WORLD HEALTH ORGANIZATION
EUROPE

PREVENTING INJURIES IN EUROPE

From international collaboration to local implementation

WORLD HEALTH ORGANIZATION
EUROPE

PREVENTING INJURIES IN EUROPE:

FROM INTERNATIONAL COLLABORATION TO LOCAL IMPLEMENTATION

Dinesh Sethi, Francesco Mitis & Francesca Racioppi

ABSTRACT

Injuries and violence are the third leading cause of death in the WHO European Region and pose a threat to economic and social development. This publication presents the results of a three-year collaborative project between WHO and the European Commission, funded by SANCO in the framework of the Public Health Programme (2003–2008), on progress achieved by European countries in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety. A web-based database of country profiles was developed using a questionnaire survey completed by health ministry focal people for preventing injury and violence. Information was provided on progress in delivering on key items of resolution EUR/RC55/R9, on the implementation of 99 selected evidence-based programmes to prevent unintentional injuries and violence and on the cross-cutting risk factors of alcohol and socioeconomic inequality. There were responses from 47 of the 51 WHO European Member States that have focal people. Good progress is taking place, and resolution EUR/RC55/R9 has catalysed change in 75% of the countries responding. The development of national policies for individual types of injury and violence varied from 95% for road safety to 40% for preventing drowning. Implementation of evidence-based programmes for preventing all types of injury and violence varied in countries, and the median score was 73% for all these together. This progress report documents that the health sector needs to commit more to the widespread implementation of effective programmes both in number and coverage and to engage with other stakeholders in a multisectoral response to prevent injuries and violence.

Keywords

Violence – prevention and control
Wounds and injuries – prevention and control
International cooperation
Program development
National health programs
Health policy
Data collection – methods
Europe

ISBN: 978 92 890 4196 6

Address requests about publications of the WHO Regional Office for Europe to:
Publications
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (http://www.euro.who.int/pubrequest).

Cover photos (left to right): CDC, M. Sedlák, iStockphoto
Inside photos: p. 1: WHO/P. Virot; p. 2: WHO/R. Simpson; p. 13: iStockphoto; p. 20: iStockphoto; p. 28: iStockphoto; p. 29: WHO/C. Black
Design: Inís Communication – www.inis.ie
Editing: David Breuer
Printing: Servizi Tipografici Carlo Colombo, Rome, Italy.

CONTENTS

ACKNOWLEDGEMENTS

We are indebted to the health ministry focal people for preventing violence and injuries who took the time to fill out and review the questionnaires and to check the validity of information reported in the country assessments. This report would not have been possible without their dedication. They are listed in Annex 3.

The report and the methods used in the questionnaire and in writing the country assessments were developed with the contribution of an expert advisory group:

- Mark Bellis, Liverpool John Moores University, United Kingdom;
- Taygeta Firman, General Directorate for Health, Malta;
- Fazil Inan, General Directorate of Primary Health Care, Ankara, Turkey;
- Christiane Hauzeur, Federal Ministry of Public Health, Brussels, Belgium;
- Rupert Kisser, Kuratorium für Verkehrssicherheit, Vienna, Austria;
- Fanka Koycheva, National Centre for Public Health Protection, Sofia, Bulgaria;
- Freja Ulvestad Kärki, Directorate of Health, Oslo, Norway; and
- Wim Rogmans, Consumer Safety Institute, Amsterdam, Netherlands.

We are particularly grateful to external peer reviewers for helpful comments in improving the completeness of the publication: Mark Bellis, María Seguí Gómez, Christiane Hauzeur, Freja Ulvestad Kärki, Wim Rogmans and Fimka Tozija.

We thank David Breuer for text editing.

And, finally, we are really grateful to the WHO staff members who contributed to this publication:

- Cristina Fumo and Manuela Gallitto for administrative support;
- Matthijs Muijen and Vivian Barnekow (WHO Regional Office for Europe) and Alex Butchart (WHO headquarters) for in-depth comments on drafts;
- the heads and staff members of WHO country offices, who helped in facilitating national responses;
- Clare Lord and Myriam Andersen, who translated and facilitated the translation of questionnaires from German and Russian; and
- Lars Moller and Enrique Loyola Elizondo for technical advice.

We are grateful for the positive encouragement, guidance and support given by European Commission staff, in particular Gulio Gallo, Natacha Grenier and Horst Kloppenburg from the Directorate-General for Health and Consumers and Georgios Margetidis from the Executive Agency for Health and Consumers.

We also wish to thank Nedret Emiroglu and Srdan Matic for their encouragement.

The publication describes the final results of a three-year collaborative project between WHO and the Directorate-General for Health and Consumers of the European Commission that began in April 2007 (2006WHO02 Prevention of injuries): Implementation of the European Council Recommendation on the prevention of injury and the promotion of safety and WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region. This is a three year collaborative project between WHO and the European Commission funded by SANCO in the framework of the Public Health Programme (2003–2008).

Dinesh Sethi, Francesco Mitis & Francesca Racioppi

ABBREVIATIONS

APOLLO project	Strategies and Best Practices for the Reduction of Injuries
CI	confidence interval
DALYs	disability-adjusted life-years
EU	European Union
EuroSafe	European Association for Injury Prevention and Safety promotion
GDP	gross domestic product
TEACH-VIP	Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
URL	uniform resource locator
VIP	violence and injury prevention
WHO	World Health Organization

EXECUTIVE SUMMARY

Injuries, whether intentional or unintentional, are the third leading cause of death in the World Health Organization (WHO) European Region and pose a threat to economic and social development. Preventing injuries is a critical public health challenge in the Region. Resolution EUR/RC55/R9 on the prevention of injuries in the WHO European Region (September 2005) and the European Council Recommendation on the prevention of injury and the promotion of safety (May 2007) provide a public health framework for action that includes the support of Member States in addressing this problem more comprehensively. These have placed injury and violence prevention firmly on the public health agenda.

Aims and methods

This report presents the results of a three-year collaboration between WHO and the European Commission on a project on progress made in implementing the WHO European Regional Committee Resolution and European Council Recommendation on the prevention of injury and the promotion of safety. An additional aim is to report on the development of web-based tools comprising a database of country profiles compiled through a questionnaire survey and an inventory of national policies.

A database of country profiles has been developed using a questionnaire survey and WHO information sources such as the Health for All database, using similar methods to that described in *Progress in preventing injuries in the WHO European Region*. In 2009, there were questions on whether 78 evidence-based programmes for the primary prevention of 10 types of injury and violence are being implemented. These were selected from a WHO guide based on good or promising evidence of effectiveness, which was developed using systematic reviews of the literature. In addition, 21 questions were added on programmes for the prevention of alcohol-related harm and those targeting the reduction of socioeconomic disparities in injuries and violence.

Health ministry focal people for preventing injuries and violence received and completed the questionnaire electronically. They provided information on progress in delivering key items of resolution EUR/RC55/R9 and on implementing evidence-based programmes to prevent unintentional injuries (road traffic, poisoning, drowning, falls and fires) and violence (youth violence, child maltreatment, intimate partner violence, elder abuse and self-directed violence). This information was analysed to provide a regional overview and country profiles. An inventory of national policies on preventing injuries and violence was collated. After being verified by focal people, the country profiles were uploaded on the WHO Regional Office for Europe web site to act as a resource and catalyst for action. Responses on 47 of 51 WHO European Member States with at least one focal person were obtained; of these, 25 are from the European Union (EU) and 10 from countries in which Russian is widely used. Of the country respondents (21 from EU countries) who returned a questionnaire in 2008, 37 returned one in 2009. Identical items are used to assess progress at these two points in time.

Progress made

Good progress is taking place, and resolution EUR/RC55/R9 and the European Council Recommendation catalysed change; 75% of the responding countries stated that the resolution had placed violence and injury prevention higher on the national policy agenda and had helped to stimulate action. During the past year, progress has been reported in the following items of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety: developing national policy in 67% of countries,

surveillance in 74%, multisectoral collaboration in 78%, evidence-based emergency care in 61% and capacity-building in 63%. In terms of national policy development, 60% of countries have overall national policies for preventing injuries and 46% for preventing violence. The development of national policies for individual types of injury and violence varied. Whereas most countries had a national policy on road safety (95%), half or less had national policies for preventing other unintentional injuries. For preventing violence, 71% of responding countries had national policies on child maltreatment, 76% on preventing intimate partner violence, 64% on preventing sexual violence, 62% on youth violence and less than half on preventing elder abuse and self-directed violence. The number of countries with national policies has increased considerably since 2008; the largest increase has been for those concerned with preventing violence and the least for preventing fires, poisoning and drowning.

Of the 99 programmes assessed for preventing injuries and violence, the median[1] implementation score was 73% for all these together. The median was 72% for preventing unintentional injuries and 81% for preventing violence. The median values for individual types of unintentional injury ranged from 81% for preventing road traffic injuries to 60% for preventing fires, and for preventing violence this ranged from 100% for preventing child maltreatment to 67% for elder abuse and neglect. The median value was 76% for all the alcohol-related interventions combined, 71% for the fiscal and legal measures and 67% for the health system–based programmes. In many countries, policies were implemented in selected geographical areas rather than nationally. Progress has also been made between 2008 and 2009 in preventive programming for most types of injuries and violence, although progress has been minimal for some types such as drowning, fires, elder abuse and youth violence. This mapping exercise has shown that the health sector needs to commit to more widespread implementation of effective programmes both in number and coverage and to engage with other stakeholders in a multisectoral response to prevent injuries and violence.

The use of a survey has limitations of validity, reliability and completeness, but these findings are nevertheless an important baseline against which to measure progress for future evaluation and as a resource to advocate for greater action. The use of policy indicators needs to be supplemented in the future with epidemiological indicators to properly evaluate change.

How this progress has been achieved

Countries have shown increased interest in working in this previously neglected area. Momentum has been gained through a combination of World Health Assembly resolutions, resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety, which have catalysed action. The number of countries working through biennial collaborative agreements with WHO has increased from 5 in 2004–2005 to 18 in 2010–2011. WHO has been working with countries to develop national policy (16 countries) and injury surveillance (13 countries). Subregional train-the-trainer workshops using the WHO TEACH-VIP (Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention) curriculum have been held for countries in which Russian is widely used and countries in the South Eastern Europe Health Network. Capacity-building workshops have been held in a dozen countries using TEACH-VIP, which has been translated into eight languages (Hungarian, Latvian, Lithuanian, Macedonian, Romanian, Russian, Spanish and Turkish). Work is ongoing to mainstream the TEACH-VIP curriculum into health professional training. A new module on alcohol and violence has been developed. Lessons in national policy-making, advocacy and surveillance that are relevant for a European audience are being piloted. Mentoring workshops in the Nordic and Baltic subregion and in the southern and central Europe subregion are being held to promote the exchange of expertise.

Five European network meetings of health ministry focal people for preventing violence

1 The median value is the value in the mid-point of the distribution. Thus it means that 50% of countries implement less than 73% of the interventions and 50% implement more than 73%.

and injuries have been held, and the focal people have proven to be a conduit for the exchange of best practice and experience. Joint working has increased with other networks and with other international organizations, including the European Commission and civil society networks. The *European report on child injury prevention* has been launched in 13 countries, further advocating for evidence-based action to combat this leading cause of child death. A project on the global status report on road safety involved 49 countries and promoted intersectoral collaborative working between health and other sectors. Launches are being planned to advocate for road safety.

Conclusions and way forward

Encouraging progress has been made in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety. The health sector and partners need sustained action to decrease the inequality in violence and injury between and within countries of the WHO European Region. The progress mapped in this report is encouraging and underlines the fact that future success can only be sustained through political and resource commitment by countries and international organizations. The key steps forward are listed below.

1. Build on current achievements with greater development of national policies and achieve more widespread implementation of evidence-based programmes in countries in the Region.
2. Reinvigorate political commitment and collaboration between WHO, the European Commission, countries and civil society to maintain the momentum that has been achieved.
3. Use research and routine information systems to evaluate programmes with an emphasis on using outcome indicators to increase the body of knowledge in the Region.
4. Improve access to reliable and comparable injury surveillance information to make the extent, causes and consequences of the problem more visible across the Region.
5. Step up existing efforts in building institutional capacity and train health professions from health and other sectors by mainstreaming courses such as TEACH-VIP into educational curricula.
6. Address the capacity-building needs to improve high-quality trauma care services in the Region.
7. Maintain support for the existing network of health ministry focal people for preventing violence and injuries and promote the exchange of experience and expertise at the subregional level.
8. Seek new opportunities and make better use of collaborative working with other sectors and networks, including academe and civil society organizations.
9. Conduct future evaluations using comparable policy indicators to those reported here and outcome measures.
10. Ensure that international collaboration that results in local implementation is sustained.
11. Increase investment in resources and political commitment to:
    - exploit the above opportunities to the fullest;
    - build on existing progress;
    - fill the gaps identified in this report; and
    - increase momentum in Member States and the Region.

1. INTRODUCTION

Injuries[1], whether intentional or unintentional, account for 9% of all causes of death in the 53 Member States of the World Health Organization (WHO) European Region, with about 800 000 people losing their lives due to injuries and violence each year *(1,2)*. They are the leading cause of death among people aged 5–44 years and are a major cause of disability. Preventing injuries is therefore a critical public health challenge in the Region.

For each death, there are an estimated 30 hospital admissions, 300 emergency department attendances and thousands who seek help from general practitioners or treat themselves. Unintentional injuries and violence are responsible for 14% of all the disability-adjusted life-years (DALYs) lost in the WHO European Region *(3)*. It is therefore not surprising that costs to health systems and to society as a whole are enormous. For road traffic injuries alone, societal costs are estimated to be up to 3.1% of the national gross domestic product of European countries *(4,5)*. Although other types of injuries have not been widely studied, reports suggest that the costs for home and leisure unintentional injuries may be about 6.4% of gross domestic product (GDP) in Norway *(6)* and that the costs of intimate partner violence are as high as 2.2% of the GDP of the United Kingdom *(7)*.

The burden of injuries is distributed unequally across the Region. People living in low- and middle-income countries in the Region are nearly four times more likely to die from injuries than those in high-income countries *(8)*. Similarly, within countries, groups with low income are three times as likely to die from injuries as groups with high income *(9,10)*. This inequality in injuries has great implications for equity and social justice across the Region. If the societal and economic conditions (including but not limited to the presence of prevention programmes) present in the safest European countries were to prevail throughout the Region, an estimated 500 000 lives could be saved every year *(1)*. Many of the countries in the Region, such as those in northern Europe, started addressing these problems a few decades ago, whereas others have only begun to tackle this public health threat.

Resolution EUR/RC55/R9 on the prevention of injuries in the WHO European Region (September 2005) *(11)* and the European Council

Recommendation on the prevention of injury and the promotion of safety (May 2007) *(12)* provide a public health framework for action to support Member States to address this problem more comprehensively. These have placed injury and violence prevention firmly on the public health agenda (Box 1).

Health ministries in European Member States have appointed at least one focal person for preventing either injury or violence or both.

1 An injury is the damage caused by the acute transfer of energy, whether physical, thermal, chemical or radiant, that exceeds the physiological threshold, or by the deprivation of a vital element. Injuries can be unintentional such as those caused by road traffic injuries, burns or scalds, falls, poisoning and drowning or submersion, or they can be intentional. Intentional injuries can be caused by violence, which is the intentional threat or use of physical force against oneself, another person or community that results in injury, death, mental harm, maldevelopment or deprivation. Violence can be interpersonal (intimate partner violence, youth violence, child maltreatment or elder abuse), self-directed (suicide or self-harm) or collective (war).

This is in response to World Health Assembly resolution WHA56.24 *(13)* on implementing the recommendations of the *World report on violence and health (14)* and resolution WHA57.10 on road safety and health *(15)*, and 51 Member States now have focal people in place, of which 26 are European Union (EU) countries.

This report is the outcome of a three-year collaboration between WHO and the Directorate-General for Health and Consumers of the European Commission on implementing the European Council Recommendation on the prevention of injury and the promotion of safety and a Regional Committee resolution on prevention of injuries in the WHO European Region *(16)*. The project aimed to: a) develop resources and tools to assist countries in developing national policies and monitor and report progress in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety, b) facilitate the exchange of experience and c) build capacity in developing national plans, surveillance and advocacy. This publication reports on progress achieved in implementing the WHO resolution and European Council Recommendation on the prevention of injury and the promotion of safety and is one of the deliverables of work package 5: "Support the development of tools for monitoring and reporting on the implementation of the European Council Recommendation and WHO resolution RC55/R9". A preliminary report *Progress in preventing injuries in the WHO European Region* was presented to the 58th session of the WHO Regional Committee for Europe in 2008 *(17)*.

Box 1. Key items of the European Council Recommendation on the prevention of injury and the promotion of safety and WHO Regional Committee for Europe resolution RC55/R9 on the prevention of injuries

(a) To support Member States in their efforts to strengthen injury prevention and to draw up national action plans

(b) To facilitate the identification and sharing of good practice in the prevention of violence and unintentional injuries

(c) To stimulate and support the network of national focal points and further develop collaboration with other relevant networks of experts and professionals

(d) To provide assistance in building capacity at the technical and policy level in order to strengthen national response to injuries to include surveillance, evidence-based practice and evaluation

(e) To provide technical assistance to improve prehospital treatment and care for victims of unintentional injuries and violence

(f) To promote the development of partnerships and collaboration with the European Union and other international organizations

2. AIMS AND METHODS

2.1 Aims

This report aims to present an overview of progress achieved in 2009 by WHO European Member States in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety, and the EU countries in particular (Annex 1). A subsidiary aim is to present results on web-based tools that comprise a database of country profiles developed through a questionnaire survey and an inventory of national policies.

2.2 Methods

A questionnaire survey was used to obtain key information on policy development and the implementation of evidence-based interventions and supplemented with data from WHO information sources such as the European Health for All database *(18,19)*. These data were analysed to obtain a regional overview and develop country assessments. A database of country profiles has been uploaded on the WHO web site *(20)*. Surveys were implemented in 2006 *(21)*, 2007, 2008 *(17)* and 2009, and the questionnaire was developed in consultation with health ministry focal people and an expert panel. This publication reports on progress made in implementation in 2009 and provides additional comparative information on progress since 2008. The publication targets policy-makers, researchers and practitioners from various sectors concerned with preventing violence and injuries.

2.3 Developing the questionnaire

The questionnaire (Annex 2) assesses whether key items of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety (Box 1) have been implemented and whether factors considered suitable for policy development are in place *(22)*: political support, easy access to surveillance information, mapping of stakeholders, multisectoral working and the presence of a funded secretariat. It also assesses whether progress has been made in developing policy in the past 12 months. In addition, there are questions on whether 78 evidence-based programmes for the primary prevention[2] of 10 types of injury and violence are being implemented. These were selected from a WHO guide based on good or promising evidence of effectiveness supplemented using systematic reviews of the literature *(14,23–27)*. In 2009, questions on the policy priority given to alcohol and socioeconomic inequality were included, as these are major risk factors for both injuries and violence. There are an additional 21 questions on programmes for preventing alcohol-related harm and those targeting the reduction of socioeconomic disparities in injuries and violence *(28,29)*. The questionnaire included 99 programmes or interventions. Fifty-nine of these interventions or programmes were the same in the 2008 and the 2009 questionnaires and could therefore be compared for 2008 and 2009.

Focal people (Annex 3) provided information about whether these were implemented in some areas or nationally. For the purposes of this report, implementation at the national or subnational level was considered as evidence of implementation. This information was analysed to develop a regional overview of progress being made and to develop country profiles.

2.4 Questionnaires returned

The questionnaire was sent electronically in English to focal people from the 51 WHO European Member States that have at least one focal person and also in Russian to the

2 Primary prevention programmes aim to reduce injuries or violence from occurring, thereby reducing their incidence.

12 countries in which Russian is widely used. Several electronic and telephone reminders were made to improve response, and 47 completed questionnaires were returned in 2009 (Annex 4). Of these, 25 were from EU countries, and of the remaining 22, 10 were from countries in which Russian is widely used. The questionnaire results in Russian were translated into English. When necessary, focal people were contacted to improve clarity and completeness.

Thirty-seven country respondents who returned a questionnaire in 2008 also returned one in 2009. Identical items are used to assess progress at these two times. Of the 37 country questionnaires returned in 2008, only 32 countries provided information on items related to preventive interventions or programmes. The implementation of 59 interventions or programmes in 32 countries could therefore be compared for 2008 and 2009. Of these 32 countries, 19 were EU countries.

2.5 Country profiles

Epidemiological indicators were selected from the European Health for All database. Policy indicators were developed based on the responses in the questionnaire, as described previously *(17)*. An overall assessment score was developed based on the proportion of 99 effective interventions that were implemented to prevent each type of injury and violence and those to mitigate the selected risk factors. This proportion was compared with the statistical distribution of the Region. On completion, country profiles were sent to the focal people to check the validity and to get government approval to publish them. Only the countries for which this was achieved by 18 December 2009 are included in the country information.

2.6 Inventory of national policies on preventing violence and injuries

The inventory of national policies on preventing violence and injuries that had been developed using an Internet search was obtained from the WHO Department of Violence and Injury Prevention and Disability. This was supplemented with a further Internet-based search using the Google search engine with a combination of keywords.[3] The web sites of European ministries responsible for health, gender, transport, justice or interior, education, culture, youth and sport and environment were also searched for additional information. The list derived from the results of the policies identified during the Internet search was sent to focal people for verification.

This was supplemented with responses on the questionnaire regarding the existence of national policies on preventing injuries and violence. Whenever available, Internet links (URLs) and electronic and hard copies of documents were analysed. A template was developed to record the type of injury or violence being targeted, the target population, the year and time frame for implementation, institutional responsibility, the leading sector, other partners, whether evaluation was described, whether a budget was specified and whether the policy was legally binding and formally adopted by the government.

3 Each category of injury cause (road traffic injuries/road safety/accident, falls, poisoning, fire/burns/flames, drowning/submerging, interpersonal violence/homicide, self-directed violence/suicide, domestic violence/intimate partner violence/violence against women, elder abuse/maltreatment/neglect, child abuse/ maltreatment/neglect, youth violence, sexual violence), injury(ies), intentional, unintentional, violence, policy, plan, national programme, strategy, guidelines and action plan, Europe.

3. RESULTS

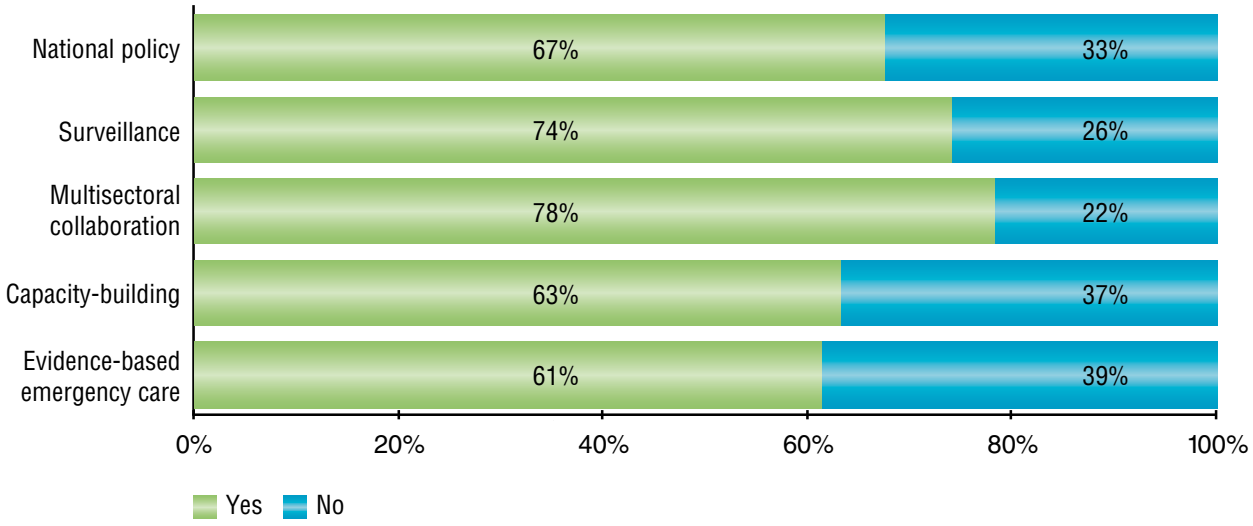
A regional overview is presented based on the collated responses from 47 Member States. Country profiles for the countries for which approval has been obtained from health ministries have been uploaded on the WHO Regional Office for Europe web site *(30)*.

3.1 Regional overview of implementation of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety

3.1.1 What difference have resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety made?

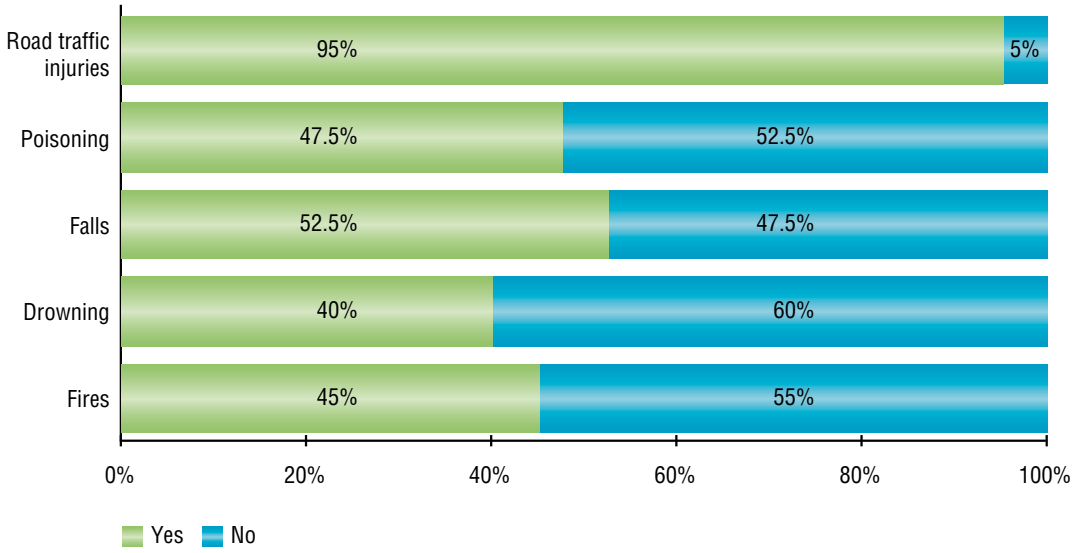
Of the 46[4] countries responding, 75% reported that the resolution has placed preventing violence and injury higher on the policy agenda and has helped to catalyse action. There has been encouraging progress in a 12-month period from 2008 to 2009 in delivering on many items of the resolution and Recommendation. For developing national policy, 67% of responding countries reported progress, 74% for surveillance, 63% for capacity-building, 78% for multisectoral collaboration and 61% for evidence-based emergency care (Fig. 1).

