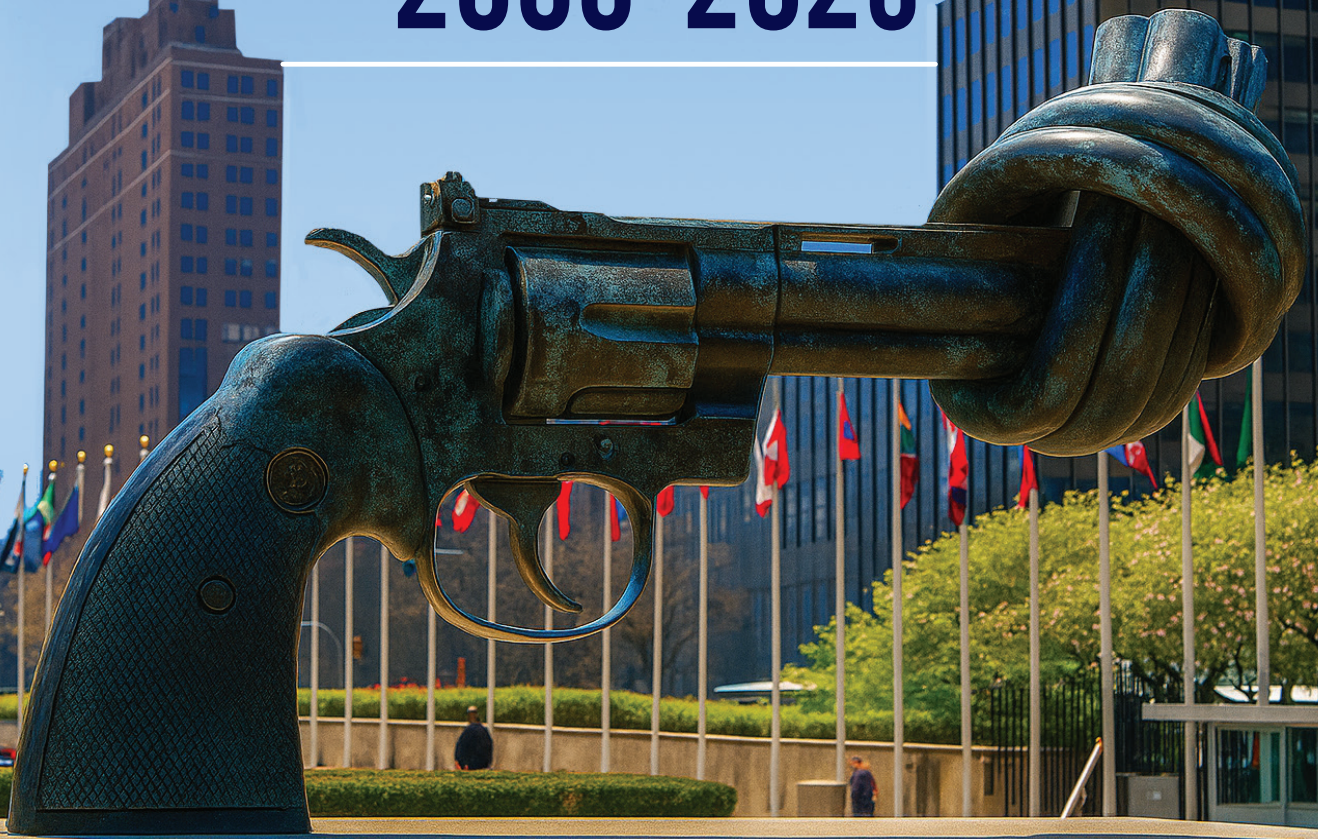


TRACKING THE WORLD HEALTH ORGANISATION'S ATTENTION TO FIREARM VIOLENCE, 2000-2025



School of Public Health
Departement Openbare Gesondheid
Isikolo Sempilo Yoluntu

UNIVERSITY OF CAPE TOWN
YUNIBESITHI YOKAKAPA • UNIVERSITEIT VAN KAAPSTAD



DIVISION OF
SOCIAL AND
BEHAVIOURAL
SCIENCES



Violence, Inequality
and Power Lab

University of San Diego | KROC SCHOOL
Institute for Peace and Justice



TRACKING THE WORLD HEALTH ORGANISATION'S ATTENTION TO FIREARM VIOLENCE, 2000-2025

A report of the Gender Centre at the Geneva Graduate Institute of International and Development Studies (IHEID); the Violence, Inequality and Power Lab at the University of San Diego; the Division of Social and Behavioural Science at the University of Cape Town's School of Public Health; the Comprehensive Injury Center at the Medical College of Wisconsin; Sou da Paz, Brazil; Gun Free South Africa and the Women's Institute for Alternative Development (WINAD), Trinidad and Tobago.

Research and report by Dean Peacock, Aleksandra Ewelina Nowakowska, Camille Lilli, Tanisha Kohli, Victoria Do Nascimento Houpert, Stephen Hargarten, Cristina Neme, Natalia Pollachi, Claire Somerville, June 2025¹.

Citation: Peacock, D. Nowakowska, AE. Lilli, C. Kohli, T. Do Nascimento Houpert, V. Hargarten, S. Neme, C. Pollachi, N. Somerville, C. (2025). Tracking the World Health Organisation's Attention to Firearm Violence 2000-2025. The Gender Centre, Geneva Graduate Institute; Violence, Inequality and Power Lab, Joan B. Kroc Institute for Peace and Justice, University of San Diego; Division of Social and Behavioural Science, School of Public Health, University of Cape Town; Comprehensive Injury Center, Medical College of Wisconsin; Sou da Paz, Brazil; Gun Free South Africa, The Women's Institute for Alternative Development (WINAD), Trinidad and Tobago.

¹ Dean Peacock, MSW, (University of Cape Town School of Public Health, Geneva Graduate Institute Gender Centre, University of San Diego Violence, Inequality and Power Lab, Lancet Commission on Global Gun Violence and Health; Senior Advisor Gun Free South Africa); Aleksandra Ewelina Nowakowska (Geneva Graduate Institute Gender Centre); (Camille Lilli Geneva Graduate Institute Gender Centre); Tanisha Kohli (Geneva Graduate Institute Gender Centre); Victoria Do Nascimento Houpert (Geneva Graduate Institute Gender Centre); Stephen Hargarten MD, MPH (Professor of Emergency Medicine, Professor, Emergency Medicine, Medical College of Wisconsin, Lancet Commission on Global Gun Violence and Health); Cristina Neme (Sou da Paz); Natalia Pollachi (Sou da Paz); Claire Somerville, PhD, (Director, Geneva Graduate Institute Gender Centre).

CONTENTS

Introduction and Executive Summary	6
Summary Recommendations for the WHO, its Executive Board and its Member States	9
Section I: A Brief Overview of the WHO and its Mandate	11
Section II: Firearm and Ammunition Violence: An Overview of the Scope of the Problem	14
Firearm violence and its range of impacts on specific groups:	19
Regional and racialised differences in gun violence	19
Violence against and amongst men	20
Guns and violence against women	21
Gun violence against members of LGBTQI+ communities:	24
Gun violence and children	24
The impact of gun violence on health care services, systems, and providers	25
Section III: Understanding gun violence as a commercial determinant of health and violence	29
Section IV: Firearm Violence and Global Health Governance: Why the WHO should address firearm violence as a public health priority within its workstreams and proactively participate in other UN efforts	33
Section V: A three-part review of WHO action on gun violence	38
Findings from an analysis of World Health Assembly Resolutions	38
Findings from a review of key WHO violence prevention documents from 1996 to 2025	40
Thematic findings from interviews with experts in gun violence and health governance and from expert reviewers	44
Section VI: The Framework Convention on Tobacco Control--A key WHO precedent for addressing gun violence	47
Section VII. Conclusion: A call for the WHO to address gun violence as a public health issue	50
Opportunities for WHO Action on Gun Violence	51
Recommendations	55
Annex I: Keywords analysis of WHA resolutions	58
Annex II: Detailed analysis of all WHA resolutions that mention violence	58
Annex III: Analysis of WHO Publications on violence and inclusion of gun violence	60
Works Cited	65

Research coordination:
Dean Peacock & Claire Somerville

Copy editing:
Vaun Cornell

Layout:
Mpho Setjeo

- Gender Centre at the Geneva Graduate Institute (IHEID), Route de Lausanne 132, 1211 Geneva 21, Switzerland, <https://www.graduateinstitute.ch/gender>
- Division of Social and Behavioural Science, School of Public Health, University of Cape Town, Falmouth Building, Level 1, Anzio Road, Observatory, Cape Town, South Africa, http://www.publichealth.uct.ac.za/phfm_social-and-behavioural-sciences
- Violence, Inequality and Power Lab, Kroc School of Peace Studies, University of San Diego is 5998 Alcala Park, San Diego, California, US, <https://www.sandiego.edu/peace/institute-for-peace-justice/violence-inequality-power-lab/>
- Comprehensive Injury Center, Medical College of Wisconsin, 8701 Watertown Plank Rd, Milwaukee, Wis. US, <https://www.mcw.edu/departments/comprehensive-injury-center>
 - Sou da Paz, R CARDEAL ARCOVERDE
359, Complemento ANDAR 13 CONJ 131 E 132, São Paulo, CEP 05508-000, Brasil
 - Gun Free South Africa
Unit 50, Inospace Wynberg, 40 5th St, Wynberg Sandton, 2090, South Africa
- The Women's Institute for Alternative Development (WINAD)
P.O. Box 10134, San Juan, Trinidad and Tobago
winad1999@yahoo.com



School of Public Health
Departement Openbare Gesondheid
Isikolo Sempilo Yoluntu

UNIVERSITY OF CAPE TOWN
YUNIBESITHI YASAKAPA - UNIVERSITEIT VAN KAAPSTAD



DIVISION OF
SOCIAL AND
BEHAVIOURAL
SCIENCES



ACKNOWLEDGEMENTS

Our hope is that this report contributes to strengthening gun violence prevention across the world—even in these challenging times for the World Health Organization (WHO) and public health advocates. The small arms and ammunition industries have prioritised profit over people and caused too much harm for far too long. In every community across the world, people and communities need the WHO to mobilise its expertise and impressive influence to champion gun violence prevention and address the health consequences of gun violence. Now, more than ever.

This report draws on an earlier research report authored by Aleksandra Ewelina Nowakowska, Camille Lilli, Tanisha Kohli and Victoria Do Nascimento Houpert, all graduate students at the Geneva Graduate Institute (IHEID) who worked together as part of the IHEID's Applied Research Project (ARP) under the supervision of Claire Somerville, Director of IHEID's Gender Centre. The ARP project was conducted in partnership with the Women's International League for Peace and Freedom's Mobilising Men for Feminist Peace Initiative, directed at the time by Dean Peacock.

We are grateful to all our interviewees for their openness and generosity in sharing their time, knowledge, and experiences.

Special thanks go to the joint ETH Zurich and the University of Geneva's Science in Diplomacy Lab (SiDLab), whose comprehensive analysis of World Health Assembly (WHA) resolutions from 1948 to 2024 (Wernli, 2023; Evrard & Rieckhoff, 2025) provided a solid foundation for identifying any mentions of guns (firearms, small arms, light weapons) during 76 years of global health governance.

We acknowledge with great gratitude the detailed, generous and supportive comments from the World Health Organization's Violence Prevention Unit who welcomed us warmly to their offices for a very constructive meeting on how we can advance firearm violence prevention amongst Member States and within the WHO itself. Our sincere thanks to the WHO's Violence Prevention team: Etienne Krug, Alex Butchart, Berit Kieselbach, Sabine Rakotamalala, and Stephanie Burrows. We also appreciate Lee Wallis, Lead for WHO's Emergency and Critical Care, and Monika Kosinska, Cross-Cutting Lead for Economic and Commercial Determinants of Health at the WHO, for meeting with us and providing very helpful guidance.

We are also enormously appreciative of the following people for their comments, questions and suggestions: Folade Mutota from the Women's Institute for Alternative Development (WINAD) based in Trinidad and Tobago; Henri Myrttinen from Gender Associates; Angelica Pino and Emma Bjerten from the Women's International League for Peace and Freedom; Natalie Briggs from the Gender Equality Network on Small Arms Control (GENSAC); Rachel Locke and Ioli Filmeridis from the Violence, Inequality and Power Lab at the University of San Diego; Callum Watson and Nicolas Florquin from Small Arms Survey; Claire Taylor from Gun Free South Africa; Sonali Rajan, Director of Research at Everytown for Gun Safety; David Atwood; and Adnan Hyder in his capacity as Co-Chair of the Lancet Commission on Global Gun Violence and Health. We also acknowledge and thank Adèle Kirsten and Naeemah Abrahams for their strategic guidance and support.

Finally, we acknowledge the remarkable work done day in and day out by the entire WHO workforce and all the health stakeholders in each and every WHO Member State doing admirable, high impact work to secure health and human rights for all. This review has deepened our appreciation for the many extraordinary advances in health and wellbeing you have made possible.

Introduction and Executive Summary

This report affirms the foundational contributions the World Health Organization (WHO) has made in global health, including early efforts to frame violence as a public health concern. Building on this legacy, we argue that WHO is uniquely poised to lead on gun violence prevention by leveraging its public health mandate, convening power, and normative authority. WHO's expertise and track record offer a vital opportunity to catalyse a renewed, multisectoral response to addressing firearm-related harm, prevention, and care.

Firearm violence is a global concern with far-reaching consequences on individuals and communities affected by firearm violence and burdened by firearm-related injuries, long-lasting trauma, deaths and prolonged grief². Firearm violence also has grave and costly consequences for the health care systems and health care providers who attend to those injured by guns and the bullets they discharge.

A few data points reveal the extent of the devastation caused by gun violence.

- In a growing number of countries, firearms and bullets are “the leading cause of death among children and teens accounting for more deaths than car crashes, overdoses, or cancers” (Villarreal et al., 2024; Castilla-Peon, 2024). Exposure to gun violence also inflicts psychological harm most acutely on children and adolescents, regardless of whether they are direct victims or gun violence witnesses and frequently results in developmental issues and anxiety disorders (Semenza & Kravitz-Wirst, 2025).
- In many countries, guns are now the primary weapon used in femicides. Research indicates a very clear and strong association between perpetrator access to a gun and increased risk of domestic violence homicides (UNODC, 2024), and it also increases the risk of multiple victims by 70% in killings committed in the private sphere” (UNODC, 2024, p.23). Access to firearms is also linked to increased perpetrator capacity to establish coercive control, heighten fear and psychological distress
- The highest rates of homicide are found in the Americas, the Caribbean, and Southern Africa, predominantly in cities. In Mexico, Brazil, Colombia, and the United States, the most common cause of death of young men ages 1-19 is a bullet, carried by a firearm (Degli Esposti et al., 2024), and across the Americas gun violence is linked to decreased life expectancy for young men (Canudas-

² For readability and writing fluency, this paper will use the terms *guns*, *firearms*, *small arms*, and *weapons* interchangeably. Similarly, we use ammunition, bullets, projectiles and cartridges interchangeably. While these terms may carry different legal, political, or cultural meanings, this analysis focuses on the individual and interpersonal use of guns, not institutional or state-level armed engagement.

Romo et al., 2019). As Adam Baird puts it: “Men killing men” disproportionately affects young people in the Global South who live in precarious economic circumstances (Baird, 2024).

- Research has shown that for more than three decades gun possession is significantly correlated with gun-related suicides in many countries across the world (Killias, 1993; Killias et al., 2001).
- Gun violence, and the fear of gun violence, has an effect markedly disproportionate to its prevalence. Whereas property crimes like shoplifting, break-ins, and employee theft are far more common than gun violence, analysts argue that they seldom have a major impact on the quality of life of victims. Shootings, on the other hand, account for fewer than 1 percent of all crimes in the US but nearly 70 percent of the total social harm of crime (Cook & Ludwig, 2022).
- Firearm-related injuries impose a substantial and largely preventable burden on health systems worldwide. Across countries with high levels of gun violence, emergency and inpatient treatment for gunshot wounds consumes millions of dollars annually, often straining already under-resourced public hospitals (Williams & Butts, 2023; Ntatomala & Adams, 2022; Engel et al., 2020).
- Gun violence increases poverty by driving people and businesses out of communities (Cook & Ludwig, 2022), which leads to further poverty, entrenching cycles of gun violence, which leads to more people and businesses leaving.
- Guns and bullets are one of the main drivers of forced migration from communities in Mexico, Central America, and the Caribbean (Vargas et al., 2024).
- Despite the extensive harms and costs caused by gun violence, a recent study of gun related mortality in 204 countries and territories covering the period 1990-2019 and excluding wars and armed conflict indicates that almost no progress has been made in reducing gun related death: firearm related mortality violence decreased from 2.41 to 2.29 deaths per 100,000 people (Patel et al. 2022).

This cursory overview of the impact of gun violence shows how guns and ammunition endanger the health and well-being of communities and increases the risk of debilitating injury for all of us, women, men and children, albeit in different ways.

Given the harm caused by firearms and ammunition, a public health approach informed by rigorous publicly funded research which expands trauma care, regulates access to and marketing of firearms and ammunition, and addresses the underlying causes of armed violence is necessary to reduce firearm-related harm. The WHO is key to shaping the response needed.

However, based on a review of more than 3,000 WHA Resolutions, analysis of relevant WHO research and meetings reports, and interviews with experts in public health, our research finds that in recent years the WHO has not prioritised gun violence as a distinct public health risk factor.

Our analysis of WHA resolutions reveals that out of 3,230 WHA resolutions produced between 1948 and 2024, only 39 resolutions included any text on violence. Not one included any mention of firearms or guns. The WHO has had multiple opportunities to integrate firearms into its violence prevention agenda including in WHA49.25, adopted in 1996, which declared violence a global public health priority and called for a classification of types of violence and their consequences.

Our analysis of WHO documents reveals that the WHO recognised and addressed gun violence as an important public health concern in the late 1990s and 2000s, but then gradually decreased its focus on gun violence to the point that it now receives little attention. This is true even in thematic areas where gun violence is a leading cause of death, such as femicide and child abuse, or in work areas where it fits well, such as the WHO's work on social and commercial determinants of health.

Our interviews provided us with insights which helped us make sense of the reviews of WHA resolutions and WHO publications, including, most prominently, the role of some Member States—especially the US—and the gun industry in blocking attention to gun violence within the WHA and the WHO's work streams.

The WHO's decreased focus on firearm violence is inconsistent with its own policies. Our research also reveals an inconsistency in the WHO's engagement with this topic. The WHO's Framework of Engagement with Non-State Actors (FENSA) excludes collaboration with just two industries: the tobacco and arms industries. Yet, it has failed to consistently apply this standard by not addressing firearms as a priority health topic in recent years.

We begin with a brief overview of the WHO's mandate and then review research on the extent and varied impacts of gun violence—in terms of geography, age, gender, and race—and we identify gaps in literature on gun violence, including especially the paucity of global data on guns as the cause of death in femicides, the use of guns as tools for coercive control in domestic violence, the role of firearms in violence against children, the impact of different types of bullets on adults and children, and the mental health effects of gun violence, especially at the community level.

We then summarise research on the impacts of gun violence and different types of ammunition, including on public health systems, especially trauma and post-trauma care.

From there, we situate gun violence within the framework of commercial determinants of violence and health, and we analyse the common tactics developed by commercial actors to minimise regulations that might hamper short term profits and avoid accountability for the harms they cause.

We then make the case that the WHO has a vital role to play in bringing the interdisciplinary expertise of public health researchers and practitioners to bear on the problem of gun violence and within the broader set of UN agencies and initiatives that have been developed in recent decades. We then discuss potential explanations for this based on our interviews and engagement with global health literature.

We move on to analyse successful advocacy the WHO has undertaken to address similar public health emergencies, focusing especially the 2003 Framework Convention on Tobacco Control, and explore its implications for potential WHO action on gun violence. We then identify several key opportunities for the WHO to take action on firearm violence advocacy and action.

We conclude by providing policy recommendations for the WHO and Member States to build the political momentum necessary for gun violence to be addressed within the public health policy architecture.

Summary Recommendations for the WHO, its Executive Board and its Member States

General recommendations for reprioritisation and consultation:

- 1. The WHO should re-affirm a clear commitment to proactively advancing gun violence prevention and ensure human and financial resources for this critical work.** The WHO has the mandate, the tools and the precedent to significantly strengthen its focus on firearm violence.
- 2. The WHO should engage in consultation and coalition building** with people affected by gun violence—researchers, civil society advocates, regional and national public health bodies, advocates for women’s rights, children’s rights, and men’s health, experts in international gun control policies, experts in strategic litigation for health—to map out priorities and develop a shared plan of action.
- 3. The WHO should support and monitor existing international treaties and commitments related to small arms and light weapons.** The WHO should engage with and support monitoring and implementation of the various multilateral treaties, resolutions, protocols and platforms related to gun violence prevention, all discussed below.
- 4. Member States and the WHO should build momentum for a WHA Resolution on gun violence.** Elevating the health impacts requires political will, coalition-building, and advocacy so that firearm violence is recognised as a global health priority, demanding coordinated and multisectoral actions.

Recommendations on research and data:

- 5. Improve data collection:** The WHO should work with Member States to improve data collection on the scale and impact of gun violence, including by exploring the role WHO could play in establishing a multi-agency global observatory to track firearm-related morbidity and mortality.
- 6. Address research gaps on gun violence:** The WHO should work with gun violence researchers across the globe to identify pressing research gaps, including gun violence prevention, gun violence against women and against members of LGBTQI+ communities, the economic impacts of gun violence, the long-term impacts of gun violence on children’s health, learning, and development, and the long-term impacts on health care providers of dealing with gun violence, among many other salient areas of research that the WHO is uniquely well-positioned to champion.

Recommendations on strengthening health sector responses to gun violence:

- 7. Provide guidance on firearms-related trauma care and hospital-based gun violence intervention:** The WHO should collect and disseminate emerging promising practices in Hospital-based Violence Intervention Programs (HVIPs) which link health care and trauma care and coordinate this vital work with the Emergency and Trauma care activities of WHO, in partnership with the Acute Care Action Network (ACAN).

Recommendations related to industry practices:

- 8. Conduct research on the international lobbying practices of the gun industry** with corresponding implications for public health challenges to these.
- 9. Broaden attention to gun violence and gun industry practices in the WHO's work on commercial drivers:** The WHO should ensure that the forthcoming WHO World Report on Commercial Determinants of Health includes a clear focus on gun violence and the gun industry and lobby.
- 10. The WHO should work with civil society and Member States to regulate the firearm industry's online and traditional marketing and lobbying practices.** The firearm industry's marketing practices on social media, video games, and other platforms, and their product placement in films and television, normalise gun ownership and reinforce harmful gender norms. Member States have adopted WHA resolutions on harmful marketing practices related to breast milk substitutes and the WHO has called on platform operators and regulators to "take responsibility for addressing the harms of addictive and antisocial online behaviours" in its 2025 World Report on Social Determinants.

Recommendations related to integration into existing streams of work:

- 11. Strengthen the focus on gun violence within the WHO's work to address and prevent violence against children,** including by encouraging Member States to include a commitment to preventing gun violence in the country pledges issued at the 2024 Interministerial Meeting to End Violence Against Children held in Bogota.
- 12. The WHO should provide support to Member States on the implementation of complex violence prevention strategies.** Firearm violence is not just a crime or security issue. As demonstrated in this research project, it is a deeply cross-cutting public health crisis intersecting with other disciplines. The nature of the issue means that no single sector can address firearm violence effectively.
- 13. Develop Strategic Guidance on Gun Violence Communication:** The WHO should leverage its expertise in strategic public health messaging to provide Member States with evidence-based communication tools to challenge the normalisation of firearm use and counter industry narratives, drawing on lessons from tobacco control and HIV/AIDS prevention.

