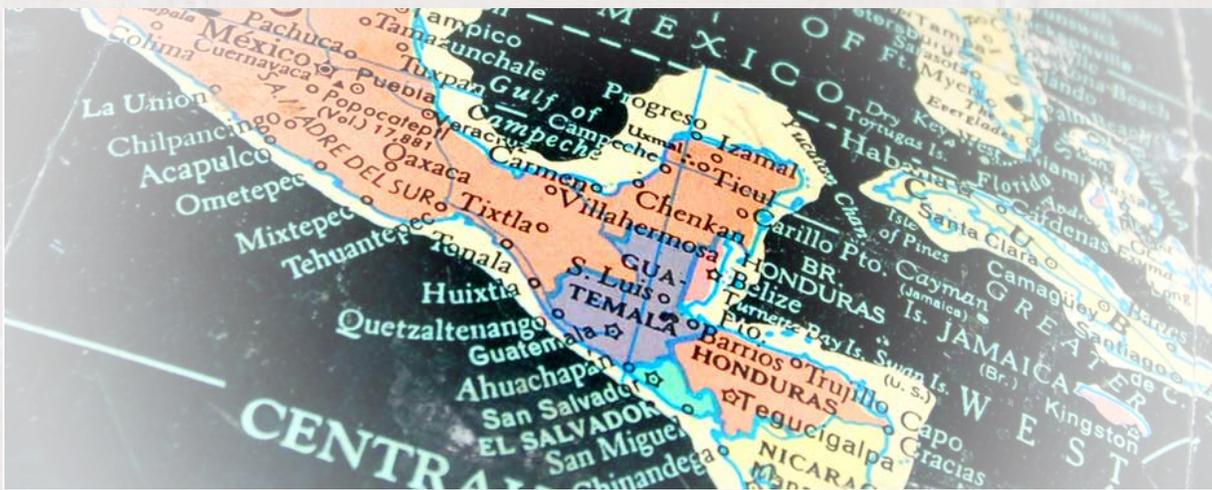


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REPORT ON THE CURE VIOLENCE MODEL ADAPTATION IN SAN PEDRO SULA, HONDURAS



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Abstract: San Pedro Sula, Honduras has had the highest levels of killing of any city around the world for several years. Violence in San Pedro is multi-faceted and has become normalized by those forced to live with it. The Cure Violence model to stopping violence is an epidemic control model that reduces violence by changing norms and behaviors and has been proven effective in the community setting. In 2012, Cure Violence conducted an extensive assessment of the violence in several potential program zones in San Pedro Sula and in April 2013 began implementing an adapted version of the model. In 2014, the first three zones implementing the model experienced a 73% reduction in shootings and killings compared to the same 9-month period in 2013. In the first 5 months of 2015, five program zones experienced an 88% reduction in shootings and killing, including one site that went 17 months without any shootings.

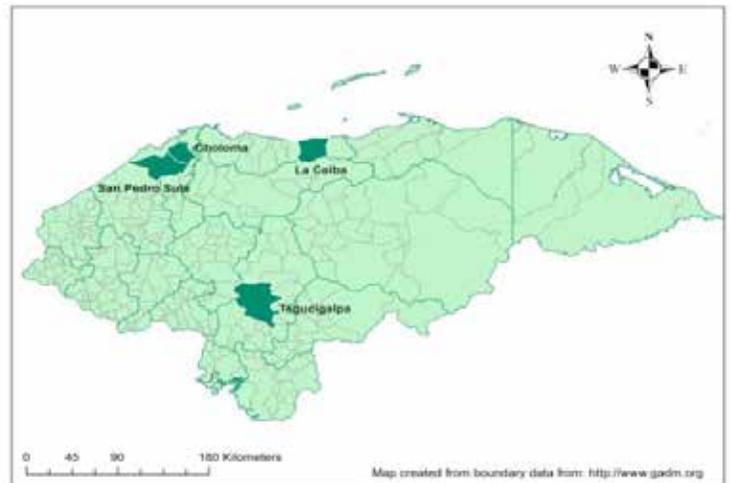
Violence in Honduras

The Americas are the most violent region in the world with an average homicide rate of 28.5 per 100,000 and an estimated 165,617 killing in 2012.¹ In total, the Americas account for roughly 36% of global homicides.² Within this most violent region, violence is most severe in the Northern Triangle of Latin America, an area that includes El Salvador, Guatemala and Honduras. The homicide rate in this region is more than ten times the global average.³ In a 2012 ranking of countries by homicide rate, Honduras ranked first (rate of 91), El Salvador ranked 4th (rate of 41) and Guatemala ranked 6th (rate of 35).⁴

Violence has been high in this region for many decades and is due to political conflicts throughout the region and full-scale civil wars in El Salvador (1980-1992), Guatemala (1960-1996), and Nicaragua (1972-1991). These conflicts affected the entire region with neighboring countries used as places for arms shipments, bases for guerrillas, sites for launching military action and destinations for those displaced by the conflict. This political violence peaked in the 1980s and officially ended with the signing of peace treaties in the 1990s; yet actual peace has been elusive.⁵ The history and social culture of violence plays a large and continuing role in the violence in this region today.

Honduras, a middle-income country with a population of just under 8 million,⁶ has ranked as the most violent country in the world since 2008.⁷ In Honduras, the causes of violence vary and include cartel level drug-related violence, higher level extortion violence, community conflicts between gangs, paid assassinations and interpersonal conflicts.