Fig. 1. Have there been any new developments in preventing violence and injuries?



4 Statistics on "Yes/No" answers are on 46 countries and not on 47. This is because for Bosnia and Herzegovina answers from both the Republic of Srpska and the Federation of Bosnia and Herzegovina were collected from different focal persons representing their political area. Whereas information on interventions were synthesized through an average of the two implementation rates calculated for each intervention, the same thing could not be done for "Yes/No" answers.

Fig. 2. Is there a policy on preventing any of the following categories of unintentional injury?



3.1.2 Do national policies exist for different causes of unintentional injuries?

Sixty per cent of the respondent countries reported an overall national policy on preventing unintentional injuries. Whereas most countries have a national policy on road safety (95%), only about half or less have national policies on preventing falls (53%), poisoning (48%), fires (45%) or drowning (40%) (Fig. 2). The priority given to developing policies differs from the ranked leading causes of unintentional injury-related death: road traffic injuries, poisoning, falls, drowning and fires.

The number of countries with national policies for all unintentional injuries, road safety, falls and drowning increased between 2008 and 2009. This was not the case for poisoning and fires: the number of countries with national policies either remained the same or declined (Fig. 3).

Fig. 3. Number of countries with national policies on preventing unintentional injuries, 2008 and 2009 (based on 37 countries)

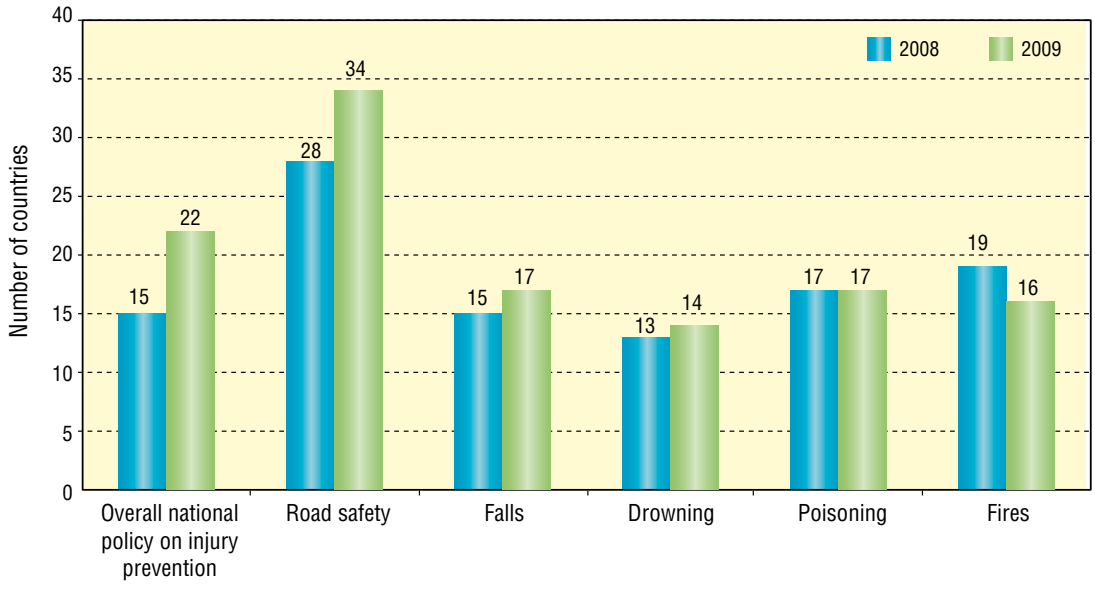
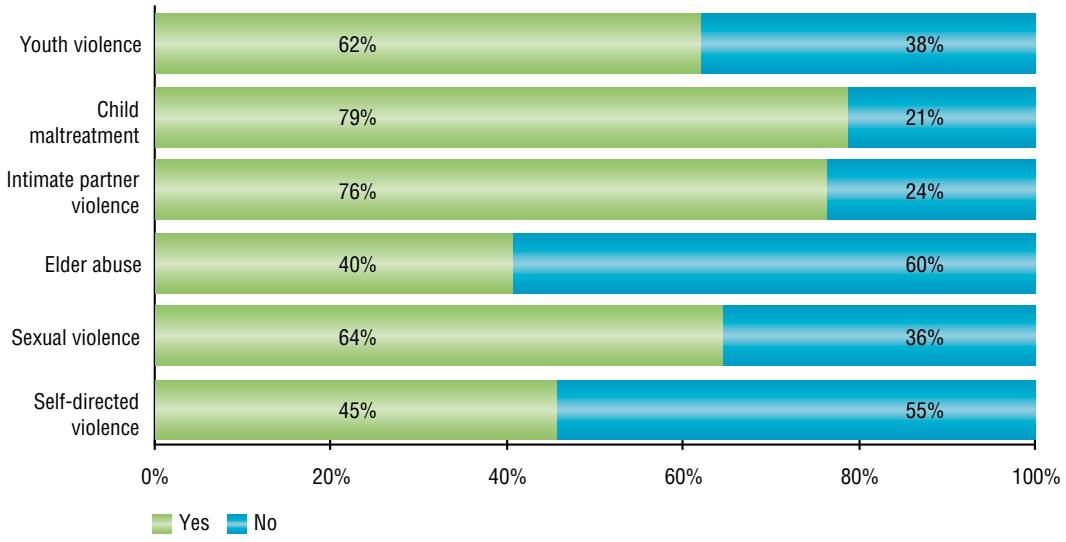


Fig. 4. Is there a policy on preventing any of the following categories of violence-related injuries?

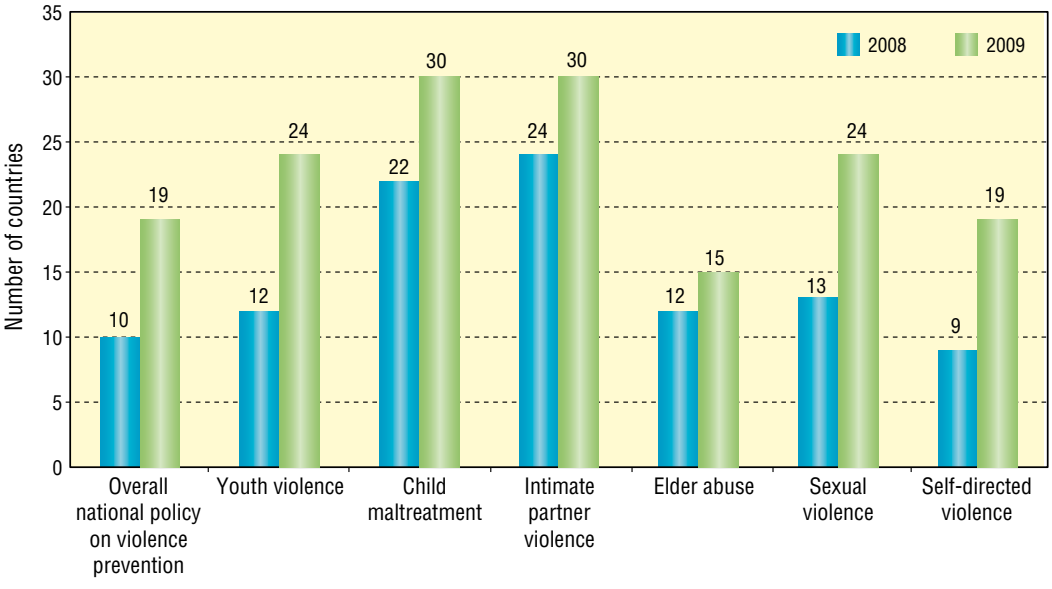


3.1.3 Do national policies exist for different types of interpersonal violence and self-directed violence?

Of the responding countries, 46% have an overall policy on preventing violence. By types of violence, 79% of countries have specific national policies for preventing child maltreatment, 76% for preventing intimate partner violence (domestic violence), 64% for sexual violence and 62% for violence inflicted on or by young people (youth violence), but less than the half have specific national policies for preventing suicide (45%) and elder abuse and neglect (40%) (Fig. 4).

There has been good progress in developing national policies on preventing violence. The number of countries reporting national policies increased between 2008 and 2009 for all types of violence in the 37 responding countries (Fig. 5). This has doubled for youth violence and self-directed violence.

Fig. 5. Number of countries with national policies on preventing violence, 2008 and 2009 (based on 37 countries)



3.1.4 Do national policies on preventing violence and injuries identify alcohol and socioeconomic differences as risk factors?

Eighty per cent of the countries reported that alcohol has been identified as a risk factor for unintentional injuries in national policies, and 87% of the countries reported this for violence.

Only one third of the countries (32%) reported that national policies have highlighted socioeconomic inequality in injuries and violence as a priority.

3.1.5 Is there political support, leadership and coordination in the policy-making process?

Of the responding countries, 93% said there was political support for preventing violence and injuries (Fig. 6). Importantly, there was good evidence of intersectoral working with stakeholders: 93% reported that stakeholders were identified, of which 84% were players from different sectors, and 88% reported that they were involved in developing policies. Of the respondents, 87% reported that they reached consensus with stakeholders from other sectors in filling out the questionnaire. There was easy access to injury surveillance data (89% of countries). There was an intersectoral injury prevention committee in 61% of countries, of which 47% had a secretariat and, in 53% of these, the focal person was the secretariat. However, only 49% reported having a funded secretariat to support their activities.

Whereas 60% of the countries had an overall national policy on preventing injuries, only 46% reported this for preventing violence. Most countries have gone through the necessary steps for the initial stages of developing a national policy such as ensuring political commitment for developing plans, defining the extent of the problem and assessing and documenting existing policies and interventions. Priorities for action have been agreed on in 80% of the responding countries.

Good progress was made between 2008 and 2009 in countries reporting access to surveillance data. However, other areas, such as the presence of a secretariat for a multisectoral committee, remain almost unchanged (Fig. 7). More countries reported that resolution EUR/RC55/R9 and European Council Recommendation had been a catalyst for change in 2009 compared with 2008. Whereas the number of countries with a budget available for the injury prevention secretariat doubled, there is still room for improvement, as about half the responding countries do not have a funded secretariat.

Fig. 6. Have the following processes in policy-making been achieved?

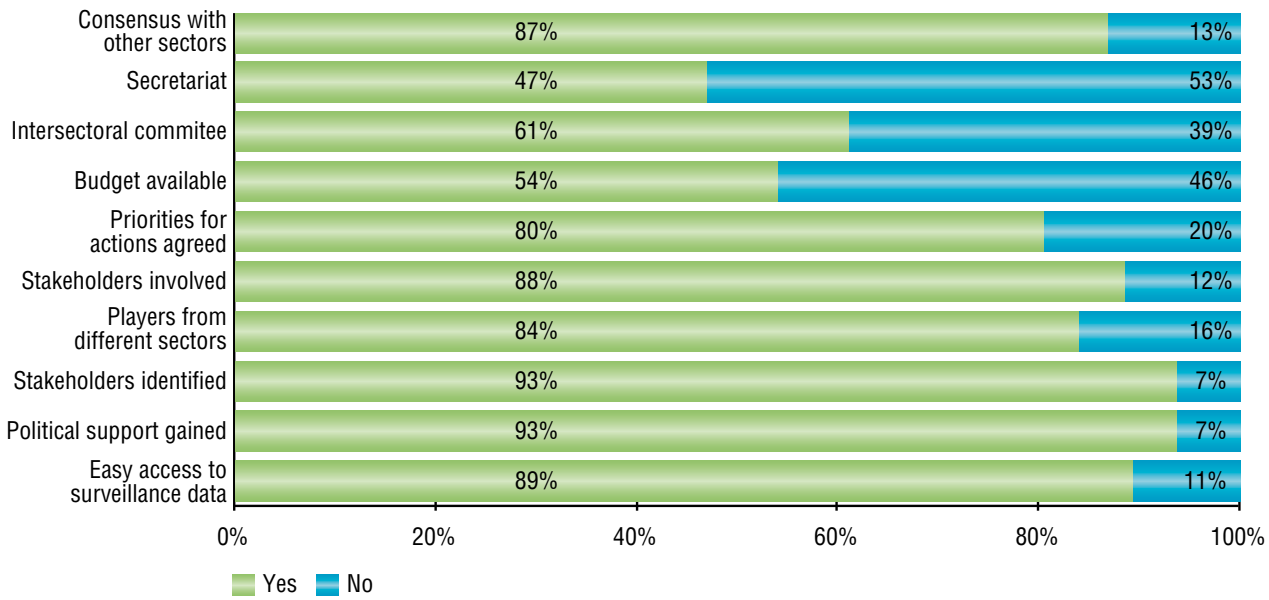
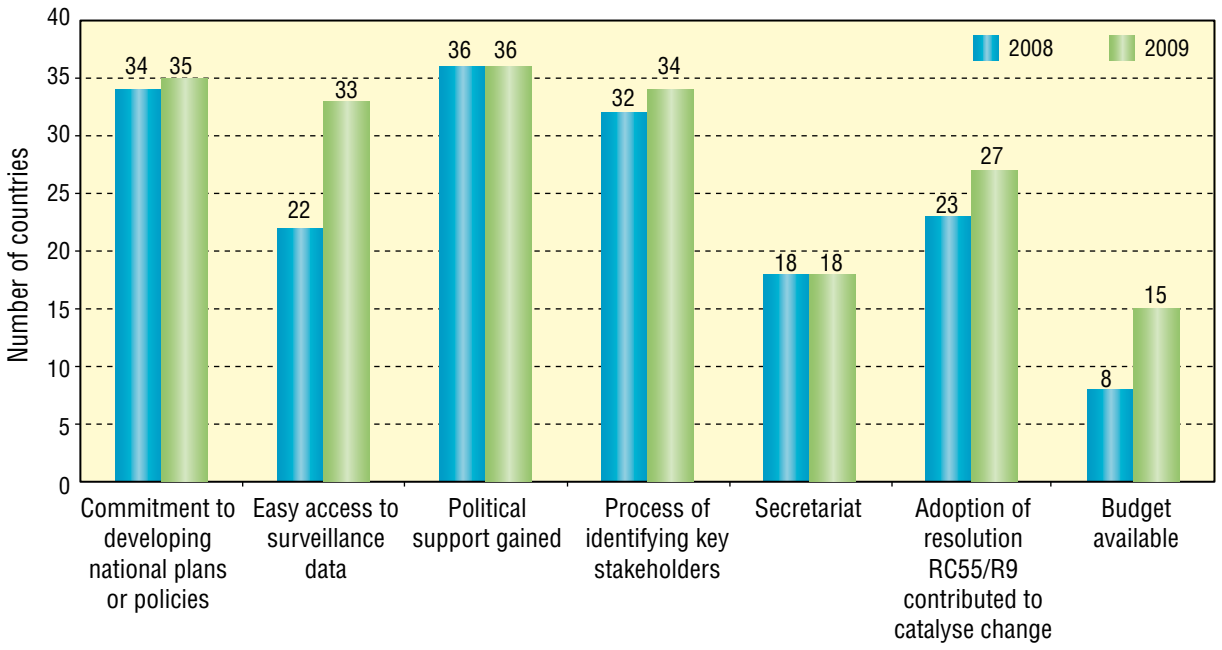


Fig. 7. Number of countries that have achieved steps essential to the national policy-making process, 2008 and 2009 (based on 37 countries)



3.1.6 Capacity-building for preventing violence and injuries and for trauma care

Having adequate capacity is a critical factor in developing a commensurate health system response to the injury burden, both for prevention and cure. Capacity-building activities were quite widespread in the Region, but one area for improvement is introducing quality assessment programmes in emergency departments for improving trauma care (Fig. 8). Encouragingly, 80% of the countries reported having courses for building capacity for violence and injury prevention, with better implementation in 2009 than 2008 (Fig. 9).

Fig. 8. Do you have the following capacity-building measures in place?

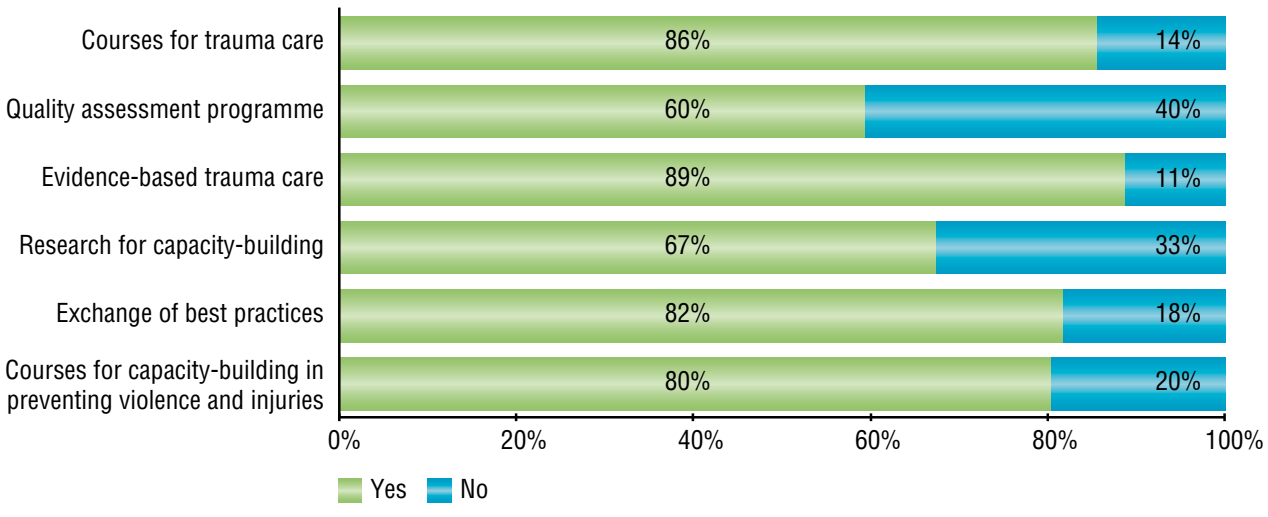
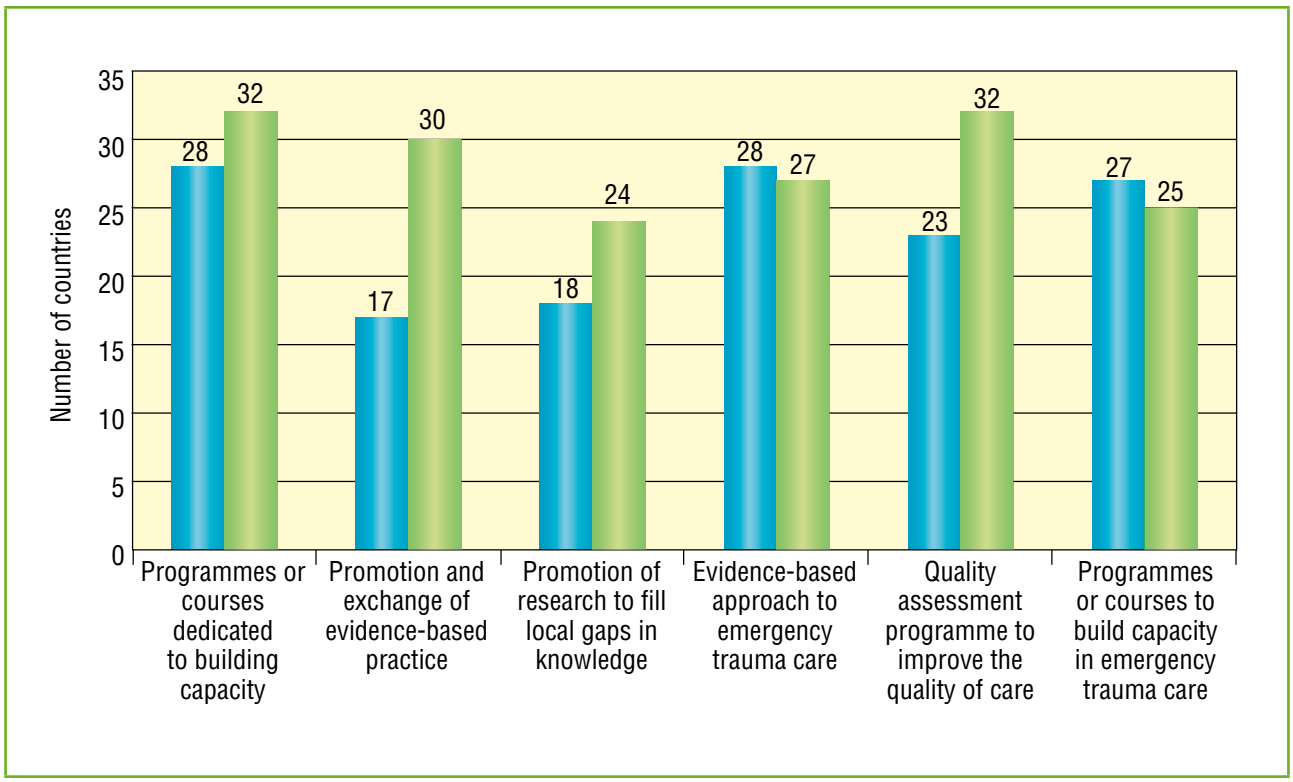


Fig. 9. Number of countries that have achieved steps essential to capacity-building, 2008 and 2009 (based on 37 responding countries)



Good progress was made between 2008 and 2009, with an increase in the number of countries reporting most capacity-building measures, especially in the exchange of good practice and courses for preventing violence and injuries (Fig. 9). Capacity-building in trauma care has not improved, and this requires attention along with quality assessment programmes.

3.2 Regional overview of the implementation of evidence-based interventions and programmes by type of injury or violence

This section describes the extent to which selected evidence-based interventions and programmes for each type of injury and violence are being implemented in the WHO European Region in 2009, based on results from 47 responding countries. The median average implementation of all interventions was 73% (mean 71%) in the Region, 72% for interventions to prevent unintentional injuries (mean 70%) and 81% for interventions on violence prevention (mean 77%) (Table 1).

The purpose of this section is to help identify gaps in prevention programmes that health systems and other sectors should fill by taking appropriate action by implementing evidence-based interventions for the different types of injury and violence. This may require reorienting the priorities in national policies to achieve such action. Many of the responses are intersectoral, and the role of the health sector may be in a leadership or coordinating role or as a key stakeholder, depending on the type of injury or violence and on the nature of the preventive programme.

3.2.1 Implementation of evidence-based interventions and programmes for preventing road traffic injuries

The median percentage of implementation for the 16 road safety programmes was 81% for the responding countries. These evidence-based measures to prevent road traffic injuries were implemented in most countries at the national level, such as laws on driver blood alcohol concentrations. Some measures were

mainly enacted locally rather than nationwide, such as those to separate different types of road users. Among the least implemented were those effective in targeting young drivers and motorcyclists. These include increasing the minimum legal drinking age (39% of countries implementing) and increasing the licensing age for driving motorcycles from 16 to 18 years (40%, Fig. 10). These measures need to be more widely implemented, as road traffic injuries are the leading cause of death among young people aged 5–29 years *(31)*.

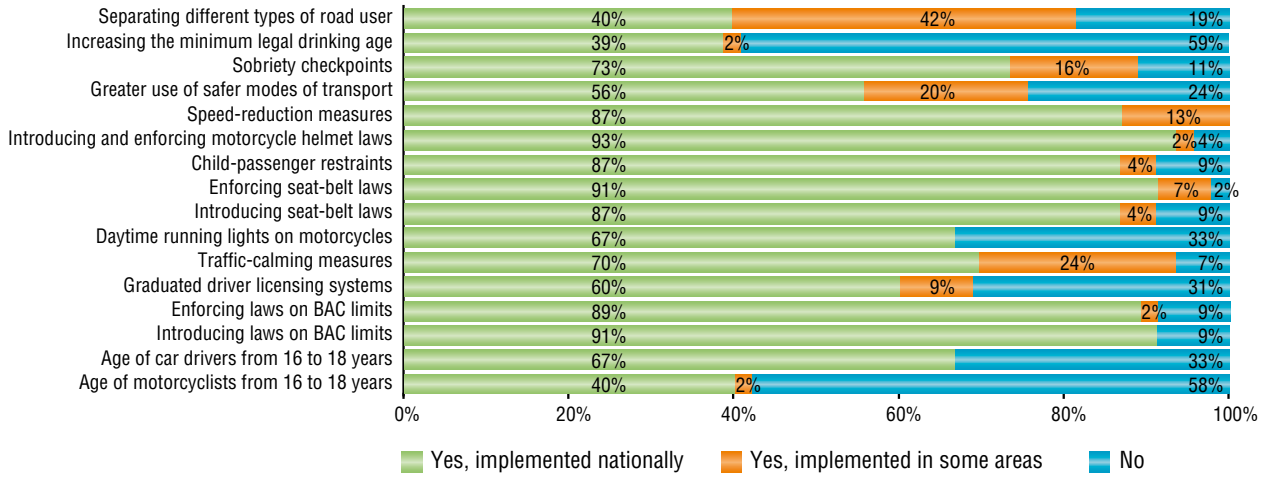
Similarly, only 56% of countries promote the use of safer modes of transport such as public transport at the national level. This is of concern given the growing public policy emphasis on the potential health-damaging effects of excessive reliance on private car use, which causes air pollution, noise, climate change and discourages physical activity *(5,26,32)*. Greater investment in and use of safer modes of transport would therefore contribute to reducing both road traffic injuries and the other adverse health effects of car transport.