SECTION I

A Brief Overview of the WHO and its Mandate

In 1945, during preliminary discussions to establish the United Nations (UN), representatives of Brazil and China advocated for the formation of an international health organisation. The WHO's Constitution came into force on 7 April 1948 – a date now celebrated every year as World Health Day (WHO, 1946).

The first World Health Assembly opened in Geneva on 24 June 1948, with delegations from 53 of the 55 Member States. WHO headquarters are in Geneva, Switzerland, and at the time of writing in mid-2025 the organisation is now governed by 194 Member States grouped into six geographic regions. Its reach and influence are impressive.

For anyone invested in public health or the role of multilateral organisations, a review of the WHO's timeline of achievements is inspirational. Many of the remarkable health gains of the last 75 years that many now take for granted are in fact a result of the remarkable work of the WHO and the many Member States it has supported. This includes pioneering work to support the roll-out of antibiotics and vaccines in the 1940s and 1950s; the articulation of a bold vision in the Alma Atta Declaration of Health for All in 1978; the eradication of smallpox in 1980; the mobilisation and human rights advocacy to prevent and treat HIV and AIDS from the 1980s on; its contribution towards both the Cairo and Beijing Platforms for Action on reproductive health and women's rights respectively; the adoption of the Framework Convention on Tobacco Control in 2003; attention to and advances in road safety; child wellbeing in the 2000s and 2010s; responding to the Covid-19 pandemic in the early 2020s and securing a Pandemic Treaty in 2025.

The WHO receives its funding through a combination of membership dues paid by Member States calculated as a percentage of gross domestic product (GDP), as well as voluntary contributions from Member States and other partners. Less than 20% of WHO's total budget comes from membership dues, while the remainder comes from voluntary contributions, mostly from Member States and philanthropic foundations. The WHO, like most UN agencies, is facing a severe funding shortfall, partly because of the withdrawal of all funding by the United States in early 2025 and the decrease in funding by other key Member States, and partly because of late or partial payment of dues by other Member States. These funding shortfalls are forcing the WHO to restructure, reprioritise and downsize both staff and ambition. Against a programme budget of US\$ 4.2 billion for 2026-2027, the organisation faces a gap of more than US\$ 1.8 billion over the next two years.

The WHO Director General, Dr Tedros Adhanom Ghebreyesus, put the WHO's current budget shortfall in perspective during his opening remarks at the 78th WHA in May 2025:

“...For an organization working on the ground in 150 countries, with the vast mission and mandate that Member States have given us, US\$ 4.2 billion for two years – or 2.1 billion a year – is not ambitious, it's extremely modest. I hope you will agree with me, and I will tell you why: US\$ 2.1 billion is the equivalent of global military expenditure every eight hours; US\$ 2.1 billion is the price of one stealth bomber – to kill people; US\$ 2.1 billion is one-quarter of what the tobacco industry spends on advertising and promotion every single year. And again, a product that kills people. It seems somebody switched the price tags on what is truly valuable in our world (WHO, 2025).”

This speech is significant in two regards. Firstly, it summarises an extraordinary set of accomplishments across its five priority areas, and, secondly, it is a rallying call for multilateralism, human rights, and a prioritisation of people over profits, and it unambiguously identifies key corporate actors for the harm their products cause to people and planet. It, too, makes for inspirational reading. It does not, however, explicitly mention guns or bullets (WHO, 2025)³.

A question reviewers of this report asked us is what the WHO would add to the work already being done by other UN agencies and UN-wide coordinating mechanisms. They pointed out that the UN and its Member States have already adopted a number of formal agreements on small arms and light weapons (SALW), some of which the WHO contributed to establishing, including: the 2001 Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects (PoA); the 2001 Protocol against the Illicit Manufacturing of and Trafficking in Firearms (the Firearms Protocol); the 2005 International Tracing Instrument (ITI); the 2014 Arms Trade Treaty (ATT); a number of recent Human Rights Council resolutions on civilian acquisition of firearms⁴; and most recently, the Global Framework for Ammunition (2023). In addition, the 2030 UN Sustainable Development Goals (SDGs) include Indicator 16.4.2: the “proportion of seized, found or surrendered arms whose illicit origin

³ Less reassuring, though, are the WHO's recent efforts to secure funding from commercial actors and high net worth individuals. The WHO established the World Health Organisation Foundation (WHOF) in 2020 with the stated aim of expanding its donor base and generating hard to secure core operating support. Maani et al. raise concerns about the WHOF's standards of transparency. The WHOF collected modest but still significant donations of nearly \$100M in its initial four years and aims to increase this to \$100M per annum. However, the WHOF increasingly relies on anonymous donors, with 87% of this amount coming from anonymous donors in 2023, and some donations being given by large corporations like Nestle, TikTok, Meta, Boehringer Ingelheim, Pfizer, and others from the food, travel and banking industries, raising additional concerns about potential conflicts of interest (Maani et al., 2025 & Report of the Independent Auditor, 2025). Maani et al. note that the WHO's current financial shortfall may increase the likelihood that it will increasingly rely on mechanisms like the WHOF, with troubling implications for independence from commercial interests. In its 2024 annual report, the WHOF states that its goal is to raise \$100M per year from 2027.

⁴ In addition, the UN convenes Member States to consider implementation of both the PoA and the ITI at a Biennial Meeting of States (BMS) and six-yearly review conferences (RevCons) that allow for a more in-depth assessment of the 'progress made' on implementation.

or context has been traced or established by a competent authority in line with international instruments". The UN Office on Drugs and Crime (UNODC) and the UN Office for Disarmament Affairs (UNODA) have been named custodian agencies of Indicator 16.4.2. Furthermore, the UN Coordinating Action on Small Arms (CASA), managed by UNODA, includes 21 UN entities, many either humanitarian, peacekeeping or focused on specific groups such as refugees, migrants, children or women⁵. The WHO is a member of CASA. In essence, we were asked whether WHO attention to firearm violence would not duplicate or compete with the existing work of other UN agencies.

This is an important question, and we offer a detailed rationale in section four of this paper. First, we turn to an overview of the extent of gun violence and its devastating impact on physical, mental and community health.

⁵ CTED, DESA, DPA, DPI, DPKO, ICAO, OCHA, OHCHR, OSAPG, OSRSG/CAAC, OSRSGA/AC, OSAA, UNDP, UNEP, UN-HABITAT, UNHCR, UNICEF, UNIDIR, UNMAS, UNODA, UNODC, UN Women, WHO.

SECTION II

Firearm and Ammunition Violence: An Overview of the Scope of the Problem

“Among the simplest technologies developed by humans to harm other humans, guns kill, maim and violate more rights on a daily basis worldwide than much more sophisticated, expensive and attended-to weapons: “about 60% of human rights violations documented by Amnesty International have involved the use of small arms and light weapons” (Mack, 2015, p.53.).

Definition and Availability of Guns: The Small Arms Survey, an independent non-partisan research institution based in Geneva, states that there are over one billion firearms globally, with 84.6% held by civilians, 13.1% by state militaries, and 2.2% by law enforcement. Of these, only 100 million, or 12%, of civilian weapons are registered (Karp, 2018). This paper focuses on the health consequences of guns and ammunition in the context of civilian violence, rather than in the context of military conflict. According to the Small Arms Survey, small arms are defined as handheld, lethal weapons designed for individual use, including revolvers and self-loading pistols, rifles and carbines, submachine guns, assault rifles, and light machine guns (Jenzen-Jones & Schroeder, 2018). This definition is important as it comprises a category of weapons most commonly associated with interpersonal gun violence in both public and private settings and ensures analytical clarity by excluding larger military-grade equipment that is typically used in organised conflicts. For readability and writing fluency, this paper will use the terms guns, firearms, small arms, and weapons interchangeably. While these terms may carry different legal, political, or cultural meanings, this analysis focuses on the individual and interpersonal use of guns, not institutional or state-level armed engagement.

Firearm violence data caveat: Global firearm data remains severely limited. The WHO found that 60% of countries lacked usable homicide data from civil or vital registration systems, and less than half had conducted nationally representative surveys on most forms of violence (WHO, 2014, pp. 21–22). These data gaps conceal the true extent of firearm-related harm and obstruct appropriate and effective policy responses. Nonetheless, we offer key trends based on existing data.

The Small Arms and Light Weapons (SALW) Market: The International Action Network on the Arms Trade (IANSA) reports that as of 2017 38 States exported at least USD 10 Billion worth of small arms and light weapons, including their

parts, accessories, and ammunition (IANSA, 2022). The top five exporters were: United States (USD 1.1 billion), Italy (USD 583 million), Brazil (USD 544 million), Germany (USD 514 million), and Austria (USD 475 million). They indicate that the largest exporter of SALW by world region in 2017 was Europe, followed by the Americas, Asia and then Africa, a much smaller market with South Africa as the main exporting country. According to the European Network Against Arms Trade (ENAAAT), the value of exports or licences of SALW manufactured in the European Union (EU) since 1998 is 25 billion Euros with exports of SALW in 2022 valued at €1.9 Billion, and combined sales of SALW and ammunition valued at €6.4B (ENAAAT, n.d.). IANSA indicate that Austria alone accounted for 33% of global exports of pistols and revolvers in 2017. The Americas was the biggest region for SALW imports (USD 2.5 billion) largely due to the United States (USD 2.1 billion) closely followed by Asia with USD 2.3 billion in imports. In 2017, the largest importer country of SALW and ammunition was the United States with USD 2.1 billion, which accounted for 32% of global SALW imports. Thirteen states accounted for 68% of the global SALW imports: United States, Saudi Arabia, Canada, United Arab Emirates (UAE), Germany, Turkey, Oman, Australia, Kuwait, France, United Kingdom (UK), Thailand and Qatar. In 2020, the United States imported 6.8 million firearms. The biggest firearms exporters to the United States are Turkey, Austria and Brazil.

Legal and illicit firearms:

Understanding the circulation of firearms globally requires attention to both the sheer scale of legal manufacture and ownership and to the blurred boundaries where licit weapons become illicit. Estimates suggest that more than one billion firearms are in circulation, with approximately 85% in civilian hands, 13% with military forces, and just over 2% with law enforcement agencies (Karp, 2018). Yet only a fraction—around 100 million—are formally registered. The remainder are unregistered but not necessarily illicit. This distinction is critical: the line between legal and illegal is porous, as firearms routinely shift from licit to illicit markets through diversion, theft, straw purchases, or failures of oversight.

UNODC data highlight that Europe is the leading region of manufacture for seized weapons, while North America—particularly the United States—is the leading regional source of inter-regional trafficking (UNODC, 2020). This dual reality reflects how legal industrial capacity and civilian access to weapons, when poorly regulated, become the wellspring of illicit supply elsewhere.

The consequences are felt globally. Crime guns in Mexico, Central America, and the Caribbean overwhelmingly trace back to US sources, reinforcing patterns of violence that drive homicide rates far above global averages. In Africa and Europe, illicit supply chains reflect different mechanisms—stockpile diversion, artisanal production, and conversion—but they are no less destructive. What unites these dynamics is the permeability between legal manufacture and ownership and illicit circulation. Without robust international regulation and stronger national controls, firearms will continue to leak into illicit markets, fuelling violence and undermining public health.

The role of US gun laws is pivotal in shaping these flows. For decades, gaps in federal law made trafficking easier: until 2022, there was no standalone offense for firearms trafficking or straw purchasing, leaving prosecutors to rely on weaker

statutes. The Bipartisan Safer Communities Act introduced these offenses only recently (DOJ, 2024). Similarly, unlicensed private sellers were long able to sell firearms without background checks; this gap was only narrowed in 2024 through an ATF rule clarifying when individuals must be licensed as dealers (ATF, 2024). At the export level, a 2020 regulatory shift transferring licensing authority from the State Department to the Department of Commerce coincided with a 7% increase in small arms export value, raising concerns about diversion (GAO, 2025). Though Commerce has since tightened controls, these shifts illustrate the enduring vulnerabilities in US regulatory frameworks.

The weak laws in the US are not an oversight. The contemporary US gun lobby—anchored by the National Rifle Association (NRA), the National Shooting Sports Foundation (NSSF), and Gun Owners of America (GOA)—has exercised sustained influence over federal and state policy. This influence has helped produce permissive legal and regulatory environments that lower commercial frictions, limit corporate accountability, and impede oversight—conditions that facilitate diversion and trafficking of US-sourced firearms to neighbouring regions (OpenSecrets, 2025a; OpenSecrets, 2025b; OpenSecrets, 2024). Indeed, with a glut of 400 million guns owned in the US, the firearms industry has been working with the government to open up markets elsewhere. Bloomberg’s recent report on the dramatically increased volume and expanded impact of US gun sales internationally documents the harm this has caused all over the world. The authors write: “they’ve reached new heights since gunmakers in 2020 won a decade-long battle to streamline export approvals. Semiautomatic American-made guns are now pouring into countries ranging from Canada, with its comparatively strict regulations, to Guatemala, where firearms are frequently diverted into the hands of criminals and the government has trampled human rights” (Riley et al., 2023). The resulting flows, captured in the image below, complicate the World Health Organization’s broader public health objectives by fuelling armed violence and undermining national prevention strategies across the Americas.

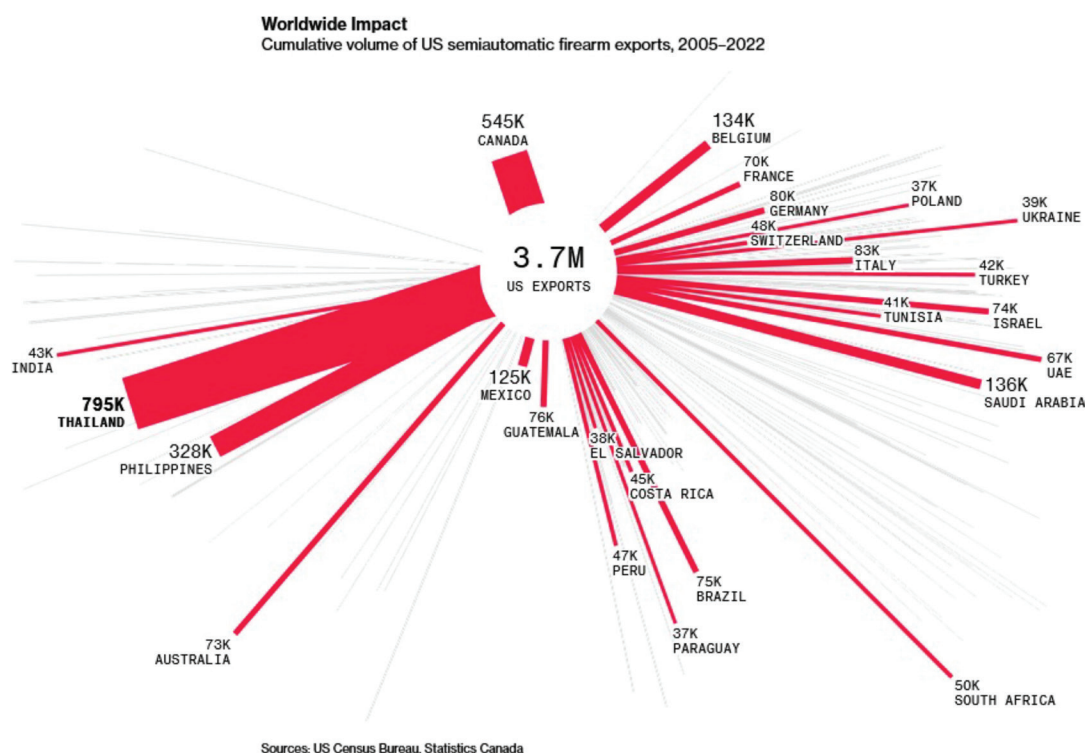


Figure 1: How the US Drives Gun Exports and Fuels Violence Around the World, Bloomberg News, July 25, 2023

The WHO has a vital role to play in ensuring that UNODC, OHCHR, the ATT, the PoA and other regional mechanisms have access to data on the health impact of gun violence that supports efforts to close the legal loopholes facilitating the illicit flow of weapons.

Firearm fatalities: Firearm violence presents a deep and persistent global crisis, claiming over 250,000 lives annually worldwide (Greenberg et al., 2024). The majority of firearm violence deaths result from interpersonal violence rather than armed conflict, with particularly high rates in the Americas. Countries such as El Salvador, Venezuela, and Brazil have experienced firearm mortality rates as high as 40 per 100,000, compared to the global average of 6 per 100,000 (Werbick et al., 2021). In the United States, firearms are the leading cause of death among youth aged 1 to 19 (Patel et al., 2022 & The Global Burden of Disease 2016 Injury Collaborators, 2018).

Firearm and ammunition related injuries and long-term health

consequences: Beyond fatalities, studies indicate that firearms and the ammunition they fire cause significant nonfatal injuries and disabilities, including chronic pain, physical impairment, and long-term trauma. Global estimates indicate for every person shot and killed as many as six victims will survive, often with severe disabilities (Buchanan, 2013).

Studies also show that over 46,000 Disability-Adjusted Life Years (DALYs) are lost annually due to firearm injuries (Dahlberg et al., 2022). In Central America, DALYs from firearm violence exceed 2,400 per 100,000, far above the global average of 171 (Werbick et al., 2021). Where data has been published, non-fatal firearm injuries are more than twice as likely as gunshot fatalities (Giraldi et al., 2025). A recent US-based study by Song et al. reports a sharp increase in pain, psychiatric and substance use disorders amongst adolescent survivors of gun violence. They detail the consequences for parents of survivors who suffered a 30-31% increase in psychiatric disorders, and 75% more mental health visits by mothers, and a decrease in the likelihood that mothers and siblings would access routine medical care. They also indicate that youth gun injuries youth have negatively affect the whole families' health (Song, 2023).

Firearm-related injuries impose a substantial and largely preventable burden on health systems worldwide. Across countries with high levels of gun violence—such as Brazil, South Africa, Jamaica, Mexico, and El Salvador—emergency and inpatient treatment for gunshot wounds consumes millions of dollars annually, often straining already under-resourced public hospitals. Between 2012 and 2021, Brazil recorded an average of 42,000 firearm deaths and 28,000 firearm injury treatments per year, including about 21,400 hospitalizations – $\frac{3}{4}$ quarters of them caused from firearm assaults, followed by accidents and self-inflicted injuries (Instituto Sou da Paz, 2023). Chelsea Parson and Rukmani Bhatia remind us of the human costs behind this dry data: “The devastation of a bullet wound to a human body is often irreparable: Spinal injury leaves survivors paralyzed; blood loss and infections can require amputations; intestinal perforations often result in survivors needing colostomy bags to replace their damaged gastrointestinal tracks. Many gunshot survivors are plagued with a lifetime of chronic pain and suffer premature death from ongoing complications” (Parson & Bhatia, 2019). First responders and emergency medicine experts also carry a heavy burden of trauma.

Effects of firearms and gun violence on mental health: The mental health consequences of firearm violence are also acute and multifaceted yet often omitted in the discussions surrounding the public health impacts of guns. Survivors often experience post-traumatic stress disorder, anxiety, depression, and substance use disorders (Anderson & Sidel, 2011; Dahlberg et al., 2022), as well as “increased chronic pain, new functional limitations, reduced physical and mental health composite scores, ... lower employment and return to work rates, poor social functioning” (Giraldi et al., 2025, p.1). Indeed, a recent review in the *Lancet* draws attention to gaps in understanding the broader effects of gun violence stating: “Our findings suggest that research most often explores short-term and psychological impacts on direct survivor-witnesses. The review highlights notable gaps, particularly regarding long-term and cumulative impacts among both the immediate social networks of survivor-witnesses and their wider communities” (Giraldi et al., 2025).

Firearms, ammunition, and increased risk for suicide: Studies from across the world have for many years demonstrated a strong association between gun ownership and access, and increased risk of suicide (Killias, 1993; Grassel et al., 2003; Siegel & Rothman, 2016). Research by Killias showed that gun possession in 21 developed countries was significantly correlated with gun-related suicides (Killias, 2001). In the US, 52% of firearm deaths are suicides and nearly 60% amongst men (Hemenway & Nelson, 2020; Centers for Disease Control, 2023). Because of their lethality, suicide attempts in which a gun is used are far more likely to result in death than other forms of attempted suicide. US studies reveal that suicide attempts that involve firearms are far more likely to have a deadly outcome. Only 8.5% of attempted suicides resulted in death when a gun was not used, compared to 90% of attempted suicides with guns (Conner et al., 2019). Semenza et al.’s research in the US shows that exposure to gun violence also increases suicidality. They write: “the relationship between homicide and subsequent suicide is more pronounced for firearm-specific fatalities” (Semenza et al., 2025 p. 118406). They conclude that “community-level firearm violence may have uniquely salient effects on population mental health, potentially due to the highly lethal nature of firearms and their role in both interpersonal and self-directed violence (Semenza et al., 2025, p.6). Restricting access to guns decreases suicide. Suicidality and suicide attempts are often impulsive; the vast majority of those who attempt suicide never attempt suicide again and die of natural causes (Hawton et al., 2003; Florentine & Crane, 2010). Reducing access to guns even for small periods of time creates an important opportunity for people to reconsider, change their minds, and seek help (Stroebe, 2023). In Switzerland, studies have shown that changes in the number of men in military service and subsequent decreased possession of guns led to a 9% reduction in male suicides (Balestra, 2018). Similar findings were reported after the Israeli Defence Force decreased access to guns amongst recruits over the weekend (Lubin et al., 2010).

Ammunition and violence: Despite being the actual cause of injury and death, bullets receive far less attention than guns. In their article *Bullets as Pathogen—The Need for Public Health and Policy Approaches*, Fleegler and colleagues point our attention to the impact of the ammunition fired by guns. As emergency room physicians and gun violence researchers, they write: “We know what bullets do to human bodies: they tear through flesh, shred tissue and vital organs, and

their destructive path leads to bleeding, pain, shock, disability, and death. They leave permanent emotional scars and lasting mental health burdens on people who have experienced gun violence, families, and communities” (Fleegler et al. 2025, p. E1.). They point out that the type of bullet matters—their calibers, weight, shape, material, travel velocities and the number of rounds held by magazines—all produce particular effects, some far more damaging than others. Analysts argue that policymakers have largely failed to update laws and regulations governing the slew of new and more lethal bullets produced by the ammunition industry. These include armour piercing bullets, .50-caliber bullets designed for use with the lethal Browning machine gun, hollow nosed and lead tipped bullets which expand upon impact, and high-capacity magazines able to carry 20/30/50 and/or 100-round magazines and drums (Parson & Bhatia, 2019). Ironically, bullets now easily available to civilians were once, like chemical weapons, banned in armed combat or subjected to serious international review. For instance, hollowed or exposed lead point bullets were “deemed to create ‘a very cruel wound’ and banned at the Hague Convention in 1898 on the basis that they caused ‘ravages to the body’” (Shah, 2025). Prompted by the widespread use by the US army of smaller calibre single projectiles in the US war against Vietnam, the International Committee of the Red Cross convened international consultations in Lucerne and Tehran “to undertake a searching appraisal before these and even smaller projectiles became accepted as a normal feature of modern warfare” (Shah, 2025, p.5). It is past due for those deliberations to be revisited.

Firearm violence and its range of impacts on specific groups:

Regional and racialised differences in gun violence: The rates and impacts of gun violence vary markedly across the world. Brazil, Colombia, India, Mexico, the US, and Venezuela account for two-thirds of global gun deaths (Hyder & Barberia, 2024). The US is the country with the largest number of guns, more than one for every citizen. Proximity to the US is also associated with high rates of gun violence because gun dealers in the US appear to deliberately facilitate legal and illegal cross border trade in guns (Grillo, 2021). Global Action on Gun Violence indicates that in 2021 the percentage of seized guns traced back to the United States was 99.2% in the Bahamas, 92.6% in Canada, 84.8% in Haiti, 86.2% in the Dominican Republic, 69.4% in Jamaica, 67.5% in Mexico, 62.0% in Honduras, 52.0% in Panama, and 49.2% in El Salvador. They point out that this is almost certainly an undercount (Lowy, 2024). Data on ammunition indicates similar trends. About half of the ammunition used in violent crime Caribbean countries was manufactured in the United States. Italy, Germany, the Czech Republic, and Mexico, respectively, fill out the top five (Fabre, 2023).