Over the last 15 years, lethal violence has significantly increased - some have attributed this increase to changes in drug trafficking patterns.⁸ The amount of drugs arriving in Honduras from Venezuela have substantially increased since 2007, the earliest data are available. It is estimated that 88% of the cocaine trafficked to the United States comes through the Central America/Mexico corridor, a switch from the 1970s and 1980s when the Caribbean was used for trafficking.⁹ About 70% of the drugs come into Honduras by sea, transported by fishing vessels (Pacific coast) and fast-boats (Caribbean coast) and



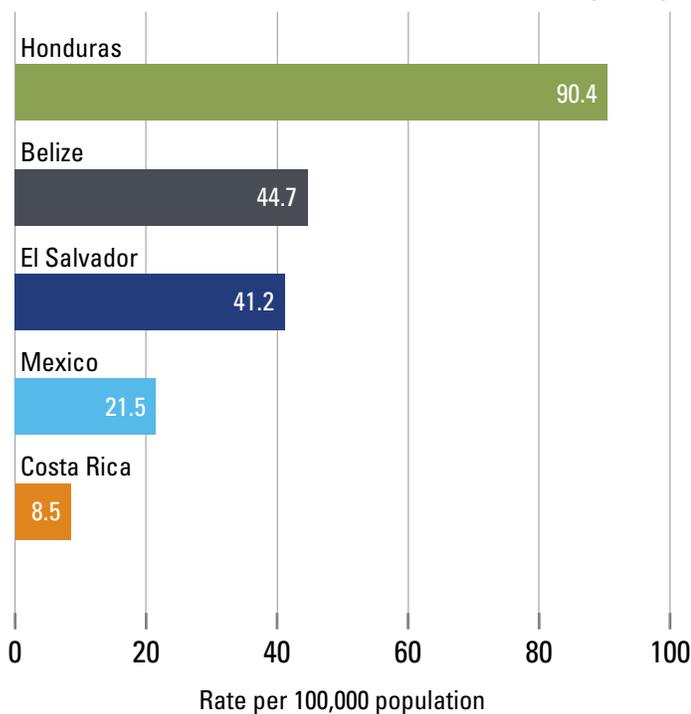
Map of Honduras

are moved to the Guatemalan and El Salvadorian borders and ultimately through Mexico to the United States. The flow of drugs along the coast has resulted in conflict among Honduran gangs trying to gain a share of the lucrative businesses involved in transporting and storing the drugs.

Gang activity is also considered a major factor in the high-violence levels in Honduras. It is clear violence has resulted from gangs' involvement in the drug trade, extortion and other criminal activities, and has a dominating influence on the overall violent culture in many communities. However, the UNODC estimates that only about 30% of all homicides in Latin American are linked to gangs or organized crime, with other estimates as low as 7%.¹⁰ While still a major concern, the problem of violence in Honduras is much more complex than gang violence and approaches to stopping violence must be able to address violence across its many motivating factors. As some have pointed out, all forms of violence in Latin America, and globally, are interconnected – organized crime, community, family and others.¹¹

Furthermore, preventive approaches to violence must consider unintended consequences. The efforts to crack down on gangs in Latin America to date have led to mass incarceration and further development and strengthening of the gangs.¹²

National Homicide Rates in Latin America (2012)¹³



Violence in San Pedro Sula

The two largest urban areas in Honduras are the Central District and San Pedro Sula. Central District, which includes the Honduran capital Tegucigalpa, has just over 1.1 million residents and has been ranked in the top 10 most dangerous cities recently (6th in 2015) due to its high homicide rate (73.5 in 2015).¹⁴

San Pedro Sula, the second largest city in Honduras at just under 800,000 residents,¹⁵ has frequently been ranked at the top of the list of most violent cities. San Pedro Sula held this top spot from 2011 to 2014, with a peak homicide rate in 2014 of 187 people killed per 100,000.¹⁶ In 2015, San Pedro Sula improved slightly to 2nd place with a rate of 111 people killed per 100,000.¹⁷

The victims of homicide in San Pedro Sula are mostly male (93%), largely involve firearms (84%)¹⁸ with nearly all crimes of violence going unsolved by police (97%).¹⁹ Also, in Honduras, while the number of victims in the 15-29 male age group is greater than other age groups, the rate of homicide is highest for males aged 30-44.²⁰ This suggests that violence involves an older population than is typically seen in other countries.

Violence is an everyday fact of life for people who live in San Pedro Sula, which has led to a social/cultural normalization of violence.²¹ This is true not only among the adults in the community, but is visibly true as well with very young children who are continually exposed to violence through personal victimization, death and injury to loved ones, witnessing events and seeing the traumatic scenes after the fact. One crime scene reporter observed, "At almost every crime scene there are children watching."²²

Traditional efforts to reduce violence in San Pedro Sula have not been able to reverse the trend thus far. The rates of violence have been at a crisis level for a prolonged period of time and new approaches are needed to bring this epidemic of violence under control.

Cure Violence Model for Reversing the Epidemic of Violence

The Cure Violence model²³ draws on key components of disease control methodology that are applied to violence prevention. It recognizes and addresses the contagious nature of violence²⁴ by adapting the World Health Organization's model for successfully addressing other epidemics.²⁵ The Cure Violence Model has three main components:



1. Detect and interrupt the transmission of violence by anticipating where violence may occur and intervening before it erupts.



2. Change the behavior of the highest potential transmitters by identifying those at highest risk for violence and working to change their behavior.



3. Change community norms by influencing social norms to discourage the use of violence.

Cure Violence's approach to violence prevention focuses directly on those persons or groups who are at the highest risk for initiating violence or being a victim of it and intervenes in conflicts likely to result in violence. Cure Violence's participants are usually beyond the reach of conventional social services. A central characteristic of the Cure Violence model is the use of credible messengers as workers – individuals from affected communities who are trusted and have access to the people who are most at risk of perpetrating violence. This access and trust enables workers to talk about violent behavior credibly and persuade high-risk individuals to change. Intensive and very specific training is required, but hiring the right workers is essential to get the access, trust and credibility required for the job – as for all health workers attempting to access hard to reach populations of any type.²⁶

This model also introduces two new types of health worker. First, Violence Interrupters (VIs) are specially trained community health workers that specialize in detecting and interrupting conflicts in the community. Some VIs specialize in responding to conflicts in the community, while others specialize in responding to shootings at hospitals to prevent retaliation. The second type of new health worker, a violence prevention Outreach Worker, is similar to conventional social service outreach workers, but are specially trained to work with persons who are involved in and traumatized by violence.