Table 1. Implementation of programmes and interventions for preventing injuries and violence in countries in the WHO European Region

Interventions	European Region		
	First quartile	Median	Third quartile
All interventions	**64**	**73**	**81**
Unintentional injuries	**60**	**72**	**80**
Road traffic injuries	69	81	94
Fires	40	60	80
Poisoning	60	80	100
Drowning	38	63	75
Falls	50	75	100
Violence	**65**	**81**	**94**
Youth violence	57	86	100
Child maltreatment	80	100	100
Intimate partner violence	50	75	100
Elder abuse	50	67	100
Self-directed violence	63	88	100
Alcohol	**59**	**76**	**82**
Alcohol (legal and fiscal)	57	71	86
Alcohol (health system)	33	67	100

A quartile is a term used in descriptive statistics and is any of the three values which divide the sorted or ranked data set into four equal parts, so that each part represents one fourth of the sampled population. The first quartile cuts off the lowest 25% of the data. The second quartile (or median) cuts the data set in half. The third quartile cuts off the highest 25% (or lowest 75%) of the data. Thus for all interventions, 64% is the first quartile value, below which a quarter of countries implement, and 81% is the third quartile value, above which a quarter of countries implement. Half the countries implement below the median of 73% and half implement above this.

Fig. 10. Do you have in place any of the following programmes for preventing road traffic injuries?



BAC: blood alcohol concentration.

3.2.2 Programmes and interventions to prevent fires and burns

The median percentage of implementation of the 10 programmes for preventing fires and burns was 60%. Most countries reported programmes to treat patients at dedicated burn centres (76% reporting implementation), in making building standards safer (76%) and restricting the manufacture and sale of fireworks (73%) (Fig. 11). The least action has occurred in setting laws on hot-water temperature (15%), reducing the storage of flammable substances at home (35%), modifying household products such as cookers, stoves and candleholders to make them safer, so that fires are less likely to start (30%), setting standards for child-resistant lighters (38%) and developing standard and codes for fire-retardant garments (29%). This insufficient uptake partly reflects the lack of national policy development, with policies in place in only 45% of responding countries (Fig. 2). The housing and consumer safety sectors need to be engaged more to ensure better regulatory control and enforcement.

Fig. 11. Do you have in place any of the following programmes for preventing fires or burns?

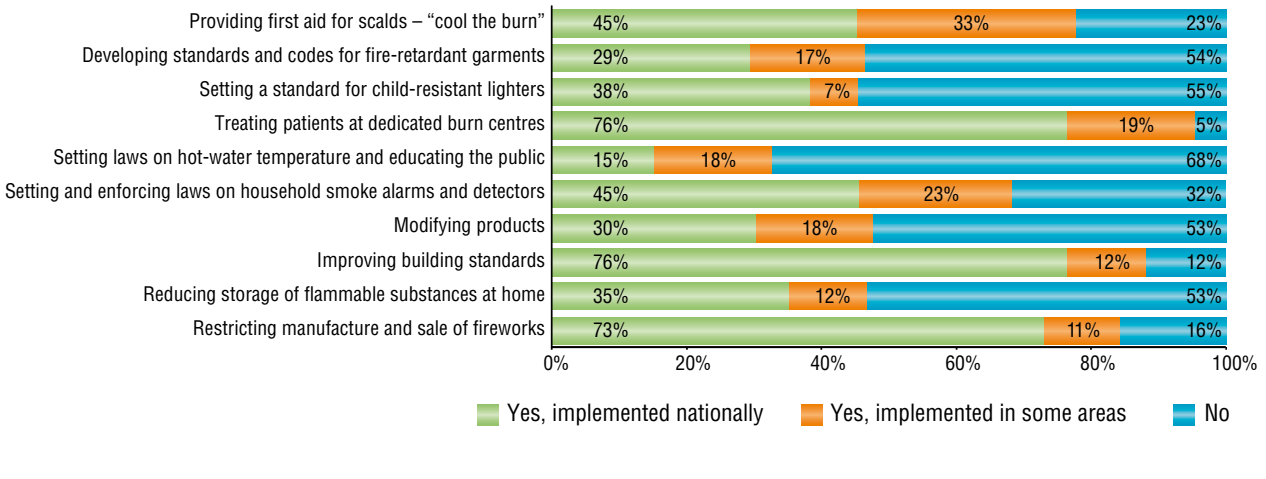
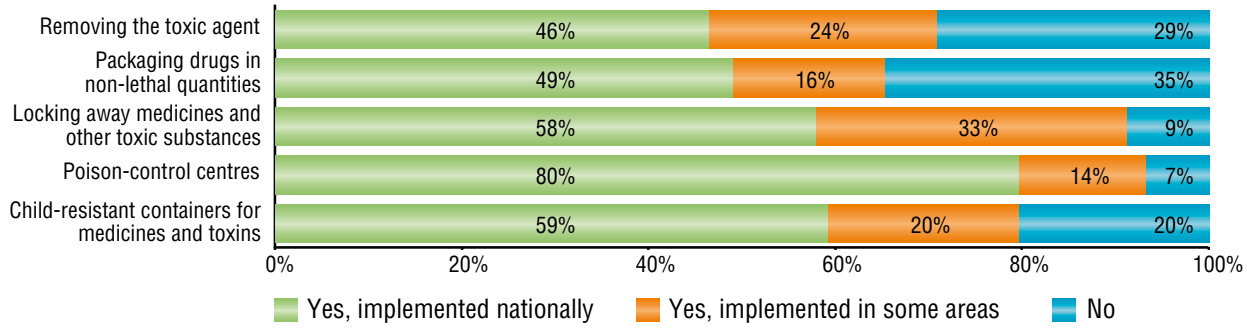


Fig. 12. Do you have in place any of the following programmes for preventing unintentional poisoning?



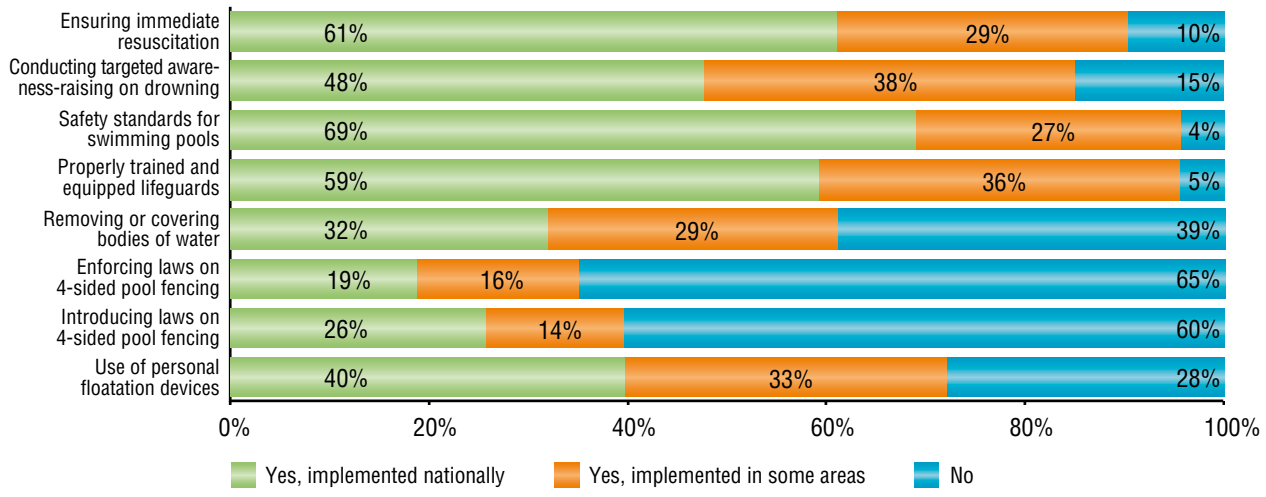
3.2.3 Programmes and interventions to prevent unintentional poisoning

The median percentage implementation of the five measures to prevent poisoning was 80% for responding countries (Fig. 12). Poisoning is the second leading cause of unintentional injury death in the Region. Poison control centres are widely available (80%). Other measures such as locking away medicines, toxic and corrosive substances, the use of containers that hold non-lethal quantities of drugs or child-resistant closures for medicines, toxic and corrosive substances could be better implemented at the national level.

3.2.4 Programmes and interventions to prevent drowning or submersion

The median percentage implementation of the eight measures to prevent drowning is 63% for the responding countries. Drowning is the second leading cause of unintentional injury-related death among children in the Region. Some of the most effective measures for preventing drowning, such as introducing and enforcing four-sided pool fencing (26% and 19% of countries reporting implementation respectively), removing (or covering) bodies of water such as wells (32%) and using personal flotation devices (40%) were among the least frequently implemented (Fig. 13). This insufficient uptake partly reflects the lack of national policy development, with only 38% of responding countries having a national policy to safeguard against drowning (Fig. 2). Much of the implementation was at the local level, and coverage in many countries needs to be extended nationwide.

Fig. 13. Do you have in place any of the following programmes for preventing drowning or submersion?



3.2.5 Programmes and interventions to prevent unintentional falls

The median percentage of implementation of the eight evidence-based measures to prevent fall injuries is 75% for the responding countries. Children and older people are the age groups most vulnerable to this injury cause. Falls are an important cause of injury among children, where they are associated with a large burden and also in older people, where fatality is high *(1,33)*. Many of the measures to prevent falls among children were not well implemented nationally, such as redesigning nursery furniture or other products (40%), stair gates and guard rails (35%) and safety mechanisms on windows (35%). Similarly, for older people, implementation of interventions such as muscle-strengthening exercises and balance training was lacking (12%). In many countries there is local implementation, and coverage needs to be extended nationwide (Fig. 14). The low implementation levels may partly reflect the lack of national policy development, since only 53% of the responding countries have this (Fig. 2). Greater engagement with the housing, leisure and urban planning sectors is needed to ensure safer environments that prevent falls.

Fig. 14. Do you have in place any of the following programmes for preventing unintentional falls?

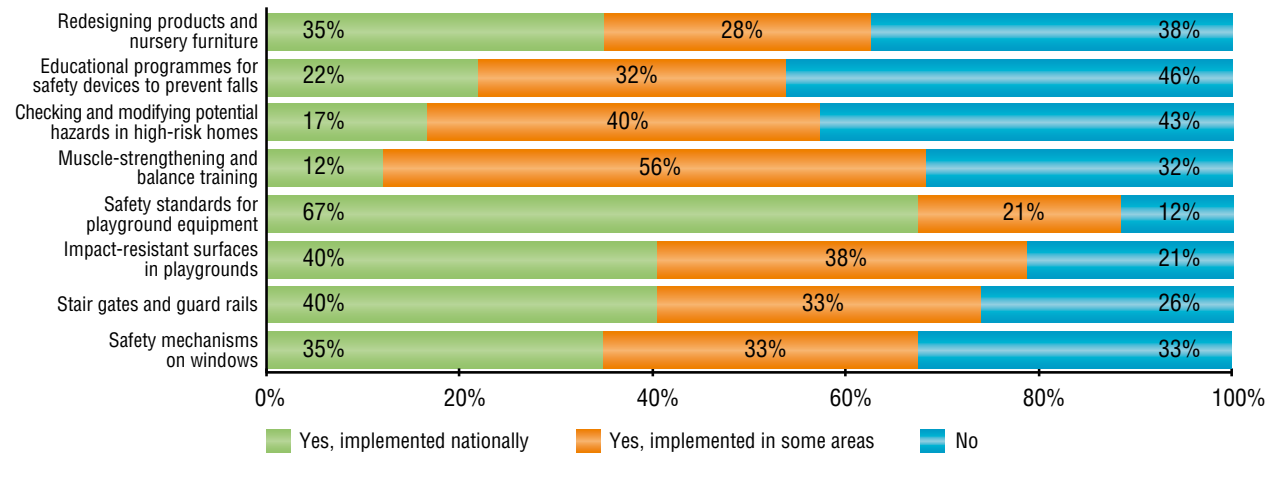
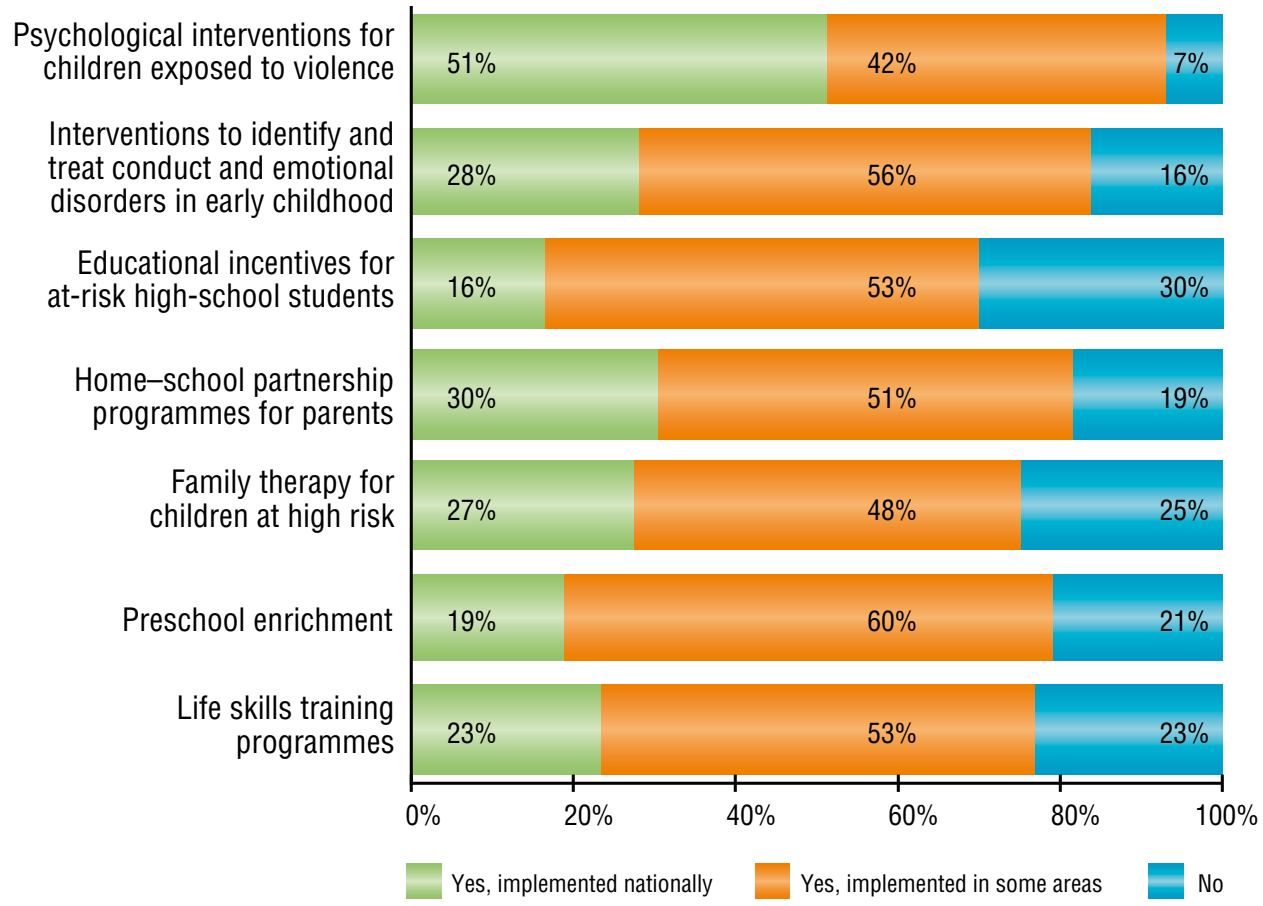


Fig. 15. Do you have in place any of the following programmes for preventing youth violence?



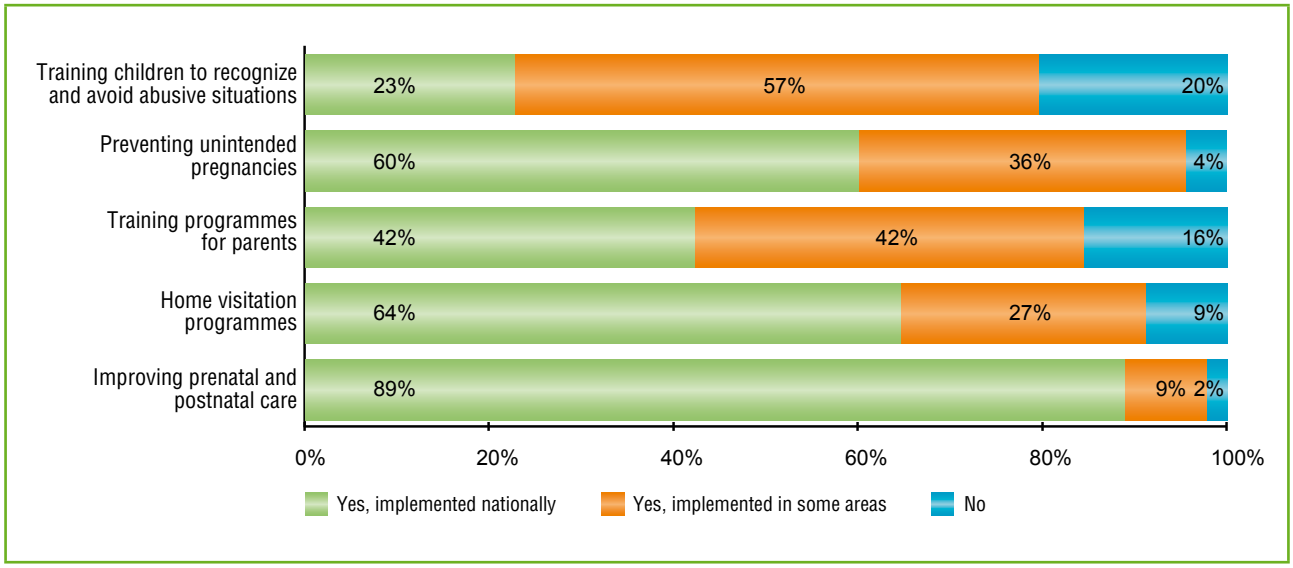
3.2.6 Programmes and intervention to prevent youth violence

The median percentage of implementation of the seven programmes to prevent violence inflicted on or by young people is 86% for the responding countries. The implementation of programmes in many countries was patchy and only covered the whole country from 16% to 51% (Fig. 15). More could be done to achieve coverage on a wider scale, and this stresses the importance of cooperating with local educational authorities as well as local mental health support services. Youth violence is perceived as a growing problem in many countries, and greater action is needed *(14,34,35)*. Only 62% of the responding countries have a national policy (Fig. 4). A stronger national policy that emphasizes greater coordination and implementation of these programmes may be one way forward.

3.2.7 Programmes and interventions to prevent child maltreatment

The median percentage of implementation of the five programmes to prevent child maltreatment is 100%. However, many countries have only implemented these programmes locally and not nationally (Fig. 16). For example, the intervention on training children to recognize and avoid potentially abusive situations was implemented nationally in only 23% of the countries and training programmes to improve parenting skills in parents in only 42% of the countries. Most countries reported action to improve the quality of and access to prenatal and postnatal care (89%). More widespread coverage of programmes is an important way of reducing child maltreatment in these countries.

Fig. 16. Do you have in place any of the following programmes for preventing child maltreatment?

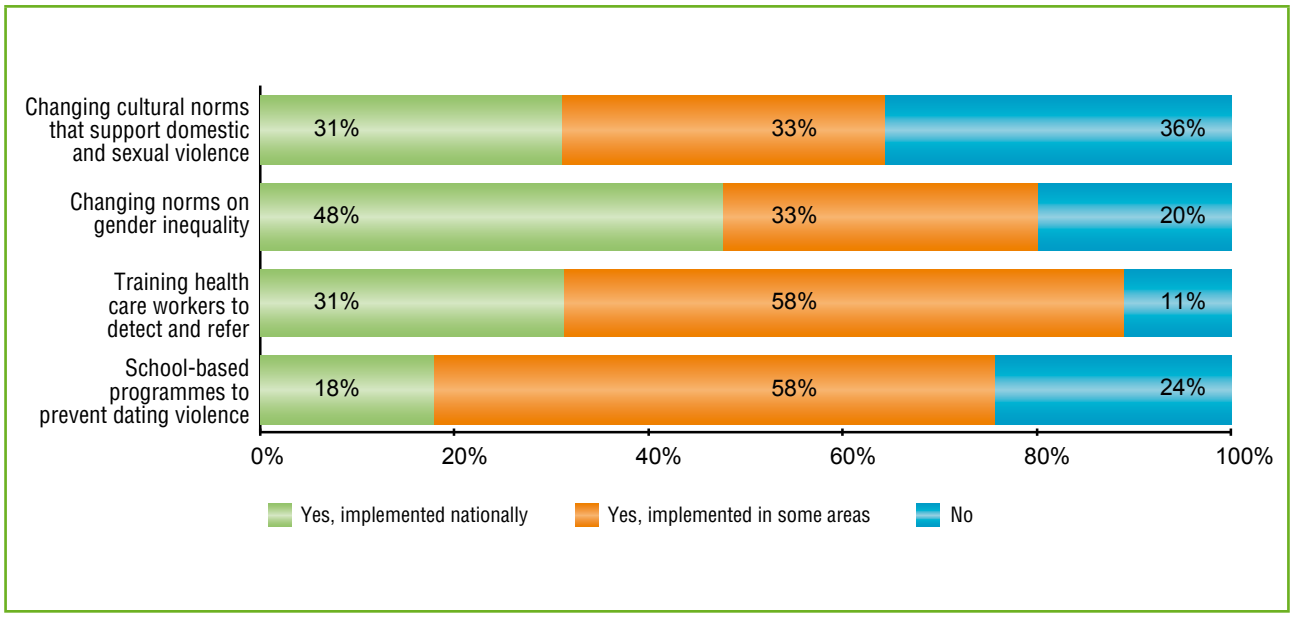


3.2.8 Programmes and interventions to prevent intimate partner violence

The median percentage of implementation for the four evidence-based programmes to prevent intimate partner violence was 75% for responding countries. There was training for health care workers to detect and refer cases of intimate partner violence in 31% of responding countries nationally, with local coverage in a further 58% (Fig. 17). Only 18% of countries had school-based programmes to prevent dating violence nationally, but 58% of the countries report local coverage. Thirty-one per cent of the countries have national programmes to change cultural norms that support intimate partner violence and sexual violence. Programmes need to be more broadly applied so that there is national coverage as well as increased uptake in more countries.

These measures also show promise for preventing sexual violence, especially school-based programmes to prevent dating violence.

Fig. 17. Do you have in place any of the following programmes for preventing intimate partner violence?



3.2.9 Programmes and interventions to prevent elder abuse

The median percentage of implementation of the three measures to prevent elder abuse was 67% for the responding countries. Developing policies and programmes to improve the organizational, social and physical environment of residential institutions for older people is an obvious area for health systems to intervene to prevent elder abuse but is only practised nationally in 38% of countries (Fig. 18). Other approaches that engage civil society and involve empowering older people to prevent violence, such as training older people to serve as visitors and companions to individuals at high risk of victimization, are implemented only at the local level (42%). Building social networks of older people (20%) shows especially low uptake at the national level but is more widely applied locally (56%). This area of violence prevention requires greater attention, especially given the demographic pressures of an ageing society in the Region. Uptake needs to be augmented both within and between countries.

3.2.10 Programmes and interventions to prevent self-directed violence

The median percentage of implementation of the eight measures to prevent self-directed violence for the responding countries was 88%. At the national level, the highest percentage of implementation is for the interventions in which the health sector leads, such as treating alcohol and substance abuse (86%), preventing alcohol and substance abuse (77%), treating depression (62%) and restricting access to medications (60%) (Fig. 19). Other interventions that require intersectoral work, such as school-based interventions focusing on crisis management, the enhancement of self-esteem and coping skills (29%) and restricting access to unprotected heights (12%), have substantially lower uptake at the national level and are more commonly locally implemented. Suicide is the leading cause of injury-related death in most countries in the Region, and much better performance is needed in the Region.

Fig. 18. Do you have in place any of the following programmes for preventing elder abuse?