In these and other countries, gun violence is also racialised. In the US, Brazil, South Africa and other multi-ethnic countries, it is young Black men and other men of colour who are most likely to be the victims of gun homicides, especially those with limited educational attainment (Dare, 2019). In Brazil, for example, black people face a firearm mortality rate three times higher than non-black people, a disparity that persists even as homicides decline (Instituto Sou da Paz, 2024). Low and Middle-Income Countries (LMICS) bear the highest mortality and disability tolls because of their lower health system capacity (Ou et al., 2022).

Cherrell Green offers important analysis of the racial bias often embedded in policing and health systems in the US but generalisable to many other countries in the Americas with racialised populations. Based on interviews with young Black men injured by gun violence, Green writes that health care providers often relied on stereotypes about young Black men and “viewed them as drug dealers, criminals or ‘thugs’ who brought their injuries upon themselves, seeing their injuries as a consequence of their bad behavior”. These stereotypes, she argues, “led to minimized care for these injured Black men both during their hospital stay and in aftercare, as well as a dismissal of their physical and psychological pain, further diminishing their dignity as people and denying their status as patients” (Green, 2024, p.9). Green’s findings point to an important area of work for the WHO—working with medical training institutions and ministries of health to develop evidence based interventions to address racial bias in the treatment of gunshot and other injuries amongst young men of colour, especially young Black men.

Violence against and amongst men: As Myrntinen and Schöb write: “The link between men, masculinities and small arms – in particular guns – is a close, multi-faceted and intimate one”. They point out that “Individual gun ownership is overwhelmingly in male hands, while militaries, police, security guards, guerrillas, gangs and other organisations that use small arms are also male dominated, especially those roles in these which require handling small arms”. In helpfully clear language, they write: “The impacts of armed violence are also highly gendered. While men are the primary owners, users and abusers of small arms, men and boys are also often the main direct victims of small arms violence, especially in countries with high levels of armed violence.” (Myrntinen & Schöb, 2022, p. 6)

The dual reality of gun violence is that men bear the brunt of public gun violence, whereas women are subjected to firearm violence by men in the private, domestic spheres, very often their intimate partners. Men, particularly young men, account for the majority of both victims and perpetrators, composing 81% of homicide victims and 90% of perpetrators globally (UNODC, 2023, p. 23). In some regions, adolescent boys experiencing firearm mortality at 12 times higher rates than their female counterparts, particularly in Latin America and the Caribbean (Cullen et al., 2024) where young Black men are the most vulnerable to gun violence. In Brazil, men represent 94% of firearm homicide victims, with guns used in around 75% of male homicides - rising to over 83% among young men aged 15–29. Hospitalized male victims of firearm injuries tend to stay longer, cost more, and have higher mortality rates, likely due to more severe injuries compared to women (Instituto Sou da Paz, 2023).

The US-based Everytown for Gun Safety make the case that:

“Research has found that among the many reasons people purchase firearms, a sense of empowerment is one that particularly resonates with men, who tend to find greater feelings of empowerment from gun ownership. Firearms can provide or re-instill a feeling of power and are even explicitly marketed as doing so.” (Everytown for Gun Safety, 2022).

Young men's attraction to guns is neither natural nor coincidental. A growing body of literature on longstanding gun industry efforts to shape men's attitudes to and about guns describes the multifaceted marketing strategies used by the gun industry to link gun ownership with particular ideas about manhood, including through product placement in films and video games, the recruitment of influencers, or "gunfluencers," on online platforms, and gun ads that create and exploit ideas about manhood to sell guns (Peacock, 2024). Indeed, findings from a recent survey conducted by US-based Sandy Hook Promise indicated 54% of boys ages 10–17 reported seeing sexually charged firearm content at least once a week. Indicative of the extent of product placement by the gun industry in video games, boys who frequently played video games were nearly 2.5x more likely to see sexually charged gun content (61%) than those who play less often (25%). The same study reported that 38% of boys had clicked on a firearm ad they saw online. Founder of Sandy Hook Promise, Nicole Hockley asserted that "the firearm industry is aggressively pushing harmful ideas about masculinity – using very sexualized and violent content to market firearms to kids" (Sandy Hook Promise, 2025). The gun industry has also successfully marketed guns for safety and protection, even as numerous studies show that those living with a gun in the home are twice as likely to die by homicide and three times as likely to die by suicide than those living in a gun-free household (Studdert et al., 2022). A growing number of people believe that guns keep them safer and report buying a gun for self-protection. The reason for this striking disparity between fact and fiction? A carefully calibrated marketing campaign by the gun industry that uses "strategic manipulation of fear and identity politics" intended to "promote gun purchasing and deregulation of gun manufacturers, not safety" (Jordan et al., 2024).

Guns and violence against women: Women face disproportionate risk of gun violence in domestic settings, accounting for approximately 54% of victims of killings in the home and 66% of victims of intimate partner killings (UNODC, 2023, p. 22). While global data disaggregating gun use in domestic or intimate partner violence (IPV) remains limited, the data show that firearms are a significant factor in lethal violence against women. In many countries, guns are the primary weapon used in femicides, although it is surprisingly difficult to find an up-to-date comprehensive overview of gun use in femicides. Research indicates a very clear and strong association between access to a gun and increased risk of domestic violence homicides. A 2024 study by UN Women and the UN Office on Drugs and Crime reports that "Available evidence in this field suggests that possession of a firearm by a perpetrator of intimate partner violence significantly increases the odds of a killing and also increases the risk of multiple victims by 70% in killings committed in the private sphere" (UNODC, 2024, p.23). A WHO report on small island developing states indicates that "firearms are a vector for gender-based violence" (WHO, 2025 p.55).

Country-specific studies bear this out. Campbell's landmark study identified gun ownership as the highest risk factor for intimate partner violence, with the odds of lethality increasing 540% where there is access to a gun in the US (Campbell, 2003). In a 2021 study by the United Nations Development Programme (UNDP) on the use of guns in situations of domestic violence and femicide in Serbia,

Govedarica et al. report that: “In families and relationships in which perpetrators have access to firearms, the risk of misusing the weapon and the risk of violence escalation is increased up to five times and the consequences of the misuse are severe” (Stevanović Govedarica, 2021, p. 5). Firearms are the main weapon used in the killing of women in Brazil; about half of the 3,900 female homicides each year involve guns. Health data do not distinguish femicides – a legal classification adopted in Brazil in 2015 – but police records show that femicides account for 40% of female homicides, and 24% of them are committed with a firearm (Anuário Brasileiro de Segurança Pública, 2024 e 2025 & Instituto Sao da Paz, 2024). Official data from Mexico for the period 2004–2024 reveals that the rate of murders of women involving firearms has increased by 375% (Martinez-Villalba, 2024).” A 2024 review of femicide in South Africa also shows an increase in femicides and indicates that guns were “the most common manner of death in which women were killed” in the most recent national femicide study (Abrahams et al., 2024, p. 4.).

The role of firearms in the dynamics of power and control in domestic violence warrants far greater attention in public health. There is little research on intimate partners’ non-fatal gun use against women, but the mere knowledge that a potential or current perpetrator has a gun increases the risk for coercive control, which is associated with chronic and escalating abuse. Sorenson and Shut report that “In the US alone, the number of US women alive today who have had an intimate partner use a gun against them is substantial: About 4.5 million have had an intimate partner threaten them with a gun and nearly one million have been shot or shot at by an intimate partner” (Sorenson & Shut, 2016, p. 6). A study in Grenada, Guyana, Jamaica, Suriname, and Trinidad and Tobago found that at least 7% of women who had ever been in a relationship had been threatened with or gun or knife or had one or the other used against them by their intimate male partner (Fabre et al., 2023) in a region in which gun ownership rates are lower than global averages. In 2023, Brazil recorded 4,300 cases of non-lethal firearm violence against women in the public health system. Most involved the use of gun in physical assaults (52.8%), psychological/moral violence (22.2%), and sexual violence (13.8%). Notably, recurrent violence - which characterizes domestic violence - was present in 35% of these cases, meaning the victims had previously suffered other episodes of violence (Instituto Sou da Paz, 2025). Far more research of this sort is needed, and the WHO is well positioned to champion it—including by building on the recent report on economic and commercial determinants of health considerations in Small Island Developing States which gives more attention to the issue than many other WHO reports (WHO, 2025).

Importantly, and with clear implications for potential WHO policy work, four research studies by the South African Medical Research Council have shown that the implementation of South Africa’s *Firearms Control Act of 2000* was associated with a steep decline in homicides and femicides up until 2010 when the relaxation of licensing conditions and police corruption including illegal diversion of guns from police stockpiles to criminals dramatically increased the availability of guns (Matzopoulos et al., 2019). These findings are consistent with global research, including a meta review of 130 studies from 10 countries on the impact of gun control laws which found that “Laws restricting the purchase of (e.g., background

checks) and access to (e.g., safer storage) firearms are also associated with lower rates of intimate partner homicides and firearm unintentional deaths in children, respectively” (Santaella-Tenorio et al., 2016).

The effects of gun violence on women reflects prevailing gender norms and structural relations of gender inequality: global estimates show women perform most unpaid care and are the majority of care workers (International Labour Organization, 2018). In households and communities, women shoulder most long-term care for gunshot-injured survivors. Where firearm injuries cause lifelong disability (especially spinal cord injury and traumatic brain injury), day-to-day care (bathing, toileting, turning to prevent pressure sores, transporting to clinics, managing medications) is overwhelmingly provided by women—most often mothers, partners, or daughters. When families lose a member to gun violence, it is disproportionately women who provide grief care, household support, and interface with institutions (Mohammed et al., 2023). Globally, women make up the majority of the health and care workforce; nursing in particular is predominantly female (WHO, 2024). As firearm injuries surge, emergency and trauma nurses face high workloads, recurrent exposure to severe injuries and death, and increased burnout. Recent South African and international nursing studies highlight heavy job demands in emergency units (Barnard et al., 2023; Engel et al., 2020); gun violence adds emotional labour and secondary trauma for providers. In hospitals, the nurses absorbing trauma care burdens are mostly women. In communities, the social workers, mental health professionals and non-governmental organisation (NGO) workers are also mostly women.

While gun violence in military conflict is not the focus of this report, it is worth noting that women are also the majority of victims of conflict-related sexual violence (CRSV). While there is little publicly available data on CRSV incidents, and a lack of specific data on weapons in relation to CRSV, in a small number of countries available disaggregated data on weapons indicated that between 70% to 90% of CRSV incidents involved weapons, especially firearms (Salama, 2023).

Surprisingly, as we describe in greater detail in our review of WHO documents and WHA Resolutions, **the WHO has not included a clear or consistent focus on gun violence in its important recent work to address gender based violence (GBV) and femicide**. Whereas a 2012 report by the WHO on femicide states unambiguously that “studies consistently show an association between ownership of guns, particularly handguns, and perpetration of intimate femicide” (Garcia-Moreno et al., 2012), the 2019 RESPECT Framework produced by the WHO as a GBV prevention road map for Member States and civil society does not mention guns or firearms at all. The same blind spot appears in the latest joint UNODC and UN Women report on femicide which includes only a cursory focus on firearms (UNODC & UN Women, 2023).

In Brazil, studies based on cross-referencing health databases indicate a higher risk of death among women with a history of interpersonal violence (previous violence). In intimate partner cases, firearms, sharp objects, and other combined means are present in incidents reported by the victim prior to death, with firearms posing the greatest risk of death by homicide. (Barufaldi, L.A et al., 2017; Pinto, I.V.

et al., 2021, Marinho, F.; Malta, D.C., 2025). Addressing this multifaceted crisis of firearms and the impact on women requires a gender-responsive approach to firearm policy that reflects both public and private dimensions of harm. To draw on an illustrative example, it is crucial to address the burden of firearm violence on Brazil's public health system and strengthen healthcare in affected areas. A pilot project in a Brazilian state capital mapped the trajectories of women victims of violence treated in the health system, showing that most cases are reported only when victims reach hospitals, despite earlier visits to primary care (Vital Strategies, 2025). Health services play a key role in detecting and breaking cycles of violence that can lead to femicide, especially when firearms are involved. Whether it is the paucity of robust global data on the use of guns in femicides and the role of guns in GBV, or the lack of UN-wide attention to the role of guns in femicide, the WHO has a vital role to play in encouraging data collection and dissemination to augment its public health work to address GBV.

Gun violence against members of LGBTQI+ communities: Gun violence against lesbian, gay, bisexual, trans, queer and intersex (LGBTQI+) or people perceived to be LGBTQI+ is a serious but often under-reported problem. A global, firearm-specific prevalence estimate for homophobic/transphobic homicide does not yet exist in the academic literature due to major data gaps. In recent years, a number of high-profile mass shootings at LGBTQI+ events in Orlando, Colorado Springs, Oslo, and Bratislava have killed and injured dozens of people (Mexico, Spain, & Small Arms Survey, 2023). Furthermore, analysing available data from Latin America and the Caribbean, Baca et al. noted that the number of homicides committed against LGBTQI+ people using firearms surpassed sharp objects in 2017 (Baca et al., 2019). The WHO has a crucial role to play in supporting Member States to collect data on and address gun violence against LGBTQI members.

Gun violence and children: Firearms are also implicated in the violence and mortality of children and young people. According to the *Gun Violence in the United States 2022* report, "guns were the leading cause of death among children and teens accounting for more deaths than car crashes, overdoses, or cancers" (Villarreal et al., 2024). In 2016-2020, the proportion of homicides involving firearms was at an all-time high for infant and toddlers 0-4 years of age (14.8%), child (53.1%), and adolescent victims (88.5%)⁶ (Berg et al., 2024). They have been the leading cause of death for Black youth in the US since at least 2001 (Cunningham et al., 2018), and are an important contributor to racial health inequities among US youth (Andrews et al., 2022). In Mexico, amongst those aged 1-19 years, the rates for homicide, firearm-related injuries and suicide increased significantly from 2000 to 2022. Deaths by firearms rose by 120.7% in Mexico from 2.2 to 4.9 per 100,000 (Castilla-Peon, 2024). The male adolescent population is the most affected by violent deaths on both sides of the border, with rates of 18.7 and 12.2 homicides per 100,000 male adolescents in Mexico and the US in 2022, respectively. Notably, female Mexican adolescents also exhibited elevated homicide rates.

⁶ Infant and toddlers defined as ages 0-4, child ages 5-12 and adolescent ages 13-19.

Exposure to gun violence also inflicts psychological harm most acutely on children and adolescents, regardless of whether they are direct victims or gun violence witnesses. For instance, exposure to gun violence during childhood can result in developmental issues and anxiety disorders (Semenza & Kravitz-Wirst, 2025). For young men already desensitised to violence, repeated exposure can shape their perception of firearms, equating them with power and security (Garbarino et al., 2002).

Sandy Hook Promise's *Untargeting Kids* report referenced above provides a thorough overview of the extent to which firearm companies market guns to children, often using regulatory loopholes and product placement in films, television and video games with sexualised and glamorised images of guns and gun ownership. A recent WHO, UNICEF, Lancet Commission paper, published in 2020, calls for a legally binding instrument to regulate commercial marketing to children. The paper proposes adding an Optional Protocol to the Convention on the Rights of the Child which they would require national governments to prohibit or regulate products that should not be marketed to or for children as well as specific methods of marketing to children like via television shows, games, and social media used by children and youth, or via sponsorship of youth activities (Clark et al., 2020).

Given that in some countries gun violence is a leading cause of death amongst children, one would reasonably expect that the WHO's work to address violence against children would include a strong focus on gun violence. This is, however, not the case. The INSPIRE framework to address violence against children published in 2016 is perhaps the WHO's most thorough work on violence against children but does not include a meaningful focus on gun violence. INSPIRE mentions alcohol nearly three dozen times. It mentions firearms just seven times, four of them in the citations section (Inspire Framework, 2016).

The impact of the absence of a WHO focus on gun violence in work to address and prevent violence against children appears evident in the outcome documents of the first-ever Global Ministerial Meeting to End Violence Against Children held in Bogota in 2024, co-convened by WHO, UNICEF, and the Government of Colombia. Attended by 110 countries, it issued the Bogota Call to Action and secured government pledges to take action to address violence against children. Unfortunately, the Bogota Call to Action has no mention of guns or firearms. None of the pledges appear to either, at least based on a search of the conference database (which does indicate 32 mentions of corporal punishment, 18 mentions of gender norms, and 2 mentions of alcohol).

The impact of gun violence on health care services, systems, and providers:

The analysis that follows describes the devastating impact of firearms and the ammunition they fire on the physical and mental health of gunshot victims and perpetrators, bystanders and family members, affected communities, and society more generally. It discusses the different impacts gun violence has on people according to gender, age, race, class, and geography. Implicit but not always

identified in the following sections is the impact of gun violence on the broader ecosystem of health care institutions and health care providers: emergency medical service first responders, emergency room physicians and nurses, mental health professionals, physical therapists, community health outreach workers, orderlies, morticians and pathologists, and public health researchers.

While there is no single, authoritative global price tag for health-service costs of firearm violence, rigorous estimates exist at country or sub-national levels. They consistently show high direct medical costs for acute care, surgery, inpatient stays, and rehabilitation services, as well as substantial mental-health care spending for survivors and affected communities. Studies show that gunshot wounds are far higher than other trauma-related injuries like stabbings, blunt trauma or road injuries (Barry et al., 2022; Spitzer et al., Bush et al., 2024). Research undertaken in the Caribbean showed that treating a single firearm injury cost between 2 and 11 times annual per capita health spending (Fabre et al., 2023). In Brazil, a firearm-related hospitalization costs at least 3.2 times more than the federal per capita healthcare expenditure. (Instituto Sou da Paz, 2023).

The financial costs of services for gunshot victims and others affected is just one metric. A different cost is borne by health systems: the effects of dealing with gunshot injuries on medical professionals. Multiple studies indicate high levels of post-traumatic stress disorder (PTSD) and mental health problems amongst medical professionals dealing with gun violence “at every level—from trainee to the most experienced...and can lead to a cycle of burnout and increased stress, which is harmful to surgeons and patients” (Williams & Butts, 2023). A recent study on the health impacts of exposure to trauma amongst ambulance personnel in South Africa indicated elevated rates of stress-related smoking, alcohol and drug use, a self-reported mental health condition, and being treated for a medical condition (Ntatamala & Adams, 2022). Relatedly, a study on the mental health sequelae among social service agency staff one year after responding to a mass shooting indicates debilitating effects with significant impact on subsequent health systems capacity (Engel et al., 2020). The widely documented impacts of gun violence on health personnel explain this response from an emergency room physician to the gun industries criticism of physician advocacy for gun violence prevention:

“ Suggesting that physicians who treat injuries and disability and witness death should say and do nothing about their causes is ludicrous. Physician advocacy for public health, interpreted broadly, is not radical; it is our moral and professional duty... Gun control policy, as with all health policy issues, should be founded upon the best available evidence. Physicians know scientific evidence and are good at producing, appraising and explaining it to the public. In contrast, the gun lobby has been good at hindering both production and discourse of evidence linking guns and health.” (Stanbrook, 2019, p.E434.)

Important language on health and small arms and light weapons was included in the report issued at the 2024 Fourth Review Conference (RevCon4) for the UN

Programme of Action (UNPoA) on the illicit trade of Small Arms and Light Weapons (SALW) and its International Tracing Instrument (ITI). Adopted in 2001, the UNPoA is a politically binding framework for UN Member States to take action on SALW. WILPF and GENSAC note that Paragraph 134 of the RevCon4 outcome document “specifically addresses the linkages between armed violence associated with illicit SALW and the health of women, men, girls, and boys”. Paragraph 134 reads: “To fully assess the intricate linkages between armed violence associated with illicit small arms and light weapons and the health of women, men, girls and boys, which constitutes both a public health and a mental health concern. Addressing the mental health impacts of such violence requires strategies and programmes aimed at prevention while also providing comprehensive social safety nets for victims and survivors.” The Women’s International League for Peace and Freedom (WILPF) and the Gender Equality Network for Small Arms Control (GENSAC) point out that “Besides a reference to the Sustainable Development Goals (SDGs) in the outcome document of RevCon3, noting that the illicit trade in SALW has implications for the realisation of several SDGs, including health, paragraph 134 is new” (Bjerten & Briggs, 2025).

Social, economic and political costs of firearm violence: Research by Cook and Ludwig in the context of the US argue that “shootings account for fewer than 1 percent of all crimes but nearly 70 percent of the total social harm of crime”. They make the case that “Gun violence, and the fear of gun violence, distort the lives of millions of Americans” in ways that other forms of crime do not. Property crimes like shoplifting, break-ins, employee theft, constitute 80 percent of all crime in the US but are “rarely life-changing events for the victims” and do not have a major impact on quality of life. Gun violence, on the other hand, they argue “substantially distorts the way that millions of people live their lives”. We have already described the mental health impacts of gun violence. Cook and Ludwig also show that gun violence increases poverty: “Gun violence drives people and businesses out, which leads to further gun violence, which leads to more people and businesses leaving. If you control gun violence, that makes it easier to retain and attract both people and businesses—that strengthens a community” (Cook & Ludwig, 2022). While Cook and Ludwig’s research is US focused, their findings are broadly generalisable to other nations. Research by Vargas and others serves as evidence of this. Guns, gangs and bullets are one of the main drivers of forced migration for communities in Mexico, Central America and the Caribbean (Vargas et al., 2024). In addition, an analysis of 36 Organization for Economic Cooperation and Development (OECD) countries, found that “under the status quo, firearm-related fatalities will result in a cumulative loss of \$239.0 billion in economic output from 2018 to 2030 across all 36 OECD countries” (Peters et al., 2020). Although the extent of economic losses varies by country, these losses, just like the lost lives and devastating health impacts, are preventable.

Effects of firearms and gun violence on active citizenship and political engagement: In addition to the social and economic costs of gun violence, a 2025 report by the United Nations High Commissioner for Human Rights on civilian acquisition of firearms highlights the costs for political participation and cultural

expression. “As a mechanism of violence, firearms enhance the lethal effects of targeted attacks and fuel high rates of societal violence, creating an environment of fear that discourages political participation and cultural expression” (A/HRC/59/39, p. 14). Research in the US also shows that the presence of guns at political demonstrations increases sixfold the likelihood that they turn violent or destructive compared to unarmed demonstrations (Everytown for Gun Safety Support Fund, & Armed Conflict Location & Event Data Project, 2021).

As we have now established, firearm violence requires coordinated, international, regional, and national interventions. Prevention, as well as strengthened support and trauma systems are necessary to decrease the harmful health effects and subsequent socioeconomic costs.

Despite the recognition of firearm violence as a major public health issue by the WHO, especially in the period 2002-2015, gun violence related research, coalition building, convenings, and intervention evaluations have received steadily decreasing attention within the WHO, limiting evidence-based policymaking.

This institutional disengagement, which we will show has been magnified by the political resistance of key Member States and by gun industry pressure, has allowed preventable firearm-related morbidity and mortality to persist.

A recent study of gun related mortality in 204 countries and territories covering the period 1990-2019 indicates that almost no progress has been made in reducing gun related death: firearm-related mortality violence decreased from 2.41 to 2.29 deaths per 100,000 people (Patel et al 2022), with countries in the Americas the most badly affected, as we have indicated above (Degli Esposti et al., 2024).