The Cure Violence approach is being implemented in more than 60 communities across more than eight countries and has been independently evaluated multiple times, with each evaluation showing large, statistically significant reductions in gun violence. Studies by *Northwestern University* and *Johns Hopkins University* showed 41 to 73 percent reductions in shootings in neighborhoods in Chicago²⁷ and as much as a 56 percent decrease in killings in Baltimore,²⁸ while an evaluation by the *Center for Court Innovations* showed that the area in New York City in which the program operated went one year without a killing and had 20 percent fewer shootings compared to the trend in the neighboring communities.²⁹ An evaluation of the program from 2012-2013 in Chicago found a 31% reduction in killings in the two target districts.³⁰

Other international adaptations of the Cure Violence model have also demonstrated large reductions although external, independent evaluations are needed to determine causality. In Cape Town, South Africa, after the first year of implementation in a community, the community had a 23% lower homicide rate and 33% lower attempted homicide rate.³¹ In Loiza, Puerto Rico, a 50% reduction in killings was associated with first year of implementation of the program.³² And in Ciudad Juarez, Mexico, after implementation of the Cure Violence model, the rate of killing dropped by 24.3%.³³

Adapting Cure Violence to San Pedro Sula

In the summer and fall of 2012 a Cure Violence team traveled to Honduras multiple times to determine the feasibility of adapting the Cure Violence model to the cultural context of San Pedro Sula. The goal of the assessment was to gain an understanding of the dynamics of the violence occurring in Honduras and determine if local capacities existed to implement the model. The Cure Violence team held a one-day workshop about the Cure Violence model with key stakeholders and over the course of several days met with a range group of individuals, community based groups, faith leaders, government ministries, youth alliances, violence prevention coalitions and law enforcement officials.

As a result of the assessment visits, the Cure Violence team determined that local capacity existed to implement the model to address violence from extortion/war tax, conflicts between gangs and crews over territory (for war tax and drug trade), paid assassinations, soccer *barra* conflicts and violence resulting from interpersonal conflicts. Some of the higher level “*para-militares*” and cartel violence would remain outside of the reach of the Cure Violence program adaptation.

In order for the Cure Violence model to be adapted to San Pedro Sula, the basic framework of the model – the major components of the model, job descriptions, and methodologies – would remain close to those used in other parts of the world. However, because the program was unknown in the community and involved a new approach to violence, the Cure Violence program staff selected a phased implementation of the program. This phased

approach was thought to be essential to ensure the safety and credibility of the workers. Cure Violence local program partners had to develop deep relationships and understandings with the “highest risk” groups to lay the ground work to be able to mediate conflicts and change norms around violence. The phased implementation also allowed for the recruiting of workers over time, which allowed the program to overcome initial problems in making contact with credible messengers.³⁴

This phased approach was also critical in addressing the fear of reprisals from individuals and groups involved in the violence. During the assessment phase, many stories were communicated about people who were killed for speaking out against violence. The strategy to address this was to ensure that the framing was as anti-violence -- not anti-gang, anti-drug or even anti-extortion -- in order to not incite or alienate the “highest risk” from the program.

Cure Violence program leaders also decided that the position of Outreach Worker would not be filled; instead, they focused all resources on the hiring of credible Violence Interrupters. Because of the lack of resources and services available in the target community, the case management elements

of the Cure Violence model performed by outreach workers could not be utilized. To accommodate this adaptation to the Cure Violence model, Violence Interrupters were trained to utilize tactics to change behavior and norms.

Implementation of Cure Violence in San Pedro Sula

Cure Violence program leaders utilized a three-phase approach to implementing the Cure Violence model in San Pedro Sula, believing a phased approach the only way to properly ensure the safety and credibility of the workers (see table below). The phases were based on the historical development of the Cure Violence model in Chicago and based on achieving specific milestones before moving on to the next phase of implementation

During the assessment visits, the two areas mentioned most frequently for piloting the Cure Violence model were Choloma and Chamelecon. The team was able to visit both of these areas and met with individuals and groups working on violence prevention. Ultimately, Chamelecon was chosen as the first area for implementation.³⁵

Phase One: Pre Implementation	Phase Two: Introductory	Phase Three: Full Implementation
<ul style="list-style-type: none"> • Select community partner • Orientation training on the Cure Violence model • Chicago training visit • Recruitment of initial workers • Hiring panels • 80-Hour training of new workers • Relationship building with highest risk • Recruitment of additional workers • Identification of areas to focus work • Mapping of hot spots and groups, leaders and other key individuals 	<ul style="list-style-type: none"> • Training additional workers • Deep relationships/inroads with high risk groups • Begin to mediate conflicts • Begin to build their caseloads and work to change the thinking of the “highest risk.” • Involve the “highest risk” by convening groups of leaders to discuss how best to proceed with the program. • Limited community mobilization focused on community-wide events to introduce the program • Development of public education materials and message strategies 	<ul style="list-style-type: none"> • Mediation of conflicts • Risk reduction with participants • Community mobilization • Public education messaging • Documentation of activities

Over many meetings and discussions with key stakeholders, the Cure Violence team identified a local faith-based group as the local community organization with the strongest capacity to implement the program. This organization has a mission in sync with the Cure Violence model, has strong ties to the community where the Cure Violence model would be implemented, had prior experience working with the target population and has the ability to hire and work with people who have criminal histories. The organization also has access to individuals who could serve as interrupters. These individuals had already been working with the “highest risk” individuals, grew up with them, and maintained good relationships with them, but were not themselves directly involved in gang activity.

In February 2013, the first workers were hired in Chamelecon and several members of the Honduran staff visited Chicago to learn about the program and examine its implementation in a Chicago community. The first 80-hour training of workers took place in March 2013 and included courses on: Cure Violence 101, changing behaviors and norms, detecting violent events, connecting with highest risk, conflict mediation, risk reduction, target area planning, management training and implementation planning.

During the Honduran staff training, a great deal of emphasis was placed on the mediation process since this would be the focus of the program. Due to the context of the violence in San Pedro Sula, it was decided that one-on-one mediations would be most productive, instead of meetings or group mediations, in order to protect the safety of the workers.