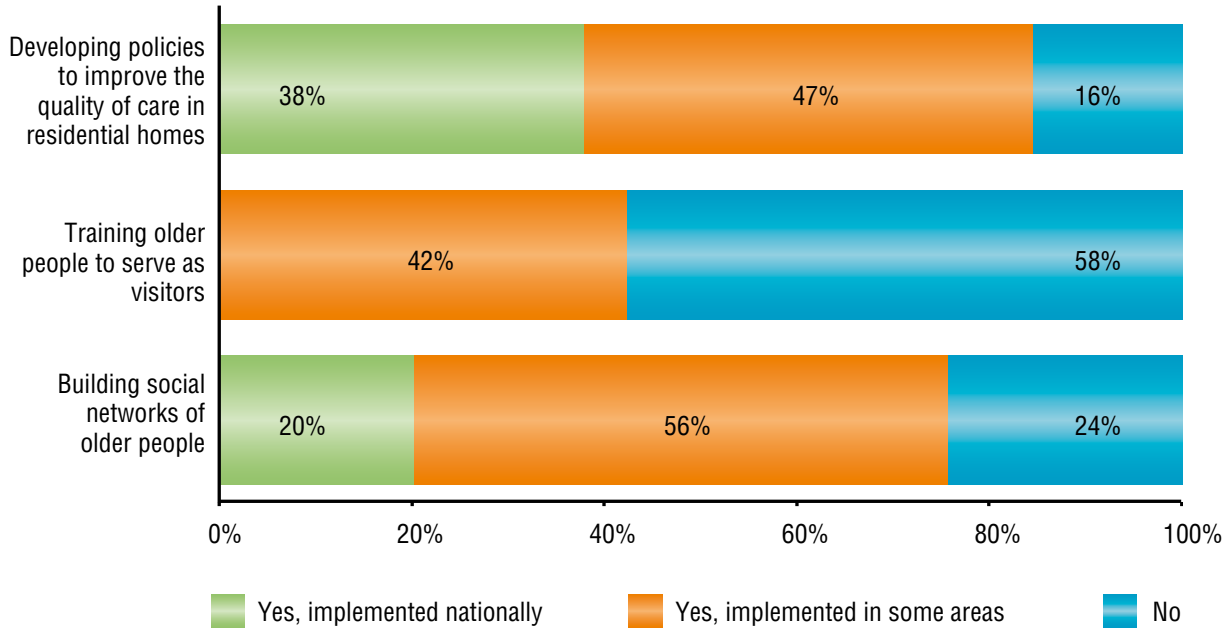
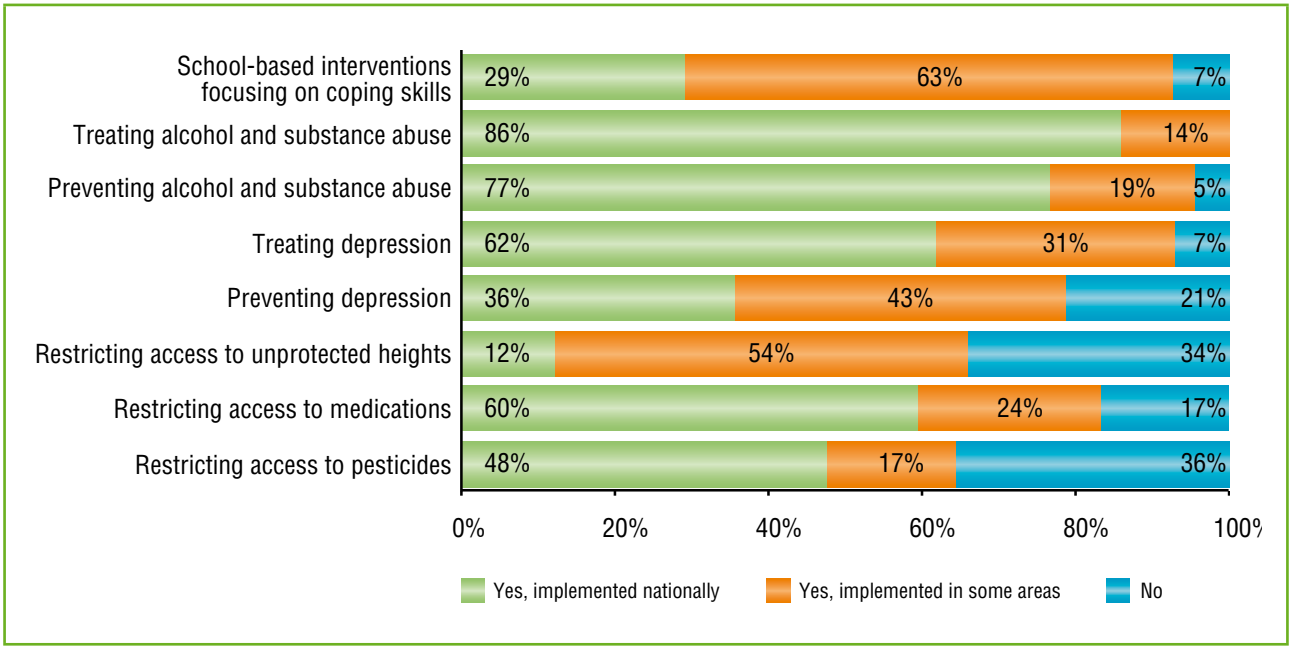


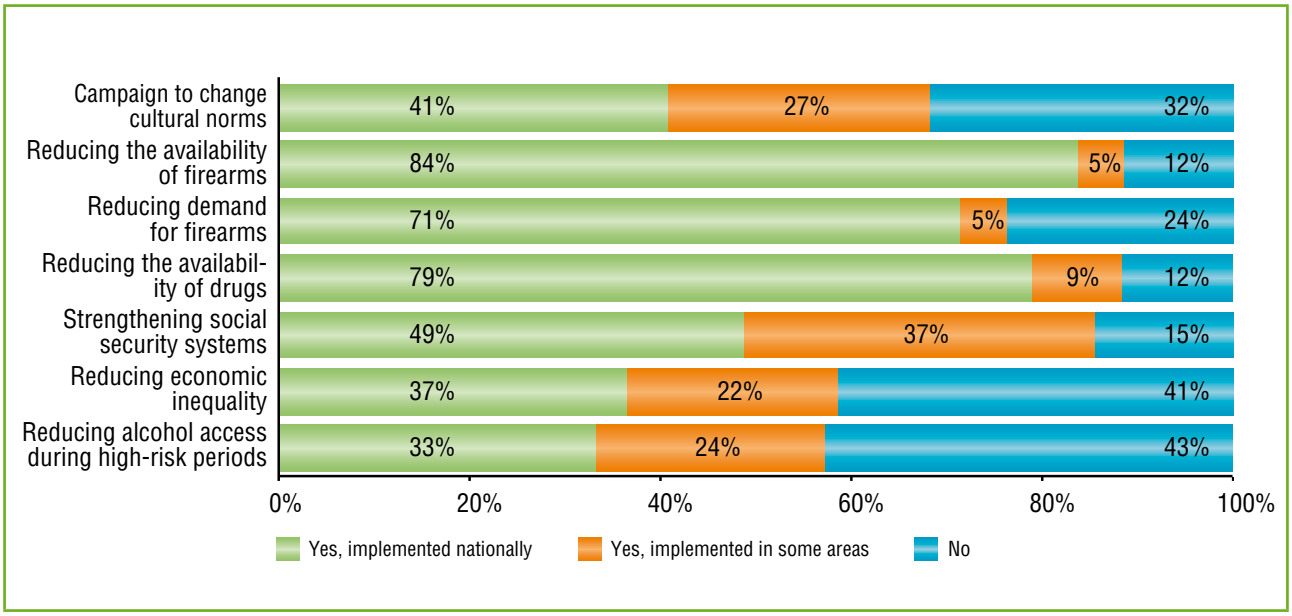
Fig. 19. Do you have in place any of the following programmes for preventing self-directed violence?



3.2.11 Programmes and interventions targeted at the societal level to reduce unintentional injuries and violence

Societal interventions targeting risk factors that are common for more than one type of unintentional injury or violence are incompletely implemented (Fig. 20). Reducing economic inequality (37% of countries implement this nationally), decreasing the access to and availability of alcohol during high-risk periods (33% of countries implement this nationwide) and reducing the availability of drugs (79% implement nationwide) are thought to be effective in preventing most types of unintentional injuries and violence. In contrast, other programmes such as sustained, multimedia prevention campaigns aimed at changing cultural norms that promote violence (41% nationwide implementation) and reducing the availability of firearms (84% nationwide implementation) focus on reducing risk factors to prevent multiple types of violence. These programmes require more widespread uptake in the Region, both within and between countries.

Fig. 20. Do you have in place any of the following programmes for preventing injuries and violence?



3.3 Programmes and interventions to reduce major risk factors for injuries and violence

This section considers interventions for reducing two major risk factors for injuries and violence in more detail. Alcohol is known to be an important risk factor for both unintentional injuries and violence and contributes to a substantial proportion of the burden *(36,37)*. Programmes and policies that contribute to minimizing alcohol-related harm are considered here *(38)*. These include fiscal and legal measures, measures to reduce advertising and hence alcohol-related harm and health service interventions. Socioeconomic inequality is also known to be an important risk factor for both unintentional injuries and violence. Programmes that address these are considered.

3.3.1 Fiscal and legal interventions to prevent alcohol-related harm

The median percentage of implementation of the 14 fiscal and legal interventions to prevent alcohol misuse for responding countries was 71%. Few countries implement interventions that reduce the number of retail outlets selling alcohol (25%) or laws limiting the time period when alcohol can be sold for off-licensed premises (30%) and for on-licensed premises (36%). Interventions, such as policies on server training of bar staff and restricting alcohol sales at specific events should be more widely implemented. Most countries had measures in place at the national level to control use by adopting fiscal measures (89%). Although governments have laws (96%) and recommendations (87%) to restrict alcohol sale to juniors (Fig. 21), there is concern as to how well these are enforced. This was reported as 6 on a scale from 1 to 10 (47 countries responding). These laws need to be better enforced to control alcohol-related harm in this high-risk group.

3.3.2 Measures to restrict advertising to reduce alcohol-related harm

Sixty-eight per cent (32) of the countries responding reported having legally binding regulations on alcohol advertising. Alcohol advertisement is more frequently totally banned on national services (both television (35%) and radio (33%) than on private or commercial television (22%) and local radio (20%). Between 37% and 46% of countries apply partly statutory restrictions, whereas between 22% and 35% of countries do not apply any kind of restriction (Fig. 22). More widespread restriction in advertising is required to reduce alcohol-related harm.

Fig. 21. Do you have in place any of the following fiscal and legal alcohol-related interventions to prevent alcohol-related harm?

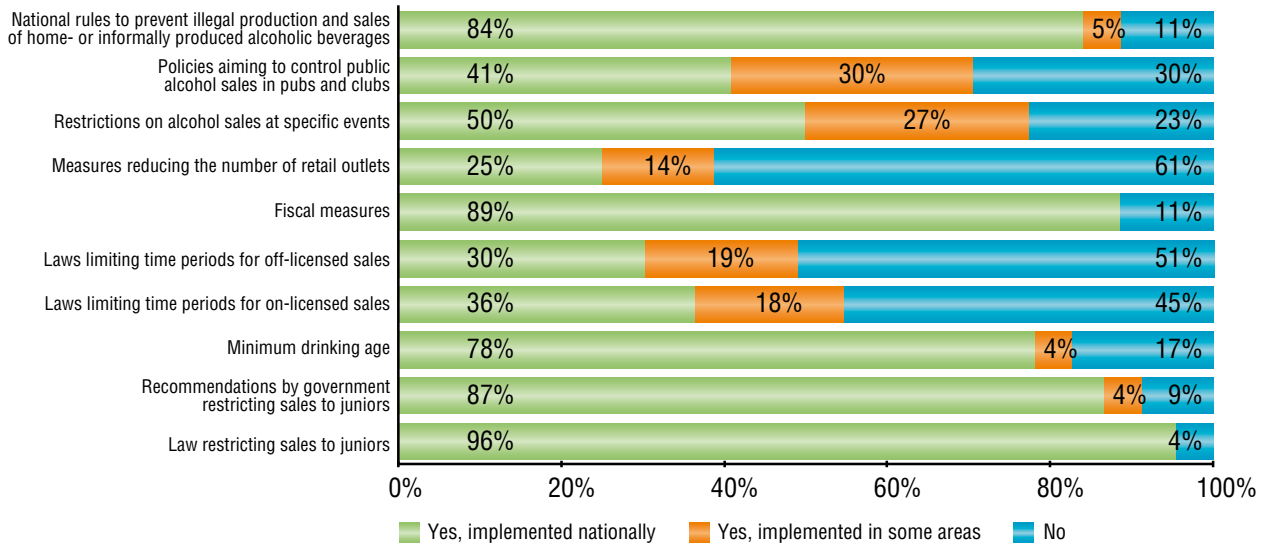
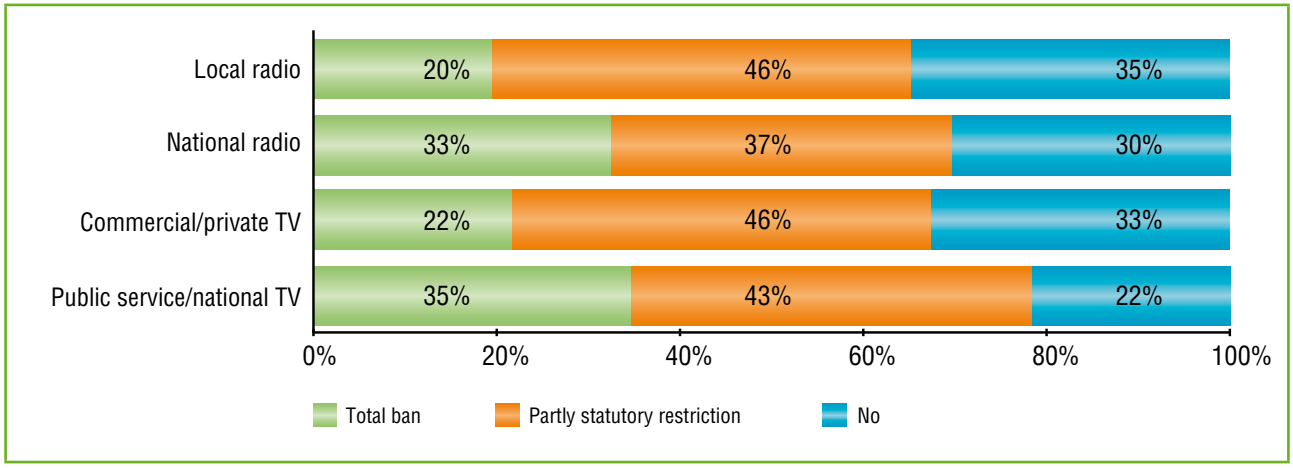


Fig. 22. Is alcohol advertising banned to prevent alcohol-related harm?



3.3.3 Health system-based programmes to reduce alcohol-related harm

The median percentage of implementation of the three evidence-based health system–based programmes to reduce alcohol-related harm was 67%. However, as shown in Fig. 23, much more of this implementation is at the local level rather than nationally. For example, only 18% of countries implemented motivational interviews by physicians in the emergency room for adolescents with alcohol-related injuries at the national level. Health systems need to develop capacity to ensure that national coverage of these brief interventions is increased.

3.3.4 Programmes to reduce socioeconomic differences

The implementation of programmes aiming to reduce socioeconomic differences in unintentional injuries and violence was generally low, ranging from 11% to 23% (Fig. 24). Much of the implementation is at the local level rather than nationally, which may be unsurprising, since minorities and more disadvantaged groups tend to live in localized deprived areas. However, even at the local level such programming is low, ranging from 19% to 35%. These programmes and those to reduce social inequality alongside efforts to strengthen social security systems (Fig. 20) need to be improved to reduce inequality from injuries and violence and to achieve more equitable and just societies. The health sector needs to improve access to services for disadvantaged people but also work with other sectors such as finance, urban planning and social welfare to improve preventive and support services for those at risk, to reduce differential exposure to risk and to reduce social stratification *(29)*.

Fig. 23. Do you have in place any of the following health system–based interventions to reduce alcohol-related harm?

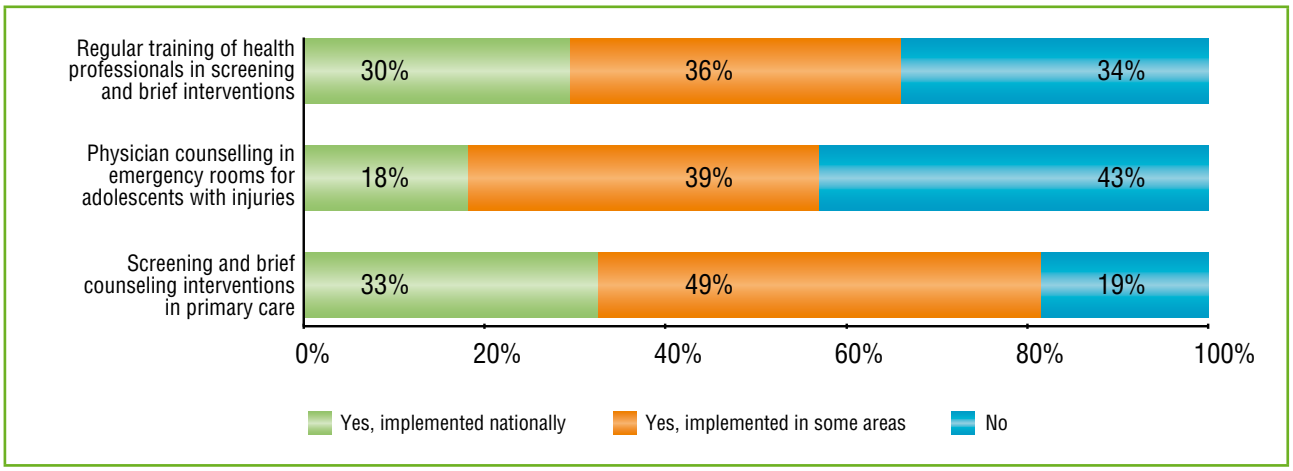
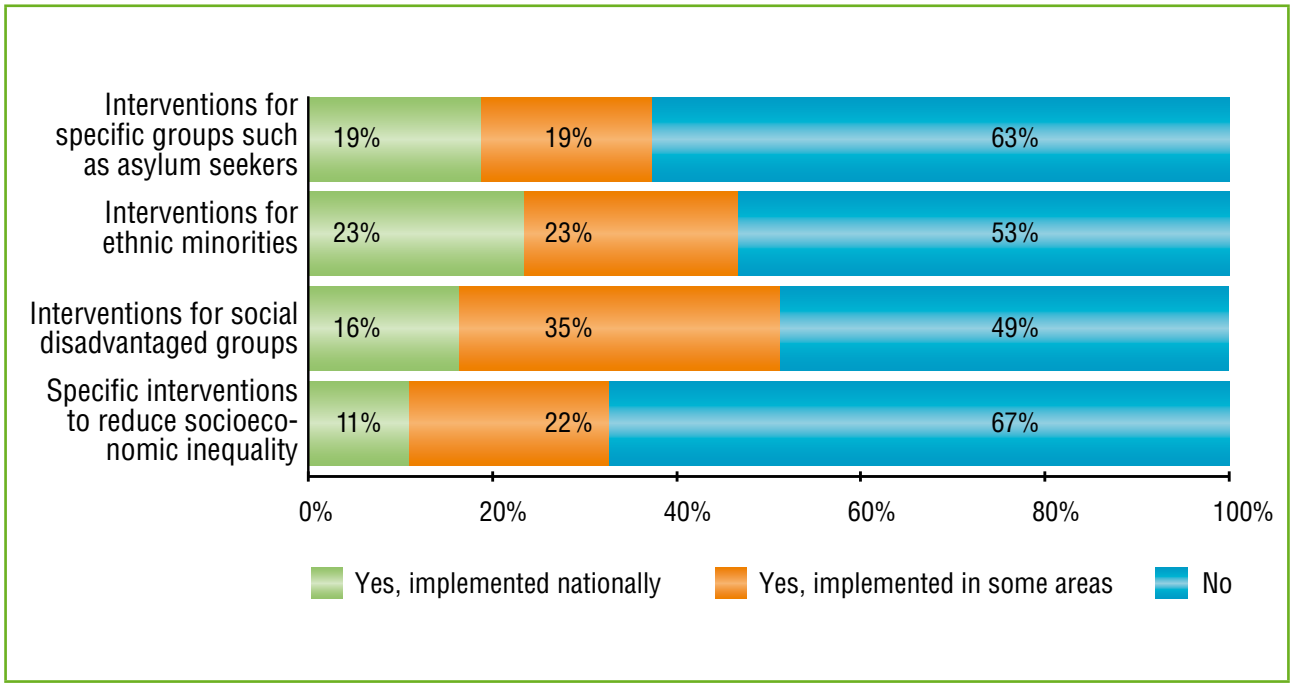


Fig. 24. Do you have in place any of the following interventions to reduce socioeconomic differences in injuries and violence?



3.4. Progress achieved in implementing evidence-based interventions for preventing injuries and violence between 2008 and 2009

Thirty-two country respondents provided information on 59 interventions or programmes for preventing injuries and violence in 2008 and 2009. The overall percentage of implementation for all interventions increased from 69% to 74% in this time period (Table 2).

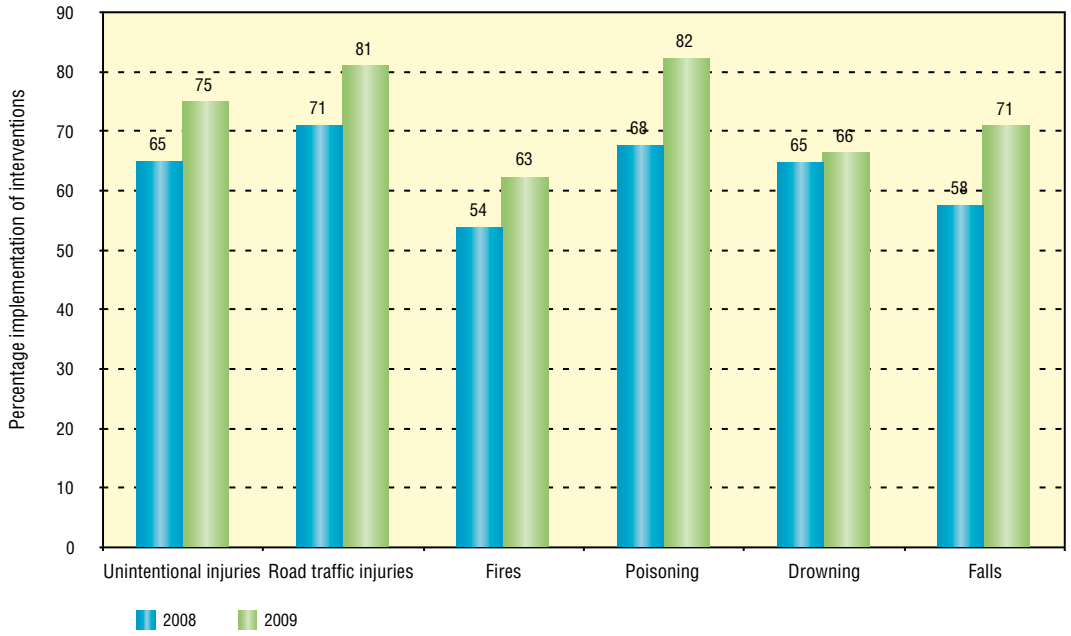
3.4.1 Change in implementation of interventions for preventing unintentional injuries

Implementation of 33 preventive interventions for all unintentional injuries increased from 65% to 75% between 2008 and 2009 (Fig. 25). Increases were reported for all types of injuries, with the largest for poisoning and falls and the smallest for drowning and fires. Of interest, fewer countries also reported having national policies for these latter types of unintentional injuries.

Table 2. Proportion of implementation of 59 interventions in 32 countries, 2008 and 2009 (means and 95% confidence intervals (CI))

Type of injury or violence	2008		2009	
	Mean %	95% CI	Mean %	95% CI
Total	**69**	**61–77**	**74**	**70–79**
Unintentional injuries	**65**	**57–74**	**75**	**70–80**
Road traffic injuries	71	62–80	81	76–86
Fires	54	42–66	63	52–73
Poisoning	68	54–81	82	72–92
Drowning	65	54–76	66	55–78
Falls	58	46–69	71	59–83
Violence	**75**	**67–84**	**77**	**70–83**
Youth violence	58	47–69	71	59–83
Child maltreatment	84	74–94	90	82–98
Intimate partner violence	63	49–76	78	66–91
Elder abuse	53	40–66	63	51–74
Sexual violence	50	33–67	66	48–84
Self-directed violence	56	44–68	80	71–89

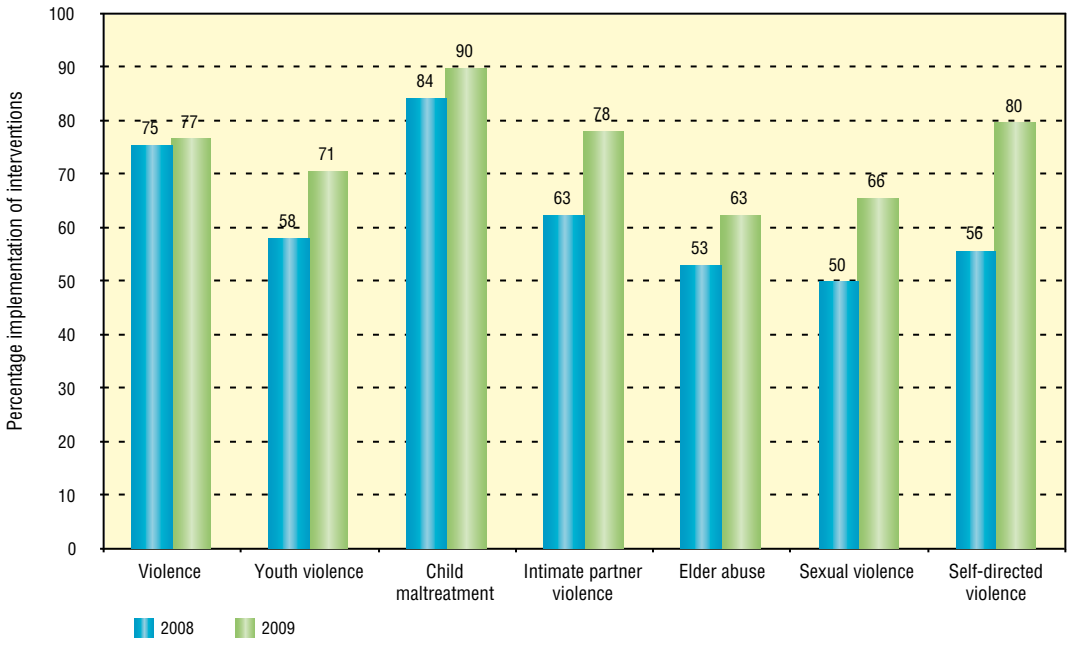
Fig. 25. Proportion of implementation of interventions on unintentional injuries in 32 countries, 2008 and 2009



3.4.2 Change in implementation of interventions for preventing violence

The percentage of implementation of preventive interventions for all types of violence taken together improved from 75% to 77% between 2008 and 2009 (Fig. 26). Self-directed violence and sexual violence had the largest increases and preventing elder abuse, youth violence and child maltreatment the smallest increases.

Fig. 26. Proportion of implementation of interventions for preventing violence in 32 countries, 2008 and 2009



3.5 Country profiles

Forty-seven country profiles were sent to health ministry focal people for validation and for permission to publish. As of January 2010, 37 Member States had given permission to publish validated country profiles. The approval process is ongoing, and it is hoped that all 47 country profiles will be posted on the WHO web site *(39)*.

3.6 Inventory of national policies

As of November 2009, the full text of 97 documents from 30 countries was uploaded on the web site of the WHO Regional Office for Europe. Based on the questionnaire responses, a further 72 documents were identified, and policies are now available for 32 countries, of which 23 are EU countries. Only policies written in English or German have been analysed. The new policies identified are being analysed and uploaded on an ongoing basis. This inventory is a resource for policy-makers and practitioners interested in seeking more information on European national policies on preventing injuries and violence *(20)*.

3.7 What are the barriers to and factors enabling the prevention of violence and injuries?

3.7.1 Constraining factors

In their responses, focal people identified factors that constrain prevention activities (Box 2). A quote from one focal person was: "There is a need for a more holistic approach, overview and better understanding from politicians and those who work with policies and legislations, in acknowledging the importance regarding prevention of injuries and violence."

3.7.2 Enabling factors

Focal people identified factors enabling prevention activities (Box 3). One focal person quoted the following factors: "Political commitment and a national plan with a higher awareness of the huge impact of injuries on people's lives through research and media".