Against this backdrop, it is more critical than ever that the WHO reprioritises its work on gun violence and provides critical leadership with Member States to reduce gun violence across the world.

Understanding gun violence as a commercial determinant of health and violence

The WHO describes commercial determinants as “the private sector activities that affect people’s health” via “a wide range of risk factors, including smoking, air pollution, alcohol use, obesity and physical inactivity, and health outcomes, such as noncommunicable diseases, communicable diseases and epidemics, injuries on roads and from weapons, violence, and mental health conditions”. They go on to say: “Commercial determinants often disproportionately affect countries and populations that are not profiting from the product or service that causes harm to health or planet but instead are faced with the burdens of these harms. As a result, they shape health equities, both within and between countries.” Importantly, they assert that “there are effective public health actions to respond to these determinants, which are key to building back better after COVID-19”⁷. The WHO’s definition of commercial determinants as transnational forces is also why the WHO has a mandate to act to contain the harm these transnational forces cause.

Bellis et al. have refined this analysis further by drawing attention to the commercial determinants of violence, those industries whose practices and products contribute to violence. They write: “The roles of commercial bodies in fostering and preventing violence remain largely unaddressed. The wealth and influence of some companies now exceeds that of many countries. Consequently, it is timely to explore the roles of commercial processes in violence” (Bellis et al., 2024, p.1).

There is now a significant body of literature, including a recent special issue of the *Lancet*, on commercial determinants of health (Lancet, 2023). A key finding is that commercial actors work together across a wide range of industries to develop strategies to counter public health regulations. Some analysts refer to this as a “corporate playbook” of carefully tested and coordinated strategies to increase profits, no matter the health implications. They argue that this “playbook” is used by many industries, including alcohol, gambling, pharmaceutical companies, ultra-processed and fast foods, automobiles, sugar and sweetened beverages, big tech companies, oil and gas, and firearms, amongst others. They point out that “The corporate playbook also spans the actors enlisted to support these

⁷ <https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health>

industries, such as lobbyists, lawyers, tax advisers, consultants, front groups, financial services, media, marketing, and public relations” (Lacy-Nichols et al., 2022, p. 1067).

Like other corporate actors, the gun industry and its lobbyists have developed a range of lobbying and marketing strategies which include gender exploitative marketing (Mencken & Froese, 2019), much of it now online, often linking gun ownership with manhood, and more recently marketing guns to women as a means to achieve greater safety and empowerment. Carlson details the gun lobby’s strategic deployment of fear about exaggerated levels about crime to appeal to men as “citizen protectors” (Carlson, 2015), and about imminent government and UN restrictions on access to guns to sell weapons (NSSF, 2020), and they have popularised the notion that citizens have, or should have, the right to own weapons (Everytown for Gun Safety, 2020).

To date, guns have not been a significant focus of work on commercial determinants of ill-health and harm. In a recent scoping review of published literature on commercial determinants, Burgess et al. concluded that “articles most often discussed corporate activities in relation to the food and beverage (51/116; 44%), tobacco (20; 17%), and alcohol industries (19; 16%), with limited research on activities occurring in other industries. Most articles (42/58 articles reporting a regional focus; 72%) focused on corporate activities occurring in high-income regions of the world” (Burgess, 2024).

The WHO’s treatment of gun violence within its work on commercial determinants of health mirrors Burgess’s findings. In May of 2025 WHO released its World Report on Social Determinants of Health Equity. It affirms that the public sector can effectively mitigate the effects of commercial practices that damage health, including through enacting regulatory and legislative changes that better value human and planetary health (WHO, 2025). It does not, however, include any mention of firearms, guns or weapons.

It is important to understand the mechanisms that allow corporate actors to influence and shape health policy. To be clear, we have no reason to believe that the WHO has been directly influenced by the gun industry, and we are not in any way suggesting that here. Rather, we are saying that the gun industry has exerted pressure on key Member States, especially the US, to discourage them from supporting any WHO efforts to address gun violence.

A few concrete examples expose how this gun lobby influence plays out.

The US has historically been by far the largest contributor to the WHO’s budget and it has repeatedly threatened withdrawal of financial contributions to the WHO when it has disagreed with WHO’s positions and priorities.

However, the influence of the US government on the WHO goes beyond just its financial clout. Within the US, the gun industry plays an outsized role in blocking legislative efforts to regulate guns and supporting the notion that gun control is a fundamental right and the guarantor of all other rights (Brady United Against Gun Violence, 2022) and then disseminates this norm globally.

By funding political candidates, the gun lobby also influences US political appointments to key multilateral bodies, including the UN (Open Secrets, 2024).

Furthermore, the gun industry has been successful in its efforts to drastically limit the US Centers for Disease Control (CDC) from conducting research on gun violence via passage of the 1996 Dickey Amendment which led to a 90% reduction in funding for gun-related research in the US (Kapadia, 2022). In 2012, the US National Rifle Association and its political allies extended the ban to include the US National Institute of Health (NIH) (Lin et al., 2024). In both instances, the motivation for the gun industry interference with gun violence was the publication of research findings funded by the CDC and the NIH which revealed the extent of gun violence in the US, including one that found that owning a gun increased the risk of being murdered in one's home (Kellerman, 1993), an awkward finding for an industry marketing guns as a way to increase home safety. Kapadia explains that "The presence of this ban for more than 20 years is one of the most prominent examples of lobbying and corporate manifestation of power and of setting rules that eliminate funding for gun control research (Kapadia, 2022 p. 1711). In 2018, Congress clarified the Dickey Amendment to permit funding, which has led to increased funding in recent years, although the funding remains politically vulnerable (Poitras, 2024).

The decades long restrictions on CDC and NIH research on gun violence in the US also had ripple effects on international gun violence research (Rajan et al., 2018; Galea et al., 2018). Not only did it hinder research collaboration, but neither institution was able to fund international research on gun violence. In a context in which gun violence outside of the US disproportionately occurs in countries with limited research budget and capacity, this restriction of US funding and the limited publication of US gun research, greatly affected knowledge about gun violence.

With regards to UN treaties and multilateral mechanisms, again the US gun lobby plays an active role in blunting their impact. The NRA participates actively in multilateral deliberations to restrict global gun regulations, including at the ATT and PoA review conferences.

The NRA has also exported their playbook to Australia, Brazil, Canada, and South Africa, amongst others, to impede regulatory efforts in those countries (Erickson, 2018). In the writing of this report, a reviewer shared a concrete example of how the US constrained action on guns at the World Conference on Injury and Violence Prevention in 2006. The US delegation insisted that the conference logo be changed so that it did not include a gun with a line through it, which put pressure on the WHO delegates and made it difficult for them to support those advocating for this more explicit focus on gun violence prevention.

Cumulatively, then, the effects of the gun lobby on US government activities at the UN have been to discourage the WHO from prioritising gun violence research whilst also limiting the available evidence base for effective interventions and policy making.

It is of course not just the US that shapes UN and WHO willingness to address gun violence and the firearms industry. Daniel Mack argues that US-based funders have historically been reluctant to deal with gun violence because of “fear of controversy around the tense domestic debate on firearms”. He points to similar dynamics in Europe, saying “Several European governments, which have poured funds into other arms control initiatives, operate with too much deference to a notion of ‘non-intervention’ into an area that entails direct advocacy and often ignites political storms. Some are perhaps mindful that they are major producers and exporters of small arms and certain choices are bad for business” (Mack, 2015, p. 53.).

Nonetheless, despite these industry pressures, the WHO has a key role to play in bringing gun violence into focus as a commercial determinant of injury and ill-health. It should ensure that its forthcoming WHO Global Report on the Commercial Determinants of Health has a robust emphasis on gun violence.

We turn now to why it is so important for the WHO to prioritise gun violence in its current workstreams, even in the midst of the current funding shortfall.

SECTION IV

Firearm Violence and Global Health Governance: Why the WHO should address firearm violence as a public health priority within its workstreams and proactively participate in other UN efforts

“ A public health approach is designed to prevent and reduce harm by changing the conditions and circumstances that contribute to risk of firearm violence as measured by deaths, injuries, as well as the reverberating mental health and emotional impacts.” US Surgeon General Vivek Murthy, 2024 advisory on firearm violence as a public health crisis in America.

Within the UN system, gun violence has been addressed primarily as a security issue. The ATT, the POA, and the Firearms Protocol all focus on either the illicit trade in small arms and light weapons, or on incapacitation, redress, and deterrence after violence has occurred, although the deterrent effect of criminal legal responses on gun violence is contested. Mack reminds us that “human rights violations perpetrated or facilitated by arms are not more important when the weapons have been internationally transferred or banned by a UN instrument”, or are part of illicit trade (Mack, 2015, p. 54).

In addition, the focus of UN processes has been very much on controlling the supply of guns through top-down interventions that do not address drivers of demand.

The WHO, however, adds a number of important additional areas of influence and expertise that must be a part of the multi-sectoral efforts needed to successfully address gun violence, including the ability to declare violence an epidemic, the mandate to provide clinical guidance and training to nearly 200 Ministries of Health on trauma care, and expertise in public health-based violence prevention.

Firstly, each of the UN agencies involved in addressing gun violence has a critical and specific role within the UN ecosystem—whether that is research, coordination,

legal expertise, monitoring treaty related commitments, or strengthening gun violence-related clinical care and public health violence prevention interventions. However, With 193 Member States, nearly 5,000 staff, 150 country offices working closely with host governments and domestic civil society organisations, and a budget of nearly 7 billion US dollars, the WHO has far greater reach, influence and powers than the other UN agencies working on firearm violence. By way of comparison, UNODC has one tenth of the revenue at USD 514.7 million, half the staff, and 30% fewer country offices. UNODC has a budget of USD 27 million and 60 staff, and the United Nations Institute for Disarmament Research (UNIDIR) has a budget of USD 14 million and 70 staff. Thus, the WHO is uniquely positioned within and outside of the UN system to respond to the needs and mandates of its Member States, and co-produce policy guidance with and for Member States and their national departments of health. The WHO's mandate includes engaging with Member States to identify best practices in public health-based laws, policies and programmes for violence prevention, health and wellbeing and to then disseminate guidance to Ministries of Health in all of its nearly 200 Member States. Currently, only a small number of staff at the WHO work on topics directly relevant to firearms, and their time is currently fully absorbed by efforts to support uptake and implementation of the INSPIRE strategies. Nonetheless, even in the midst of unprecedented budgetary cuts at WHO, there is scope for Member States and civil society organisations to seek additional funding and push for increased attention to gun violence. Funding firearm violence prevention and firearm related trauma care costs significantly less than addressing the many consequences of firearm violence and the threats thereof.

Comparison of UN Agencies Involved in Small Arms & Light Weapons:

This table provides a side-by-side comparison of the WHO, UNODC, UNODA, and UNIDIR, in relation to their roles and resources on SALW. It compares their budget, staff, reach, influence, and illustrative impacts. Figures are based on most recent official reports.

Agency	Budget (latest)	Staff	Reach	Influence	Impact
WHO	US\$ 6.834 billion (2024–25 biennium)	4,498 staff in 153 country offices	166 of 194 Member States; 153 country offices	Normative guidance on violence/injury prevention;	Evidence-based public health approaches adopted in national plans
UNODC	US\$ 514.7 million revenue (2024)	3,276 workforce (2025)	150 countries supported; presence in ~111 countries	Custodian of UNTOC Firearms Protocol; Global Firearms Programme; Illicit Arms Flows Questionnaire	Global firearms trafficking datasets; model laws; capacity-building for law enforcement

UNODA	US\$ 27.2 million regular budget (2022–23)	61 posts (regular budget;)	HQ (NY/ Geneva) + 3 Regional Centres	Chairs CASA (24 UN entities); leads PoA/ ITI; MOSAIC; UNROCA transparency register	717,712 weapons destroyed reported in 2022–23 PoA cycle
UNIDIR	US\$ 13.9 million received (2024)	~71 staff	Geneva-based; global convening of states, experts, CSOs	Independent research feeding into UN disarmament processes	SALW policy-relevant studies shaping UN debates and recommendations

Secondly, gun violence clearly meets the criteria for a global health challenge: it transcends borders, causes over 250,000 deaths a year, and an uncoun­ted toll of injuries and severe mental health problems that disproportionately affect vulnerable and socially excluded populations, requiring coordinated, multisectoral responses, much like is done for infectious diseases.

Gun violence prevention also aligns with leading conceptual frameworks of global health that emphasise equity, collective well-being, and shared transnational determinants (Werbick et al., 2021). Despite this alignment, the WHO has not consistently treated firearm violence effects on health with the urgency and cohesion it requires, showcasing a critical governance gap that must be addressed.

Understanding firearm violence from a public health governance perspective requires attention to the multilevel risk factors driving its health impacts, as well as the broader structural forces such as globalisation and the firearms industry:

- At the individual level, risk factors include firearm accessibility, substance abuse, gender norms, and untreated mental health conditions (Butchart et al., 2019).
- At the community level, factors such as poverty, neighbourhood disorganisation, and alcohol outlet density, are shown to increase risks of gun violence (Butchart et al., 2019; Dahlberg et al., 2022).
- At the national level, the failure of some governments to provide adequate human security safeguards in particular areas and to particular groups can create incentives for people to purchase weapons, even if the data shows that the presence of a gun increases the likelihood of gun violence.
- At the global, or transnational, level, the licit and illicit arms trade, dominated by commercial actors in high income countries and by transnational criminal groups in many other parts of the world, increases violence in LMICs (Werbick et al., 2021).
- Additionally, the cultural globalisation of *gun culture*, exported through media and commerce, has influenced gender roles and normalised firearm possession in diverse settings (Werbick et al., 2021).

Thirdly, because the WHO provides guidelines for health policies and clinical practice including for trauma care, the WHO is well positioned to document, standardise and call on Member States to implement emerging trauma care-based approaches that maximise outcomes for victims of gunshots and coordinate multi-sectoral responses to address the longer-term physical and mental health needs of survivors, including establishing and disseminating a victim's charter, and engage in community based violence prevention programs. Initiatives like the WHO's Acute Care Action Network (WHO, n.d), an alliance of over 70 organisations convened by the WHO is committed to advancing acute care to meet the mandate of WHA 76.2 resolution, and the Hospital Alliance for Violence Intervention (HAVI), have developed and tested trauma- and hospital-based approaches that serve as examples to be built upon (Health Alliance for Violence Intervention, n.d.). As two examples amongst many others: The *Five A's of Firearm Safety* counselling framework has been shown to improve the quality and content of education on gun violence prevention (Hoops et al., 2022), and the introduction of a prompt to encourage physicians to discuss gun safety during child well checks increased gun safety discussions from 3% to 84% within four months (Gastineau et al., 2020).

Fourth, unlike the security-based approaches common to most UN agencies working on gun violence which typically respond to gun violence after it has already occurred and caused death, injury and trauma, the WHO's public health paradigm includes a strong focus on primary prevention. In other words, alongside its work to develop model trauma- and hospital-based multi-sectoral responses to gun violence, the WHO's work is also to develop, test and scale up policies, plans and interventions that prevent gun violence from occurring in the first place. Many evidence-based primary prevention approaches have been shown to reduce gun violence via rigorous randomised control trials and other quasi-experimental research designs. These include greening public spaces (Dobbs & Sakran, 2023), training violence interrupters (Braga et al., 2001; Skogan et al., 2009; Delgado et al., 2017), intervening in schools (Rajan et al., 2022), supporting bystander action (Mitchell et al., 2025), job placement, including engaging directly with those gang members who are shooters and providing them with opportunities that can serve as an off-ramp from violence (Krupa et al., 2025), cognitive behavioural therapy and other social support (Bhatt et al., 2024). Public health practitioners have also successfully used behaviour change communication strategies to address HIV and AIDS, tobacco and alcohol related harm, GBV, and gun violence, amongst many others. WHO should work with Member States to ensure their widespread implementation. Because the WHO is already focused on addressing various forms of violence, including urban violence, violence against women, and violence against children in which firearms are sometimes mentioned, and because it has a history of work on gun violence, it can integrate a stronger focus on gun violence into these areas of work.

Fifth, the WHO can convene public health researchers and practitioners working on gun violence prevention and on gun violence and health care responses,

representatives of Member States and other UN agencies, and local and international civil society organisations, to establish and implement shared research agendas on the extent, causes of and solutions to gun violence, and disseminate findings to Member States, academia, civil society organisations and the media.

Sixth, WHO and the broader field of public health has been strengthened by and can draw upon longstanding close partnerships with civil society organisations from which it has learned critically important expertise in community mobilisation, citizen activism, media advocacy and strategic litigation to advance health and human rights, and has built connections and trust with health activists, as with many other health and human rights-related issues. These include access to essential medicines; HIV and AIDS (Heywood, 2015); tobacco and alcohol regulation (Mamudu & Gantz, 2009; Lesch & McCambridge, 2024); access to Covid-19 vaccines and the 2025 Pandemic Treaty (GAVI, 2020), amongst others.

Seventh, public health research has demonstrated that gun violence, like many other public health challenges, is exacerbated by multiple systemic factors: poverty, economic inequalities, racism and discrimination, degraded public spaces and lack of access to recreational facilities, low trust in public institutions, and under-funded public services, especially education and mental health services (Patel et al., 2022; Cunningham et al., 2023). The WHO has decades of experience working to address such social determinants of health and should bring this expertise to bear on gun violence.

Lastly, health systems offer a unique opportunities to break cycles of violence with several entry points to identify vulnerable victims (trauma and emergency, but also during psychological care, gynecological and pediatric appointments etc) and inform people of their rights and about public services that can support them (directly by trained health professionals or by requesting social services assistance) and understanding that if the aggression/threat involve a firearm, those victims should receive more intense/priority support, once it is recognized as a higher risk factor.

Thus, our answer to the question of why the WHO should reprioritise its focus on firearm violence is that the WHO has already demonstrated its global leadership in tackling complex public health threats—including tobacco use, road injuries, and pandemics—through evidence-based frameworks and treaties. By extending this leadership to firearm violence, WHO can offer complementary and collaborative value to existing UN mechanisms by foregrounding prevention, equity, and the social and commercial determinants of health.

Despite this alignment, gun violence has not been a priority within the workstreams of the WHO, showcasing a critical gap that must be addressed.

We turn now to our analysis of WHO achievements and gaps with regards to addressing and preventing gun violence.

A three-part review of WHO action on gun violence

The section that follows provides findings from the three research methods used for this study: 1) an analysis of WHA Resolutions; 2) a review of WHO violence prevention documents; and 3) expert interviews. Together, they provide an overview of the WHO's attention to firearm violence.

Findings from an analysis of World Health Assembly Resolutions

The WHO is a key arena for change, given its mandate under Article 2 of its Constitution to develop international norms. While WHO's influence has largely manifested through soft law rather than binding treaties, the resolutions adopted by the WHA since 1948 have contributed to emerging *systems of norms* in various health domains including efforts to regulate and thereby reduce consumption of tobacco, alcohol, sweetened beverages and fast foods, or raise awareness about the health benefits of fresh foods, green areas and parks, social connectedness and exercise (Wernli et al., 2023). In turn, these resolutions formed a “global health complex of interlinked issues” through interconnected policy communities (Wernli et al., 2023; Evrard & Rieckhoff, 2025, p. 105). As observed by Evrard, Rieckhoff and colleagues, the number and diversity of topics addressed by WHA resolutions have expanded over time (Evrard & Rieckhoff, 2025, p. 103). This suggests a certain adaptability within the WHO, which, despite state-driven priorities and funding constraints, has shown an ability to expand its agenda and “promote what they see as good policy” (Littoz-Monnet, 2017, p. 5).

This institutional flexibility is evident in the realm of violence and injury prevention. Our analysis of WHA resolutions confirms that violence is recognised as a public health issue, not only for its direct physical and psychological harms, but also for its impact on years of life spent in good health. Importantly, violence exposure is recognised to be unevenly distributed along socio-economic and demographic lines.

As detailed in Annex II, out of 3,230 WHA resolutions produced between 1948 and 2024, we identified 39 resolutions that included any text on violence, including⁸:

1. Violence-specific resolutions (n=6): these focus explicitly on violence as their core subject (WHA49.25, WHA50.19, WHA56.24, WHA67.15, WHA69.5, WHA74.17).

⁸ We excluded resolutions related to geopolitical conflicts, anti-personnel mines, or disease-specific violence (poliomyelitis, dengue) as these fall outside the scope of this analysis.

2. Violence-related resolutions (n=16): these address violence more indirectly, by citing violence-specific resolutions or proposing actions that engage with violence as part of broader issues (e.g., WHA60.22, WHA61.16, WHA64.28, WHA68.15, WHA72.16, WHA68.20).
3. Incidental mentions of violence (n=17): these resolutions reference “violence” peripherally or rhetorically, without contributing substantively to violence prevention or understanding (e.g., WHA16.25, WHA38.27, WHA60.12).⁹

Of the more than 3,000 WHA resolutions we reviewed, none included any mention of guns, firearms, or small arms and light weapons.

The WHO has had multiple opportunities to integrate firearms into its violence prevention agenda. As early as WHA49.25 (1996), which declared violence a global public health priority, the organisation called for a classification of types of violence and their consequences. While intentional injuries to women and girls received early and sustained attention, this framing has tended to overlook the high rates of firearm violence affecting men, who, though often the perpetrators, are also the primary victims, both through direct violence and through aggressive marketing by the firearms industry.

WHA56.24 (2003) includes, in its annex, a recommendation from the *World Report on Violence and Health* to “seek practical, internationally agreed responses to the global drugs trade and the global arms trade” (WHA56.24). However, this merely suggests that states seek guidance from other forums, rather than recognising the WHO’s own regulatory potential, as demonstrated by the 2003 Framework Convention on Tobacco Control which we deal with in detail further on in this report.

This absence is not due to a lack of evidence or urgency. Instead, it reflects deeper political and institutional bottlenecks that constrain the WHO’s ability to confront firearms as a public health issue, despite clear implications for women, children, and men alike. Key amongst these, as we discuss below, is the lack of action on firearm violence by Member States. The WHO’s violence prevention team explained that the WHO “has not received any formal Member State communications about the topic of firearms or firearm-related violence in the past 25 years”. They also told us that “from an NGO perspective, only International Physicians for the Prevention of Nuclear War (IPPNW), for a period from around 2010–2020 when they supported their “Aiming for Prevention” programme, alluded to the issue in the context of verbal feedback on WHA resolutions” (R.A. Butchart, personal correspondence, September 22, 2025).

Tracking the WHA resolutions that deal with violence also clarifies the generative nature of the resolutions. As the timeline below demonstrates, the years immediately following a WHA resolution (marked with a pink star) are periods in which key related WHO documents are published.