As part of the planning process, a considerable amount of time was spent discussing the ‘highest risk,’ developing the talking points to be used to change violent behaviors and on developing mediation techniques. Maps were developed to identify gangs/mobs/crews, hot spots, conflict groups, leaders and other key individuals in the area. These maps were used to generate the target area strategy. The initial criteria for being considered at high risk for involvement in violence were developed and included: being male, between the age of 14-44, membership in a gang, membership in a *barra*, involvement in the informal economy (sales of narcotics, extortion, kidnapping), history of violence, weapons carrier, low education level, recently

released from prison and recently deported from the United States.³⁶

In addition to the initial training, in 2014 the Cure Violence team provided three 24-hour in-person booster trainings, 4 distance trainings (via Skype), 2 one day planning workshops and has had weekly monitoring phone calls with the leadership of the implementing organization. In February 2015, senior members of the Cure Violence team again traveled to San Pedro Sula for training with the entire program staff on the third phase including community engagement and mobilization aspects of the program to make program events more strategic and connected to the work of changing community norms.

After the initial training, staff focused its time building relationships of trust and devising ways to approach ‘high risk’ individuals and groups in the area. The first task was to introduce the program. During this phase, the concept of resolving disputes through other means is introduced and mediations/violence disruption begins. Over time, Violence Interrupters begin to mediate deeper conflicts, build their caseloads and work to change the way of thinking of ‘high risk’ individuals or groups.

During this introductory phase, the local partner initiated limited community involvement focused on community-wide events to introduce the program, including public education materials and message strategies. Cure Violence worked with the implementing agency to develop targeted public education messaging strategies to promote individual behavior change and to transform the social norms that support the behavior. Drawing on social marketing techniques, which use private-sector marketing strategies for public health behavior change initiatives, Cure Violence engaged in a widespread “mass messaging” campaign saturating the neighborhoods with simple, straightforward communications to deter violence and reinforce positive community behavior and norm change delivered through multiple media channels.

The full implementation phase began once the Interrupters established solid relationships and trust with ‘high risk’ individuals and groups in the target areas. The Cure Violence model began implementation in San Pedro Sula in April of 2013 in three zones with six interrupters and two managers. The program

expanded to an additional two zones in January 2014 and added two additional zones in August 2014 for a total of seven zones and 10 total staff members.

Effect of Cure Violence in San Pedro Sula

Data on violence and crime in Honduras is notoriously difficult to obtain.³⁷ The data used in this report resulted from the Cure Violence program site, in conjunction with the Violence Observatory based at the *Instituto Universitario de Democracia, Paz y Seguridad* and covers the period from implementation through May 2015. No baseline data was initially gathered for any of the communities that chose to deploy the Cure Violence program. Because the Cure Violence model is associated with rapid and sustained reductions, this would typically make analysis of the results impossible. However, because of the phased implementation approach of the Honduras adaptation, the full program implementation was delayed, and the beginning months of the health intervention serve as an effective baseline.

Since programming began in Zones 1, 2 and 3 in April 2013, it's possible to compare the levels of reported shootings and killings from April to December 2013 and 2014 to determine if any changes resulted from the full implementation of the program. Program implementation began in Zones 4 and 5 in January 2014; therefore data on levels of reported shootings and killing from January to May 2014 can be compared to the same period in 2015. Zones 6 and 7 were not included in this analysis since the programs were implemented in August 2014, leaving only 8 months, an insufficient time period for analysis.

Cure Violence program sites each showed large reductions in shootings and killings in Zones 1, 2, and 3 from April to December 2014 compared to the same period in 2013. As shown in *Figure 1*, Zone 1 had an 89% drop in shootings and killings; Zone 2 had a 64% drop; and Zone 3 had a 74% drop. On average across all three zones, a 73% drop in shootings and killings in Cure Violence program sites in 2014 occurred as compared to 2013.

When looking at shootings and killing separately, several interesting findings emerge. First, the overall reduction in shootings is much greater – 88% across the three sites. While killings also decreased,

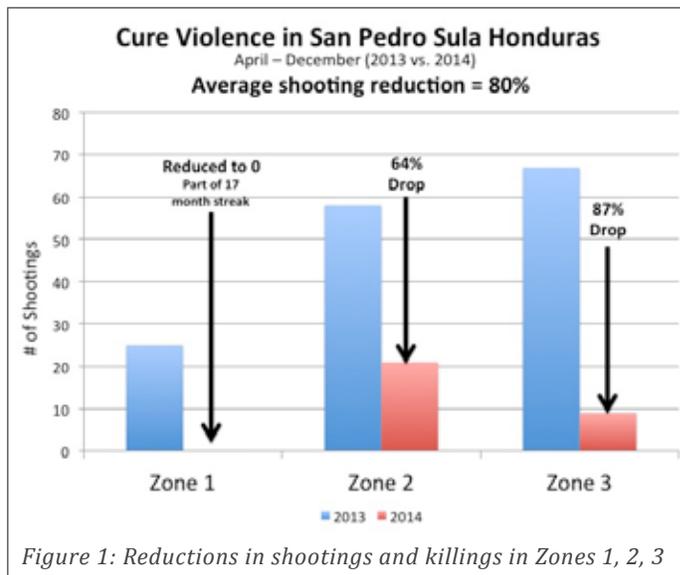


Figure 1: Reductions in shootings and killings in Zones 1, 2, 3

it was by a much more modest 14% and two of the three sites had no change in the level of homicides. Second, Zone 1 drops to no shootings during this period in 2014, starting an extended streak which will be the focus of further discussion in the next analysis.