Box 2. Constraints on prevention identified by focal people

- Weak political will
- Poor institutional capacity
- Weak legislative and regulatory frameworks
- Weak governance mechanisms
- Lack of nationwide coordination
- Fragmented political responsibility
- A multisectoral approach is difficult to put into practice
- A federal structure is a challenge to coordination
- Working without a common objective between the sectors
- Inadequate resources with no defined financing mechanism
- The economic downturn has reduced the priority given to violence and injury prevention
- Poor training and motivation of staff
- Not a priority area of public health
- Inadequate access to reliable data
- Deregulation and increased access to alcohol
- Inadequate emphasis in university curricula
- Poor mass-media interest in prevention
- Tolerance of violence in patriarchal societies
- Gender and social inequity
- The public is less informed and interested in this area than in others

Box 3. Enabling factors identified by focal people

Support by the international legal framework

Strong political will is helpful

Intersectoral cooperation and common approach to the problems

Statement of the seriousness of the injury problem in the national health plan

Health and safety ranking high on the list of public demands

Having action plans and defined activities with effective means to reach objectives

A well-informed public through research and mass media

Willingness of the mass media to participate in positive preventive efforts

Strong institutions that promote injury prevention

Well-trained and committed professions

Small size of a country facilitates communication and collaboration

Laws that mandate child protection for the health professions

High-profile cases that triggered changes in laws on child protection and intimate partner violence

Laws to ban firearms

Regulation of alcohol sales

Donor interest in preventing interpersonal violence

Active nongovernmental organizations

3.8 How was progress achieved in preventing violence and injury?

Countries have had increased activity and interest in taking up the challenge of reducing the burden of injuries and violence through prevention. Much of this interest has been stimulated by the policy momentum that has been gained through the World Health Assembly resolutions, the WHO Regional Committee for Europe resolution and the European Council Recommendation on the prevention of injury and the promotion of safety *(11–13,15,40)*.

3.8.1 Work through biennial collaborative agreements

Member States increasingly seek collaboration with WHO through biennial collaborative agreements. These have steadily increased: 5 in 2004–2005, 9 in 2006–2007, 14 in 2008–2009 and 18 in 2010–2011. The activities undertaken within biennial collaborative agreements focus on four priority areas: preventing road traffic injuries, preventing interpersonal violence, capacity-building and surveillance, including surveys.

3.8.2 Developing national policies

Specific support has been given for developing national policies on preventing violence and injuries in 16 countries, including 10 from the EU (Austria, Belarus, Czech Republic, Cyprus, Estonia, Germany, Hungary, Kyrgyzstan, Latvia, Lithuania, Romania, Russian Federation, Slovakia, The former Yugoslav Republic of Macedonia, Turkey and Turkmenistan). This has ranged from advocacy to more specific involvement in the policy-making process.

3.8.3 Capacity-building

Much work has also gone to strengthen the capacity of national health systems to respond to injuries. Much of the emphasis has been on policy development, surveillance, evidence-based practice and evaluation. Several capacity-building workshops for focal people in violence and injury prevention have been held with the aim of developing the stewardship role of the health sector in mounting a multisectoral response to preventing injuries.

WHO's TEACH-VIP (Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention) curriculum *(41)* was developed by international experts and has been translated into Russian. It has been used for train-the-trainer workshops. The first such workshop in the WHO European Region was held in September 2007 with Russian-speaking participants. A second such workshop was held in November 2009 with focal people and trainers from the countries in the South Eastern Europe Health Network. These were favourably received, and follow-up in several countries has shown that the curriculum is being adapted for local use and mainstreamed for health professional training. In fact, train-the trainer workshops have been held in Belarus, Kyrgyzstan, the Russian Federation, The former Yugoslav Republic of Macedonia and Uzbekistan.

TEACH-VIP been translated into other languages such as Hungarian, Latvian, Lithuanian, Macedonian, Romanian, Russian, Spanish and Turkish, and capacity-building workshops have been held in these countries with the aim of incorporating it into training curricula for graduates and for continuous professional development. Future activities will include adapting and/or translating the TEACH-VIP curriculum in Albania, the Czech Republic, Estonia, Kazakhstan, Montenegro, the Republic of Moldova and Turkmenistan.

A TEACH-VIP module on alcohol and violence has been developed and translated into Russian. Work is underway to produce new lectures for surveillance, national policy-making and advocacy with a specific emphasis on the European context.

A mentoring programme (MENTOR-VIP), coordinated by WHO headquarters, which aims to impart both knowledge and skills for preventing violence and injuries, has also been initiated with mentors and mentees from European countries participating *(42)*. An online version of TEACH-VIP in 2010 is now available for remote learning, with considerable cost abatement and greater flexibility to account for the needs of participants *(43)*.

3.8.4 Improving injury surveillance

Hospital-based injury surveillance activities are being implemented in such countries as Belarus, Lithuania, Malta and the Russian Federation, and a community survey on injuries has been undertaken in The former Yugoslav Republic of Macedonia using guidelines developed by WHO *(44)*. Community surveys of adverse childhood experiences are underway in Latvia, Lithuania, Romania and The former Yugoslav Republic of Macedonia *(45)*.

Assistance has been given to Belarus, Hungary, Kyrgyzstan, Turkmenistan and Uzbekistan to develop situation analysis documents on injury prevention using surveillance data. In addition, WHO is on the advisory committee for injury registries in such countries as the Czech Republic, Hungary, Lithuania and Slovakia and for the European Commission–funded project to develop a European Injury Database *(46,47)* being implemented in 15 EU countries.

3.8.5 Supporting the network of national focal people

Since 2005, five European network meetings have been held, hosted by the health ministries of the Netherlands (2005), Austria (2006), Portugal (2007), Finland (2008) and Germany (2009). All the meetings have centred around key items of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety, such as building capacity, surveillance and advocacy. At one of these meetings, a brief training workshop was held using the TEACH-VIP curriculum *(41)* to familiarize focal people with the public health approach to preventing injuries and violence and to promote the use of the curriculum to build capacity in countries. At the 2009 network meeting, new lessons for the TEACH-VIP curriculum on surveillance, national policy and advocacy were shared with focal people. The Working Party on Injury Prevention and Safety promotion hosted by the European Commission meets annually with representation by EU countries (many of the national representatives are also focal people) and WHO.

In addition, two global meetings of focal people have been held in conjunction with the 8th World Conference on Injury Prevention and Safety Promotion in Durban, South Africa (2006) and the 9th Conference in Merida, Mexico (2008), both including strong representation from European countries. These meetings have promoted the exchange of best practice and experience among focal people from diverse countries. The third such meeting is planned at the 10th World Conference on 21–24 September 2010 in London, United Kingdom *(48)*.

Two subregional mentoring workshops for focal people have been planned. Focal people from the Nordic Baltic subregion participated in a mentoring workshop in 2009 in Estonia, and a second such workshop is being held in Italy in 2010 for focal people from the southern and central Europe subregion. These workshops enable the exchange of different levels of experience. A subregional workshop was also held on preventing family violence in Latvia that involved focal people and experts from the Nordic and Baltic countries to exchange experiences in best practice.

3.8.6 Technical support on best practice

Several publications *(5,23,25,49)* and policy briefings *(29,47,50–56)* have been written to collate state-of-the-art knowledge on the burden of violence and injuries in the WHO European Region and to provide evidence-based solutions. These publications have been disseminated widely to the focal people and a broader audience of other policy-makers, practitioners and scientists so that best practices can be shared and implemented through the network of focal people on violence and injury prevention and other networks. Annex 5 lists relevant publications on preventing violence and injuries.

3.8.7 Developing collaboration with other networks and partnership

Collaboration has also been developed with other injury prevention networks, such as EuroSafe (European Association for Injury Prevention and Safety Promotion); the European Child Safety Alliance, the EuroSafe initiative of the Child Safety Action Plan; Public Health Action for a Safer Europe; Best Practice Measures in Road Safety; the European Alcohol Policy Network; and the South-eastern Europe Injury Prevention Network. Partnerships have also been developed with the European Commission Directorate-General for Health and Consumers and Directorate-General for Transport and Energy. Collaboration is also ongoing with other international bodies such as the United Nations Children's Fund (UNICEF), the Organisation for Economic Co-operation and Development, the United Nations Economic Commission for Europe, the Council of Europe, the European Transport and Safety Council, the International Transport Forum and the World Bank. The Scottish Executive hosted the Meeting on Third Milestones of a Global Campaign for Violence Prevention in Scotland in 2007, and WHO headquarters hosted the Fourth Milestones meeting in 2009 with more than 200 international participants, many from European countries. An international policy dialogue on youth violence and knives and was held in London in 2009, hosted by the Government of the United Kingdom. A European report on youth and knife violence is being prepared as proposed at the policy dialogue. There is also exchange of technical expertise with the network of WHO collaborating centres. There is growing interest from European centres to qualify for collaborating centre status.

3.8.8 Technical assistance to improve care for victims

In June 2008, the Government of Italy hosted a regional consultation on the preparation of a world report on disability and rehabilitation organized in collaboration with WHO headquarters. The report, expected to be launched in 2010, will be a joint publication of WHO and the World Bank involving the collaboration of many experts in the field of disability and rehabilitation. It will comprehensively describe the importance of disability, characterize the responses currently provided and make recommendations for action based on the best available scientific evidence. The report will target a broad audience ranging from policy-makers, service providers and people with disabilities.

3.8.9 Global status report on road safety

Bloomberg Philanthropies has funded a project on the global status report on road safety *(49)*. In Europe, national surveys were undertaken in 49 countries. Many focal people took the lead to coordinate data collection nationally *(5)*. The *European status report on road safety* was launched at the First Global Ministerial Conference on Road Safety, hosted by the Russian Federation in November 2009. The Conference adopted the Moscow Declaration *(57)*.

The report is the first thorough analysis of the road safety situation. It shows that achievements in road safety are unequal across the WHO European Region, with 70% of victims from lower-income countries, and emphasizes the plight of vulnerable road users. National launches are planned in 2010 to further advocate for road safety. A second phase of the project is expected to commence in 2010 and will involve implementing and evaluating pilot projects in the Russian Federation and Turkey and reassessing the global status of road safety.

3.8.10 World and European reports on child injury prevention

These reports highlight injuries as the leading cause of death among children and outline evidence-based action for prevention. The European report targets policy-makers, professionals and activists and has been successfully launched in several countries, including Belarus, the Czech Republic, Estonia, Finland, Italy, Hungary, Kyrgyzstan, Portugal, Slovakia, the Russian Federation, Spain, The former Yugoslav Republic of Macedonia and Uzbekistan. It advocates for greater priority to be given to this leading cause of child death by mainstreaming prevention both within and outside the health sector.

3.8.11 Advocacy for road safety

Support was provided during the First United Nations Global Road Safety Week (23–29 April 2007), a successful global advocacy event led by WHO headquarters, which raised the profile of youth and road safety as a priority *(58)*. In the European Region, active support to 20 countries, in close cooperation with WHO country offices, helped health ministries in engaging with other sectors in mounting an advocacy response in promoting road safety. In addition, collaboration was established with the European Commission Directorate-General for Transport and Energy for an event to mark the first European Road Safety Day in 2007 and the second European Road Safety Day on 13 October 2008 in Paris.

4. CONCLUSION AND WAY FORWARD

4.1 Progress made and remaining challenges

Forty-seven WHO European Member States responded to the survey. This is an improvement from previous years. Of these, 25 were EU countries (response rate 96%) and 22 were not (response rate 85%). Encouragingly, more countries with a federal structure such as Germany and Switzerland participated than in 2008 despite the difficulties in data collection. Future survey instruments need to take account of these contextual differences. Further, more countries in the eastern part of the Region participated. This is important given the higher injury mortality rates in the eastern part of the Region.

This report shows that sustained and increasing collaboration between Member States and international organizations has led to good progress in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety. The resolution has been a catalyst for change, as evidenced by 75% of the respondent countries stating that it has placed preventing violence and injuries higher on the national policy agenda and has catalysed action. Further, this past year has witnessed encouraging progress in implementing the resolution and European Council Recommendation: 65% of countries reported national policy development, 74% surveillance, 63% capacity-building, 76% multisectoral collaboration and 59% evidence-based emergency care. To enable this, 93% of the countries had favourable policy environments, with political support for formulating national policies for preventing violence and injuries and with the health sector taking a lead role in coordination, working with other sectors to achieve implementation. However, only 54% have a budget to support activities, and this needs to be improved to enhance coordination.

4.1.1 Progress made in preventing unintentional injuries and remaining challenges

In terms of national policy development, 60% of countries have integrated policies on unintentional injuries, an increase of 19 percentage points from 2008 in countries with comparable data. Many countries have also developed national policies for individual types of injury. Whereas most countries have a national policy on road safety (95%), half or less have national policies for other types of unintentional injury: poisoning, fires, falls or drowning.

The transport sector has shown leadership in developing road safety policies, and this is reflected in widespread implementation of effective measures by many countries. However, least has been done to reduce road traffic injuries among youth, for whom road crashes are still the leading cause of death, and this has not improved since 2008 *(31)*. Further, alternative, safer forms of transport should be developed to ensure a reduction in health risks (such as pollution and lack of physical activity) arising from the current dependence on private cars *(26)*.

National policy development for preventing drowning (40%), falls (53%) and poisoning

(48%) is low and this is reflected in the relatively infrequent national implementation of evidence-based interventions for these types of injury. The percentage of implementation in preventive programmes for all unintentional injury improved overall by 10 percentage points from 2008 to 2009, but drowning and fires had the smallest gains. This is of concern, because, for example, drowning is the leading cause of unintentional injury–related death among children 1–5 years old *(1)*. Implementation of programmes to prevent poisoning, the leading cause of injury-related death in some countries, is also low. An important way forward is more widely implementing measures to reduce child poisoning, such as child-resistant closures *(1,25)*. A large proportion of poisoning deaths among adults are linked to acute alcohol intoxication *(1,59)*. Greater action is needed to address this. At the subregional level, greater attention is needed in the Baltic countries, which have high drowning and poisoning rates but less implementation of programmes that is not commensurate with the scale of the problem.

4.1.2 Progress made in preventing violence and remaining challenges

There are integrated policies for preventing violence in 46% of countries, and there was a larger increase of 24 percentage points compared with 2008. The adoption of national policies for specific types of violence varied in respondent countries. Whereas this was quite high for child maltreatment (79% of countries) and intimate partner violence (76% of countries), this was lower for elder abuse (40% of countries), youth violence (62% of countries) and self-directed violence (45% of countries). Policy development has improved considerably since 2008, but the implementation of preventive programmes has only increased by 2 percentage points; the increase in implementation has been smallest for preventing elder abuse, youth violence and child maltreatment. Suicide is the leading cause of injury-related death in most countries in the Region, and the recent emphasis by the health sector on policy development needs to be continued, as does implementation of evidence-based programmes *(1)*. Youth violence is perceived as a growing problem in many countries, and more countries need to develop policies to prevent it *(14)*. The median percentage of implementation of programmes to prevent youth violence in the Region was high, although in most countries these were implemented in some areas rather than nationwide. Several important interventions for preventing youth violence require leadership by the education and health sectors. The health sector could contribute by playing a coordinating role, by sharing information and through evaluation. Preventing child maltreatment is a priority for most countries. As preventive programming is restricted to local areas in most responding countries, this needs to be more widely implemented, especially given the evidence that child maltreatment is closely linked to cycles of violence and has long-term health effects *(14,45)*. Preventing elder abuse is another challenge in the Region, particularly given the demographic trends. Health systems can ensure that this does not happen in residential homes, and other approaches involve engaging civil society and empowering older people to prevent violence *(14)*. For most types of violence, the current main challenge is to expand the coverage of evidence-based programmes to the national level. The health sector should ensure that such implementation is evaluated.

4.1.3 Progress made in reducing risk factors for violence and injury and remaining challenges

The importance of alcohol as a leading risk factor for both injuries and violence is widely recognized in the Region. It is encouraging that 80% of the responding countries reported that national policies on unintentional injuries have identified alcohol as a risk factor, and 87% reported that this is also the case for violence. Of the alcohol-related interventions, 76% were implemented, but alcohol-related mortality rates are still too high in several countries, especially in the eastern part of the Region. Wider implementation of health system–based programmes is needed. Clearly, the patterns and levels of alcohol consumption vary enormously across the Region, and some countries have high alcohol-related harm, such as those in the eastern part of the Region, the Nordic countries and western Europe, whereas this is less so in southern European countries *(36,59)*.

Measures such as fiscal and regulatory controls with taxation and enforcement and, above all, health system–based interventions such as brief counselling in emergency departments and by physicians need to be practised more widely in the high-risk countries *(8,37,60)*. Of particular concern is the poor enforcement of laws to prevent alcohol-related harm among underage drinkers.

Whereas more than two thirds of the countries reported that national policies have highlighted socioeconomic inequality in injuries and violence as a priority, only 52% have policies targeting the reduction in socioeconomic differences in health between segments of society. There is low implementation of interventions targeting disadvantaged groups to reduce socioeconomic differences, and redressing this would be important to attain greater equity *(61)*. The health sector faces a challenge of working with the finance, urban planning, education and social welfare sectors and others in improving access to preventive and curative services, mitigating risk factors and improving social support networks and social stratification.

4.2 Limitations

This assessment was carried out using a questionnaire survey of national focal people. As reported previously and as with all surveys, limitations include issues of reliability and validity. To correct for this, focal people were given an opportunity to verify country profiles before publication *(17)*. Nevertheless, some validity issues remain unresolved.

An example is health visitation to prevent child maltreatment, as this may be interpreted to mean all types of health visitation rather than those specifically tailored to support high-risk families. Similarly, certain programmes such as pool fencing may not have the same relevance in cold climates. Countries with a federal structure may necessarily have regional policies rather than national policies and regional programming rather than national programmes. Countries with devolved responsibilities face a challenge not only in gathering data but also need a lead agency with the pivotal role of ensuring uniformity in developing and implementing policy across the regions.

Reliability can also be affected. For example, activities to prevent injuries and violence covered by other sectors present a challenge, as recording such activities may not be easy. To minimize this, focal people were encouraged to contact stakeholders from other sectors. Similarly, there may have been challenges related to questionnaire completeness and this may affect results, especially in comparing successive years. Further, whereas much information was provided on the questionnaire, the country profile provides a synopsis of this. Nevertheless, the country questionnaires are available for practitioners and policy-makers who wish to have more detailed country information. It is hoped that this will provide a useful baseline to assess further progress.

In addition, there may be issues of responder bias. For example, national policies and programmes may be over- or underreported. To improve this, respondents were asked to provide additional information to support their responses, such as web sites for national policies.

The level of detail presented in this report, which provides summary information, is also limited. For example, the responses to questions on national policy development are presented as frequencies. However, the country questionnaires provide rich contextual information and specific details on policy, and this can be studied further by examining the web sites where policies have been uploaded *(20)*.

Another limitation of this survey is that it did not include all interventions and programmes for preventing violence and injuries; selected ones were included from among those regarded as effective, and this list may have some omissions. However, the list of interventions was updated for the 2009 survey, and it is hoped that the data for that year are more inclusive.

Some information should be interpreted with caution. For example, results on fatal and nonfatal road traffic injuries due to alcohol are difficult to compare since they mostly depend both on levels of enforcement and on the maximum allowed blood alcohol concentration, which varies across countries. Intercountry comparisons could therefore be problematic. Similarly, for country assessments, the analysis of the survey results did not distinguish between

programmes implemented in some areas versus nationwide. Countries, however, are encouraged to implement more widely successful local programmes.

Further, policy development is a dynamic process, and more recent policy initiatives or the very old ones may not have the same visibility *(21,62)*. Given this constraint, focal people have an opportunity to update developments annually, and some of this dynamism is being captured. The same constraint applies to programming, and information on the duration of programme implementation has not been collected.

Gathering and publishing such information may not necessarily catalyse action. However, it can be used successfully to advocate for action, as demonstrated in the European environment and health indicators *(63)* and the child safety action plan project *(64)*. Country reports that overestimate the national implementation of programmes (for example, for preventing child maltreatment) may lead to complacency. These qualitative policy indicators, which are useful for advocating action and for benchmarking, are not a substitute for outcome indicators, and long-term evaluation needs to be conducted using mortality and morbidity data on a defined time scale. Whereas this would have been desirable, it will only be possible to do this in the future because of the two- to three-year time lag for preparing mortality datasets and the longer periods of data collection needed before national policy development can be shown to affect outcomes. This has not been feasible for the current report, as the period of observation has been too short since resolution EUR/RC55/R9 was adopted in 2005 and the European Council Recommendation on the prevention of injury and the promotion of safety was adopted in 2007. Future evaluations should be able to overcome this limitation.

4.3 Challenges and opportunities ahead

There are several challenges in preventing injuries and violence. Among these is how to ensure that this can be kept high on the policy agenda, how to better use the expertise and experience to build capacity in the WHO European Region and how to overcome the human resource and financial constraints. The following opportunities have been identified for health systems to respond to this leading public health threat in the Region.

- A critical mass of policy-makers, focal people and practitioners related to preventing violence and injuries has been developed during the last decade in Europe. These collaborative networks are gaining momentum in developing and implementing public health policy and represent an investment for the future.
- Networks such as the health ministry focal people represent an opportunity to exchange and disseminate evidence-based practice and experience.
- Subregional networks of practitioners, trainers and focal people are being fostered, and working through these represents an opportunity because of contextual, linguistic and geographical similarities.
- The body of evidence is growing, and this report has mapped the extent to which programmes are being implemented in the Region and the EU countries in particular (Annex 1). This mapping exercise represents an initial step in documenting the public health response to the burden of injuries and serves as a baseline for evaluating future progress at the regional and country levels.
- Country assessments together with the inventory of national policies have been uploaded on the web site of the WHO Regional Office for Europe and represent a resource of accessible information that can be used as a baseline to map future progress and to advocate for greater commitment and action *(39)*.
- Many programmes are being implemented at the local level, and such programmes can be used as examples with which to advocate for national policy development and provide lessons for further implementation.
- Initiatives to build human resource capacity in preventing violence and injuries using the WHO curriculum TEACH-VIP are gaining momentum, and there is an opportunity to mainstream this into the curricula for professional education in health and other sectors.
- There is an opportunity to make such capacity development sustainable by investing in

networks of trainers who could be used as a resource nationally and subregionally.

- There are opportunities for interagency working within and across sectors, and this is also true at international level such as between WHO, the European Commission, UNICEF and the United Nations Development Fund for Women (UNIFEM).
- There is an opportunity to raise the awareness of the justice, education and other sectors about the benefits of using cost-effective interventions in early prevention of violence and engaging them as leaders and partners.
- Health systems have an opportunity to fulfil their stewardship role by providing leadership and coordinating a multisectoral response for the types of injury and violence for which there is no clear ownership, such as preventing drowning, falls, poisoning, child maltreatment, intimate partner violence, elder abuse and self-directed violence. Similarly, there is an opportunity to advocate for evidence-based action in areas such as preventing fires and youth violence, where other sectors have a lead.
- The health sector is in a central position to assess the needs of the population and in assisting with the evaluation of programmes as part of their role in intersectoral collaboration.
- There is an opportunity to better describe the burden, causes and effects of intentional and unintentional injuries by developing reliable and comparable injury surveillance systems using hospital data supplemented by community surveys of interpersonal violence.
- Member States are actively seeking technical guidance from WHO, and this represents an opportunity to assist health systems in fulfilling their preventive obligations. This is evidenced by the increase in the number of requests for biennial collaborative agreements received by WHO.
- There is an opportunity to use materials such as TEACH-VIP to develop training for other sectors such as education, environment, welfare, housing and justice that are key partners in preventing violence and injuries.
- For some areas, there is an opportunity for synergistic action within health systems for practitioners preventing injury and violence, such as with networks working on mental health, alcohol policy and social determinants *(59)*.
- The 5th Ministerial Conference on Environment and Health in Parma, Italy on 10–12 March 2010 represents an opportunity to reaffirm political commitment to preventing injuries and violence. This could be developed further at the proposed High Level Meeting of Health Ministers for Injury and Violence Prevention to be hosted by the Government of the United Kingdom at the 10th World Conference on Injury Prevention and Safety Promotion in London on 21–24 September 2010.

4.4 Way forward and next steps

The health sector and partners need sustained action to decrease the inequality in violence and injury between and within countries of the Region. The progress mapped in this report is encouraging and underlines the fact that future success can only be sustained through political and resource commitment by countries and international organizations. The key steps forward are listed below.

1. Build on current achievements with greater development of national policies and achieve more widespread implementation of evidence-based programmes in countries in the Region (Table 3).
2. Reinvigorate political commitment and collaboration between such international organizations as WHO and the European Commission, countries and civil society to maintain the momentum that has been achieved.
3. Improve access to reliable and comparable injury surveillance information to make the extent, causes and consequences of the problem more visible across the Region.
4. Use research and routine information systems to evaluate policies and programmes, with an emphasis on using outcome indicators to increase the body of knowledge in the Region.

5. Step up existing efforts in building institutional capacity and train professions from health and other sectors by mainstreaming courses such as TEACH-VIP into educational curricula.
6. Address the capacity-building needs to improve high-quality trauma care services in the Region.
7. Maintain support for the existing network of health ministry focal people for preventing violence and injuries and promote the exchange of experience and expertise at the EU level.
8. Seek new opportunities and make better use of collaborative working with other sectors and networks, including academe and civil society organizations.
9. Conduct future evaluations using comparable policy indicators to those reported here and outcome measures.
10. Ensure that international collaboration that results in local implementation is sustained.
11. Increase investment in resources and political commitment to:
    - exploit the above opportunities to the fullest;
    - build on existing progress;
    - fill the gaps identified in this report; and
    - increase momentum in Member States and the Region.

Table 3. Future action needed to decrease the burden of injuries and violence in the WHO European Region and the role of health systems

Action needed	Lead sectors
Formulating and implementing policies for preventing drowning and poisoning	Health
Formulating and implementing policies for preventing falls	Health, housing, leisure
Formulating and implementing policies for preventing burns	Housing
Formulating and implementing policies for preventing suicide	Health
Formulating policies for preventing youth violence	Education, justice and health
Implementing policies for preventing youth violence	Education, justice and health
Formulating and implementing policies for preventing intimate partner violence, child maltreatment and elder abuse	Health and justice
Improving the surveillance of injuries and violence	Health
Building capacity by mainstreaming TEACH-VIP into the curricula of health professions	Health
Building capacity through the exchange of best practice and introducing quality assurance programmes	Health
Developing road safety policy and implementing programmes	Transport
Developing safer alternative forms of transport	Transport
Reducing socioeconomic inequality	Finance
Reducing alcohol availability during high-risk periods	Health and leisure
Working with local authorities to ensure greater national coverage across a range of interventions	Health

5. REFERENCES

(1) Sethi D et al. *Injuries and violence in Europe. Why they matter and what can be done*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/E88037.pdf, accessed 5 February 2010).

