other relatives) that can impact upon individuals to increase or reduce their likelihood of violence. Family violence, parental divorce or separation, and substance abuse in the family are associated with child abuse. The community level focuses on the contexts in which immediate social relationships are embedded, such as the neighbourhood, workplace, school and municipality. Factors at this level that may contribute to child abuse include low socio-economic status, high population density, and social isolation. The structural level of the ecological model refers to factors that contribute to violence or reduce its likelihood through their influence on the general climate of social life. Included here are factors such as the strength and characteristics of the State, inequalities of all kinds, policies and practices in respect of employment, education and welfare, and demographic factors such as the teenage pregnancy rate and proportion of youth and young adults in the population.

Identifying factors that increase or reduce the risk for violent victimization and perpetration at each level of the ecological model is an important first step to preventing violence. Once these factors are identified, prevention specialists can then begin to develop prevention programmes aimed at reducing the risk for violence. Each level of the ecological model represents a level of risk and a key point for intervention, and experience has shown that interventions, which target several levels at the same time, are more effective than single-level interventions.

## **The Added Value of Health and Human Rights**

A question often asked in the health field is: what is the added value of a human rights approach to public health? The health field is already supported by ethical standards such as the Hippocratic Oath, so what can we get from a human rights perspective that we do not have already?

Ethical medical standards, such as those established under the Hippocratic oath, provide a restricted framework that applies to a set of medical practitioners but may not be used by public health practitioners or support staff involved in health promotion and provision of care, nor is it recognised by those partners working with health, such as social workers or educators, or those involved in shaping the national priorities that may affect health, such as the policymakers and representatives of the judiciary.

A human rights approach can reinforce and build commitment towards the type of multidisciplinary public health action that is necessary to prevent violence. The human rights perspective is based upon an established set of internationally recognised and enforceable legal standards. Most of these standards have become part of general international law and as such apply to every state irrespective of their more specific commitments within the frame of specific conventions. The framework includes the interests of many different partners promoting health and safety, including health support staff, social workers, educators, and policymakers, and in this way it also helps gather allies from different sectors around a common goal. Moreover, unlike ethical guidelines, which imply an individual ethical commitment, human rights law establishes a range of social responsibilities for actors: values are recognised as collective, and the promotion and protection of these values are also collective. It sets obligations for governments to endeavour to, and in certain cases, carry out certain actions. The CRC, the most widely ratified international human rights treaty, sets obligations for child protection, prevention of violence, as well as the right to health. These responsibilities include the child, her family, community, community leaders as well as national and international entities. The States Parties to the treaties have the responsibility, in conjunction with the treaty body, UN agencies and other treaty bodies, to determine the specific actions to address particular concerns. International law, emphasising the interdependence of rights, reinforces the need to approach complex problems from many directions and open up a range of possibilities for responding. In this way, the international legal framework can serve as an overarching structure to support the ecological approach to violence prevention.

### **Activities for the Prevention of Violence against Children**

Just as international human rights law can provide comprehensive legal mechanisms to child health and safety, public health can serve to operationalize State legal commitments to protect children's rights to life and development, and to protection from violence. WHO's Violence Prevention Team aims to build bridges between human rights approaches to child safety and child safety itself by assisting in the development and dissemination of practical tools that can be used by policy makers and practitioners to deliver the best possible preventive interventions to the groups and individuals that most need them.

Among many CRC articles in which the prevention of violence against children is mentioned, Article 19(1) is useful in suggesting the fit between WHO's violence prevention activities and the CRC vision:

State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical and mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse ...

Where the CRC defines the aim of prevention, WHO has helped to define the objects of prevention (i.e. violence and neglect) and methods of prevention.

In March 1999 WHO convened a consultation of experts from around the world, at which a general definition of child abuse and neglect was agreed upon, available information about the size of the problem and risk factors was summarised, prevention strategies reviewed, and a set of recommendations for future work drawn up (WHO, 1999).