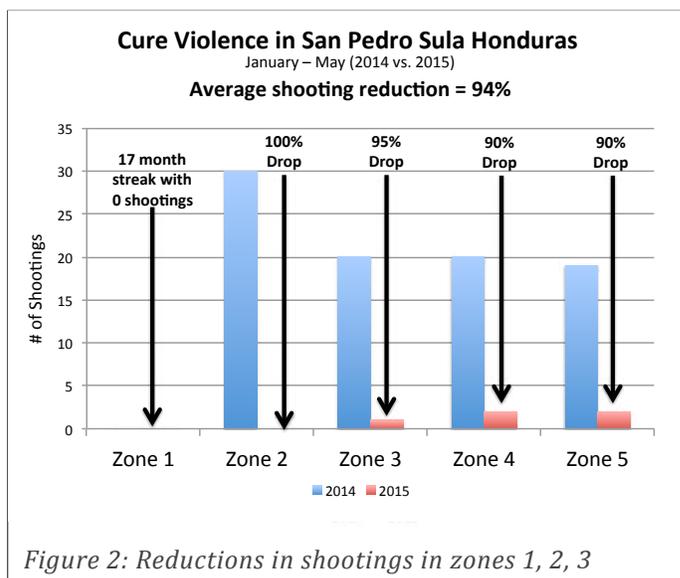


Figure 2: Reductions in shootings in zones 1, 2, 3

The second analysis focused on the levels of shootings and killings in Zones 1, 2, 3, 4, and 5 from January to May 2015 as compared with the same period in 2014. Once again, each of the Cure Violence sites showed large reductions in shootings and killings. As shown in *Figure 3*, Zone 1 showed

an increase of 100%, but this was moving from one killing to two killings. All other zones had very large decreases between 80% and 97%. On average across all five zones, an 88% drop in shootings and killings occurred in Cure Violence program sites in the first five months of 2015 as compared to 2014.

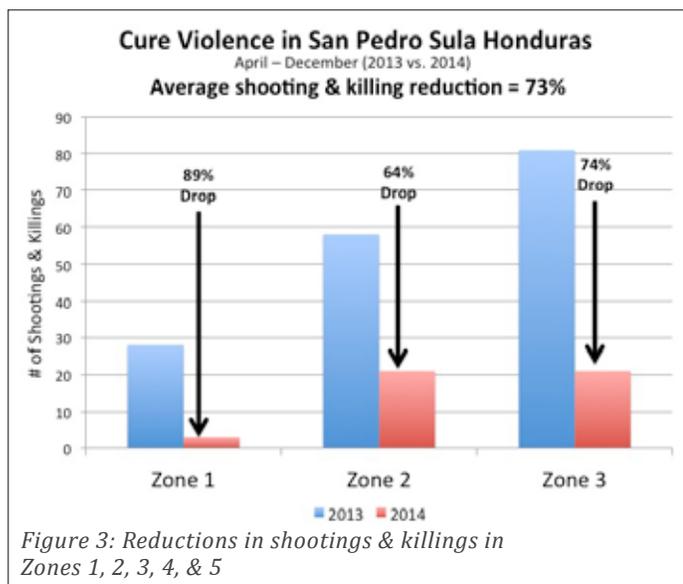


Figure 3: Reductions in shootings & killings in Zones 1, 2, 3, 4, & 5

As in the first analysis, separating the shootings from the killings again leads to similar findings. In 2014, the reduction in shootings was much greater, an average of 94% across five zones and ranged from 90% to 100%. Overall killings did decrease in the zones in 2015, but by a comparatively modest 22%, and this was primarily due to a large decrease in killings in Zone 3.

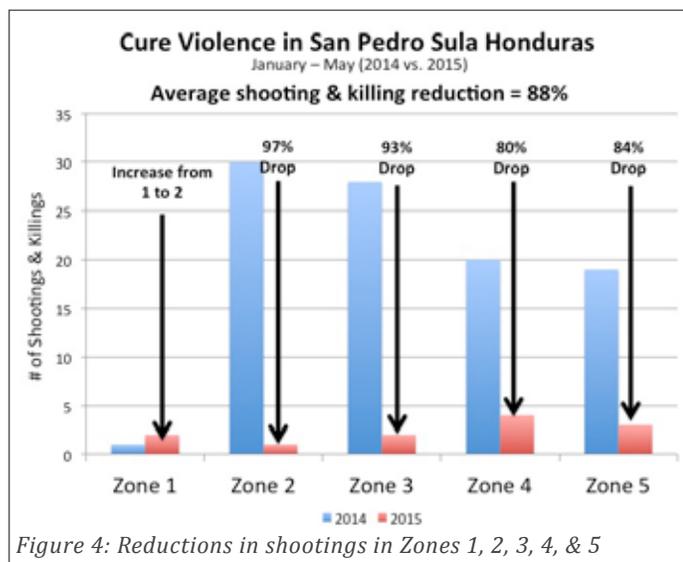
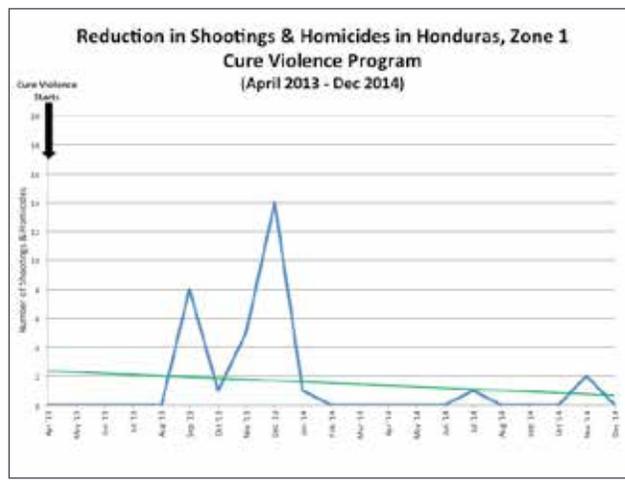
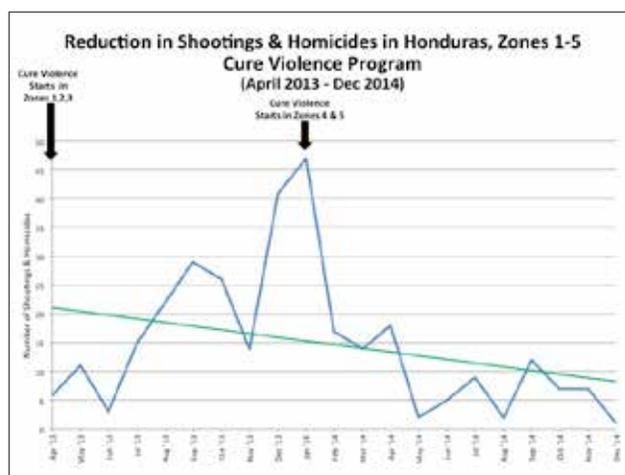