(2) *The global burden of disease: 2004 update*. Geneva, World Health Organization, 2008 (http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html, accessed 5 February 2010).

(3) Deaths and DALYs 2004: annex tables. In: *The global burden of disease: 2004 update*. Geneva, World Health Organization, 2008 (http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html, accessed 5 February 2010).

(4) Jacobs G, Aeron-Thomas A, Astrop A. *Estimating global road fatalities*. Crowthorne, Transport Research Laboratory, 2000.

(5) *European status report on road safety*. Copenhagen, WHO Regional Office for Europe, 2009 (http://www.euro.who.int/violenceinjury/injuries/20080229_1, accessed 5 February 2010).

(6) Veisten K, Nossum Å. *Hva koster skader pga hjemmeulykker, utdanningsulykker, idrettsulykker og fritidsulykker det norske samfunnet? [What is the economic cost of injuries due to accidents at home, at school, in sports and in other leisure activities in Norway?]* Oslo, Institute of Transport Economics, 2007 (http://www.toi.no/getfile.php/Publikasjoner/T%D8I%20rapporter/2007/880-2007/880-2007-internett.pdf, accessed 5 February 2010).

(7) Walby S. *The cost of domestic violence*. London, Women and Equality Unit, 2004.

(8) Sethi D et al. Reducing inequalities from injuries in Europe. *Lancet*, 2006, 368:2243–2250.

(9) Roberts I, Power C. Does the decline in child mortality vary by social class? A comparison of class specific mortality in 1981 and 1991. *British Medical Journal*, 1996, 313:784–786.

(10) Edwards P et al. Deaths from injury in children and employment status in family: analysis of trends in class specific death rates. *British Medical Journal*, 2006, 333:119.

(11) *Prevention of injuries in the WHO European Region*. WHO Regional Committee for Europe resolution EUR/RC55/R9. Copenhagen, WHO Regional Office for Europe, 2005 (http://www.euro.who.int/Governance/resolutions/2005/20050922_1, accessed 5 February 2010).

(12) European Council. Council recommendation of 31 May 2007 on the prevention of injury and promotion of safety. *Official Journal of the European Union*, 2007, C 164:1–2 (http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l3councilrecommendation.htm, accessed 5 February 2010).

(13) *Implementing the recommendations of the* World report on violence and health. World Health Assembly resolution WHA56.24. Geneva, World Health Organization, 2003 (http://whqlibdoc.who.int/wha/2003/WHA56_24.pdf, accessed 5 February 2010).

(14) Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002 (http://www.who.int/violence_injury_prevention/violence/world_report/en, accessed 5 February 2010).

(15) *Road safety and health*. World Health Assembly resolution WHA57.10. Geneva, World Health Organization, 2004 (http://apps.who.int/gb/ebwha/pdf_files/WHA57/A57_R10-en.pdf, accessed 5 February 2010).

(16) *WHO Expert Group Meeting on the WHO and DG SANCO Collaborative Project: meeting to discuss policy tools for reporting back on progress with implementing the resolution on the prevention of injuries, Lisbon, Portugal, 21 November 2007*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/Document/VIP/dgsanco_report.pdf, accessed 5 February 2010).

(17) Sethi D et al. *Progress in preventing injuries in the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/InformationSources/Publications/Catalogue/20080912_1, accessed 5 February 2010).

(18) European Health for All database [online database]. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/hfadb, accessed 5 February 2010).

(19) WHO European detailed mortality database [online database]. Copenhagen, WHO Regional Office for Europe, 2010 (http://data.euro.who.int/dmdb, accessed 5 February 2010).

(20) *European inventory of national policies for the prevention of violence and injuries*. Copenhagen, WHO Regional Office for Europe, 2008 (http://data.euro.who.int/InjuryPrevention/?TabID=149801, accessed 5 February 2010).

(21) Shields N et al. *National responses to preventing violence and unintentional injuries*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/e89258.pdf, accessed 5 February 2010).

(22) Schopper D, Lormand J-D, Waxweiler R. *Developing policies to prevent violence and injuries: a guideline for policy-makers and planners*. Geneva, World Health Organization, 2006 (http://www.who.int/violence_injury_prevention/publications/39919_oms_br_2.pdf, accessed 5 February 2010).

(23) Peden M et al., eds. *World report on child injury prevention*. Geneva, World Health Organization and UNICEF, 2008 (http://www.who.int/violence_injury_prevention/child/injury/world_report/en, accessed 5 February 2010).

(24) Peden M et al. *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004 (http://www.who.int/violence_injury_prevention/publications/road_traffic/world_report/en/index.html, accessed 5 February 2010).

(25) Sethi D et al. *European report on child injury prevention*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/violenceinjury/injuries/20081205_2, accessed 5 February 2010).

(26) Racioppi F et al. *Preventing road traffic injury: a public health perspective for Europe*. Copenhagen, WHO Regional Office for Europe, 2004 (http://www.euro.who.int/InformationSources/Publications/Catalogue/20041119_2, accessed 5 February 2010).

(27) *Preventing injuries and violence: a guide for ministries of health*. Geneva, World Health Organization, 2007 (http://whqlibdoc.who.int/publications/2007/9789241595254_eng.pdf, accessed 5 February 2010).

(28) Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/index.html, accessed 5 February 2010).

(29) Laflamme L et al. *Addressing the socioeconomic safety divide: a policy briefing*. Copenhagen, WHO Regional Office for Europe, 2009 (http://www.euro.who.int/Document/E92197.pdf, accessed 5 February 2010).

(30) National assessments on preventing violence and injuries [web site]. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/violenceinjury/network/20080812_1, accessed 5 February 2010).

(31) Sethi D, Racioppi F, Mitis F. *Youth and road safety in Europe*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/Document/E90142.pdf, accessed 5 February 2010).

(32) THE PEP – Transport, Health and Environment Pan-European Programme [web site]. Geneva, United Nations Economic Commission for Europe, 2010 (http://www.unece.org/thepep/en/welcome.htm, accessed 5 February 2010).

(33) Baker S, Ginsburg M, O'Neill B. *The injury fact book*. Oxford, Oxford University Press, 1992.

(34) *Violence prevention: the evidence: overview*. Geneva, World Health Organization, 2009 (http://www.who.int/violence_injury_prevention/4th_milestones_meeting/publications/en/index.html, accessed 5 February 2010).

(35) Butchart A, Phinney A, Check P. *Preventing violence: a guide to implementing the recommendations of the* World report on violence and health. Geneva, World Health Organization, 2004 (http://whqlibdoc.who.int/publications/2004/9241592079.pdf, accessed 5 February 2010).

(36) *European Alcohol Action Plan 2000–2005*. Copenhagen, WHO Regional Office for Europe, 2000 (http://www.euro.who.int/document/E67946.pdf, accessed 5 February 2010).

(37) Rehm J et al. Alcohol use. In: Ezzati M et al., eds. *Comparative quantification of health risks: global and regional burden of disease attributable to selected risk factors*. Geneva, World Health Organization, 2004:959–1108 (http://www.who.int/healthinfo/

global_burden_disease/cra/en/index.html, accessed 5 February 2010).

(38) Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 2009, 373:2234–2246.

(39) Violence and injury prevention: country profiles [web site]. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/violenceinjury/ctryinfo/ctryinfo, accessed 5 February 2010).

(40) *Health systems: emergency-care systems*. World Health Assembly resolution WHA60.22. Geneva, World Health Organization, 2007 (http://apps.who.int/gb/ebwha/pdf_files/WHA60/60_R22-en.pdf, accessed 5 February 2010).

(41) *TEACH-VIP users' manual*. Geneva, World Health Organization, 2005 (http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/en/index.html, accessed 5 February 2010).

(42) Mentor-VIP [web site]. Geneva, World Health Organization, 2007 (http://www.who.int/violence_injury_prevention/capacitybuilding/mentor_vip/en, accessed 5 February 2010).

(43) TEACH-VIP E-Learning [web site]. Geneva, World Health Organization, 2010 (http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/e-learning/en/index.html, accessed 5 February 2010).

(44) *Guidelines for community surveys on injuries*. Geneva, World Health Organization, 2003 (http://www.who.int/violence_injury_prevention/publications/surveillance/06_09_2004/en/index.html, accessed 5 February 2010).

(45) Butchart A, Harvey AP. *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, World Health Organization, 2006 (http://www.who.int/violence_injury_prevention/publications/violence/child_maltreatment/en/index.html, accessed 5 February 2010).

(46) EU injury database [online database]. Brussels, European Commission, 2010 (https://webgate.ec.europa.eu/idbpa, accessed 5 February 2010).

(47) Bauer R, Kisser R. *Injury surveillance: a health policy priority*. Brussels, European Commission, 2009 (Apollo policy briefing number 7).

(48) 10th World Conference on Injury Prevention & Safety Promotion [web site]. London, 10th World Conference on Injury Prevention & Safety Promotion, 2010 (http://www.safety2010.org.uk, accessed 5 February 2010).

(49) *Global status report on road safety*. Geneva, World Health Organization, 2009 (http://www.who.int/violence_injury_prevention/road_safety_status/2009/en, accessed 5 February 2010).

(50) Sethi D. *Developing national policy for injury prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 2).

(51) Sethi D. *Inequality in injury risks*. Brussels, European Commission, 2007 (Apollo policy briefing number 3).

(52) Sethi D. *Road traffic injuries among vulnerable road users*. Brussels, European Commission, 2008 (Apollo policy briefing number 4).

(53) Sethi D. *The role of public health in injury prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 1).

(54) Sethi D, Bie H, Frerick B. *Youth violence prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 6).

(55) Sethi D, Mitis F. *Alcohol and injuries*. Brussels, European Commission, 2009 (Apollo policy briefing number 5).

(56) Sethi D, Mitis F. *Using advocacy for injury prevention*. Brussels, European Commission, 2009 (Apollo policy briefing number 8).

(57) *Moscow Declaration. First Global Ministerial Conference on Road Safety: Time for Action, Moscow, 19–20 November 2009*. London, Make Roads Safe Campaign, 2009 (http://www.makeroadssafe.org/Documents/final_declaration_en.pdf, accessed 5 February 2010).

(58) First United Nations Global Road Safety Week [web site]. Geneva, World Health Organization, 2007 (http://www.who.int/roadsafety/week/en, accessed 5 February 2010).

(59) *Framework for alcohol policy in the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/e88335.pdf, accessed 5 February 2010).

(60) Room R et al. International regulation of alcohol. *British Medical Journal*, 2008, 337:a2364.

(61) Marmot M et al. Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet*, 2008, 372:1661–1669.

(62) Towner E, Towner J. UNICEF's child injury league table. An analysis of legislation: more mixed messages. *Injury Prevention*, 2002, 8:97–100.

(63) ENHIS – European Environmental and Health Information System: indicators [web site]. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.enhis.org/object_class/enhis_about_indicators.html, accessed 5 February 2010).

(64) MacKay M, Vincenten J. *Action planning for child safety: a strategic and coordinated approach to reducing the number one cause of death for children in Europe*. Amsterdam, European Child Safety Alliance (EuroSafe), 2007.

ANNEX 1. ANALYSIS FOR EUROPEAN UNION COUNTRIES

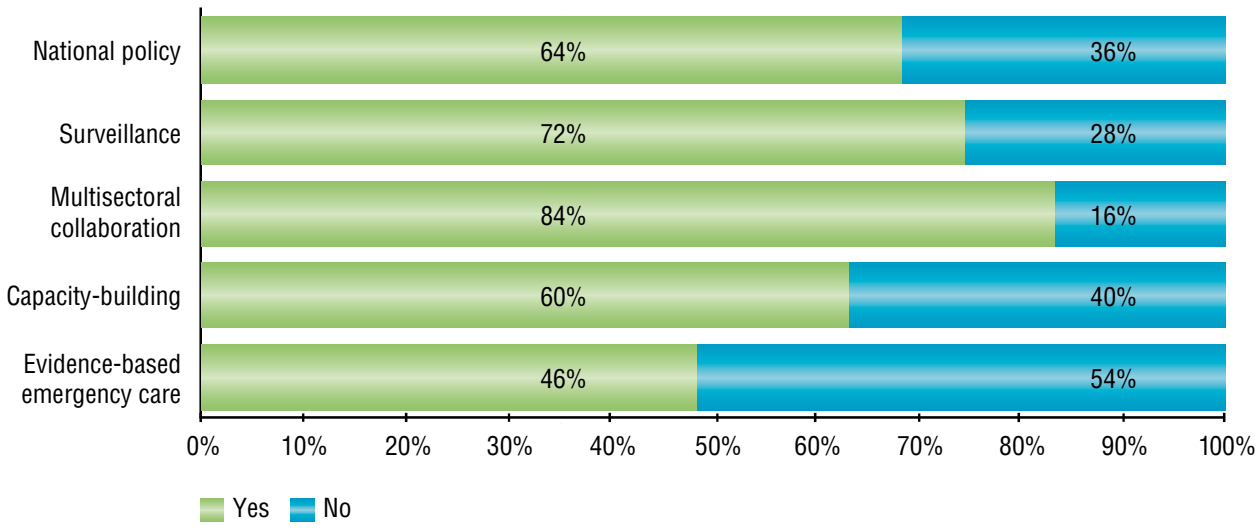
In 2008, EU countries returned 21 completed questionnaires and notable progress was made in 2009, with 25 of 26 countries with focal people returning the questionnaire.

A.1 Overview of implementation of resolution EUR/RC/55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety

A.1.1 What difference have resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety made?

Seventy per cent of the countries acknowledged that the adoption of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety helped to raise the policy profile of preventing violence and injury as a health priority by the health ministry. Encouraging progress was made in a 12-month period from 2008 to 2009 in delivering on many items of the resolution. For developing national policy, 64% of responding countries have achieved progress, 72% for surveillance, 60% for capacity-building, 84% for multisectoral collaboration and 46% for evidence-based emergency care (Fig. 1). Greater attention is needed to areas such as capacity-building and evidence-based emergency care.

Fig. 1. Have there been any new developments in preventing violence and injuries?



A.1.2 Do national policies exist for different causes of unintentional injuries?

Almost two thirds of EU countries (64%) have a national policy on preventing unintentional injuries. Most countries have a national policy on road safety (96%), 63% on fires and 58% on poisoning. Only about half or less have national policies on preventing falls (46%) and drowning (50%), and these areas warrant greater attention (Fig. 2). Among the 21 EU countries that responded in 2008 and 2009, the number of countries with national policies on all unintentional injuries, road safety, falls, drowning and poisoning has increased. This has not been the case for fires (Fig. 3). More attention is needed in such areas as falls, drowning, poisoning and fires.

Fig. 2. Is there a policy on preventing any of the following categories of unintentional injuries?

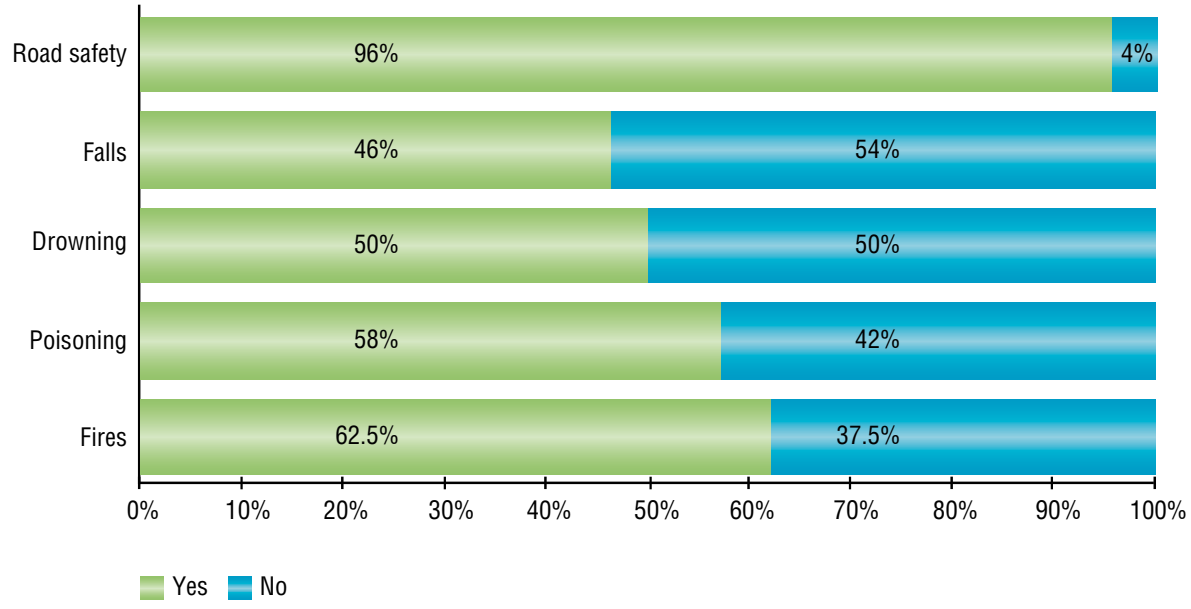
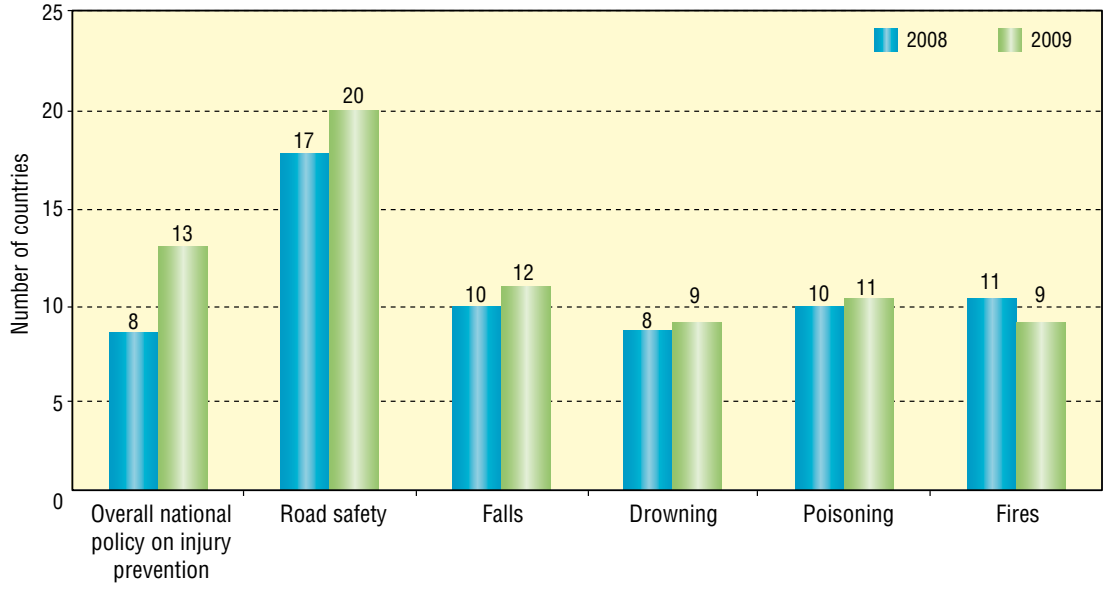


Fig. 3. Number of countries with national policies on preventing unintentional injuries in 2008 and 2009 based on 21 responding countries



A.1.3 Do national policies exist for different types of interpersonal violence and self-directed violence?

Forty-four per cent of the countries reported an overall policy on preventing violence. Among types of violence, 88% of countries have specific national policies on preventing child maltreatment and intimate partner violence, 68% on youth violence, 64% on sexual violence and 57% on self-directed violence, but only 44% of the countries have specific national policies on preventing elder abuse and neglect (Fig. 4). More attention is needed on developing national policies on these types of violence.

There has been good progress in developing national policies on preventing violence. The number of countries reporting national polices increased between 2008 and 2009 in the 21 responding countries, especially self-directed violence, for which the number of countries has doubled. No progress was registered for elder abuse (Fig. 5), and this requires greater political priority.

Fig. 4. Is there a policy on preventing any of the following categories of violence-related injuries?

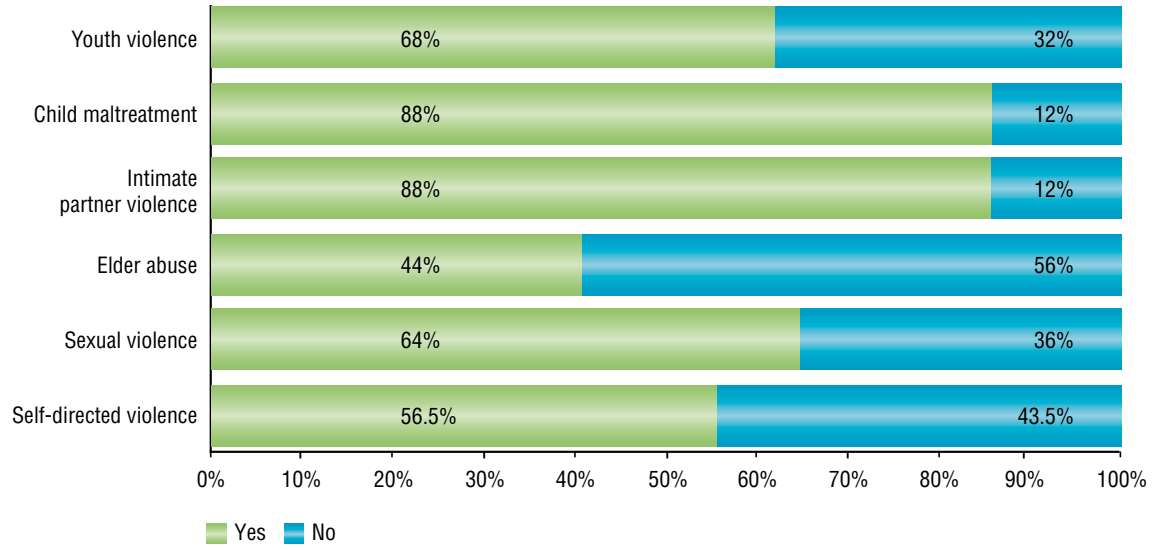
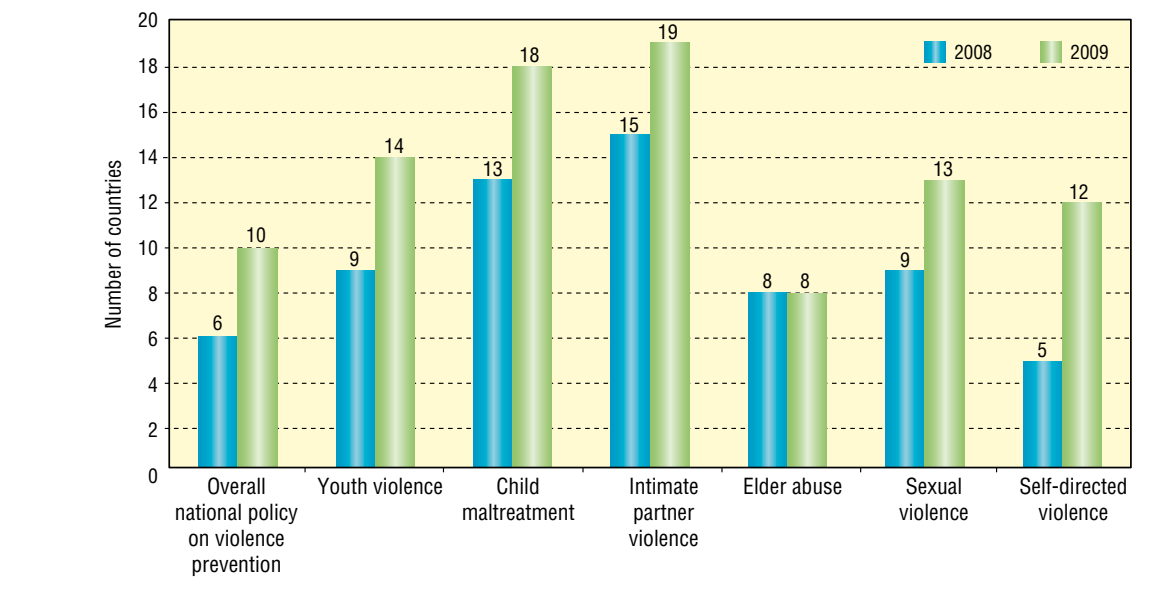


Fig. 5. Number of countries with national policies for preventing violence, 2008 and 2009 (based on 21 responding countries)



A.1.4. Do national policies on preventing violence and injuries identify alcohol and socioeconomic differences as risk factors?

In 88% of the countries, alcohol has been identified as a risk factor for both unintentional injuries and violence in national policies. Only 36% of the countries reported that national policies have highlighted socioeconomic inequality in injuries and violence as a priority. This is of particular importance given the current economic downturn.

A.1.5 Capacity-building for preventing violence and injury and for trauma care

Evidence-based emergency care and capacity-building are widespread across the EU countries and improved considerably between 2008 and 2009 (Fig. 6 and 7). Nevertheless, more progress needs to be made since this is essential for tackling the burden of injuries and violence.

Fig. 6. Do you have the following capacity-building measures in place?