⁹ WHA Resolution 69.5 endorsed the *global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children lists laws to reduce access to firearms as part of section 3.C. All forms of interpersonal violence: cross-cutting actions, where it calls on Member States to: Advocate for the adoption and reform of laws, policies and regulations, their alignment with international human rights standards and their enforcement, so as to address common risk or causal factors and determinants of several types of violence. These laws, policies and regulations include those that: promote gender equality; prevent harmful alcohol and substance use; reduce firearm availability; ensure access to education and keep adolescent boys and girls in secondary school; and reduce concentrated poverty.* (see page 37). <https://iris.who.int/handle/10665/252276>

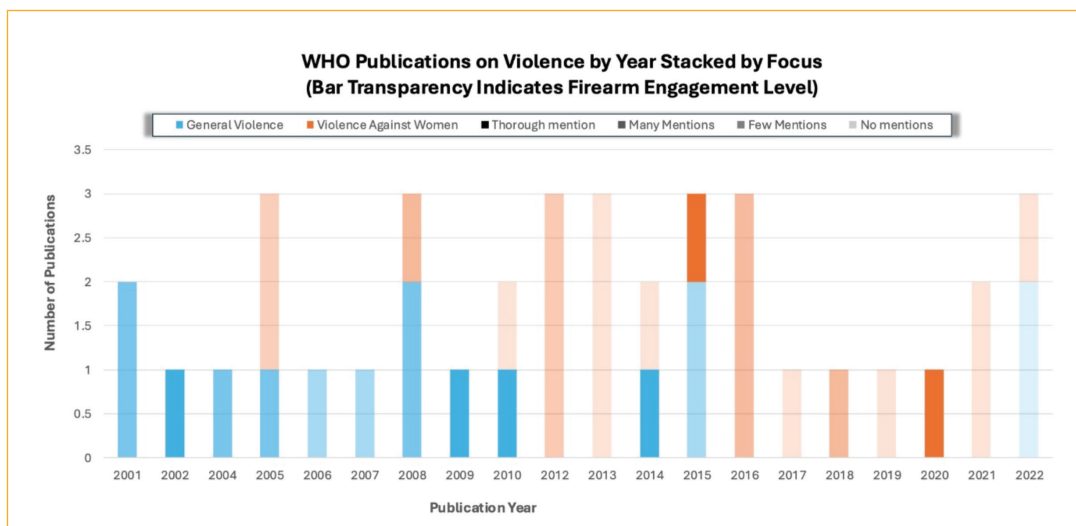


Figure 2: WHO publications and WHA resolutions by year

We turn next to a review of WHO reports and plans that address violence, including those that include mention of gun violence.

Findings from a review of key WHO violence prevention documents from 1996 to 2025

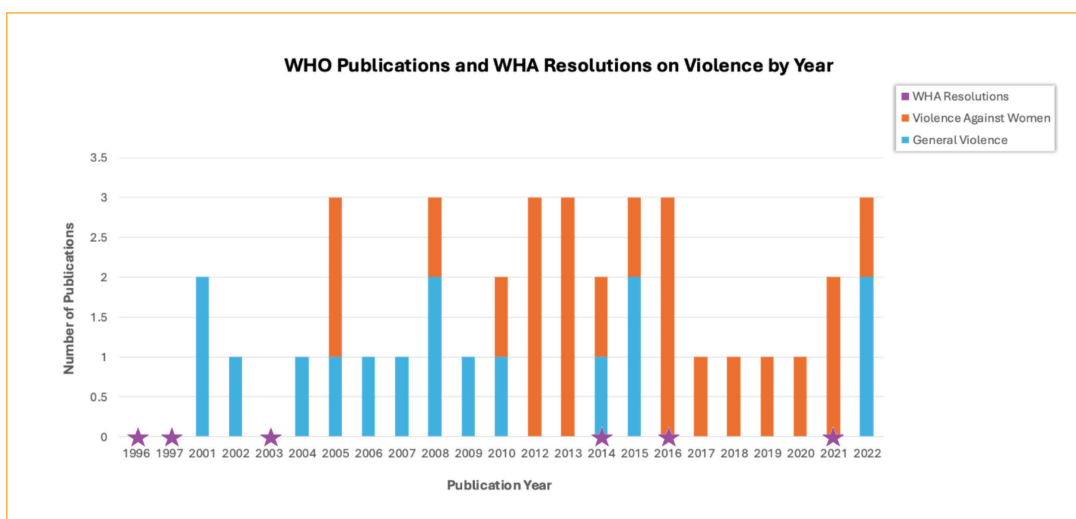


Figure 3 Timeline of WHO violence related publications and their focus

The takeaway finding from our non-exhaustive review of WHO documents on gun violence is that the WHO's early 2000s work on small arms and its sustained commitment to addressing violence against women and children represent important institutional strengths. These efforts provide a precedent for expanding a public health response to include a dedicated focus on firearms. Rather than starting anew, this report advocates for a revival and deepening of WHO's earlier initiatives.

The graph above visualises WHO publications on violence by year, stacked by thematic focus - either General Violence or Violence Against Women and Children. The transparency of each bar represents the degree of firearm engagement within those publications: fully opaque bars indicate thorough mention of firearms; semi-opaque bars correspond to many or few mentions; and the most transparent bars signal publications where firearms are mentioned minimally or not at all. A complete table of all 38 WHO publications analysed, including their focus areas, mentions of firearms, and the extent of engagement, is provided in Annex III.

The early 2000s marked a critical moment in WHO's engagement with firearms. In 2001, announcing the establishment of "A new department for injuries and violence prevention at the World Health Organization", Krug, Butchart and Peden identified six priority areas for the new team: surveillance, violence prevention, traffic injuries prevention, small arms, landmine victim assistance, and pre-hospital care. The mission of the new department, they wrote was to "spearhead global action to prevent violence and unintentional injuries as major threats to public health". They pointed out that up until then, injury prevention efforts had occurred primarily in high income countries despite the higher burden of injury and mortality borne by LMICs.

They described its goals as:

1. To act as a facilitating authority for international science-based prevention efforts.
2. To promote and facilitate international research.
3. To promote improved standards of teaching and training.
4. To foster multidisciplinary collaboration between relevant global, regional, and national stakeholders.
5. To compile and disseminate "best practices" for violence and unintentional injury prevention and control.
6. To facilitate implementation of violence and unintentional injury prevention and control at country level.
7. To collate, analyse, and disseminate global data on violence and unintentional injuries.

Clarifying their priorities, they wrote: "Developing strategies with low and middle income countries is a main focus for violence and injury prevention" (Krug et al, 2001, p. 331).

That same year, the WHO engaged in advocacy to address gun violence by contributing to the United Nations Conference on the Illicit Trade in Small Arms and Light Weapons in All Its Aspects that adopted the *Programme of Action to Prevent, Combat and Eradicate the Illicit Trade of Small Arms and Light Weapons in All its Aspects* (PoA). The WHO's contribution, published under the title of Small Arms and Global Health, exposed the long-term injuries of firearms and their public health importance (WHO, 2001, p. 1). This document highlights the necessity of WHO's involvement in the eradication of the small arms illicit trade, asserting that: "the burden of death and injury related to firearms, explains why the World Health Organization (WHO), as the directing and coordinating authority on international

health is concerned about the illicit trade in small arms” (WHO, 2001, p. 1). This active participation of the WHO demonstrated its position on situating health at the heart of the matter when drafting strategies to prevent gun violence. Since the adoption of the PoA, UN Member States now hold regular meetings to review the progress in implementing the programme, as well as Review Conferences for a more comprehensive analysis of its application.

Small Arms and Global Health (2001) explicitly identified firearms as a major contributor to premature death, disability, and the global burden of disease, and framed gun violence as both a physical and mental health crisis. This framing was reinforced in the *World Report on Violence and Health* (2002), which introduced an ecological model for violence prevention and situated firearm-related deaths as a preventable public health issue. At this stage, WHO publications treated firearms as distinct policy concerns requiring evidence-based, multisectoral responses.

In *Preventing Violence and Reducing its Impact: How Development Agencies Can Help* (2008), the organisation acknowledged that weapon access, alongside poverty, inequality, and weak institutions, contributed to violence rates. While guns were not the focal point, the report reflected a structural understanding of the root conditions that enable gun violence.

In preparation for its first report on social determinants in 2008, the WHO and the Commission on Social Determinants of Health invited input from civil society organisation. The report prepared by the civil society group convened included many references to weapons, militarism, the military industrial complex, arms industry and war, none of which made it into the final report (WHO, Commission on Social Determinants of Health, 2007). Unfortunately, we were unable to locate any documentation that explains why the WHO and the Commission on Social Determinants of Health chose not to include the recommendations made by their own civil society advisory group.

Between 2009 and 2010, WHO returned briefly to firearm-specific policy engagement. *Guns, Knives, and Pesticides: Reducing Access to Lethal Means* (2009) called for concrete measures such as bans on certain firearms, licensing regimes, amnesties, and safe storage laws. These recommendations were grounded in global evidence showing the efficacy of firearm control in preventing both homicides and suicides. The WHO’s Department of Gender, Women and Health’s Policy Approaches to Engaging Men and Boys (Flood et al., 2010) added a gendered analysis, highlighting how harmful male gender norms contribute to firearm misuse and interpersonal violence. Together, these reports represent a period of targeted policy attention to the public health dimensions of firearm access and violence.

However, from 2014 onward a thematic shift became evident in WHO’s agenda. Rather than a comprehensive focus on gun violence as major public health problem itself, WHO publications such as the *Global Status Report on Violence Prevention* (2014) and *Preventing Youth Violence: An Overview of the Evidence* (2015) began to embed firearm references within targeted violence prevention strategies, especially toward youth. While these documents acknowledged the legal and policy importance of regulating firearm access, they no longer framed firearms as a standalone public health issue. Instead, they were treated as one of many

tools of violence, with limited follow-through on firearm-specific programming or monitoring. More significantly, WHO's focus gradually shifted from 'general violence' to violence against women and children (VAWC). By the mid-2010s, publications increasingly centred on GBV, child protection, and household-level interventions, with less attention to community violence or gun-related harm outside domestic contexts.

WHO publications from 2016 onward reflect this narrowed approach. *INSPIRE: Seven Strategies for Ending Violence Against Children* (2016) which serves as WHO's primary roadmap for implementing seven evidence-based strategies to prevent violence against children, mentions firearms only in passing, mostly as a method of suicide or one among several lethal means. *INSPIRE's* attention to firearm violence prevention is focused just on laws limiting youth access to firearms and other weapons. While still focused mostly on the use of the law, the more detailed *INSPIRE Handbook* of 2018 includes a broader focus on firearm violence, including a reference to violence interruption interventions. *Preventing Injuries and Violence: An Overview* (2022) adopts a broad framework that largely excludes firearms. The move toward generalised and multisectoral models of violence prevention has been accompanied by a dilution of firearm-specific interventions. Guns are mentioned less frequently, and when they are, it is typically in the context of youth suicide prevention rather than interpersonal, gender-based, or structural violence.

The WHO's narrowing focus on VAWC, while essential, has contributed to the limited visibility of gun violence against men, who make up the overwhelming majority of firearm homicide victims and perpetrators globally as well as the majority of suicide victims. This omission reflects a blind spot in global health discourse—one that downplays the devastating consequences of gun violence for far too many men and boys as well as how guns shape masculinity, male vulnerability, and community trauma. This is evident in the joint Pan American Health Organization & WHO report on masculinities and men's health in the Caribbean which fails to mention guns, firearms or ammunition whilst discussing the health of men in a region with high and rapidly increasing rates of gun violence (Pan American Health Organization, 2023) and in which heads of state recently issued a high level commitment to address guns and gangs, both of which cause grave health problems for men (CARICOM, 2023).

This trajectory of decreased focus on gun violence in WHO publications and the absence of any text on firearms in any of the WHO's 3,230 WHA Resolutions, let alone a standalone resolution on the issue, is particularly incongruous given WHO's formal recognition of the arms industry as incompatible with public health engagement under the Framework of Engagement with Non-State Actors (FENSA), adopted in 2016 (Seitz, 2016). Under FENSA, the WHO is explicitly prohibited from partnering with or receiving funding from just two industries: the tobacco and arms industries. Yet, the contrast in institutional response is profound. While tobacco control has been the subject of WHO's most robust and well-resourced treaty framework—the *Framework Convention on Tobacco Control* (FCTC) — firearm-related harm has not resulted in much institutional investment or strategic clarity, at least not in the last 15 years.

This disparity raises critical questions about how the WHO prioritises public health risks and what explains inaction on some issues and not others. Firearms, like

pesticides or road traffic injuries, do not fit within the non-communicable disease framework, but they do contribute to a significant burden of injury, physical and mental health issues as well as death. As we show below, the WHO has adopted strong language and global policy recommendations related to tobacco, pesticides, road safety, and formula milk, while remaining markedly more cautious in addressing firearms—despite the fact that they are the main and increasing cause of homicide and a major contributor to youth violence and violence against women and children in many regions—with all of the implications for health and rights already discussed.

Thematic findings from interviews with experts in gun violence and health governance and from expert reviewers

WHO's stated commitment to preventing violence from a public health approach is clear. The relative silence from the WHA and consequently in WHO publications and programmes in recent years raised several questions that led us to investigate the factors influencing this gap. For additional insights, we turned to experts in gun violence and health governance. We interviewed ten experts in the first and second quarters of 2025. In addition, we sought the input of 15 expert reviewers who shared their insights on WHO's attention to gun violence. We turn to an analysis of their comments next.

Coordinated strategies by commercial actors to counter regulations: Some of our interviewees indicated that industries contributing to ill-health have developed increasingly sophisticated and coordinated strategies to counter regulatory efforts, what we have referred to earlier as the “corporate playbook”. One interviewee raised concerns that the very successes of the 2003 Framework Convention on Tobacco Control may have increased coordination amongst commercial actors responsible for ill-health to ensure that they countered any future regulatory efforts.

Member-State Resistance and “Horse Trading” at the WHA: We were reminded by our interviewees that the WHO is made up of and has its priorities determined by Member States, often by those that make the biggest financial contributions. The inclusion of topics, their prioritisation and all the decisions within the WHA agenda are decided by Member States, pursuant to Article 18 of the WHO Constitution. Member State interests, based on their own domestic agenda, play a huge role in the determination of the WHA's agenda. For some countries, agreeing to a WHA Resolution on gun violence, is counter to their political interests, especially when it contradicts their own domestic laws on gun control or threatens to anger a key political constituency of gun lobbyists and gun owners. Therefore, an essential step for passing resolutions is the coalition-building between Member States (Irwin & Smith, 2019, p. 168). Often, in order to have support from other Member States, the proposing country might have to commit to vote in favour of other Member State resolutions (Irwin & Smith, 2019, p. 168). This is what one of the experts interviewed described as the ‘horse trading’ of international politics: mutual concessions and advantages for anticipated future returns on favours (Irwin & Smith, 2019). Given that WHO

priorities are formalised by the political commitments made in WHA Resolutions, this 'political' nature of the WHA influences what is regarded as possible on a given issue.

Donor dependence and budgetary constraints: We also heard that WHO's donor-dependent funding means new resolutions must come with clear, funded mandates. Without this funding, experts said a given issue will not rise high enough on the agenda to generate support for a WHA resolution. We heard that "every resolution entails new costs," so WHO requires rigorous justification, including clarity on the availability of funds and certainty that attention to gun violence will not lead to withdrawal of funding for other initiatives by Member States opposed to a focus on firearms.

Securitisation of the field: Interviewees pointed out that the field of international firearm regulations has also become securitised. While in the early 2000s, experts from diverse backgrounds, including public health, were involved in the discussion, this is not the case anymore. Within the UN, firearms are currently addressed as a security and trade issue because of the salience of discussions around wars, civil, and interstate conflict, while firearm-related harm prevention and care for the civilian populations are often in the background. Civil society advocacy is mostly focused on monitoring implementation of the PoA and its associated Review Conferences. This, they said, may be off-putting for WHO staff who regard themselves first and foremost as health and public health experts. One interviewee put it this way "Small arms control has become a profession due to the existence of international instruments. 'Experts' in small arms control are those with expertise regarding what's in the instruments – or what's funded in terms of implementation. So, while you can talk from the perspective of community violence reduction, there's no job for you to do in small arms control because the funding is in physical security and stockpile management."

The complexities of multi-agency governance: We heard in interviews that the very cross cutting nature of gun violence is contributing to the exclusion of gun violence as a public health topic. Interviewees noted that gun violence sits at the intersection of health, security, trade, and rights—requiring coordination with other UN bodies. While the UNAIDS co-sponsorship model exists and could be regarded as a template, we heard that the current politics "goes against" forming a similar multi-UN agency model to address gun violence. One reviewer asked whether the WHO might have decreased its focus on gun violence because of increased attention and advances made by other UN agencies and within the international mechanisms and commitments mentioned above. For instance, the Geneva Declaration on Armed Violence and Development was adopted in 2006 and subsequently endorsed by 113 states. Two ministerial review conferences took place in 2008 and 2011, and in 2014 a series of Regional Review Conferences was organised. The Geneva Declaration called for and helped secure the inclusion of indicators on armed violence within the 2030 SDGs (which the previous Millenium Development Goals had not included). With this goal accomplished, the Geneva Declaration was seen to have achieved its mission and was effectively brought to a close. It is certainly possible that the cumulative effect of the 2001 PoA, the 2001 Firearms

Protocol, the adoption of the Arms Trade Treaty in 2014, and the inclusion of indicators on gun violence in the SDGs, provided the WHO with reason to believe that gun violence was being addressed elsewhere in the UN system.

Firearms, femicide and violence against children: Given the centrality of firearms to femicides, we sought to understand why the WHO has not incorporated a stronger focus on gun violence into its more recent efforts to address violence against women. We interviewed a number of people with significant expertise in gun violence and violence against women and children. From one interviewee, we heard that WHO's global, systematic reviews did not find evidence that firearm-specific interventions (e.g., education on gun safety) are effective in preventing GBV. We also learned that firearms are sometimes regarded as a GBV-related risk only in certain countries so discussions might be considered "meaningless" in those where it is not. While it is indeed true that there are countries with few guns where gun violence is not especially relevant for GBV, it remains the reality that in those where guns are more widely available, they exacerbate coercive control, increase fear and fatalities. Lastly, we were told that, within the WHO, gun violence is regarded as an area of expertise of the Violence Prevention Unit rather than the Unit on Rights and Equality across the Life Course within the Department of Sexual and Reproductive Health which is the team within the WHO that leads on work to address violence against women. Perhaps most importantly, we heard that the WHO regards gender-related social norms, especially norms about manhood, as the main drivers, or root causes, of GBV. Gun violence is regarded as downstream from rigid and inequitable norms and in this sense may be seen as less relevant to WHO's work on GBV. Debates about whether gun violence is a driver of GBV-related harm are similar to those in the GBV field on alcohol. Describing the debates about how much alcohol should be seen as a contributor to GBV, Levtoev and colleagues at the Prevention Collaborative write: "At the heart of the debate, then, is a concern that a focus on alcohol as a contributor to violence would undermine feminists' efforts to bring attention to how gender inequality and patriarchal power drive men's violence, and that it would allow perpetrators to evade responsibility and accountability for their choice to use violence against women and children and for the harm they cause" (Levtov, 2024, p. 4). The Prevention Collaborative issue a clear recommendation that "Not addressing harmful alcohol use is a missed opportunity to reduce violence in the home!" (Levtov, 2024, p. 2). Based on the evidence, we make the same argument about gun violence and violence against women and children.

Despite the obstacles identified by our interviewees, they remained optimistic. History tells us, they said, that progress is possible when health is placed above narrow national or industry interests. As we will see in the next section, there are recent precedents we can turn to for inspiration and insights about how to successfully overcome these obstacles to galvanise the WHO secretariat and Member States to advance public health for all. We turn to that later in the paper.

The Framework Convention on Tobacco Control– A key WHO precedent for addressing gun violence

In our interviews, as noted above, we sometimes heard that gun violence prevention is seen as being addressed within the UN system by the PoA adopted in the General Assembly in 2001. Accordingly, the argument is made that gun violence does not fit easily within the WHO's public health architecture which gives prominence to communicable diseases, non-communicable diseases, and health emergencies such as war, pandemics and natural disasters.

To understand how the WHO has dealt with other complex health issues, this section will explore lessons learned from concerted action by the WHO and its Member States to address the harm caused by tobacco through the 2003 Framework Convention on Tobacco Control. As noted in the overview of WHO included above, there are other examples of successful health advocacy by the WHO we could draw on, but that is outside the scope of this paper.

Insights for gun violence prevention from the Framework Convention on Tobacco Control (FCTC):

The FCTC was the first use of the WHO's treaty powers and it was adopted despite significant efforts from the US and the tobacco industry to prevent it from coming into effect. The FCTC focuses on adopting tax and price measures to reduce tobacco consumption; banning tobacco advertising, promotion and sponsorship; creating smoke-free work and public spaces; putting prominent health warnings on tobacco packages; and combating illicit trade in tobacco products (WHO, 2003).

The WHO Framework Convention on Tobacco Control Secretariat outlines the FCTC provisions (FCTC Secretariat, May 2021). We cite some of the key language here because it offers a roadmap for gun violence prevention.

- Article 4: “make a political commitment to develop and maintain comprehensive multisectoral measures and coordinated responses, to engage in international cooperation; to consider taking action to deal with criminal and civil liability, provide support to tobacco workers and growers, and ensure participation of civil society.”
- Article 5: “establish essential infrastructure for tobacco control, including a national coordinating mechanism, and develop and implement comprehensive, multisectoral tobacco-control strategies, plans and legislation to prevent and

reduce tobacco use, nicotine addiction and exposure to tobacco smoke.” It stipulates that these activities “must be protected from the interests of the tobacco industry” and it calls “for international cooperation and refers to raising the necessary financial resources for implementation of the Convention”.

- Article 13: a comprehensive ban of all tobacco advertising, promotion and sponsorship.
- Article 19: to “consider taking legislative action or promoting their existing laws to deal with liability and to provide each other with assistance in legal proceedings relating to liability”.
- Article 20: “develop and promote national research and coordinate research programmes internationally, as well as to establish and strengthen surveillance for tobacco control and to promote exchange of information in relevant fields”.
- Article 26: “provide financial support for their programmes intended to achieve the objective of the Convention, in accordance with their national plans, priorities and programmes”.

The FCTC has been credited with saving more than 37 million lives and contributing to a rapid decline in tobacco use from almost 33% in 2000 to 22% in 2020 (WHO, 2021). As such, and as McHardy writes: “Just as the tobacco industry was a pathfinder for other harmful industries in developing tactics for expanding the depth and reach of the market for their deadly products, the WHO FCTC experience is the obvious pathfinder for countering the commercial determinants of health across all sectors and industries (McHardy, 2021, p. i39)”.

Viewing firearm violence through the same lens as tobacco (i.e., as a preventable health issue and a commercial determinant of health) opens the possibility for regulatory frameworks at both national and international levels. In terms of potential interventions, many parallels can be drawn between tobacco and firearms. For instance, FCTC Part III addresses demand reduction (e.g. through price and tax measures, but also the regulation of advertising, promotion and sponsorship), and Part IV targets supply reduction (e.g. by targeting illicit trade or sales to minors). In addition, the FCTC’s strong language on marketing and sponsorship bans (see Article 13, FCTC) offers an interesting potential model for regulating firearm advertising and industry influence on gun violence prevalence.

Understanding how alliances, evidence, and reputational incentives aligned can help identify similar conditions for advancing firearm violence prevention today. Scholars note that the FCTC “is a landmark treaty, as it is the first and only international instrument that regulates the consumption and commercialisation of a legal consumer product”. Kickbusch and Liu offer useful analysis of the tactics employed:

“ The WHO Secretariat was able to present its anti-tobacco position as consistent with the prevailing neoliberal logic. The WHO Secretariat did so by strategically and explicitly opposing the tobacco industry and questioning its unethical actions as a legitimate exception to otherwise accepted business and market principles (Kickbusch & Liu, 2022, p.2161).

NGOs and academic institutions gathered extensive, systematic evidence, revealing not only the health harms of tobacco but also industry efforts to distort science, sow doubt, and manipulate policy (Vasselin & Cuveillier, 2020). The scientific case was clear, and the public health benefits, especially in terms of reduced mortality and morbidity, were undeniable. Finally, the leadership of the then Director-General and former Norwegian Prime Minister Gro Harlem Brundtland, backed by Norway’s diplomatic priorities, gave the campaign additional momentum. For Norway, tobacco control was also a reputational investment on the global stage.

The FCTC example shows how the WHO can work together with Member States and civil society organisations to counter the strategies used by commercial actors whose products and marketing strategies contribute to ill health. The same approach must be applied to the discussions around firearms and ammunition to push for a consensus between Member States and achieve meaningful regulations that prevent gun violence.