Figure 4: Reductions in shootings in Zones 1, 2, 3, 4, & 5

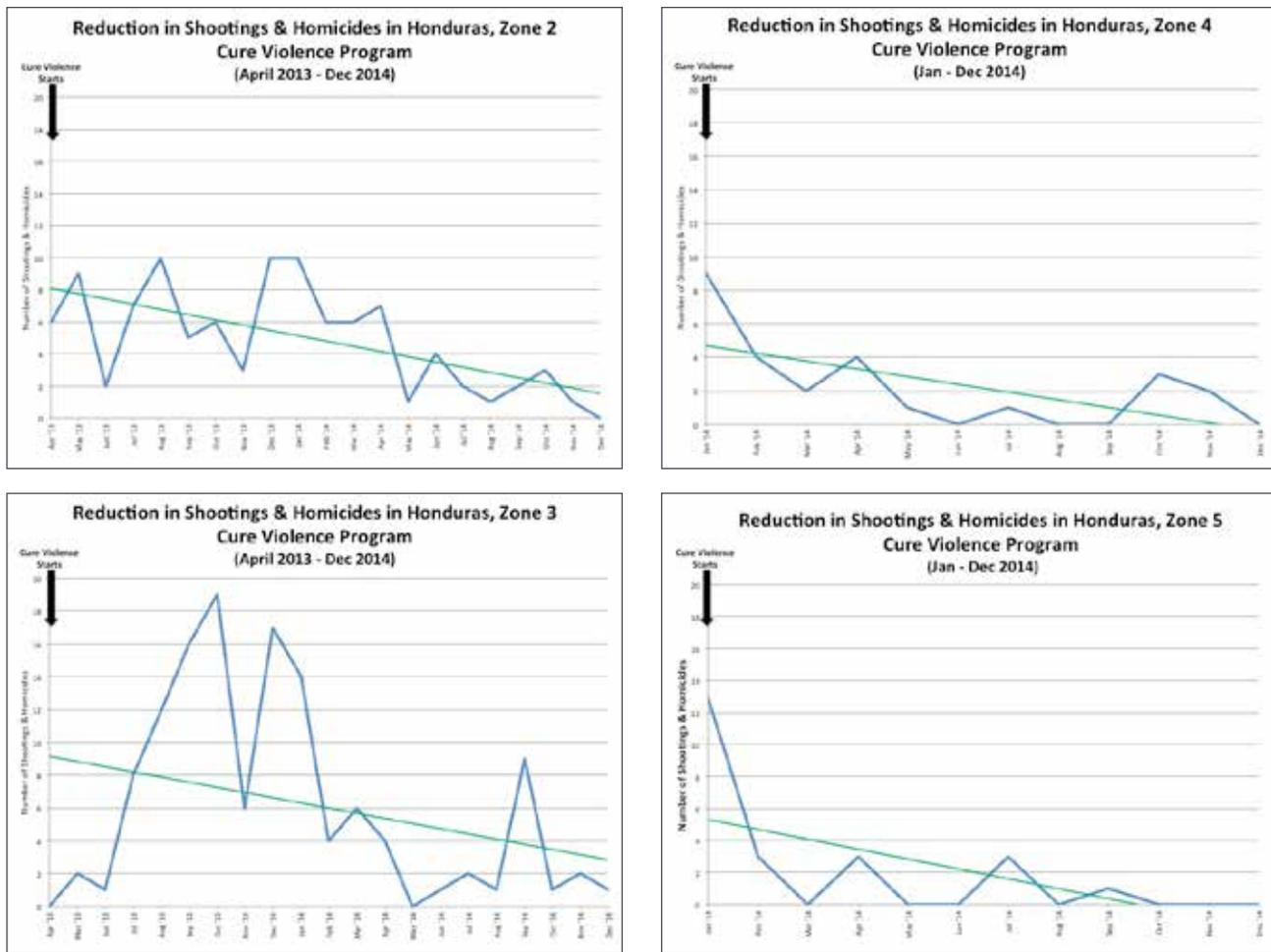
The data on the level of shootings also show that two of the zones went an entire 5-month period in 2015 without a shooting, while one zone reported only one shooting and the other two zones only recorded two shootings. For communities previously experiencing between 19 and 30 shootings each a year, this data represent massive change. These low-violence reports mean that each community went extensive periods of time without any shootings, the longest of which was Zone 1 at 17 months without a shooting.

Figure 5: Timelines for Zones 1, 2, 3, 4 and 5



(Figure 5 continued on page 9)

Figure 5: Timelines for Zones 1, 2, 3, 4 and 5 (continued from page 8)



Limitations

As indicated, the data used in this report on number of shootings and killings in the program sites was generated from the program site itself, as there are no alternate sources of data available. This is a major limitation of this report, and of any evaluation of the San Pedro Sula health intervention program. Because of the lack of reliable data, these results should be viewed as preliminary until additional sources of official, independent data are available.

Conclusion

San Pedro Sula, Honduras has been experiencing extreme levels of violence for many years. Many

different violence prevention efforts have been tried, but the problem of violence persists. The Cure Violence model offers a new approach to addressing violence in Latin America that adds several important elements to reverse the spread of violence.

The adaptation of the Cure Violence model in Honduras demonstrates the feasibility of several of important approaches to preventing violence. First, it demonstrated that credible messengers can be identified, trained and deployed successfully. In the complex and ruthless culture of violence in San Pedro Sula, an initial uncertainty was present concerning the ability to tap into a network of workers who could reach and influence those committing violence. Even in this environment, much of the

violence is interpersonal violence and frequently is a result of trivial conflicts. Through working with carefully selected local partners, the Cure Violence approach was able to identify workers, gain access to the highest risk and successfully mediate conflicts.

Second, the adaptation demonstrated that capacity exists at the local level to implement the Cure Violence approach in Latin America. Working with a local partner is a critical element of the Cure Violence approach. Local partners have credibility within the community and an understanding of the community to be able to implement the program effectively. During the assessment visits the Cure Violence team identified several organizations that met the criteria for a local partner and the selected partner was found to be very well aligned with the Cure Violence approach.