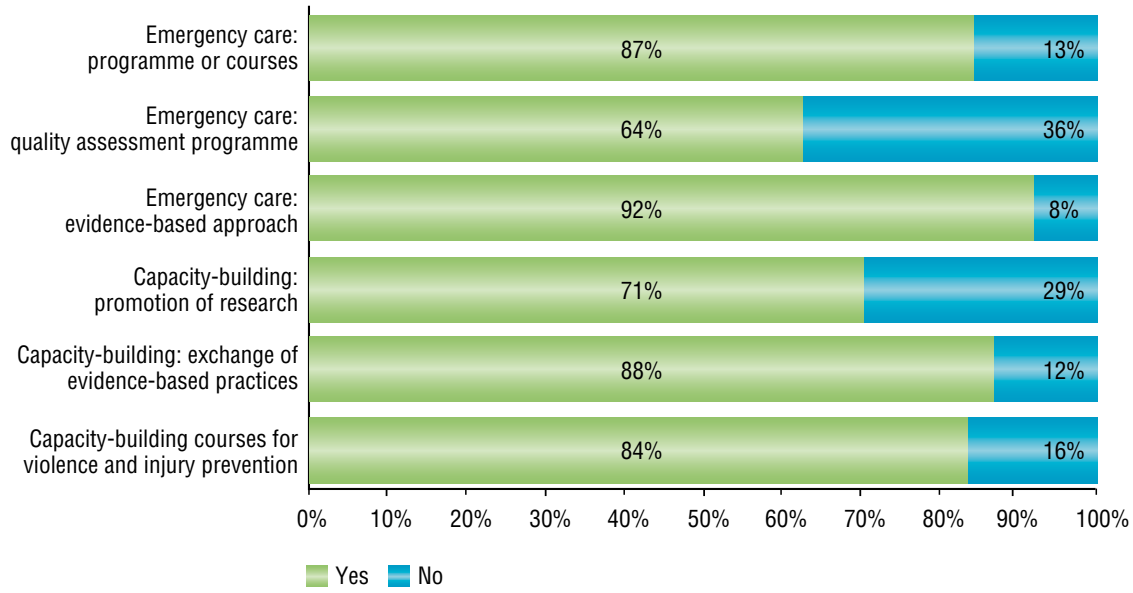
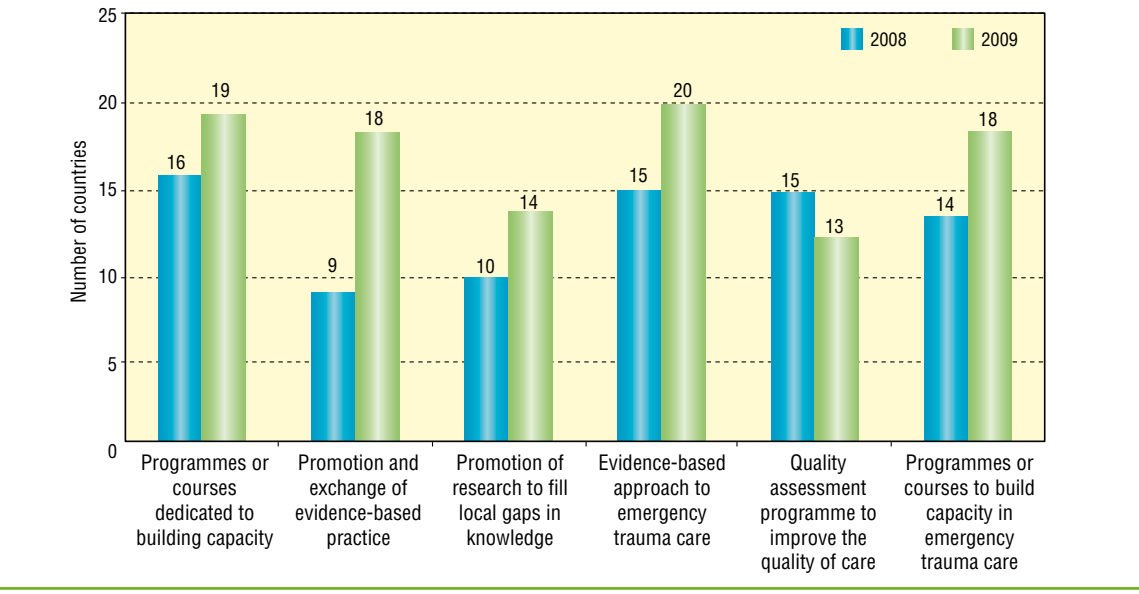


Fig. 7. Number of countries that have achieved steps essential to capacity-building, 2008 and 2009 (based on 21 responding countries)



A.2 Overview of the implementation of evidence-based interventions and programmes by type of injury or violence

Table 1 shows the distribution of the implementation scores for the whole WHO European Region and separately for the EU countries. With few exceptions, the situation is quite similar; the European Region as a whole has greater implementation for preventing poisoning, and the EU countries have greater implementation for intimate partner violence.

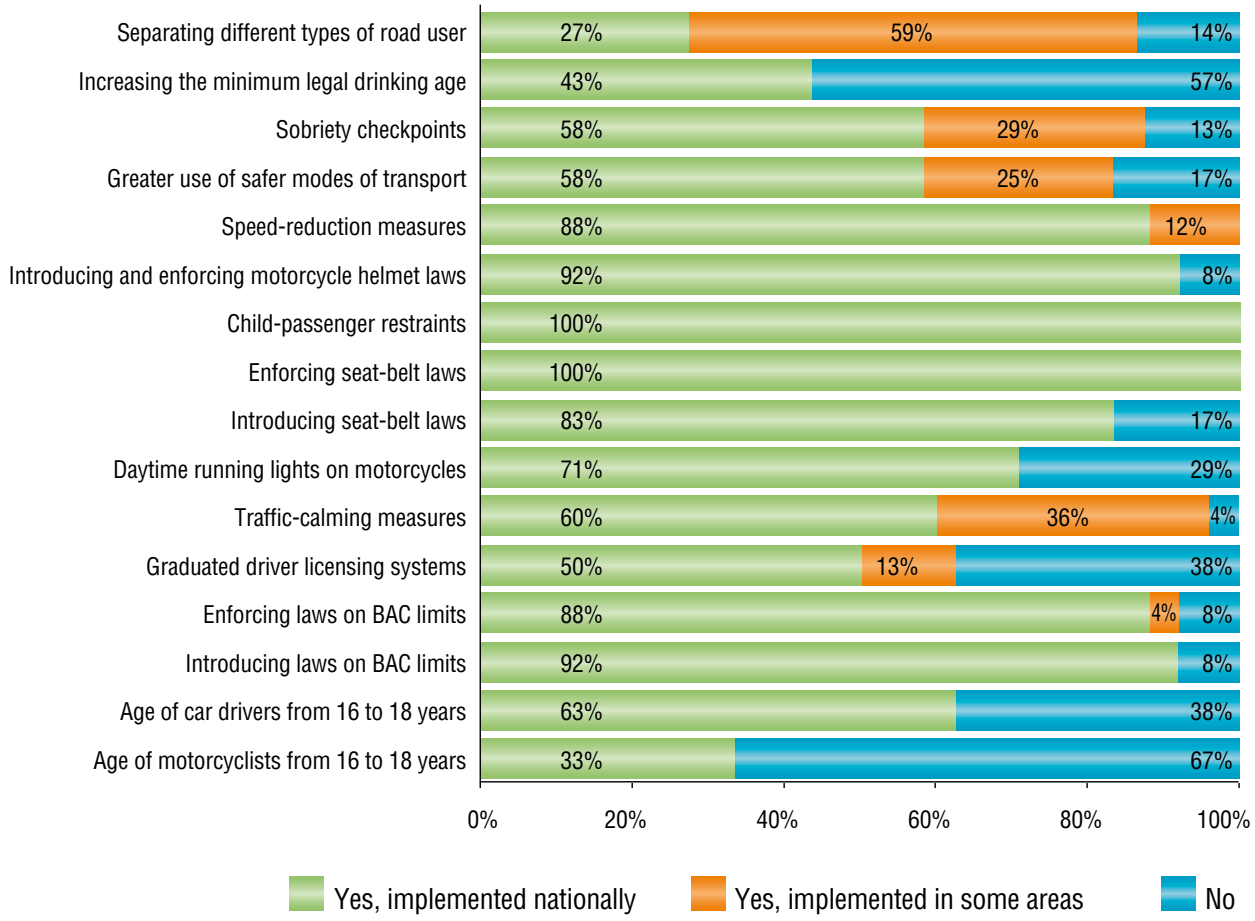
A.2.1 Implementation of evidence-based interventions and programmes for preventing road traffic injuries

For road safety, interventions on enforcing seat-belt laws and on child-passenger restraints have been fully implemented, and laws on helmets for motorcyclists and on blood alcohol concentration limits have been very highly implemented. In contrast, less than one third of the countries have implemented interventions on increasing the minimum age of motorcyclists from 16 to 18 years and on separating different types of road users (Fig. 8), and this warrants attention.

Table 1. Distribution of implementation of interventions in the EU and in the WHO European Region

Interventions	EU			WHO European Region		
	First quartile	Median	Third quartile	First quartile	Median	Third quartile
All interventions	**63**	**73**	**82**	**64**	**73**	**81**
Unintentional injuries	**66**	**72**	**77**	**60**	**72**	**80**
Road traffic injuries	75	81	88	69	81	94
Fires	40	60	80	40	60	80
Poisoning	60	60	100	60	80	100
Drowning	25	63	75	38	63	75
Falls	75	75	100	50	75	100
Intentional injuries	**68**	**81**	**97**	**65**	**81**	**94**
Youth violence	71	86	100	57	86	100
Child maltreatment	80	100	100	80	100	100
Intimate partner violence	50	100	100	50	75	100
Elder abuse	67	67	100	50	67	100
Self-directed violence	75	88	100	63	88	100
Alcohol	**65**	**76**	**88**	**59**	**76**	**82**
Alcohol (legal and fiscal)	64	71	86	57	71	86
Alcohol (health system)	33	83	100	33	67	100

Fig. 8. Do you have in place any of the following programmes for the preventing road traffic injuries?



BAC: blood alcohol concentration.

A.2.2 Programmes and interventions to prevent fires and burns

Improving building standards and restricting manufacture and sale of fireworks are the most frequently implemented interventions for preventing fires. Few countries have implemented interventions on modifying products and on laws on hot water temperature (Fig. 9). The rate of implementation of these interventions needs to be improved.

A.2.3 Programmes and interventions to prevent unintentional poisoning

Less than 40% of countries have implemented poisoning-related interventions on packaging drugs in non-lethal quantities, although 75% of the countries have a national-level poison-control centre (Fig. 10). Childproof closures need to be implemented more thoroughly.

A.2.4 Programmes and interventions to prevent drowning or submersion

Interventions on drowning and submersion have not been well implemented. The only exception is safety standards for swimming pools, which almost 70% of countries report being implemented at the national level. Introducing and enforcing laws on four-sided pool fencing is the area that requires most attention (Fig. 11). The low implementation levels may partly reflect the lack of national policy development.

Fig. 9. Do you have in place any of the following programmes for preventing fires or burns?

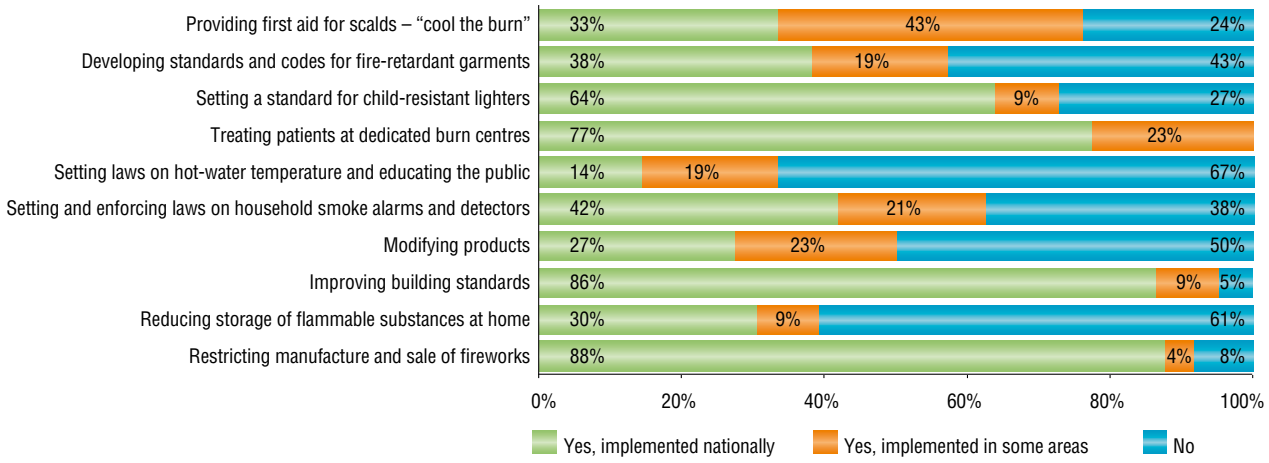


Fig. 10. Do you have in place any of the following programmes for preventing unintentional poisoning?

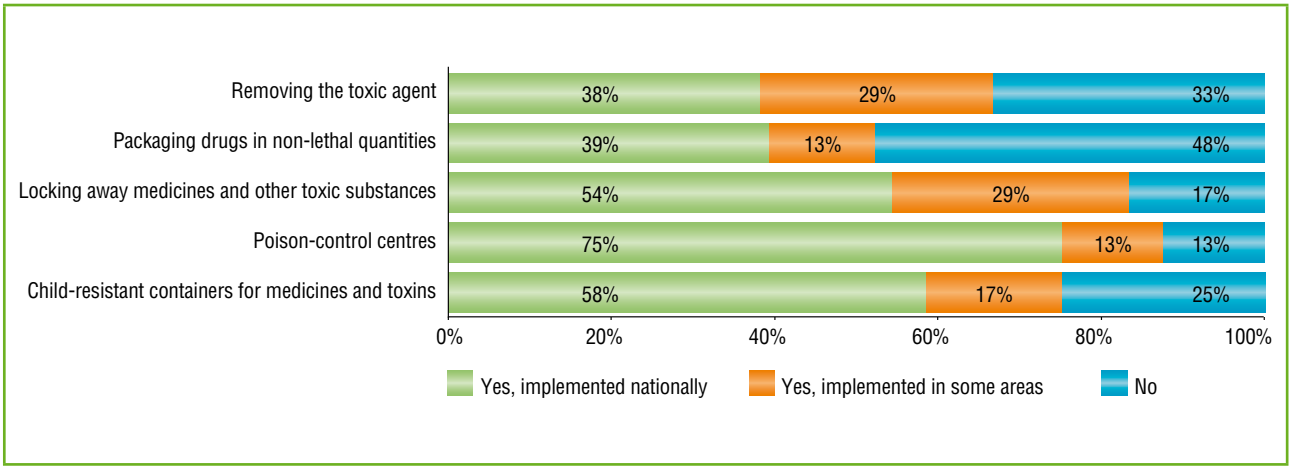


Fig. 11. Do you have in place any of the following programmes for preventing drowning or submersion?

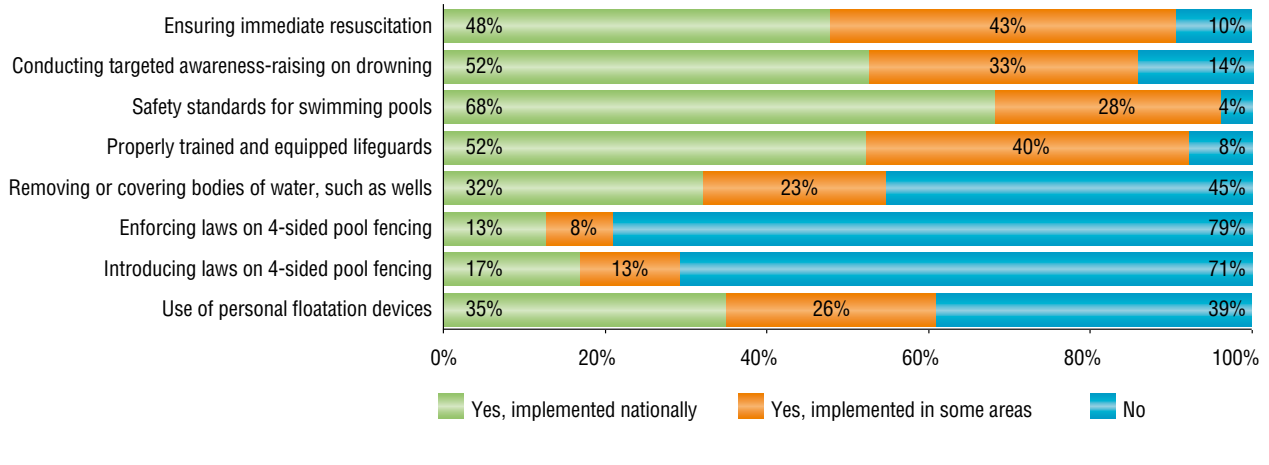
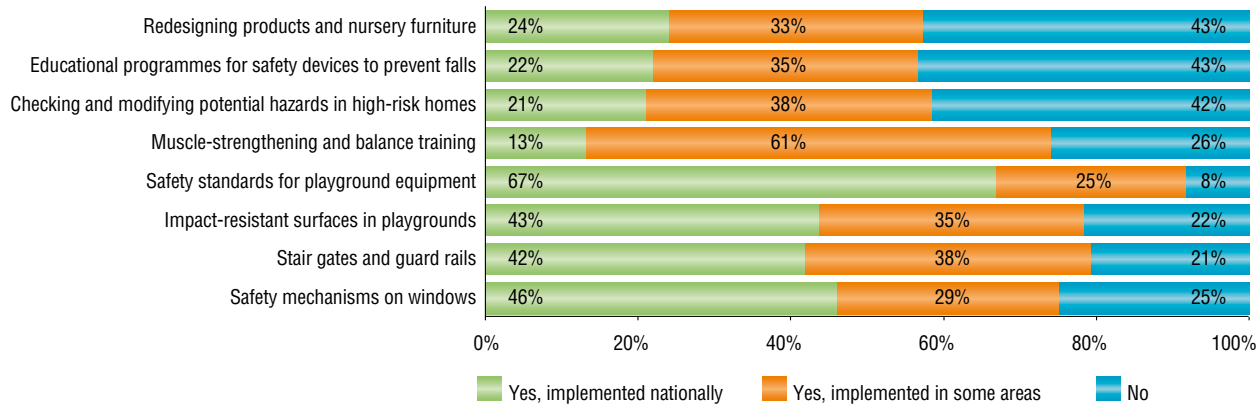


Fig. 12. Do you have in place any of the following programmes for preventing unintentional falls?



A.2.5 Programmes and interventions to prevent unintentional falls

Most of the interventions related to falls are implemented at the local level rather than nationally (Fig. 12). The low implementation levels may partly reflect the lack of national policy development. More widespread implementation is required.

A.2.6 Programmes and intervention to prevent youth violence

Programmes for preventing youth violence are widely implemented at the local level, but more national implementation is needed (Fig. 13).

A.2.7 Programmes and interventions to prevent child maltreatment

There is high implementation for programmes for preventing child maltreatment, although many are only applied locally. Improved prenatal and postnatal care at the national level was reported for 92% of the EU countries (Fig. 14). More nationwide implementation is needed for most of these measures.

A.2.8 Programmes and interventions to prevent intimate partner violence

Only one intervention dealing with intimate partner violence (changing norms to gender inequality) has been implemented at the national level by more than the half the EU countries (Fig. 15). The other interventions need to be more widely implemented.

Fig. 13. Do you have in place any of the following programmes for preventing youth violence?

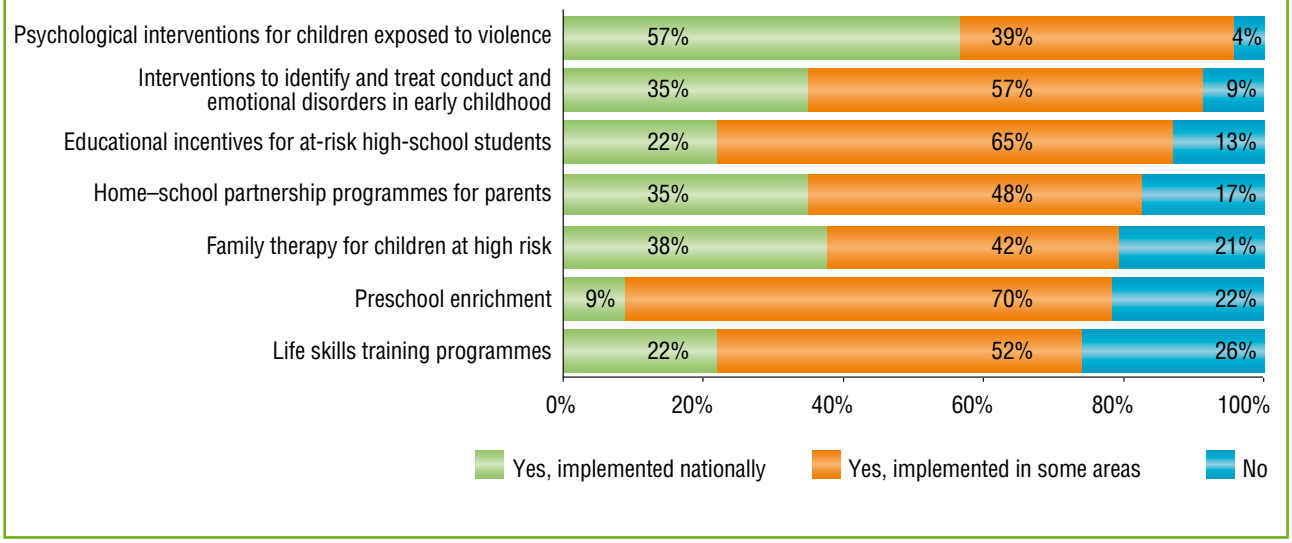


Fig. 14. Do you have in place any of the following programmes for preventing child maltreatment?

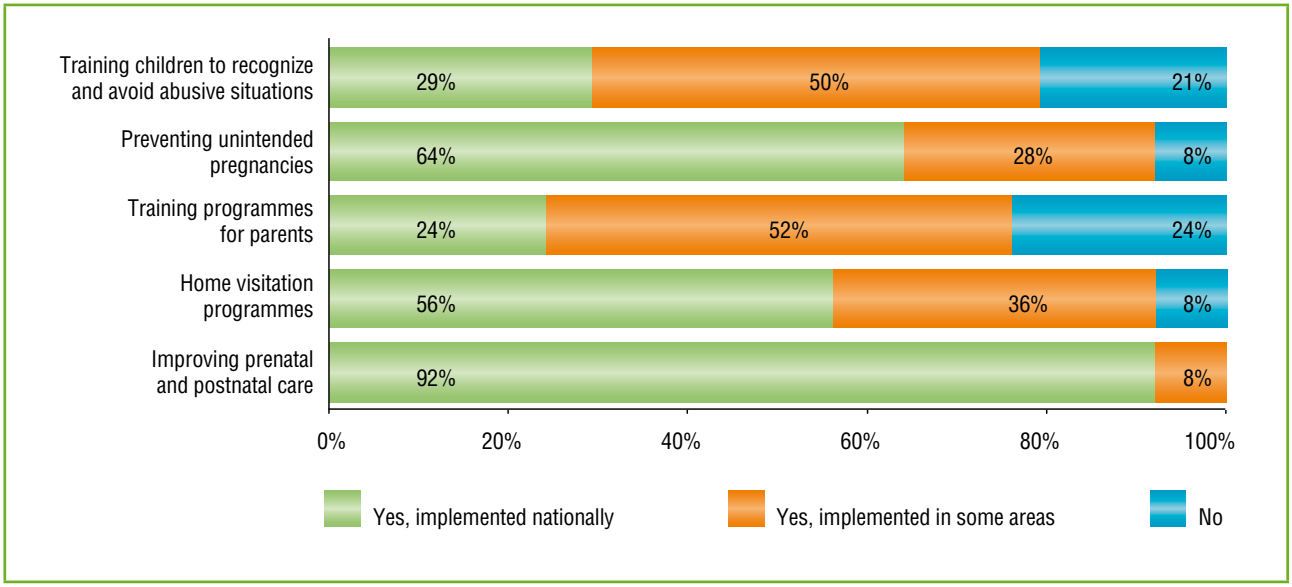


Fig. 15. Do you have in place any of the following programmes for preventing intimate partner violence?

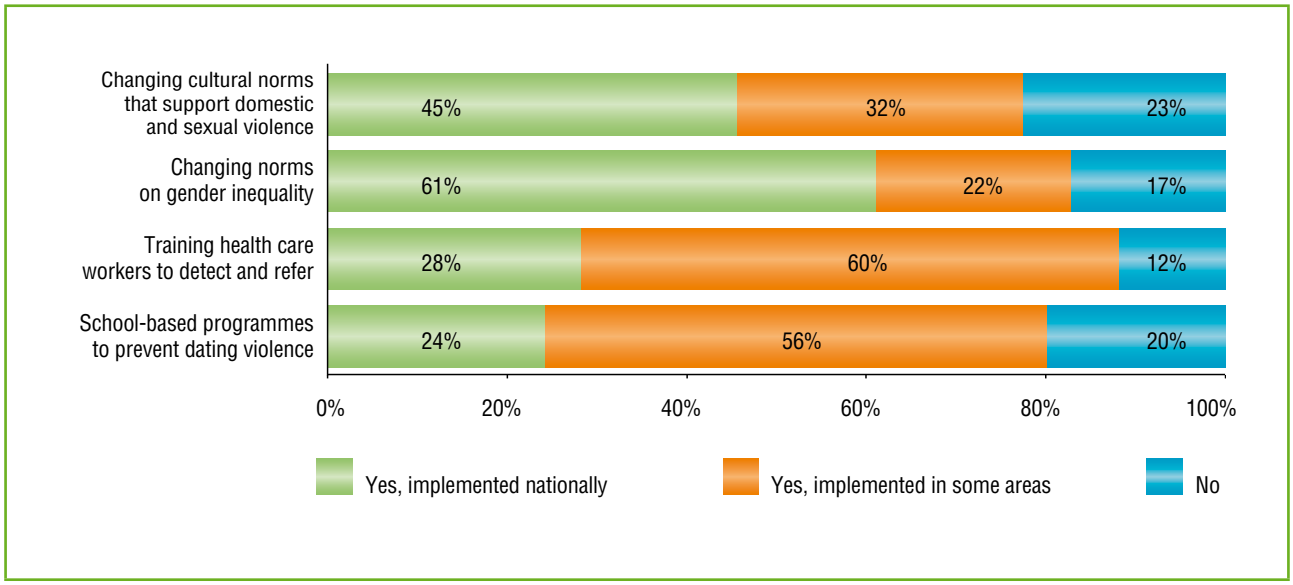


Fig. 16. Do you have in place any of the following programmes for preventing elder abuse?