The consultation agreed that the recommendations should be implemented within a framework of guidelines that would provide policy supports and technical standards for the strengthening of country and local-level capacity to prevent child abuse and neglect. A working group was formed to develop these guidelines, and in December 2000 WHO entered into an agreement with the International Society for the Prevention of Child Abuse and Neglect to develop the guidelines. The tool will provide guidance to multiple sectors, such as health, social welfare, justice and education, and it has adopted human rights principles common across treaties as the guiding principles for response. Once developed, the guidelines will be pilot tested in countries around the world, published and disseminated as a joint WHO publication, and implemented at country level.

WHO's Violence Prevention Team is also developing guidelines for health sector responses to child and adult victims of sexual violence. These guidelines are necessitated by the highly specific issues connected to the obtaining of forensic evidence in cases of sexual violence and the special concerns around HIV/AIDS and other sexually transmitted diseases that must be addressed in the medical care of victims of sexual violence. The guidelines will: 1) review existing models for integrated medico-legal and health services within a multisectoral service framework; 2) Identify a necessary package of medico-legal and accompanying health services for persons who experienced sexual violence, and 3) Identify appropriate models for medico-legal and health assistance to victims of sexual violence in resource-rich and resource-poor environments.

### **Global Framework for Violence Prevention**

Guidelines for specific areas of violence prevention (e.g. child abuse and neglect; sexual violence) are one way of increasing the likelihood that policy makers and practitioners in the area of concern will alter course in the desired direction, and are necessary if more standardised responses are to be established across different regions. Alone, however, guidelines are probably insufficient to create the political will for action and the consensus across different social sectors required to secure investment in their implementation and ensure ongoing support. Accordingly, WHO is spearheading a more encompassing violence prevention drive in the form of a global framework for violence prevention.

The global framework for violence prevention aims to provide a structure that will enhance the synchronisation and increase the intensity of prevention activities across all levels and sectors in all regions and countries of the world. It will do this by providing for the strengthening of national action and promoting an international violence prevention response that mobilises the strongest possible collaborative, multilateral action.

At international level, the global framework for violence prevention will prioritise the promotion of violence prevention through existing international legal instruments, such as the CRC. This activity implies an analysis of international legal mechanisms and their relevance to the area of public health and protection from violence, and the development

of a coherent strategy to harness the potential of international law to promote international and national commitment to action. International-level activities also include the conduct of international comparative research into risk factors and best practices for prevention, and improved co-operation between United Nations agencies.

At national level, the global framework for violence prevention will support the initiation, expansion, evaluation and continuation of prevention activities through the provision of scientific guidelines, technical information and advocacy documents, and technical collaboration agreements between countries.

The global framework for violence prevention is as much a process as it is a product, and will be significantly advanced by the release in 2002 of the *World Report on Violence and Health*.

### **World Report on Violence and Health**

The *World Report on Violence and Health* was commissioned in 1999, and involves over 100 experts in the prevention of all types of violence from around the world. In 2002 the *World Report on Violence and Health* will be launched around the time of the World Health Assembly. The Report aims to raise awareness about violence as a global public health problem, highlight the contributions of public health to understanding and responding to violence, and increase the level of response taken by the public health community to preventing violence.

The specific objectives are to: 1) describe the magnitude and impact of violence cross-nationally, 2) elucidate cross-national patterns of violence to provide a baseline for measuring change and progress, 3) summarize existing information on risk and protective factors and prevention and policy responses, 4) provide directions for future research, and 5) make recommendations for future action in public health.

The Report includes an introduction and chapters on Child Abuse and Neglect, Youth Violence, Violence Against Women by Intimate Partners, Sexual Violence, Elderly Abuse, Self-directed Violence and Collective Violence. The final chapter of the Report summarizes the important lessons learned from the research, highlights current gaps in knowledge and practice, and describes actions necessary to reduce and prevent violence. In addition to the topic-specific chapters, the Report includes a statistical annex with country and regional data derived from the WHO Mortality and Morbidity Database and an annex with a listing of websites, violence prevention agencies and other useful resources.