Finally, the program in San Pedro Sula demonstrated that norms that encourage the use of violence can be successfully changed. While this study did not include any measures of attitudes or belief around violence, the strong decreases in shootings and killings suggest that people in the community were finding alternatives to acting violently. For example, Zone 1 went from averaging 3 shootings per month to 17 straight months without a shooting.

Overall, the results in San Pedro were very strong. Large drops in violence occurred in every program site, with average reductions in shootings of 88% in 2014 and 94% in 2015. This level of reduction resulted in a massive change for these communities, saving many lives and preventing further exposure to violence for the whole community.

Ending violence in Honduras – and everywhere – is of the utmost importance. Violence is an urgent health crisis. More than 1 million children are killed every year as a result of violence³⁶ and more than 1 billion children – half of all children in the world – are exposed to violence every year.³⁷ People exposed to

violence suffer severe consequences, including an increased risk of becoming violent themselves.³⁸

As more people around the world move to cities where exposure to violence is higher, addressing this exposure and preventing the spread of violence becomes even more urgent. Hondurans, for example, are rapidly moving to cities in search of employment and opportunity. Between 1975 and 1999 the urban population in Honduras increased from 32% to almost 52%.³⁹

Stopping violence in these global hotspots is not only a moral imperative; it is also crucially important to the safety and security of the entire world. Violence spreads like an epidemic, and the violence that occurs in these fragile cities can easily spread to other parts of the world, just as these cities themselves are vulnerable to spread of violence from outside. Technology has made this spread much easier as it makes it possible for marginalized groups to destabilize regions and potentially, a country and even the world. Further, violence undermines democracy, since protecting its citizenry is the primary responsibility of the government, and when it fails at this, it loses legitimacy.⁴⁰

These results from the adaptation of the Cure Violence model in San Pedro Sula suggest that this method of stopping violence can drastically reduce violence in the Northern Triangle and other parts of the world. These results also suggest that a new understanding and theory of change can be used to eradicate violence.

This new theory of change understands and treats violence as contagious. The contagion perspective is important because it is based on a scientific understanding that reveals to us that violence is a behavior developed through exposure and is thereby transmissible, allowing us to see and understand people differently. Imagine the success if every response to violence was based on this scientific understanding.

Endnotes

- ¹ World Health Organization. (2014). Global status report on violence prevention 2014.
- ² United Nations Office on Drugs and Crime. (2013). *Global study on homicide 2013: trends, contexts, data*.
- ³ Moser, C., & Winton, A. (2002). *Violence in the Central American region: towards an integrated framework for violence reduction*. London: Overseas Development Institute.
- ⁴ UN Office on Drugs and Crime's International Homicide Statistics database. Available at http://data.worldbank.org/indicator/VC.IHR.PSRC.P5?order=wbapi_data_value_2013+wbapi_data_value+wbapi_data_value-last&sort=desc
- ⁵ Moser, C., & Winton, A. (2002). *Violence in the Central American region: towards an integrated framework for violence reduction*. London: Overseas Development Institute.
- ⁶ World Health Organization. (2014). Global status report on violence prevention 2014.
- ⁷ UN Office on Drugs and Crime's International Homicide Statistics database. Available at http://data.worldbank.org/indicator/VC.IHR.PSRC.P5?order=wbapi_data_value_2013+wbapi_data_value+wbapi_data_value-last&sort=desc
- ⁸ United Nations Office on Drugs and Crime. (2013). *Global study on homicide 2013: trends, contexts, data*.
- ⁹ Central_America_Study_2007.pdf
- ¹⁰ Abt, Thomas, and Christopher Winship. (2016). What Works in Reducing Community Violence: A Meta-Review and Field Study for the Northern Triangle. United States Agency for International Development. Available at: <https://www.usaid.gov/sites/default/files/USAID-2016-What-Works-in-Reducing-Community-Violence-Final-Report.pdf>
- ¹¹ Abt 2016
- ¹² InSight Crime and the Asociacion para una Sociedad mas Justa. (2015). Gangs in Honduras. USAID. Available at: <http://www.insightcrime.org/images/PDFs/2015/HondurasGangs.pdf>
- ¹³ UNODC Homicide Statistics (2013). Available: <http://www.unodc.org/unodc/en/data-and-analysis/homicide.html>.
- ¹⁴ Vice News. (2015). San Pedro Sula Nights. Vice News. Available at: <http://www.seguridadjusticiaypaz.org.mx/sala-de-prensa/1356-caracas-venezuela-la-ciudad-mas-violenta-del-mundo-del-2015>
- ¹⁵ <http://www.seguridadjusticiaypaz.org.mx/sala-de-prensa/1356-caracas-venezuela-la-ciudad-mas-violenta-del-mundo-del-2015>
- ¹⁶ Ortega, J. A. (2014). Por tercer año consecutivo, San Pedro Sula es la ciudad más violenta del mundo. *Recuperado de:* <http://www.seguridadjusticiaypaz.org.mx/sala-de-prensa/941-por-tercer-anoconsecutivo-san-pedro-sula-es-la-ciudad-mas-violenta-del-mundo>.
- ¹⁷ <http://www.seguridadjusticiaypaz.org.mx/sala-de-prensa/1356-caracas-venezuela-la-ciudad-mas-violenta-del-mundo-del-2015>
- ¹⁸ United Nations Office on Drugs and Crime. (2013). *Global study on homicide 2013: trends, contexts, data*.
- ¹⁹ <https://news.vice.com/video/san-pedro-sula-nights>
- ²⁰ United Nations Office on Drugs and Crime. (2013). *Global study on homicide 2013: trends, contexts, data*.
- ²¹ Vice News 2015
- ²² Vice News 2015
- ²³ Slutkin, G., Ransford, C. L., Decker, R.B., Volker, K. "Cure Violence – An Evidence Based Method to Reduce Shootings and Killings." World Bank. (2015).