Unlike in 2003, in 2025 the WHO can now draw on additional legal and normative tools such as the UN Guiding Principles on Business and Human Rights (GP-BHR), the Arms Trade Treaty (ATT), relevant Human Rights Council resolutions on civilian acquisition of firearms (e.g. A/HRC/RES/29/10; A/HRC/RES/45/13), SDG 16.4.2. and the expanded language on gender and gun violence in PoA RevCon 2018 and 2024 outcome documents (Bjerten and Briggs, 2025). These instruments can offer institutional leverage and political pressure to support firearm and ammunition regulation as a global health issue.

Conclusion: A call for the WHO to address gun violence as a public health issue

Gun violence is a pressing public health issue, causing deaths and lasting physical, psychological and social harm across continents. It generates widespread fear, trauma and chronic insecurity, differently affecting vulnerable groups. Yet, in some countries, firearms are actively embedded in commercial marketing practices that normalise their use. Inspired by public health approaches to Tobacco Control and Road Safety, this study reframed firearm violence as a commercially driven epidemic— one that cannot be addressed solely through regulation of advertising, but demands a broader, prevention-oriented, public health response.

This research project shows how gun violence endangers the health and well-being of communities and how it increases violence against all of us—women, men and children—albeit in different ways. It is crucial to develop a global health response and prevention strategies that position guns at the source of direct and indirect effects on health and well-being.

Our research also reveals a troubling inconsistency in the WHO's engagement with this topic. Although early efforts acknowledged firearm violence as a health issue and integrated it into broader violence prevention efforts, small arms and light weapons have never been mentioned in any WHA resolutions. In recent decades, this omission has been compounded by a decline in governance attention to the health impacts of firearms in other violence prevention frameworks.

In line with its own principles, the only two industries that WHO excludes collaboration with are the tobacco and arms industries. Yet, it has failed to consistently apply this standard by not addressing firearms as a health topic. Many of the interviews highlighted that political, cultural, and economic factors are preventing the appropriate treatment of gun injuries and deaths as a preventable health issue.

Lessons from other health governance regimes, such as Road Safety, UNAIDS and FCTC, underscore the need for a multisectoral approach and a global coalition to tackle the cross-cutting nature of gun violence. The FCTC, in particular, demonstrates the power of regulating both demand and supply, and offers

a model for limiting firearm promotion and industry interference under the commercial determinants of health framework.

Opportunities for WHO Action on Gun Violence

The current moment can be characterised by both setbacks and opportunities for progress for WHO action on gun violence. We explore key opportunities next.

1. **Withdrawal from the WHO by the Trump Administration:** The US withdrawal of funding and its stated commitment to withdraw altogether from the WHO, while extremely destabilising and damaging for global health, has also opened a political space to advance issues that the US has not supported within the UN—gun violence prevention among them. The recent successes in adopting the pandemic agreement suggest shifting grounds in global health diplomacy, where new coalitions and priorities are emerging.
2. **Recent advances in research on gun violence:** After more than two decades of legislative restrictions on gun violence research in the US, recent years saw a resurgence of research funding and a commensurate increase in publications exploring key research gaps, both in the US and internationally with US funding. This has generated an increase in publications identifying evidence-based gun violence prevention approaches, including research on safe firearm storage, violence prevention interventions, and analyses of the positive effects of laws and policies that regulate access to firearms. The all too brief availability of funding on gun violence also renewed interest in gun violence research and produced a new cohort of skilled researchers.
3. **Identification of research gaps:** This momentum should be harnessed to address research gaps, including those we identified through this study: (1) the need for greater attention to the social and commercial determinants of firearm harm, including the corporate playbook used by the gun industry to defeat regulatory efforts; (2) limited detailed data collection on guns and femicide; (3) a limited understanding of the indirect, cumulative, and long-term mental health impacts of firearm exposure; (4) the causes and impact of limited attention to gun violence in global and national efforts to address violence against children and adolescents; (5) limited focus on men and masculinities in firearm-related research; (6) additional documentation and assessment of gender transformative gun violence prevention; (7) the effects of bullets and the wounds they inflict on children, teenagers, and adults; and (8) evidence-informed regulations governing access to ammunition. These gaps constrain the development of effective public health interventions and perpetuate blind spots in global policy frameworks. Prioritising these underexplored areas is crucial for designing context-sensitive and equitable prevention strategies, as well as for informing WHO's global action plan on violence prevention.
4. **Momentum in addressing the gender exploitative marketing practices of the gun industry:** In June of 2024, WILPF, GENSAC, Small Arms Survey, Pathfinders for Peaceful, Just and Inclusive Societies, and the South Eastern

and Eastern Europe Clearinghouse for the Control of Small Arms and Light Weapons (SEESAC) convened a three-day global meeting to understand and address gender exploitative marketing of SALW. A 2024 desk review prepared by the Women's International League for Peace and Freedom and the Gender Equality Network for Small Arms Control reviews informed discussions (Peacock, 2024). The meeting report includes clear and actionable recommendations for how to reduce gender exploitative marketing of guns (Antonakis & Peacock, 2024). WHO should collaborate with this group.

5. **Lancet Commission on Global Gun Violence and Public Health:**
Established in 2024, the commission includes leading global experts in gun violence response and prevention. It aims to inform policies and priorities within key UN agencies, especially the WHO, as well as governments (including health ministers) and civil society across the world (Hyder, 2024).
6. **Global Ministerial Conference on Ending Violence Against Children:**
In November 2024, the first-ever Global Ministerial Conference on Ending Violence Against Children was co-convened by the Government of Colombia, the Government of Sweden, UNICEF, the United Nations Special Representative of the Secretary-General on Violence against Children, and the WHO. The Conference generated important commitments to ending violence against children, with 110 Member States announcing pledges for child protection. Given the pervasive nature of gun violence against and amongst children, the momentum generated by the Bogota Call to Action represents an opportunity for action on gun violence.
7. **Increased attention to the gendered impacts of gun violence in the PoA:**
Recent developments at the Fourth Review Conference of the UNPoA on the illicit trade of Small Arms and Light Weapons offers potential inspiration for the work that the WHO needs to do to integrate gun violence into their work on gender and gun violence. The UNPoA is a politically binding framework for UN Member States that was adopted in 2001. In its first 18 years an analysis of the gendered impact of guns was almost entirely absent from review documents of the PoA. In their report on the 4th Review Conference (RevCon4), they indicate that, starting in 2018, Member States began including more language on the gendered effects of gun violence. They write that "In 2024, twenty-three of the 228 paragraphs in the final outcome document contained language related to gender. The document recognises gender roles, norms, and expectations for women and men to acquire illicit arms. It includes new language on violence associated with SALW, new references to encouraging the engagement and participation of men and boys in mainstreaming a gender perspective as well as new language on public and mental health concerns" (Women's International League for Peace and Freedom, Reaching Critical Will, & Gender Equality Network on Small Arms Control, 2024 p. 4).
8. **UN General Assembly adoption of the Global Framework for Ammunition Through-life Conventional Ammunition Management:**

In December 2023, UN Member States adopted a new international instrument containing political commitments to prevent diversion, illicit trafficking, and misuse of ammunition. It registers its “grave concern over the risks posed by the diversion of conventional ammunition of all types and calibres” ... as well as their “contribution to the intensity and duration of armed conflict, armed violence, including gender-based armed violence, around the world, and the threat (they pose) to peace, security, stability, and sustainable development at the national, subregional, regional and global levels” (United Nations Office for Disarmament Affairs, 2024). The WHO has a critical role to play in collaborating with Member States to develop standards of multisectoral care for trauma caused by bullets and for developing models that use trauma care as an opportunity to engage local communities with evidence-based violence prevention.

9. **Expanded focus on commercial determinants of ill-health and violence:**

As mentioned above, WHO has championed a growing body of work on social and commercial determinants of health within WHO and amongst academic researchers. While the 2025 World Report on Social Determinants of Health Equity does not mention guns, there is an immediate opportunity to ensure that the forthcoming Global Report on Commercial Determinants of Health includes a clear focus on gun violence and the gun industry.

10. **Pioneering partnerships between gun violence researchers and practitioners and regional public health and security bodies.**

The recent partnership between Small Arms Survey, the Caribbean Public Health Agency (CARPHA), the University of the West Indies George Alleyne Chronic Disease Research Centre (GA-CDRC), and the Caribbean Community (CARICOM) Implementation Agency for Crime and Security (IMPACS) is an example of the sort of collaboration the WHO should foster. Established in late 2023, the partnership aims to enhance the availability and quality of up to date evidence and analysis on gun violence in the Caribbean and engage regional security, public health and research stakeholders through regional knowledge sharing and policy prioritisation with the goal of establishing an effective pathway from regionally grown research to evidence-based policymaking to prevent and reduce the risk of firearms-related firearms trafficking and violence (Small Arms Survey, 2023).

11. **The recent passage of laws and regulations to limit harmful online marketing practices:**

With clear implications for addressing online marketing of guns, 2024 saw significant country action to address harmful online marketing, including the EU Digital Marketing Act and Digital Services Act (DSA), the UK’s Online Safety Act, Australia’s Online Safety Amendment Act 2024 which bans social media for individuals under 16, and Brazil’s enforcement of regulations on large online platforms. EU enforcement of its regulations has been robust: it has launched at least ten investigations (Pingen, 2024), and X, formerly Twitter, currently faces fines of as much as \$1 billion for its failure to comply (Satariano, 2025). In May of 2025, the European Commission initiated legal action at the Court of Justice of the European

Union (CJEU) against five European Union member countries who have failed to adhere to the agreed upon DSA regulations (Fincken, 2025). The WHA has now adopted nearly 20 resolutions limiting marketing of harmful products, including, most recently, WHA 78.18 targeting digital marketing of breast-milk substitutes. WHA 60.23 (2007) similarly focused on *“Prevention and control of noncommunicable diseases: implementation of the global strategy”*, and it includes clear guidance on marketing practices—especially those targeting children—as part of the broader response to the commercial determinants of noncommunicable diseases. Given the extent of online marketing of firearms, including to children, the WHO should work with civil society and Member States to regulate online advertising of guns and ammunition.

12. **Key events in the international calendar of women’s rights movements:** 2025 is the 30-year anniversary of the Beijing Platform for Action, the 25-year Anniversary of SCR 1325 on Women, Peace and Security, and the theme of the 2026 UN Commission on the Status of Women is Access to Justice. All of these represent opportunities to highlight the role of guns in violence against women and to mobilise support for concerted action.
13. **The 2026 International Conference on Violence and Injury Prevention and the 2026 World Congress for Public Health:** both will take place in Cape Town, South Africa, in September 2026, and both are co-sponsored by the WHO and will coincide with the 30-year anniversary of the first WHA Resolution on violence as a public health issue, a resolution sponsored by South Africa and will have a strong focus on commercial determinants of health (Foundation for Professional Development, n.d.).

Recommendations

Based on our analysis of WHA resolutions, our review of WHO publications, our interviews with experts in gun violence, and detailed reviews by leading researchers in the field, we offer the following recommendations.

General recommendations for reprioritisation and consultation:

1. **The WHO should re-affirm a clear commitment to proactively advancing gun violence prevention and ensure human and financial resources for this critical work.** The WHO has the mandate, the tools and the precedent to significantly strengthen its focus on firearm violence and should use the current window of opportunity in which those Member States which have opposed WHO focus on gun violence have withdrawn from the WHO.
2. **The WHO should engage in consultation and coalition building** with people affected by gun violence, researchers, civil society advocates, regional and national public health bodies, advocates for women's rights, children's rights, and men's health, experts in international gun control policies, experts in strategic litigation for health, amongst other key stakeholders, to map out priorities and develop a shared plan of action to reduce and prevent gun violence.
3. **Support and monitor existing international treaties and commitments:** The WHO should engage with and support monitoring and implementation of the various multilateral treaties, resolutions, protocols and platforms related to gun violence prevention, including : the 2001 Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects , the 2001 Protocol against the Illicit Manufacturing of and Trafficking in Firearms (the Firearms Protocol), the 2005 International Tracing Instrument, the 2014 Arms Trade Treaty, relevant Human Rights Council resolutions on civilian acquisition of firearms, and the Global Framework for Ammunition Through-life Conventional Ammunition Management in December 2023.
4. **Member States and the WHO should build momentum for a WHA Resolution on gun violence:** A WHA Resolution is essential to trigger action and legitimise the issue as a health topic on the global health agenda. A formal recognition ensures the WHO's commitment to mobilising resources

and developing technical guidance, supporting Member States in the planning and implementation of violence prevention frameworks, and closing the existing policy gap on guns. Without advocating for Member States to scale-up this issue, the preventable physical and psychological harms caused by guns will remain in the margins of public health. Elevating the health impacts requires political will, coalition-building, and advocacy so that firearm violence is recognised as a global health priority, demanding and requiring coordinated and multisectoral actions.

Recommendations on research and data:

5. **Improve data collection:** The WHO should work with Member States to improve data collection on the scale and impact of gun violence, including by exploring the role WHO could play in **establishing a multi-agency** global observatory to track firearm-related morbidity and mortality, modelled after its Global Road Safety and Suicide Prevention initiatives. This would include harmonised coding of firearm injuries in health surveillance systems and integration into the International Statistical Classification of Diseases and Related Health Problems (ICD)¹⁰.
6. **Address research gaps on gun violence:** WHO should work with the Lancet Commission on Global Gun Violence and Health and others leading gun violence research efforts across the globe to identify pressing research gaps. There is, for instance, very little research on the international lobbying practices of the gun industry with corresponding implications for public health challenges to these. There are also significant gaps in research on gun violence prevention, including gun violence against women and against members of LGBTQI+ communities, the economic impacts of gun violence, the long-term impacts of gun violence on children's health, learning, and development, and the long-term impacts on health care providers and health system functioning of dealing with gun violence, among many other salient areas of research that the WHO is uniquely well-positioned to champion.

Recommendations on strengthening health sector responses to gun violence:

7. **Provide guidance on firearms related trauma care and hospital based gun violence intervention:** The WHO should collect and disseminate emerging promising practices in Hospital-based Violence Intervention Programs which link health care and trauma care and coordinate this vital work with the emergency and trauma care activities of WHO, in partnership with the Acute Care Action Network—all with the goal of unifying multisectoral clinical and community services to address the long-term physical and mental health needs of survivors and prevent recidivism and further reduce firearm related harm.

¹⁰ In Brazil the National System uses the following ICDs for firearms' aggression (there are other separated codes for accidents, suicides and undetermined situations with firearms): X93.- aggression by handgun // X94.- aggression by shotgun, carbine or higher caliber firearms // X95.- aggression by other types of firearms or non identified firearms. In practice, health services rarely distinguish between X93 and X94 (probable lack of training on wounds' specificity)

Recommendations related to industry practices:

8. **Conduct research** on the international lobbying practices of the gun industry with corresponding implications for public health challenges to these.
9. **Broaden attention to gun violence and gun industry practices in the WHO's work on commercial drivers:** The WHO should ensure that the forthcoming WHO Global Report on Commercial Determinants of Health includes a clear focus on gun violence and the gun industry and lobby and that it builds on the attention given to firearm violence in the recent report on economic and commercial determinants of health in Small Island Developing State (WHO, 2025).
10. **WHO should work with civil society and Member States to regulate the firearm industry's online and traditional marketing and lobbying practices.** The firearm industry's activities directly and indirectly harm public health. Their marketing practices on social media, video games, and other platforms, and their product placement in films and television, normalise gun ownership and reinforce harmful gender norms. The WHO, civil society and academia have an important role to play in exposing these tactics, just as they did with the tobacco industry. WHO has acknowledged the potential threats to physical and mental health posed by new technologies in its 2025 World Report on Social Determinants and calls on platform operators and regulators to "take responsibility for addressing the harms of addictive and antisocial online behaviours" (WHO, 2025, p. xx).

Recommendations related to integration into existing streams of work:

11. **Strengthen the focus on gun violence within the WHO's work to address and prevent violence against children,** including by encouraging Member States to include a commitment to preventing gun violence in the country pledges issued at the 2024 Interministerial Meeting to End Violence Against Children held in Bogota.
12. **WHO should provide support to Member States on the implementation of complex violence prevention strategies.** Firearm violence is not just a crime or security issue. As demonstrated in this research project, it is a deeply cross cutting public health crisis intersecting with other disciplines. The nature of the issue means that no single sector can address firearm violence effectively.
13. **Develop strategic guidance on gun violence communication:** WHO should leverage its expertise in strategic public health messaging to provide Member States with evidence-based communication tools addressing the normalisation of firearm use and countering industry narratives, drawing on lessons from tobacco control and HIV/AIDS prevention.

This report concludes not with criticism but with conviction: that the WHO, with its unmatched institutional experience and mandate, can and should lead the global health response to gun violence. Building on its prior achievements and its commitment to health equity, WHO has the capacity to inspire coordinated international action on this preventable epidemic.

Annex I: Keywords analysis of WHA resolutions

WHA resolutions word-match method's keywords	Light weapon; firearm; small arm; gun; lethal means; violence; interpersonal violence; gender-based violence; domestic violence; youth violence; suicide; homicide; femicide; coercion; commercial determinant of health.
Terms excluded for production of unrelated references, skewing the dataset away from violence-specific content	Women; girls; men; boys; children; injury.
Considered but excluded terms	Mental health; shooting; intimate partner violence; child abuse; sexual violence; trauma; post-traumatic stress disorder; disability; militarization; disarmament.

Annex II: Detailed analysis of all WHA resolutions that mention violence

Type of resolution	Reference	Number
Violence-specific	WHA49.25 (1996) Prevention of violence: public health priority; WHA50.19 (1997) Prevention of violence; WHA56.24 (2003) Implementing the recommendations of the World Report on Violence and Health; WHA67.15 (2014) Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children; WHA69.5 (2016) WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children; WHA74.17 (2021) Ending violence against children through health systems strengthening and multisectoral approaches.	6

Violence-related	<p>WHA55.19 (2002) WHO's contribution to achievement of the development goals of the United Nations Millennium Declaration; WHA57.11 (2004) Family health in the context of the tenth anniversary of the International Year of the Family; WHA58.1 (2005) Health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004; WHA58.23 (2005) Disability, including prevention, management and rehabilitation; WHA58.26 (2005) Public-health problems caused by harmful use of alcohol; WHA60.22 (2007) Health systems: emergency-care systems; WHA61.16 (2008) Female genital mutilation; WHA61.4 (2008) Strategies to reduce the harmful use of alcohol; WHA64.28 (2011) Youth and health risks; WHA66.9 (2013) Disability; WHA68.15 (2015) Strengthening emergency and essential surgical care and anesthesia as a component of universal health coverage; WHA68.20 (2015) Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications; WHA72.16 (2019) Emergency care systems for universal health coverage: ensuring timely care for the acutely ill and injured; WHA73.1 (2020) COVID-19 response; WHA76.2 (2023) Integrated emergency, critical and operative care for universal health coverage and protection from health emergencies; WHA77.3 (2024) Strengthening mental health and psychological support before, during and after armed conflicts, natural and human-caused disasters and health and other emergencies.</p>	16
Incidental mentions of violence	<p>WHA16.25 (1963) Television influence on Youth; WHA38.27 (1985) Collaboration within the United Nations System: Women, Health and Development; WHA45.24 (1992) Collaboration within the United Nations System: General Matters - Health and Development; WHA46.27 (1993) Collaboration within the United Nations System: International Year of the Family (1994); WHA46.18 (1993) Maternal and child health and family planning for health; WHA55.21 (2003) Strategy for child and adolescent health and development; WHA57.14 (2004) Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS; WHA60.12 (2007) Appropriation resolution for the financial period 2008-2009; WHA62.9 (2009) Appropriation resolution for the financial period 2010-2011; WHA64.3 (2011) Appropriation resolution for the financial period 2012-2013; WHA65.4 (2012) The global burden of mental disorders and the need for a comprehensive, coordinated response from health and</p>	

	social sectors at the country level; WHA74.14 (2021) Protecting, safeguarding and investing in the health and care workforce; WHA74.15 (2021) Strengthening nursing and midwifery: investments in education, jobs, leadership and service delivery; WHA74.7 (2021) Strengthening WHO preparedness for and response to health emergencies; WHA76.16 (2023) The health of Indigenous Peoples; WHA77.12 (2024) Strengthening health and well-being through sport events; WHA77.8 (2024) Strengthening health emergency preparedness for disasters resulting from natural hazards.	17
Total	All	39

Annex III: Analysis of WHO Publications on violence and inclusion of gun violence

Publication Title	Publication Year	Focus	Mention of Guns - yes/no	Extent of mentions
Small Arms and Global Health	2001	General Violence	yes	thoroughly
Injury surveillance guidelines	2001	General Violence	yes	few times
World report on violence and health	2002	General Violence	yes	thoroughly
Preventing violence: a guide to implementing the recommendations of the World report on violence and health	2004	General Violence	yes	many times
Milestones of a global campaign for violence prevention 2005: Changing the face of violence prevention	2005	General Violence	yes	many times

Researching violence against women: a practical guide for researchers and activists	2005	Violence Against Women and Children	yes	few times
WHO multi-country study on women's health and domestic violence against women	2005	Violence Against Women and Children	yes	once
Developing policies to prevent injuries and violence: guidelines for policymakers and planners	2006	General Violence	yes	few times
Preventing injuries and violence: a guide for Ministries of health	2007	General Violence	yes	few times
Preventing violence and reducing its impact: How development agencies can help	2008	General Violence	yes	few times
World report on child injury prevention	2008	Violence Against Women and Children	yes	few times
Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence	2008	General Violence	yes	thoroughly
Guns, knives, and pesticides: reducing access to lethal means	2009	General Violence	yes	thoroughly
Violence prevention: the evidence	2010	General Violence	yes	thoroughly
Preventing intimate partner and sexual violence against women	2010	Violence Against Women and Children	yes	once

Understanding and addressing violence against women: femicide	2012	Violence Against Women and Children	yes	many times
Understanding and addressing violence against women: intimate partner violence	2012	Violence Against Women and Children	no	no
Understanding and addressing violence against women: sexual violence	2012	Violence Against Women and Children	no	no
Global and regional estimates of violence against women	2013	Violence Against Women and Children	yes	once
Responding to intimate partner violence and sexual violence against women	2013	Violence Against Women and Children	no	no
Preconception care to reduce maternal and childhood mortality and morbidity	2013	Violence Against Women and Children	no	no
Global status report on violence prevention 2014	2014	General Violence	yes	thoroughly
Improving efforts to prevent children's exposure to violence: a handbook to support the evaluation of child maltreatment prevention programme	2014	Violence Against Women and Children	no	no
Preventing youth violence: an overview of the evidence	2015	Violence Against Women and Children	yes	thoroughly
Violence in the Western Pacific region 2014	2015	General Violence	yes	few times

Injuries and violence: the facts 2014	2015	General Violence	yes	few times
Ethical and safety recommendations for intervention research on violence against women	2016	Violence Against Women and Children	no	no
INSPIRE: Seven strategies for Ending Violence Against Children	2016	Violence Against Women and Children	yes	many times
Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children	2016	Violence Against Women and Children	yes	few times
Leading the realization of human rights to health and through health	2017	Violence Against Women and Children	no	no
INSPIRE handbook: Action for implementing the seven strategies for ending violence against children	2018	Violence Against Women and Children	yes	few times
School-based violence prevention: a practical handbook	2019	Violence Against Women and Children	yes	once
Global status report on preventing violence against children 2020	2020	Violence Against Women and Children	yes	thoroughly
Addressing violence against women in health and multisectoral policies: a global status report	2021	Violence Against Women and Children	no	no
Violence Against Women Prevalence Estimates, 2018	2021	Violence Against Women and Children	yes	once