Two complementary versions of the *World Report on Violence and Health* will be released in 2002: the main technical background report for public health researchers and practitioners, and a concise advocacy-oriented report for policy and other decision-makers. WHO headquarters and regional and country offices will plan a series of events related to the release of these publications. The Reports, which will be widely distributed, will ultimately facilitate the work of the numerous public health practitioners, activists, volunteers, and community members who work tirelessly to reduce violence, enhance security and improve quality of life for all.

## **Regional activities to promote child rights and prevent violence**

WHO regional offices are gradually incorporating the child rights framework into their work in violence prevention. The WHO Regional Office for Europe (EURO) represents a case where a child rights approach has been significantly incorporated into regional action. EURO has promoted accountability of States Parties to the CRC by sending ten country reports to the Committee on the Rights of the Child, focusing on the status of child and adolescent health and development, including child abuse and neglect, at the country level. Further, the Office has compiled a set of legal texts concerning child abuse and neglect and child protection, to provide the Committee with information concerning national legislation at the time of the States Parties reporting process.

EURO has conducted research on violence in order to raise awareness among policymakers about the problem and advocate for a national response. National surveys on gender-based violence and on the prevalence of child abuse and neglect have been carried out in selected countries. The results were disseminated to policymakers as an aide for the design of appropriate policies.

Countries have also been provided with the tools they need to respond to their commitments to prevent child abuse and promote health and development. EURO is in the process, for example, of developing training materials and guidelines to strengthen the health sector capacity to address issues of child abuse and neglect and domestic violence. The region is also developing a model for the integration of child protection screening and intervention into a wider system of good peri-natal/maternal care and integrated management of childhood illness.

## **Potential areas for future action**

Further collaboration between the Committee on the Rights of the Child and WHO can serve to strengthen the current approach to violence prevention. The CRC provides a strong legal framework to promote national commitment to the study and prevention of violence. The potential of the treaty can be maximized by analysing the extent of its application at the country level. WHO, as a technical agency, can conduct a study on the magnitude of violence against children in different countries, the existing responses to the problem, and the use of the CRC at country level to promote investment in violence prevention. The Committee on the Rights of the Child can use the results of the study to further inform their work in the promotion of child rights. Further, WHO can support the Committee in the operationalization of the treaty stipulations that relate to violence: the Committee can develop recommendations for countries to invest in violence prevention programmes and in protection policies to address the violence-related aims of the CRC, and can ask countries to report on the implementation of such recommendations. At the same time, WHO can provide the technical support necessary for their implementation at the local level. WHO would also welcome and strongly assist in the preparation of a general comment on the protection of children from violence, as stipulated in Article 19 of the CRC. A general comment represents a key way to expand on the protection potential of the treaty with regard to the problem of violence against children.

## **Conclusion: A Contextual Approach to Preventing Violence Against Children**

This paper has emphasised a public health approach to prevention that places specific types of violence (such as child abuse and neglect) within the context of other types of violence and other forms of prevention. This has the advantage of retaining the impetus for prevention brought to the problem by sector-specific interest groups (such as child safety advocates) while at the same time bridging each particular type of violence to some of the more general causes (e.g. alcohol and substance abuse; inequalities) and shared prevention strategies (e.g. surveillance, early developmental interventions) that cut across different types of violence.

WHO believes that this contextual approach to the prevention of child abuse and neglect is the most promising approach to bridging the needs for and rights to safety of millions of children around the world with violence prevention opportunities scattered widely throughout the social and political fabric. Child abuse and neglect are social pathologies in their own right, and also symptoms of a broader social malaise that changes across space and time.

Twenty years ago what kids worried about was getting bad grades. But now, kids are worried about getting killed ... I'm scared too and I don't want to die. I have a whole life to go and make my own goals and be what I want to be ... (Miguel M, 12 years old).

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