Slutkin, G., Ransford, C. L., Decker, R.B. "Cure Violence— Treating Violent Behavior as a Contagious Disease," in Eds. Maltz, M. & Rice, S. *Envisioning Criminology: Researchers on Research as a Process of Discovery*. Springer (2015).

Slutkin, G. "Violence Is a Contagious Disease." The Contagion of Violence. Institute of Medicine. Available at: www.cureviolence.org/wp-content/uploads/2014/01/iom.pdf. (2013): 94-111
- Ransford, C. L., Kane, C., Slutkin, G. "Cure Violence: A Disease Control Approach to Reduce Violence and Change Behavior." In Eds. Akers, T. & Waltermauer, E. *Epidemiological Criminology*. Routledge. (2013): 232-242
- Slutkin, G. "Treatment of Violence as an Epidemic Disease." in John Snow's Legacy, *Epidemiology Without Borders*, (2013) *Lancet* 381 (9874): 1302 - 11.
- ²⁴ Slutkin, G., Ransford, C. L., Decker, R.B. "Cure Violence— Treating Violent Behavior as a Contagious Disease," in Eds. Maltz, M. & Rice, S. *Envisioning Criminology: Researchers on Research as a Process of Discovery*. Springer (2015).

Slutkin, G. "Violence Is a Contagious Disease." The Contagion of Violence. Institute of Medicine. Available at: www.cureviolence.org/wp-content/uploads/2014/01/iom.pdf. (2013): 94-111

- ²⁵ Heymann D (2008) Control of communicable diseases manual. Washington: American Public Health Association.
- ²⁶ McDonnell, Jerome. (Host) (2011, August 24). Cure Violence employs public health methodology to fight urban violence [Audio Podcast]. Retrieved from <http://www.wbez.org/episode-segments/2011-08-24/Cure-Violence-employs-public-health-methodology-fight-urban-violence-90962>
- ²⁷ Skogan, W., Harnett, S. M., Bump, N., & DuBois, J. (2009). Evaluation of Cure Violence-Chicago. Chicago: Northwestern University Institute for Policy Research. Overall reductions in shootings in the seven program sites were between 41% and 73%. When compared to control communities to control for other factors such as law enforcement, statistically significant reductions that were specifically attributable to the Cure Violence Chicago program were found to be between 16% and 28% in four communities by time series analysis. Hot spot analysis found reductions of shooting density between 15% and 40% in four partially overlapping communities. Six of the seven communities examined had reductions due to the program as determined by either time series analysis or hot spot analysis. The seventh community had -100% drop in retaliation killings and large reductions in shootings, but the neighboring comparison community had similar reductions in shootings.
- ²⁸ Webster, D. W., Whitehill, J. M., Vernick, J. S., & Parker, E. M. (2012). Evaluation of Baltimore's Safe Streets Program: Effects on Attitudes, Participants' Experiences, and Gun Violence. Baltimore, MD: Johns Hopkins Center for the Prevention of Youth Violence. The Baltimore evaluation examined four communities, each with differing levels of implementation. All four Safe Streets sites had a statistically significant reduction in at least one measure associated with the implementation of the program. The evaluation found "strong and consistent evidence" that Safe Streets was associated with reductions in shootings and killings in the South Baltimore program site where killings were reduced by -56% and non-fatal shootings by -34%. There was also "strong evidence" of a program effect in the initial East Baltimore program site where there were no killings during the first 22 months of the program. The remaining two East Baltimore program sites had statistically significant reductions in nonfatal shootings, but not in killings. In one community, killings increased. In this community a gang war had started just prior to implementation. These two sites are also the same sites where there were fewer mediations, indicating that the mediation component was not implemented as strongly.
- ²⁹ Picard-Fritsche, S., & Cerniglia, L. (2013) Testing a Public Health Approach to Gun Violence. New York: Center for Court Innovation.
- ³⁰ Henry, D., Knoblauch, S., & Sigurvinsdottir, R. (2014). The Effect of Intensive Cure Violence Intervention on Crime in Four Chicago Police Beats: Quantitative Assessment. Chicago, IL: Robert R. McCormick Foundation.
- ³¹ Cure Violence report forthcoming
- ³² Data source: University of Puerto Rico, Official Police data
- ³³ Data source: Mesa De Seguridad Y Justicia De Ciudad Juarez
- ³⁴ USAID - Pre-Assessment report on the adaptation of Cure Violence model for San Pedro Sula, Honduras
- ³⁵ USAID - Pre-Assessment report on the adaptation of Cure Violence model for San Pedro Sula, Honduras
- ³⁶ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. (2002). World report on violence and health. Geneva: World Health Organization.
- ³⁷ Centers for Disease Control and Prevention. Violence Against Children Survey (VACS) [Online]. (2015) National Center for Injury Prevention and Control. Centers for Disease Control and Prevention (producer) [2007] Available from URL: www.cdc.gov/injury.
- ³⁸ Kracke K. (2001). Children's Exposure to Violence. The Safe Start Initiative. US Department of Justice. Office of Justice Programs. Office of Juvenile Justice and Delinquency Prevention. Fact Sheet April 2001.
- Fowler P.J., Tompsett C.J., Braciszewski J.M. et al. (2009) Community violence: a meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology*. Vol. 21. Iss. 1 January 2009. pp 227-259.
- Guerra, N. G., Huesmann, L. R., & Spindler, A. J. (2003). Community violence exposure, social cognition, and aggression among urban elementary-school children. *Child Development*, 74(5), 1507-1522. Guerra, Huesmann, and Spindler 2003; Schwab-Stone et al. 1995).
- Schwab-Stone, M., Ayers, T., Kaspro, W., Voyce, C., Barone, C. Shriver, T., et al. (1995). No Safe Haven: A study of violence exposure in an urban community. *Journal of the American Academy of Child and Adolescent Psychiatry*, 10, 1343-1352.
- ³⁹ Moser, C., & Winton, A. (2002). *Violence in the Central American region: towards an integrated framework for violence reduction*. London: Overseas Development Institute.
- ⁴⁰ United Nations Office on Drugs and Crime. (2007). Crime And Development In Central America. Available at: https://www.unodc.org/pdf/research/Central_America_Study_2007.pdf