Preventing injuries and violence: an overview	2022	General Violence	yes	once
Improving the collection and use of administrative data on violence against women: global technical guidance	2022	Violence Against Women and Children	no	no
WHO Violence Prevention Unit: approach, objectives and activities, 2022-2026	2022	General Violence	no	no

Works Cited

- Abba-Aji, M. Koya, Shaffi Fazaludeen, M. Abdalla, Salma. K. Ettman, Catherine. Cohen, Gregory Herschel. Galea, Sandro. (2024) The mental health consequences of interpersonal gun violence: A systematic review, *SSM - Mental Health*, Volume 5, 100302,
- Abdalla, S. M., Keyes, K. M., & Galea, S. (2021). A Public Health Approach to Tackling the Role of Culture in Shaping the Gun Violence Epidemic in the United States. *Public health reports* (Washington, D.C.: 1974), 136(1), 6–9. <https://doi.org/10.1177/0033354920965263>
- Abrahams, N., Mathews, S., Martin, L. J., & Lombard, C. (2024, September). *20 years of femicide research in South Africa* (Research brief). Gender and Health Research Unit, South African Medical Research Council.
- Anderson, M. R., & Sidel, V. W. (2011). Violence as a public health issue. *Public health in the 21st century*, 1, 307-321.
- Andrews AL, Killings X, Oddo ER, et al. Pediatric Firearm Injury Mortality Epidemiology. *Pediatrics*. 2022;149(3):e2021052739
- Antonakis & Peacock, 2024 WILPF, GENSAC, Pathfinders, and Small Arms Survey Meeting on Militainment, the Arms Industry and the Marketing of Militarised Masculinities 15 - 17 July 2024, Geneva available at <https://www.wilpf.org/mobilising-men-for-feminist-peace/latest-news/highlights-militainment-the-arms-industry-and-the-marketing-of-militarised-masculinities-weapons-and-war/>.
- Baca, Lucía, David Alonzo and Yarly Katery Madrid. 2019. El prejuicio no conoce fronteras: Homicidios de lesbianas, gay, bisexuales, trans en países de América Latina y el Caribe 2014 – 2019. Bogotá: Sin Violencia LGBTI, p.26-27
- Baird, A. (2024) “No man’s land? Focusing on men to reduce global armed violence”. Geneva: UNIDIR,
- Balestra S. Gun prevalence and suicide. *J Health Econ*. 2018 Sep;61:163–77. <https://doi.org/10.1016/j.jhealeco.2018.08.003>
- Barufaldi, L. A. et al. Violência de gênero: comparação da mortalidade por agressão em mulheres com e sem notificação prévia de violência. *Ciência & Saúde Coletiva*, 22(9):2929-2938, 2017.
- Barnard, N. B., Rothmann, S., De Beer, L. T., & Lubbe, W. (2023). Burnout of emergency nurses in a South African context: The role of job demands and resources, and capabilities. *Frontiers in Psychology*, 14, 1119063. <https://doi.org/10.3389/fpsyg.2023.1119063>
- Barry LE, Crealey GE, Nguyen NTQ, Weiser TG, Spitzer SA, O'Neill C. Hospital Costs and Fatality Rates of Traumatic Assaults by Mechanism in the US, 2016-2018. *JAMA Netw Open*. 2022;5(6):e2218496. doi:10.1001/jamanetworkopen.2022.18496
- BBC News. (2025, February 5). ‘There was blood everywhere’ – Witnesses shocked after Sweden school shooting. BBC News. <https://www.bbc.com/news/articles/c0lze6zjrww0>
- Bellis, M. A.; McManus, S.; Hughes, K.; Adisa, O.; Ford, K. The Commercial Determinants of Violence: Identifying Opportunities for Violence Prevention through a Public Health-Based Framework Analysis. *Int. J. Environ. Res. Public Health* 2024, 21, 352. <https://doi.org/10.3390/ijerph21030352>
- Berg, M. T., Rogers, E. M., & Rochford, H. (2024). Perpetrator characteristics and firearm use in pediatric homicides: Supplementary Homicide Reports - United States, 1976 to 2020. *Injury epidemiology*, 11(1), 37. <https://doi.org/10.1186/s40621-024-00518-0>
- Bhatt, M. Heller, S. Kapustin, M. Bertrand, M. Blattman, C. (2024) Predicting and Preventing Gun Violence: An Experimental Evaluation of READI Chicago, *The Quarterly Journal of Economics*, Volume 139, Issue 1, Pages 1–56,

Bjerten, E. and Briggs, N. (2024) Advancing Gender and Inclusivity in Small Arms Control: Key Takeaways from RevCon4, Women's International League for Peace and Freedom and the Center on International Cooperation at New York University

Bjertén, E. and Briggs, N. (2025) Advancing Gender and Inclusivity in Small Arms Control: Key Takeaways From Revcon4 Reaching Critical Will (RCW), & the Gender Equality Network for Small Arms Control (GENSAC): 2024 Women's International League for Peace and Freedom and the Center on International Cooperation at New York University.

Brady United Against Gun Violence. (n.d.). *Origin of an insurrection: How Second Amendment extremism led to January 6*. <https://www.bradyunited.org/resources/research/origin-of-an-insurrection>.

Braga, A. A., Kennedy, D. M., Waring, E. J., & Piehl, A. M. (2001). Problem-oriented policing, deterrence, and youth violence: An evaluation of Boston's Operation Ceasefire. *Journal of Research in Crime and Delinquency*, 38(3), 195–225. doi:10.1177/0022427801038003001

Briefing Document: 16th World Conference on Injury Prevention and Safety Promotion, Foundation for Professional Development.

Buchanan, Cate (Editor). 2013. *Gun Violence, Disability and Recovery*. Xlibris, Bloomington, United States of America.

Buchholz, K. (2024, March 13). The World's Biggest Arms Exporters. Statista. <https://www.statista.com/chart/18417/global-weapons-exports/>

Buggs, S. A. L., Kravitz-Wirtz, N. D., & Lund, J. J. (2023). Social and Structural Determinants of Community Firearm Violence and Community Trauma. *The ANNALS of the American Academy of Political and Social Science*, 704(1), 224-241.

Burgess RC, Nyhan K, Dharia N, Freudenberg N, Ransome Y (2024) Characteristics of commercial determinants of health research on corporate activities: A scoping review. *PLoS ONE* 19(4): e0300699. <https://doi.org/10.1371/journal.pone.0300699>

Bush, L., Hendrikse, C., Van Koningsbruggen, C., & Evans, K. (2024). The burden and outcomes of firearm injuries at two district-level emergency centres in Cape Town, South Africa: A descriptive analysis. *South African Medical Journal*, 114(2), e1176. <https://doi.org/10.7196/SAMJ.2024.v114i2.1176>

Butchart, A., Burrows, S., & Kieselbach, B. (2019, March). Violence and public health. In *Public Health Forum* (Vol. 27, No. 1, pp. 2-5). De Gruyter.

Campbell, J. C. et.al., "Risk factors for femicide in abuse relationships: results from a multisite case control study", *American Journal of Public Health*, vol. 93, No. 7 (2003)

Canudas-Romo V, Aburto JM. Youth lost to homicides: disparities in survival in Latin America and the Caribbean. *BMJ Global Health*. 2019;4:e001275.

Caribbean Community (CARICOM), Declaration by Heads of Government on Crime and Violence as a Public Health Issue, April 18, 2023, available at

Carlson, J. (2015). *Citizen-protectors: The everyday politics of guns in an age of decline*. Oxford University Press.

Castilla-Peon MF, Rendón PL and Gonzalez-Garcia N (2024). The leading causes of death in the US and Mexico's pediatric population are related to violence: a note on secondary analyses of registered deaths from 2000 to 2022. *Frontiers in Public Health* 12:1428691. doi: 10.3389/fpubh.2024.1428691

Centers for Disease Control and Prevention (CDC). (2023). *WISQARS Fatal Injury Reports, National, Regional and State, 1981–2021*.

Clark, H., Coll-Seck, A. M., Banerjee, A., Peterson, S., Dalglish, S. L., Ameratunga, S., Balabanova, D., Bhan, M. K., Bhutta, Z. A., Borrazzo, J., Claeson, M., Doherty, T., El-Jardali, F., George, A. S., Gichaga, A., Gram, L., Hipgrave, D. B., Kwamie, A., Meng, Q., Mercer, R., ... Costello, A. (2020). A future for the world's children? A WHO-UNICEF-Lancet Commission. *Lancet* (London, England) , 395 (10224), 605–658. [https://doi.org/10.1016/S0140-6736\(19\)32540-1](https://doi.org/10.1016/S0140-6736(19)32540-1)

Conner A, Azrael D, Miller M. Suicide case-fatality rates in the United States, 2007 to 2014: a nationwide population-based study. *Ann Intern Med*. 2019 Dec;171(12):885–95. <https://doi.org/10.7326/M19-1324>

Cook, P. & Ludwig, J. Gun Violence is THE Crime Problem in Vital City, March 2, 2022 available at <https://www.vitalcitynyc.org/articles/gun-violence-is-the-crime-problem>

Cullen, P., Peden, A. E., Francis, K. L., Cini, K. I., Azzopardi, P., Möller, H., ... & Ivers, R. Q. (2024). Interpersonal violence and gender inequality in adolescents: A systematic analysis of global burden of disease data from 1990 to 2019. *Journal of Adolescent Health*, 74 (2).

Cunningham, R. M., M. Rosenberg, T. Corbin, C. Branas, S. A. L. Buggs, L. Harbold DeStefano, S. Haring, J. Heymann, R. Jackson, A. Jain, M. Laitner, J. Parsonnet, and B. Weston. 2023. Using science to reduce firearm injuries and deaths. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202310a>.

Cunningham, R. M., Walton, M. A., & Carter, P. M. (2018). The Major Causes of Death in Children and Adolescents in the United States. *The New England journal of medicine* , 379 (25), 2468–2475. <https://doi.org/10.1056/NEJMsrl804754>

Dahlberg, L., Butchart, A., Mercy, J., & Simon, T. (2022). Firearm injuries and public health. Oxford Research Encyclopedia of Global Public Health.

Dare, A. J., Irving, H., Guerrero-López, C. M., Watson, L. K., Kolpak, P., Reynales Shigematsu, L. M., Sanches, M., Gomez, D., Gelband, H., & Jha, P. (2019). Geospatial, racial, and educational variation in firearm mortality in the USA, Mexico, Brazil, and Colombia, 1990-2015: a comparative analysis of vital statistics data. *The Lancet. Public health* , 4 (6), e281–e290. [https://doi.org/10.1016/S2468-2667\(19\)30018-0](https://doi.org/10.1016/S2468-2667(19)30018-0)

Davis, A. B., Gaudino, J. A., Soskolne, C. L., Al-Delaimy, W. K., & International Network for Epidemiology in Policy (Formerly known as IJPC-SE). (2018). The role of epidemiology in firearm violence prevention: a Policy Brief. *International journal of epidemiology*, 47(4), 1015–1019.

Degli Esposti M, Pulcini CD, Fleegler EW, et al. Youth Firearm Mortality in the Americas From 2015 to 2022. *JAMA Netw Open*. 2024;7(10):e2437395. doi:10.1001/jamanetworkopen.2024.37395

Delgado, Sheyla A., Laila Alsabahi, Kevin Wolff, Nicole Alexander, Patricia Cobar, and Jeffrey A. Butts (2017). The Effects of Cure Violence in the South Bronx and East New York, Brooklyn. In *Denormalizing Violence: A Series of Reports From the John Jay College Evaluation of Cure Violence Programs in New York City*. New York, NY: Research and Evaluation Center, John Jay College of Criminal Justice, City University of New York.

Demortain, D. (2017). Experts and the production of international policy knowledge: do epistemic communities do the job? *The Politics of Expertise in International Organizations: How International Bureaucracies Produce and Mobilize Knowledge*. London: Routledge, 76-92.

Dobbs, J & Sakran, J. (2023) “How Green Spaces Can Combat Gun Violence in America”, *American Journal of Public Health* 113, no. 7: pp. 739-741.

Engel, R. J., Lee, D. H. J., & Rosen, D. (2020). Psychiatric Sequelae Among Community Social Service Agency Staff 1 Year After a Mass Shooting. *JAMA network open*, 3(8), e2014050. <https://doi.org/10.1001/jamanetworkopen.2020.14050>

Erickson, A. (2018, March 14). *How the NRA has shaped the world's gun laws*. *The Washington Post*. <https://www.washingtonpost.com/news/worldviews/wp/2018/03/14/how-the-nra-has-shaped-the-worlds-gun-laws/>

Everytown for Gun Safety. (2020, September 30). *Armed and dangerous: How the gun lobby enshrines guns as tools of the extreme right*. <https://everytownresearch.org/report/armed-and-dangerous>

Everytown for Gun Safety Support Fund, & Armed Conflict Location & Event Data Project. (2021, August 23). *Armed assembly: Guns, demonstrations, and political violence in America*. Everytown Research & Policy. <https://everytownresearch.org/report/armed-assembly-guns-demonstrations-and-political-violence-in-america/>

Everytown for Gun Safety. (2022, January). *Misogyny, extremism, and gun violence*. Everytown for Gun Safety. <https://everytownresearch.org/report/misogyny-extremism-and-gun-violence/>

Evrard, M., Rieckhoff, A., Shipton, L., Jørgensen, P. S., Falcone, J. L., Bouffanais, R., ... & Wernli, D. (2025). The environment in global health governance: an analysis of environment-related resolutions adopted at the World Health Assembly from 1948 to 2023. *The Lancet Planetary Health*, 9(2), e103-e113.

European Network Against Arms Trade (ENAAAT), available at <https://enaat.org/eu-export-browser/overview?metric=hybrid&rating=ml1F>

Fabre, A.-S., Florquin, N., Karp, A., & Schroeder, M. (2023). *Weapons Compass: The Caribbean Firearms Study. CARICOM IMPACS & Small Arms Survey*, Graduate Institute of International and Development Studies.

FCTC Secretariat, May 2021 available at

Fincken, E. (2025, May 8). *Five countries referred to top EU court over enforcement failings*. ICLG. Retrieved from <https://iclg.com/news/22581-five-countries-referred-to-top-eu-court-over-enforcement-failings>

Fleegler, E. W., Vargas, L., Pulcini, C. D., & Hargarten, S. (2025). Bullets as Pathogen-The Need for Public Health and Policy Approaches. *JAMA*, 333(7), 565–566. <https://doi.org/10.1001/jama.2024.25535>

Flood, M. Peacock, D. Barker, G. Stern, O. Greig, A. (2010). Policy approaches to involving men and boys in achieving gender equality . Paper prepared by Sonke Gender Justice Network for the Department of Gender, Women and Health, World Health Organization.

Florentine JB, Crane C. Suicide prevention by limiting access to methods: a review of theory and practice. *Soc Sci Med*. 2010 May;70(10):1626–32. <https://doi.org/10.1016/j.socscimed.2010.01.029>

Fórum Brasileiro de Segurança Pública. Anuário Brasileiro de Segurança Pública. FBSP, 2024 e 2025

Foundation for Professional Development. (n.d.). *Briefing document: 16th World Conference on Injury Prevention and Safety Promotion*. Foundation for Professional Development.

Galea, S., Branas, C. C., Flescher, A., Formica, M. K., Hennig, N., Liller, K. D., Madanat, H. N., Park, A., Rosenthal, J. E., & Ying, J. (2018). Priorities in Recovering From a Lost Generation of Firearms Research. *American journal of public health*, 108(7), 858–860.

GAO. (2024). *Caribbean Firearms: Agencies have anti-trafficking efforts in place, but State should improve its data* (GAO-25-107007). Washington, DC.

GAO. (2025). *Export Controls: Improvements needed in licensing and enforcement following firearms jurisdiction transfer* (GAO-25-106849). Washington, DC.

Garbarino, J., Bradshaw, C. P., & Vorrasi, J. A. (2002). Mitigating the Effects of Gun Violence on Children and Youth. *The Future of Children*, 12(2), 73–85.

Garcia-Moreno, C. Guedes, A. & Knerr, W. (2012) Understanding and addressing violence against women: Femicide. World Health Organization. https://iris.who.int/bitstream/handle/10665/77421/WHO_RHR_12.38_eng.pdf?sequence=1

Gastineau, K. A., Stegall, C. L., Lowrey, L. K., Giourgas, B. K., & Andrews, A. L. (2021). Improving the frequency and documentation of gun safety counseling in a resident primary care clinic. *Academic pediatrics*, 21(1), 117-123.

- Gavi, the Vaccine Alliance. (2020, October 30). COVAX welcomes appointment of civil society representatives. Retrieved from <https://www.gavi.org/news/media-room/covax-welcomes-appointment-civil-society-representatives>
- Geller, L.B., Booty, M. & Crifasi, C.K. (2021). The role of domestic violence in fatal mass shootings in the United States, 2014–2019. *Inj. Epidemiol.* 8, 38
- Giraldi, D. M., Swingler, S., Kirk, D. S., Jacoby, S. F., Melendez-Torres, G. J., Kaufman, E. J., & Humphreys, D. K. (2025). Understanding the broader impacts of non-fatal firearm violence trauma in the United States: a scoping review. *Lancet regional health.Americas*, 46, 101091. <https://doi.org/10.1016/j.lana.2025.101091>
- Grassel KM, Wintemute GJ, Wright MA, et al Association between handgun purchase and mortality from firearm injury. *Injury Prevention* 2003;9:48-52.
- Green, C. (2024). Code Blue: How Police and Health Care Providers Disrupt Healing for Violently Injured Black Men. Violence, Inequality and Power Lab, University of San Diego.
- Greenberg, B., Bennett, A., Naveed, A., Petrut, R., Wang, S. M., Vyas, N., ... & Ahmed, N. (2024). How firearm legislation impacts firearm mortality internationally: A scoping review. *Health Policy OPEN*, 100127.
- Grillo, I (2021) *Blood Gun Money: How America Arms Gangs and Cartels*. London: Bloomsbury Publishing.
- Grinshteyn, E., & Hemenway, D. (2019). Violent death rates in the US compared to those of the other high-income countries, 2015. *Preventive medicine*, 123, 20-26.
- Gruszczynski, L. & Melillo, M. (2022). The Uneasy Coexistence of Expertise and Politics in the World Health Organization. Learning from the Experience of the Early Response to the COVID-19 Pandemic. *International Organization Law Review*, 19, 301-331.
- Hawton K, Zahl D, Weatherall R. Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. *British Journal of Psychiatry* . 2003;182(6):537-542. doi:10.1192/bjp.182.6.537
- Health Alliance for Violence Intervention. (n.d.). What is an HVIP? In The HAVI. Retrieved September 7, 2025, from <https://www.thehavi.org/what-is-an-hvip>
- Hemenway, D., & Nelson, E. (2020). The scope of the problem: gun violence in the USA. *Current Trauma Reports*, 6 (1), 29–35. <https://doi.org/10.1007/s40719-020-00166-3>
- Heywood, M. (2015). The Treatment Action Campaign's quest for equality in HIV and health: learning from and lessons for the trade union movement. *Global Labour Journal*, 6(3).
- Hoops, K., McCourt, A., & Crifasi, C. K. (2022). The 5 A's of firearm safety counseling: Validating a clinical counseling methodology for firearms in a simulation-based randomized controlled trial. *Preventive medicine reports*, 27, 101811. <https://doi.org/10.1016/j.pmedr.2022.101811>
- How the US Drives Gun Exports and Fuels Violence Around the World . No company has benefited more from the federal government's push to boost overseas sales than Sig Sauer Inc . Michael Riley, David Kocieniewski and Eric Fan, Bloomberg News, July 25, 2023
- Hyder, A.A., & Barberia, L. (2024). Addressing global gun violence: a Lancet Commission on Global Gun Violence and Health. *The Lancet* , 404 (10465), 1794-1795.
- International Action Network on Small Arms (2021). Women, gun violence and the home. International Action Network on Small Arms. <https://iansa.org/wp-content/uploads/2021/04/en-iansa-wn-information-kit-1.pdf>
- International Action Network on Small Arms (IANSA) & International Peace Information Service (IPIS). (2022, June 1). *Small arms and light weapons proliferation and violence: Estimating its scale and forms* [Briefing paper]. IANSA & IPIS. https://iansa.org/wp-content/uploads/2022/06/IANSA-AND-IPIS_Small-Arms-and-Light-Weapons-Proliferation-and-Violence-Estimating-its-Scale-and-Forms-June-2022-1.pdf

IHME. (2021). Physical violence by firearm – Level 4 cause. Institute for Health Metrics and Evaluation.

Infante, M., Mohor, A., Salvo, P., M. I., Bellalta, A., Del Canto, P. S. (2025) Critical Gaps: Firearms and Gender-based Violence in Chile. Small Arms Survey.

Instituto Sou da Paz. (2023). Custos da Violência Armada – Gastos da saúde pública com atendimento de vítimas de arma de fogo, 2ª edição. Instituto Sou da Paz .https://soudapaz.org/wp-content/uploads/2023/11/CUSTOS-DA-VIOLENCIA-ARMADA_SDP-1.pdf

Instituto Sou da Paz. Violência armada e racismo: o papel da violência armada na desigualdade racial, 3ª edição, 2024

Instituto Sou da Paz. Protecting women's lives: the role of firearms in gender violence. 4th edition, 2025. International Labour Organisation, (2018). Care work and care jobs for the future of decent work. Geneva: ILO.

Irwin, R., & Smith, R. (2018). Rituals of global health: Negotiating the World Health Assembly. *Global Public Health*, 14(2), 161–174. <https://doi.org/10.1080/17441692.2018.1504104>

Jenzen-Jones, N. R., & Schroeder, M. (2018). An introductory guide to the identification of small arms, light weapons, and associated ammunition. Small Arms Survey.

Jordan, A. Hall, C. Hughes, D. , Feb 12, 2024, Debunking the 'Guns Make Us Safer' Myth, Center for American Progress. <https://www.americanprogress.org/article/debunking-the-guns-make-us-safer-myth/>

Kapadia F. Gun control for health: a public health of consequence, December 2022. *Am J Public Health*. 2022;112(12):1710–171

Karp, A. (2018). Estimating Global Civilian-Held Firearms Numbers. Small Arms Survey.

Kellermann, A. Rivara, F. Rushforth, N. (1993). Gun ownership as a risk factor for homicide in the home *The New England Journal of Medicine*. ; 329:1084-1091

Kickbusch, I. & Liu, A. (2022). Global health diplomacy — reconstructing power and governance. *Lancet*, 399, 2156-2166.

Killias M, Van Kesteren J, Rindlisbacher M. Guns, violent crime, and suicide in 21 countries. *Can J Criminol*. 2001 Oct;43(4):429–48.

Killias M, Van Kesteren J, Rindlisbacher M. Guns, violent crime, and suicide in 21 countries. *Can J Criminol*. 2001 Oct;43(4):429–48. <https://doi.org/10.3138/cjcrim.43.4.429>

Killias M. International correlations between gun ownership and rates of homicide and suicide. *CMAJ*. 1993 May;148(10):1721–5.

Krug, E. Butchart, A. Peden, M. (2001) A new department for injuries and violence prevention at the World Health Organization, *Injury Prevention* 2001; 7 :331–333

Krupa, J. Andrews, C. & Elam, P. A 24-Month Assessment of Shooting Victimization in Lansing, MI: Pre- and Post-Advance Peace, Michigan Public Health Institute and Michigan State University accessed from

Lacy-Nichols, J., Marten, R., Crosbie, E., & Moodie, R. (2022). The public health playbook: ideas for challenging the corporate playbook. *The Lancet Global Health* , 10 (7), e1067-e1072

Lesch, M., McCambridge, J. Continuities and change in alcohol policy at the global level: a documentary analysis of the 2010 Global Strategy for Reducing the Harmful Use of Alcohol and the Global Alcohol Action Plan 2022–2030. *Global Health* 20, 47 (2024). <https://doi.org/10.1186/s12992-024-01034-y>

Levtov, R (2024). Evidence review: Addressing Harmful Alcohol Use To Reduce Intimate Partner Violence And Violence Against Children in the Home, Prevention Collaborative, accessed on May 26, 2025 at <https://prevention-collaborative.org/wp-content/uploads/2024/09/Alcohol-Review-FINAL.pdf>

Lin JC, Chang C, McCarthy MS, Baker-Butler A, Tong G, Ranney ML. Trends in Firearm Injury Prevention Research Funding, Clinical Trials, and Publications in the US, 1985-2022. *JAMA Surg.* 2024;159 (4):461–463. doi:10.1001/jamasurg.2023.7461

Littoz-Monnet, A. (2017). Production and uses of expertise by international bureaucracies. *The Politics of Expertise in International Organizations: How International Bureaucracies Produce and Mobilize Knowledge*. London: Routledge, 1-18.

Lowy, J (2024) Global Action on Gun Violence report to the United Nations Office of the High Commissioner for Human Rights: Human rights and the regulation of civilian acquisition, possession and use of firearms.

Lubin G, Werbeloff N, Halperin D, Shmushkevitch M, Weiser M, Knobler HY. Decrease in suicide rates after a change of policy reducing access to firearms in adolescents: a naturalistic epidemiological study. *Suicide Life Threat Behav.* 2010 Oct;40(5):421–4. <https://doi.org/10.1521/suli.2010.40.5.421>

Maani N, Adrion ER, Collin J. Who funds the WHO Foundation? A transparency analysis of donation disclosures over the first 3 years of its operation. *BMJ Glob Health* 2025;10:e018932. doi:10.1136/bmjgh-2025-018932

Mack, D (2015) “Small Arms, Big Violations”, SUR 22, accessed August 8, 2025,

Mamudu, H. M., & Glantz, S. A. (2009). Civil society and the negotiation of the Framework Convention on Tobacco Control. *Global public health*, 4(2), 150–168. <https://doi.org/10.1080/17441690802095355>

Martínez-Villalba, L. Femicide and Gun Control: The Application of Symbolic Penal Law in The Mexican Criminalization of Femicide. *Int J Semiot Law* 37, 1755–1775 (2024)

Matzopoulos, R., Prinsloo, M., Bradshaw, D., & Abrahams, N. (2019). Reducing homicide through policy interventions: The case of gun control. *South African Medical Journal* 109 (11b), 63–68.

McHardy, J. (2021). The WHO FCTC's lessons for addressing the commercial determinants of health. *Health Promotion International*, 36(Suppl. 1), i39–i52. <https://doi.org/10.1093/heapro/daab143>

Mendes, W. G., Duarte, M. J. O., Andrade, C. A. F., & Silva, C. M. F. P. D. (2021). Systematic review of the characteristics of LGBT homicides. *Revisão sistemática das características dos homicídios contra a população LGBT*. *Ciencia & saude coletiva*, 26(11), 5615–5628.

Mencken, F. C., & Froese, P. (2019). Gun culture in action. *Social Problems*, 66(1), 3–27. <https://doi.org/10.1093/socpro/spx040>

Merson, M. H., O'Malley, J., Serwadda, D., & Apisuk, C. (2008). The history and challenge of HIV prevention. *The Lancet*, 372(9637), 475-488.

Mexico, Spain, & Small Arms Survey. (2023). Mitigating the risk of armed violence against people on the basis of their actual or perceived sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) through the Arms Trade Treaty (ATT) [Working paper presented to the Ninth Conference of States Parties to the Arms Trade Treaty (CSP9), Geneva, 21–25 August 2023]. Arms Trade Treaty Secretariat.

Mitchell KJ, Banyard V, Taylor BG, Mumford EA, Liu W and Turner HA (2025) Prevalence of exposure to someone else's firearm violence, threats, and risky behavior among a national sample of young people in the United States. *Frontiers in Public Health* 13:1451268. doi: 10.3389/fpubh.2025.1451268

Mohammed RS, Boateng EA, Amponsah AK, Kyei-Dompim J, Laari TT (2023) Experiences of family caregivers of people with spinal cord injury at the neurosurgical units of the Komfo Anokye Teaching Hospital, Ghana. *PLOS ONE* 18(4): e0284436.

Myrttinen, H and M Schöb (2022), Men and Masculinities in Gender Responsive Small Arms Control, GENSAC Issue Brief #2, New York and Geneva: Gender and Small Arms Control Network (GENSAC) and the Women's International League for Peace and Freedom (WILPF).

- Myrntinen, H. (2003). Disarming Masculinities. United Nations Institute for Disarmament Research 4, 37-53.
- National Shooting Sports Foundation-NSSF (2020) Firearm Consumer Personas Phase I Report, Produced by Southwick Associates, Inc for the
- Ntatamala, I., & Adams, S. (2022). The Correlates of Post-Traumatic Stress Disorder in Ambulance Personnel and Barriers Faced in Accessing Care for Work-Related Stress. *International Journal of Environmental Research and Public Health*, 19(4), 2046. <https://doi.org/10.3390/ijerph19042046>
- Office of the Surgeon General. (2024). Firearm violence: A public health crisis in America: The U.S. Surgeon General's advisory. U.S. Department of Health and Human Services.
- Open Secrets (2024) available at and
- OpenSecrets. (2024). Gun Owners of America—Summary profile. <https://www.opensecrets.org/orgs/gun-owners-of-america/summary?id=D000026353>
- OpenSecrets. (2025a). National Rifle Association—Lobbying profile. <https://www.opensecrets.org/federal-lobbying/clients/summary?id=d000000082>
- OpenSecrets. (2025b). National Shooting Sports Foundation—Lobbying profile. <https://www.opensecrets.org/federal-lobbying/clients/summary?id=D000054336>
- Ou, Z., Ren, Y., Duan, D., Tang, S., Zhu, S., Feng, K., ... & Wang, Z. (2022). Global burden and trends of firearm violence in 204 countries/territories from 1990 to 2019. *Frontiers in public health*, 10, 966507.
- O'Neill, R. (2025, April 1). How understanding the economics of guns can improve public welfare. HARVARD Kennedy School. Retrieved from <https://www.hks.harvard.edu/faculty-research/policy-topics/social-policy/how-understanding-economics-guns-can-improve-public>.
- Pan American Health Organization. Masculinities and Men's Health in the Caribbean. Washington, D.C.: PAHO; 2023. Available from: <https://doi.org/10.37774/9789275127650>.
- Patel, J., Leach-Kemon, K., Curry, G., Naghavi, M., & Sridhar, D. (2022). Firearm injury - a preventable public health issue. *The Lancet Public Health*, 7 (11), e976-e982.
- Patel, J., Leach-Kemon, K., Curry, G., Naghavi, M., & Sridhar, D. (2022). Firearm injury—a preventable public health issue. *The Lancet Public Health*, 7 (11), e976-e982.
- Peacock, D (2024) WILPF-GENSAC desk review on militainment, militarization, gender stereotyping and the marketing of militarized masculinities, September 26, 2023.
- Peters, A. W., Yorlets, R. R., Shrimel, M. G., & Alkire, B. C. (2020). The macroeconomic consequences of firearm-related fatalities in OECD countries, 2018–30: A value-of-lost-output analysis. *Health Affairs*, 39 (11), 1961–1969. <https://doi.org/10.1377/hlthaff.2019.01701>
- Pingen, A. (2024, September 2). Overview of the latest developments regarding the Digital Services Act (April–September 2024). Euclid. Retrieved from <https://eucrim.eu/news/overview-of-the-latest-developments-regarding-the-digital-services-act/>
- Pinto, I.V. et al. Fatores associados ao óbito de mulheres com notificação de violência por parceiro íntimo no Brasil. *Ciência & Saúde Coletiva*, 26(3):975-985, 2021.
- Pinto, I.V.; Marinho, F.; Malta, D.C. Risk of mortality by aggression: A retrospective cohort study in women with notification of interpersonal violence in Brazil. *Public Health*, 240: 12-17, 2025.
- Poitras, C. (2024) Lifting of federal funding ban tied to increase in gun violence research, Yale School of Public Health, February 07, 2024 available at
- Rajan, S. Branas, C, Hargarten, S. Allegrante, J (2018) "Funding for Gun Violence Research Is Key to the Health and Safety of the Nation", *American Journal of Public Health* 108

- Rajan, S., Reeping, P. M., Ladhani, Z., Vasudevan, L. M., & Branas, C. C. (2022). Gun violence in K-12 schools in the United States: Moving towards a preventive (versus reactive) framework. *Preventive medicine*, 165(Pt A), 107280. <https://doi.org/10.1016/j.ypmed.2022.107280>
- Report of the Director-General to Member States at the Seventy-eighth World Health Assembly – 19 May 2025 https://www.who.int/news-room/speeches/item/report-of-the-director-general-to-member-states-at-the-seventy-eighth-world-health-assembly-19-may-2025?utm_source=substack&utm_medium=email
- Sadat, Leila Nadya, & George, M. M. (2019). Gun Violence and Human Rights. *Washington University Journal of Law & Policy*, 60, 1-90.
- Salama, H. (2023). Addressing Weapons in Conflict Related Sexual Violence: The Arms control and Disarmament Toolbox, UNIDIR, Geneva
- Satariano, A. (2025, April 3). EU prepares major penalties against Elon Musk's X. *The New York Times*. Retrieved from <https://www.nytimes.com/2025/04/04/us/politics/musk-x-european-union-fine.html>
- Santaella-Tenorio, J., Cerdá, M., Villaveces, A., & Galea, S. (2016). What Do We Know About the Association Between Firearm Legislation and Firearm-Related Injuries?. *Epidemiologic reviews*, 38 (1), 140–157. <https://doi.org/10.1093/epirev/mxv012>
- Seitz, K. (2016). FENSA—a fence against undue corporate influence?: The new Framework of Engagement with Non-State Actors at the World Health Organization. Briefing September 2016. Global Policy Forum.
- Semenza DC, Kravitz-Wirtz N. (2025). Gun violence exposure and population health inequality: a conceptual framework. *Inj Prev*. Jan 23;31(1):1-8.
- Semenza, DC. Thomas, C. Stansfield, R. Johnson, DB. Burke, KC. Anestis, D (2025). Local homicides increase suicide in US counties, *Social Science & Medicine*, 118406, ISSN 0277-9536,
- Shah, N. (2025). Normal wounds. *Critical Military Studies*, 1–16. <https://doi.org/10.1080/23337486.2025.2507441>
- Siegel M, Rothman EF. Firearm ownership and suicide rates among US men and women, 1981–2013. *Am J Public Health*. 2016 Jul;106(7):1316–22.
- SIPRI. (2023). The SIPRI Top 100 arms-producing and military services companies in the world. Stockholm International Peace Research Institute. <https://www.sipri.org/visualizations/2024/sipri-top-100-arms-producing-and-military-services-companies-world-2023>
- Skogan, W. Hartnett, S. Bump, N. Dubois, J (2009) Evaluation of CeaseFire-Chicago. U.S. Department of Justice
- Small Arms Survey. (2022, July). Global violent deaths in 2020 (GVD Update). Small Arms Survey. <https://smallarmssurvey.org/sites/default/files/resources/SAS-GVD-July-2022-update.pdf>
- Small Arms Survey. (2023, September 5). *The Small Arms Survey signs project partnership with CARICOM IMPACS, the Caribbean Public Health Agency (CARPHA), the University of the West Indies George Alleyne Chronic Disease Research Centre (GA-CDRC)*. Retrieved from <https://www.smallarmssurvey.org/highlight/small-arms-survey-signs-project-partnership-caricom-impacs-caribbean-public-health-agency>
- Small Arms Survey. (2024). Integrating gender and demand perspectives in small arms control processes.
- Snowdon, L., Quigg, Z., & Leavey, C. (2024). The role of public health in the primary prevention of interpersonal violence: A systematic review of international frameworks. *Journal of Community Safety and Well-Being*, 9(4), 176-183.
- Song, Z., Zubizarreta, J. R., Giuriato, M., Koh, K. A., & Sacks, C. A. (2023). Firearm Injuries in Children and Adolescents: Health and Economic Consequences Among Survivors and Family Members. *Health affairs (Project Hope)*, 42(11), 1541–1550. <https://doi.org/10.1377/hlthaff.2023.00587>

- Sorenson, S. B., & Schut, R. A. (2016). Non-Fatal Gun Use in Intimate Partner Violence: A Systematic Review of the Literature. *Trauma, Violence, & Abuse*, <http://dx.doi.org/10.1177/1524838016668589>
- Spitzer SA, Vail D, Tennakoon L, Rajasingh C, Spain DA, Weiser TG (2019). Readmission risk and costs of firearm injuries in the United States, 2010-2015. *PLoS ONE* 14(1): e0209896. <https://doi.org/10.1371/journal.pone.0209896>
- Stanbrook, MB. (2019) Gun control: a health issue for which physicians rightfully advocate, *CMAJ* 2019 April 23;191:E434-5. doi: 10.1503/cmaj.190401
- Stevanović Govedarica, G. (2021). Small arms and light weapons, gender-based violence and domestic violence: Analysis of regulatory framework and practice in Serbia. United Nations Development Programme. https://www.undp.org/sites/g/files/zskgke326/files/migration/rs/undp_rs_SALW_and_DV.pdf
- Stroebe, W. (2023) Suicide in Switzerland: Why gun ownership can be deadly. *Swiss Med Wkly*. 2023;153:40026
- Studdert, D. M., Zhang, Y., Holsinger, E. E., Prince, L., Holsinger, A. F., Rodden, J. A., Wintemute, G. J., & Miller, M. (2022). Homicide Deaths Among Adult Cohabitants of Handgun Owners in California, 2004 to 2016 : A Cohort Study. *Annals of internal medicine*, 175(6), 804–811. <https://doi.org/10.7326/M21-3762>
- Tandogan, O., Ilhan, B. S. (2016) Fear of Crime in Public Spaces: From the View of Women Living in Cities, *Procedia Engineering*, Volume 161, Pages 2011-2018, ISSN 1877-7058.
- The Global Burden of Disease 2016 Injury Collaborators. Global Mortality From Firearms, 1990-2016. *JAMA*. 2018;320(8):792–814. doi:10.1001/jama.2018.10060
- The Lancet (2023). Unravelling the commercial determinants of health. *Lancet* (London, England), 401(10383), 1131.
- The Role Firearms Play in Violence Against Women, Sou Da Paz, 2024 p.9
- UNAIDS. (2008, November 3). UNAIDS: The first 10 years. UNAIDS. <https://www.unaids.org/en/resources/presscentre/featurestories/2008/november/20081103tfty>
- United Nations General Assembly. (2003). Report of the United Nations 1st Biennial Meeting of States to consider the implementation of the Programme of Action to Prevent, Combat and Eradicate the Illicit Trade in Small Arms and Light Weapons in All Its Aspects (A/CONF.192/BMS).
- United Nations General Assembly. (2023, December 7). Global framework for through-life conventional ammunition management (A/RES/78/47). United Nations.
- United Nations Office for Disarmament Affairs. (2024). Global framework for through-life conventional ammunition management. United Nations. <https://doi.org/10.18356/9789211575453>
- United Nations Office on Drugs and Crime, Global Study on Firearms Trafficking, 2020
- United Nations Office on Drugs and Crime. (2023). Global Study on Homicide 2023. UNODC Research.
- UNODC and UN Women, Femicides in 2023: Global Estimates of Intimate Partner/Family Member Femicides (United Nations publication, 2024).
- Vasselin, P. & Cuveillier, F. (2020). La fabrique de l'ignorance. ARTE France. [Documentary, 97']. Retrieved from <https://educ.arte.tv/program/la-fabrique-de-l-ignorance>.
- Villarreal, S., Kim, R., Wagner, E., Somayaji, N., Davis, A., & Crifasi, C. K. (2024). Gun Violence in the United States 2022: Examining the Burden Among Children and Teens. Johns Hopkins Center for Gun Violence Solutions. Johns Hopkins Bloomberg School of Public Health.
- Vital Strategies. (2025, January 2). *Mulheres vítimas de violência mudam o padrão de visitas às unidades de saúde cerca de 90 dias antes do agravamento do caso*. Vital Strategies. <https://www.vitalstrategies.org/mulheres-vitimas-de-violencia-mudam-o-padrao-de-visitas-as-unidades-de-saude-cerca-de-90-dias-antes-do-agravamento-do-caso/>

Weigend Vargas, E., Goldstick, J., & Vargas, L. (2024). Firearm-related threats before migrating to the USA from Latin America and the Caribbean. *Injury prevention: journal of the International Society for Child and Adolescent Injury Prevention*, ip-2024-045369. Advance online publication.

Werbick, M., Bari, I., Paichadze, N. & al. (2021). Firearm violence: a neglected “Global Health” issue. *Global Health*, 17(120).

Wernli, D., Falcone, J. L., Davidshofer, S., Lee, K., Chopard, B., & Levrat, N. (2023). Emergent patterns in global health diplomacy: a network analysis of the resolutions adopted by the World Health Assembly from 1948 to 2022. *BMJ Global Health*, 8(4), e011211.

WHO Commission on Social Determinants of Health. Civil Society Report, October, 2007 & Closing the gap in a generation: Health equity through action on the social determinants of health. WHO and the Commission on Social Determinants of Health, 2008.

Williams, A.Y., & Butts, C. C. (2023). Stress Disorders: the Trauma Surgeon as the Second Victim. Current trauma reports, 1–8. Advance online publication. <https://doi.org/10.1007/s40719-023-00259-3>

Women’s International League for Peace and Freedom, Reaching Critical Will, & Gender Equality Network on Small Arms Control. (2024, December). *Advancing gender and inclusivity in small arms control: Key takeaways from RevCon4*. Reaching Critical Will – Women’s International League for Peace and Freedom; Gender Equality Network on Small Arms Control. Retrieved from <https://www.wilpf.org/wp-content/uploads/2024/12/rcw-gensac-paper-.pdf>

World Health Assembly. (1996). Resolution WHA49.25. Prevention of violence: A public health priority. World Health Organization. <https://apps.who.int/iris/handle/10665/179463>

World Health Assembly. (1997). Prevention of violence (WHA50.19). World Health Organization. https://apps.who.int/iris/bitstream/10665/179638/1/WHA50_1997-REC-1_eng.pdf

World Health Assembly. (2003). Implementing the recommendations of the World report on violence and health (WHA56.24). World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/WHA56/ea56r24.pdf

World Health Assembly. (2014). Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children (WHA67.15). https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R15-en.pdf

World Health Assembly. (2016). WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (WHA69.5). World Health Organization. https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_r5-en.pdf

World Health Assembly. (2021). Ending violence against children through health systems strengthening and multisectoral approaches (WHA74.17). https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_R17-en.pdf

World Health Organization. (1946, July 22). Constitution of the World Health Organization. World Health Organization. <https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>

World Health Organization. (2001). Small Arms and Global Health. World Health Organization. Retrieved from <https://iris.who.int/handle/10665/66838>.

World Health Organization. (2002). World report on violence and health. World Health Organization. Retrieved from <https://www.who.int/publications/i/item/9241545615>.

World Health Organization. (2003). WHO Framework Convention on Tobacco Control. World Health Organization. Retrieved from

World Health Organization. (2005). Milestones of a global campaign for violence prevention 2005: Changing the face of violence prevention. World Health Organization. <https://apps.who.int/iris/handle/10665/43071>

World Health Organization. (2006). Constitution of the World Health Organization, 47th ed. World Health Organization.

- World Health Organization, Commission on Social Determinants of Health. (2007, October). *Civil society report*. World Health Organization.
- World Health Organization. (2008). Preventing violence and reducing its impact: How development agencies can help. World Health Organization.
- World Health Organization. (2009). Guns, knives, and pesticides: reducing access to lethal means. World Health Organization.
- World Health Organization. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence. World Health Organization.
- World Health Organization. (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence. World Health Organization. <https://iris.who.int/handle/10665/44350>
- World Health Organization. (2014). Global status report on violence prevention 2014. World Health Organization.
- World Health Organization. (2015). Preventing youth violence: an overview of the evidence. World Health Organization.
- World Health Organization. (2016). INSPIRE: seven strategies for ending violence against children.
- World Health Organization. (2018). INSPIRE handbook: Action for implementing the seven strategies for ending violence against children. World Health Organization.
- World Health Organization. (2019). Preventing suicide: a resource for pesticide registrars and regulators. World Health Organization.
- World Health Organization. (2019). RESPECT women: Preventing violence against women (WHO/RHR/18.19). World Health Organization. <https://www.who.int/publications/i/item/WHO-RHR-18.19>
- World Health Organization. (2019). Suicide and self-harm (No. WHO-EM/MNH/224/E). World Health Organization. Regional Office for the Eastern Mediterranean.
- World Health Organization (2021). WHO Report on the Global Tobacco Epidemic 2021: Addressing New and Emerging Products. Geneva: WHO. Accessed November 29, 2021. <https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2021>
- World Health Organization. (2022). Preventing injuries and violence: an overview. World Health Organization.
- World Health Organization. (2023). Commercial determinants of health. <https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health>.
- World Health Organization. (2024). Fair share for health and care: gender and the undervaluation of health and care work. Geneva: Licence: CC BY-NC-SA 3.0 IGO.
- World Health Organization. (2025). ICD-11 for Mortality and Morbidity Statistics (Version: 2025-01).
- World Health Organization. (2025). *World report on social determinants of health equity*. Geneva. World Health Organization. (2025) Economic and commercial determinants of health in Small Island Developing States: noncommunicable diseases, mental health conditions, injuries and violence. Geneva.
- World Health Organization. (n.d.). Drink-driving. World Health Organization. <https://www.who.int/initiatives/SAFER/drink-driving>.
- World Health Organization. (n.d.). Road safety. World Health Organization. https://www.who.int/health-topics/road-safety#tab=tab_3.
- World Health Organization. (n.d.). *Acute Care Action Network (ACAN)*. Retrieved 7/14/2025, from <https://www.who.int/groups/acute-care-action-network>
- Young, L. J., & Xiang, H. (2022). US racial and sex-based disparities in firearm-related death trends from 1981–2020. *PLoS one*, 17(12), e027830.



Gender Centre at the Geneva Graduate Institute (IHEID)

Maison de la Paix, Petal 1
Chem. Eugène-Rigot 2
1202 Genève
www.graduateinstitute.ch/gender



DIVISION OF
SOCIAL AND
BEHAVIOURAL
SCIENCES

Division of Social and Behavioural Science, School of Public Health, University of Cape Town

Falmouth Building
Level 1, Anzio Road, Observatory
Cape Town, South Africa
www.publichealth.uct.ac.za/phfm_social-and-behavioural-sciences



School of Public Health
Departement Openbare Gesondheid
Isikolo Sempilo Yoluntu



Violence, Inequality
and Power Lab



Violence, Inequality and Power Lab, Kroc School of Peace Studies, University of San Diego

5998 Alcalá Park
San Diego, California, US
www.sandiego.edu/peace/institute-for-peace-justice/violence-inequality-power-lab/



Comprehensive Injury Center, Medical College of Wisconsin

8701 Watertown Plank Rd
Milwaukee, Wis. US
www.mcw.edu/departments/comprehensive-injury-center



Sou da Paz

R CARDEAL ARCOVERDE, 359, Complemento ANDAR
13 CONJ 131 E 132
São Paulo
CEP 05508-000
Brasil



Gun Free South Africa

Unit 50, Inospace Wynberg
40 5th St, Wynberg
Sandton, 2090
South Africa



The Women's Institute for Alternative Development (WINAD)

P.O. Box 10134, San Juan
Trinidad and Tobago
winad1999@yahoo.com