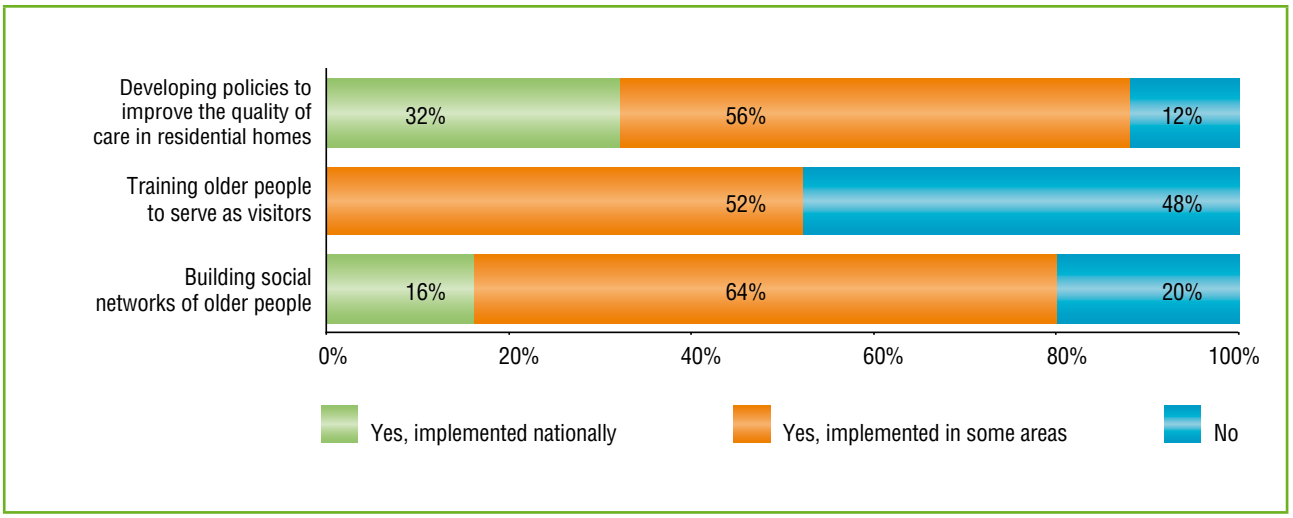
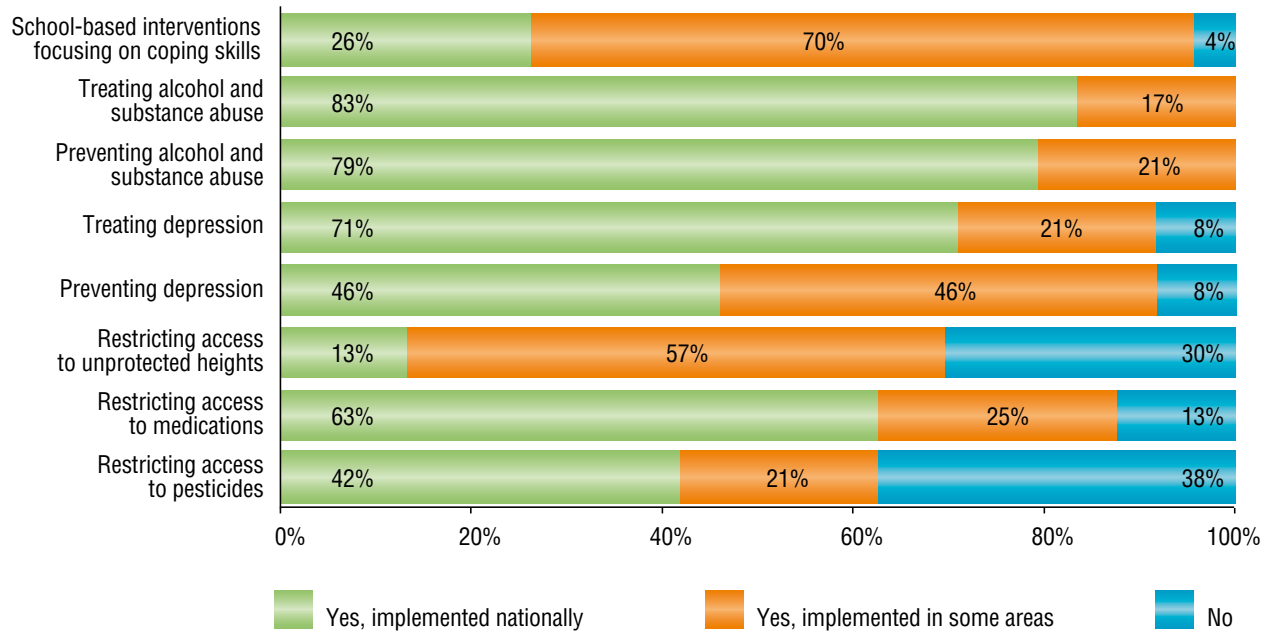


Fig. 17. Do you have in place any of the following programmes for preventing self-directed violence?



A.2.9 Programmes and interventions to prevent elder abuse

Low national-level implementation is reported for all the selected interventions (Fig. 16). Major improvements are needed for preventing elder abuse.

A.2.10 Programmes and interventions to prevent self-directed violence

The responding countries reported high national-level implementation for some interventions to prevent self-directed violence: 83% for treating alcohol and substance abuse, 79% for preventing alcohol and substance abuse and 71% for preventing depression. Other interventions are implemented more locally than nationally, and this could be an area of improvement (Fig. 17).

A.2.11 Programmes and interventions targeted at the societal level to reduce unintentional injuries and violence

Some interventions on cross-cutting issues, such as reducing the availability of firearms and drugs, are frequently implemented at the national level in the EU countries, whereas those concerned with reducing socioeconomic inequality and changing cultural norms on violence are infrequently implemented nationally (Fig. 18). This needs to be improved.

A.3 Programmes and interventions to reduce major risk factors for injuries and violence

A.3.1 Fiscal and legal interventions to prevent alcohol-related harm

All responding EU countries reported laws on restricting alcohol sales to minors. They reported high implementation of fiscal measures and of national rules to prevent the illegal production of alcohol. Further improvement is needed in reducing the number of retail outlets and on laws limiting the time periods during which alcohol can be sold in both off-licensed and on-licensed sales (Fig. 19).

Fig. 18. Do you have in place any of the following programmes for preventing injuries and violence?

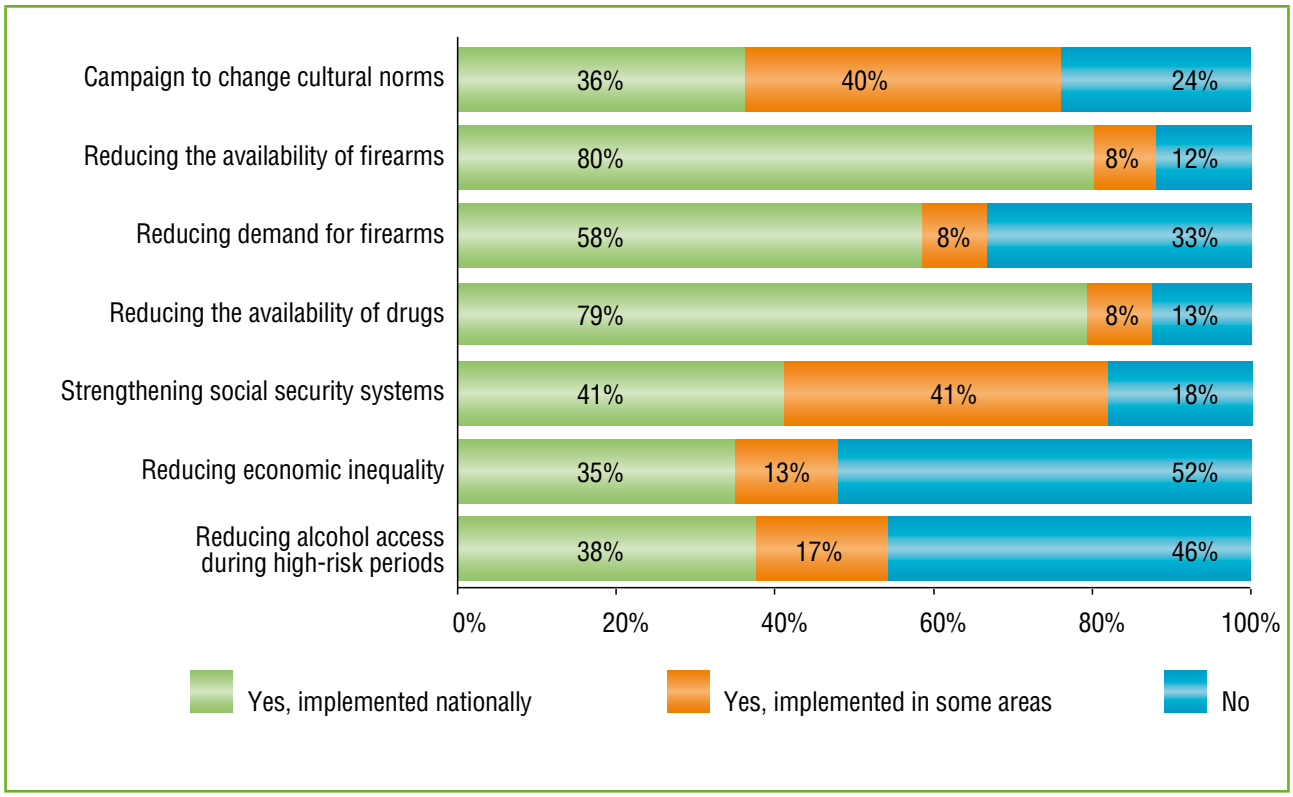
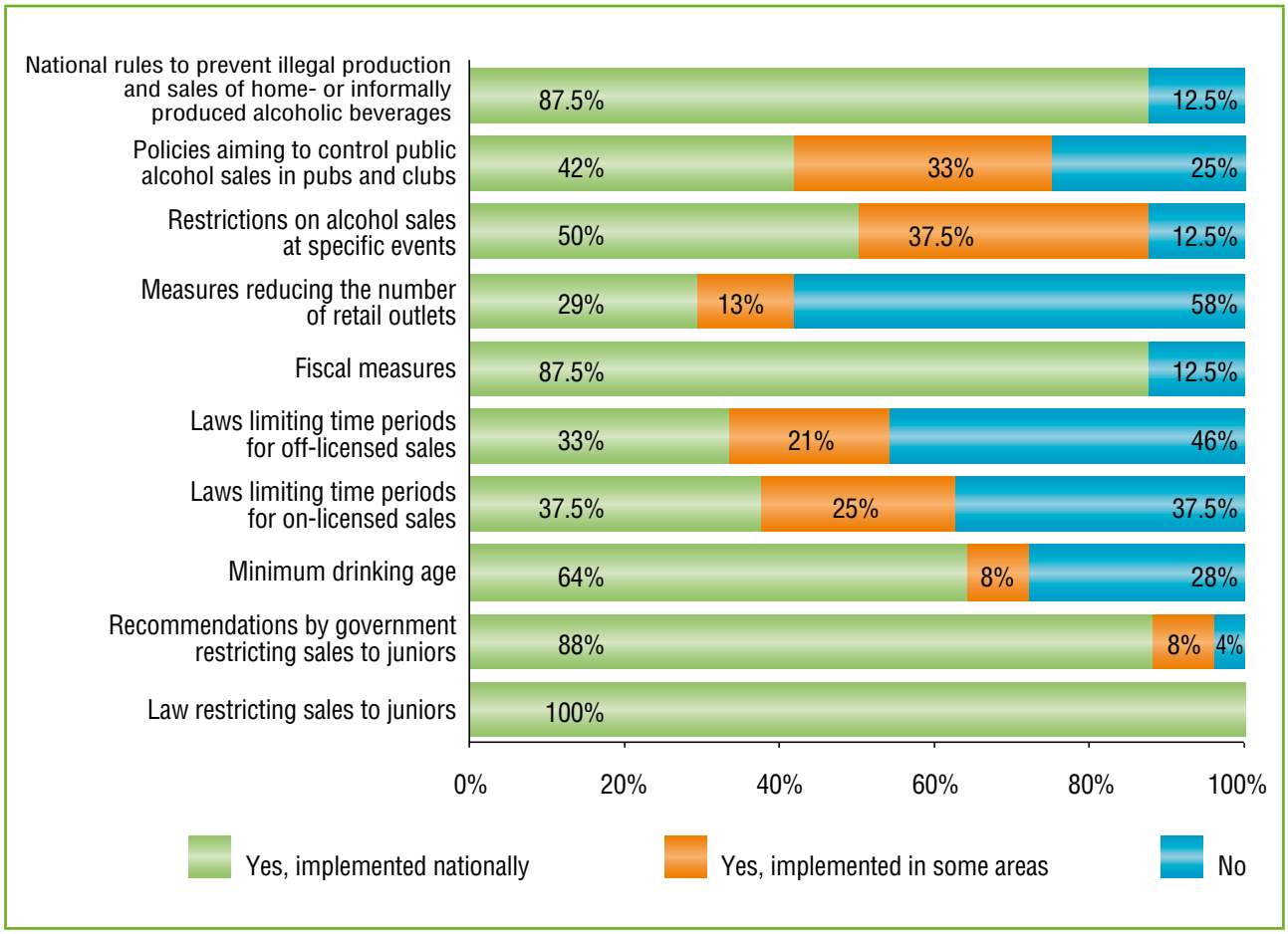


Fig. 19. Do you have in place any of the following fiscal and legal alcohol-related interventions to prevent alcohol-related harm?



A.3.2 Measures to restrict advertising to reduce alcohol related harm

Most EU countries do not totally ban alcohol advertising, especially on local radio and commercial television (Fig. 20).

A.3.3 Health system–based programmes to reduce alcohol-related harm

Health system–based interventions to reduce alcohol-related harm are implemented locally rather than nationally, and the health sector could do more to implement this more widely in the EU (Fig. 21).

A.3.4 Programmes to reduce socioeconomic differences

There is very low implementation at the national level of interventions targeting the reduction of socioeconomic inequality (Fig. 22). Addressing this area is of importance, especially given the economic downturn being experienced by many EU countries.

Fig. 20. Is alcohol advertising banned to prevent alcohol-related harm?

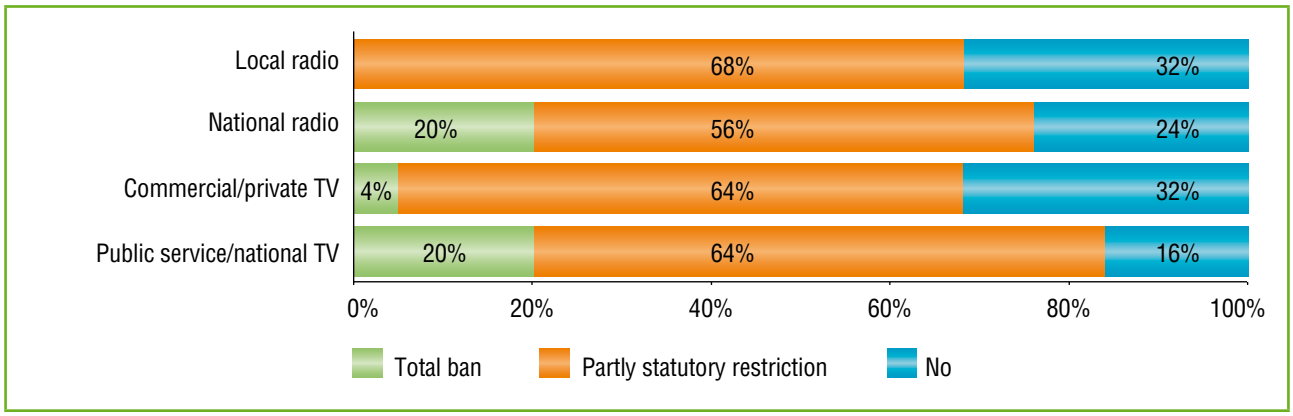


Fig. 21. Do you have in place any of the following health system–based interventions to reduce alcohol-related harm?

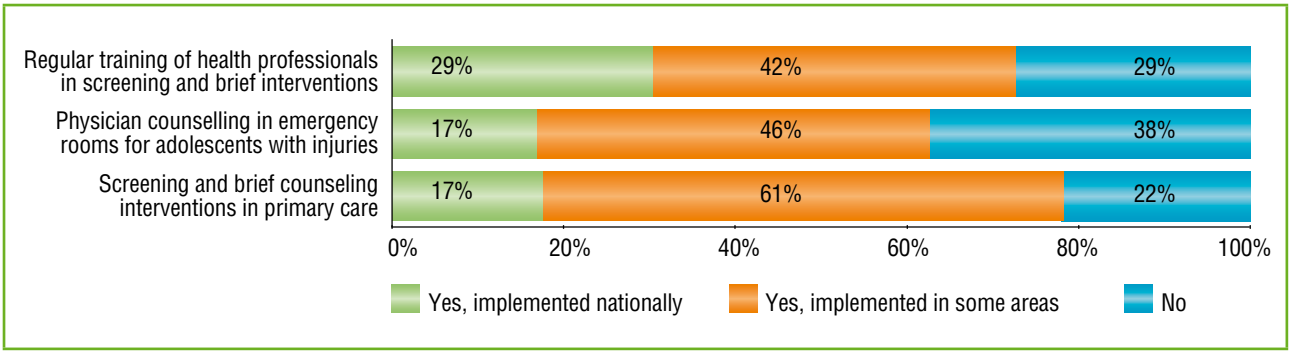
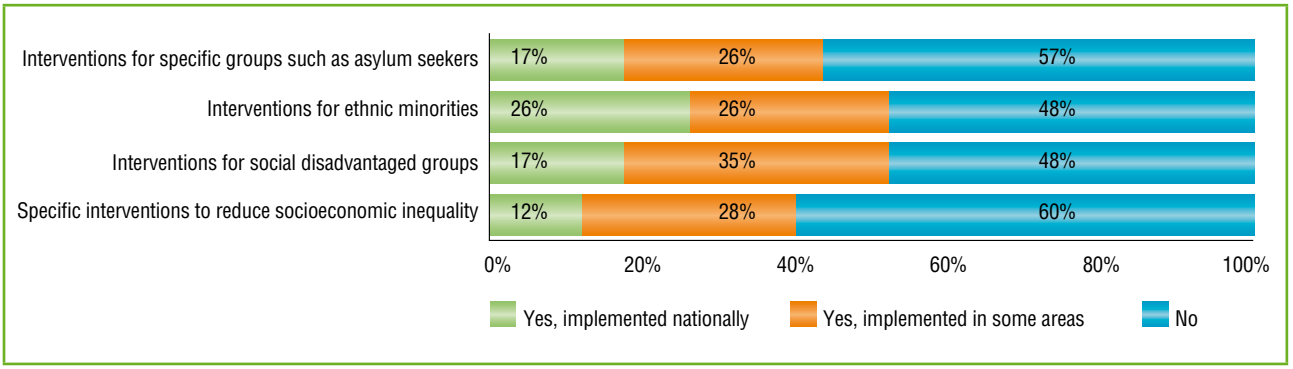


Fig. 22. Do you have in place any of the following interventions to reduce socioeconomic differences in injuries and violence?



A.4. Progress achieved in implementing evidence-based interventions for preventing injuries and violence between 2008 and 2009

Nineteen country respondents from the EU provided information on 59 interventions or programmes for preventing injuries and violence in 2008 and 2009. The overall percentage of implementation for all interventions increased from 70% to 75% in this time period (Table 2).

A.4.1 Change in implementation of interventions for preventing unintentional injuries

Implementation of 33 preventive interventions for all unintentional injuries increased from 68% to 73% between 2008 and 2009 (Fig. 23). Increases were reported for all types of injuries, with the largest for falls, poisoning and fires. Programming for drowning actually decreased, which is of concern since this is the leading cause of injury death among children younger than five years. Of interest, fewer countries have national policies for these types of unintentional injuries.

A.4.2 Change in implementation of interventions for preventing violence

The percentage of implementation for preventive interventions for all types of violence taken together improved from 73% to 79% between 2008 and 2009 (Fig. 24). Self-directed violence prevention and sexual violence had the largest increases and preventing child maltreatment, elder abuse and youth violence the smallest increases.

Table 2. Proportion of implementation of 59 interventions in 19 EU countries, 2008 and 2009 (means and 95% confidence intervals (CI))

Type of injury or violence	2008		2009	
	Mean	95% CI	Mean	95% CI
Total	**70**	**61–79**	**75**	**70–81**
Unintentional injuries	**68**	**61–76**	**73**	**67–79**
Road traffic injuries	77	68–86	80	74–86
Fires	51	37–66	59	47–71
Poisoning	67	50–84	75	62–89
Drowning	66	52–80	59	46–72
Falls	62	47–76	71	56–87
Violence	**73**	**60–85**	**79**	**71–86**
Youth violence	54	39–68	72	58–85
Child maltreatment	79	63–95	88	79–97
Intimate partner violence	66	48–84	84	71–97
Elder abuse	51	44–68	68	55–82
Sexual violence	47	25–70	68	48–89
Self-directed violence	57	40–73	83	72–94

Fig. 23. Proportion of implementation of interventions for unintentional injuries in 19 EU countries, 2008 and 2009

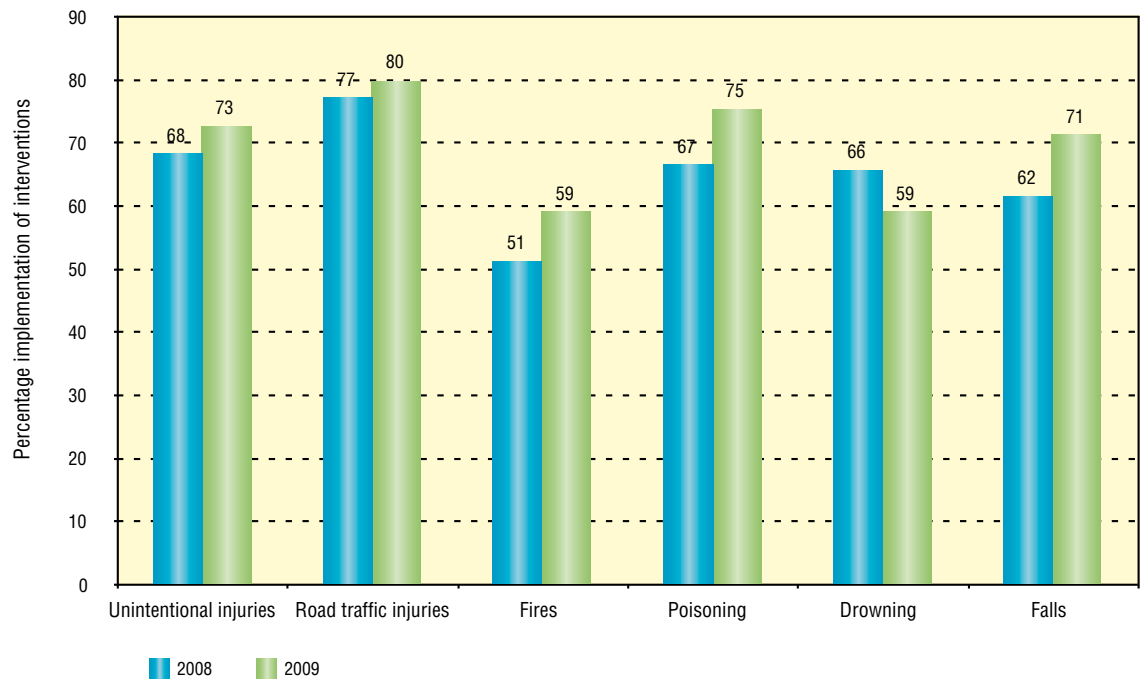
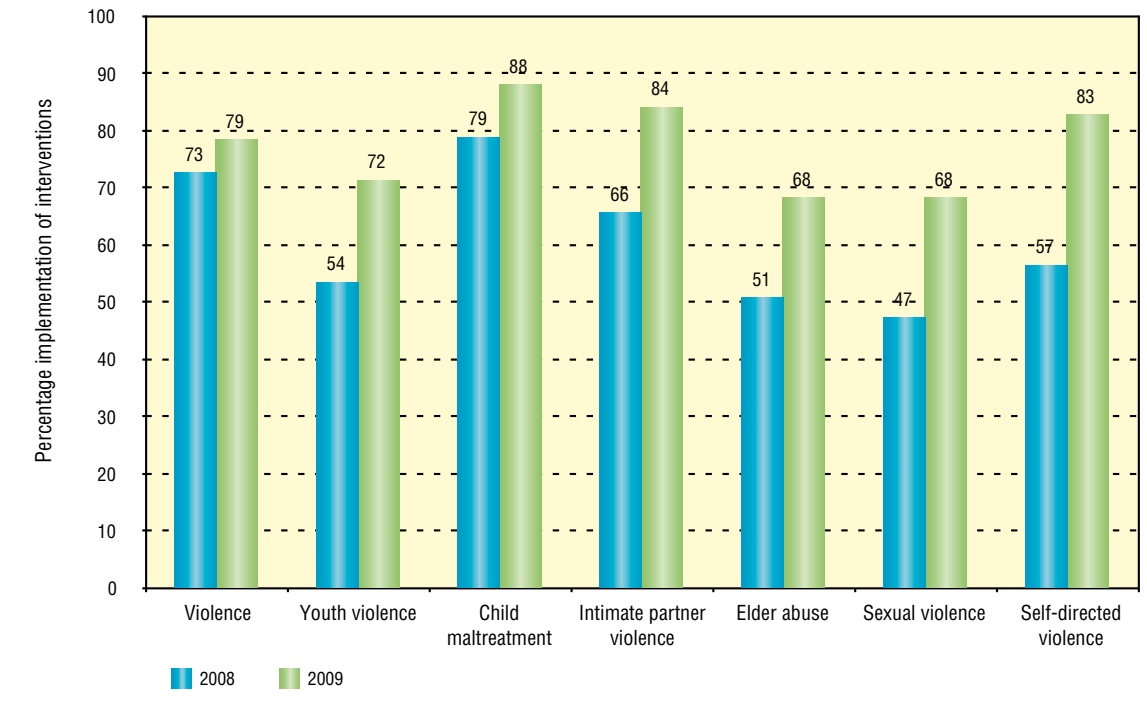


Fig. 24. Proportion of implementation of interventions for preventing violence in 19 EU countries, 2008 and 2009



A.5 Conclusion

A.5.1 Progress made and remaining challenges

Twenty-five EU countries responded to the survey (response rate 96%). This is an improvement from previous years. Only one country with a focal person appointed by the health ministry did not respond. Encouragingly, some large countries, such as France and Italy, participated in the survey. Countries with a federal structure such as Germany also participated despite the difficulty in collecting data. Future surveys need to have instruments adapted to take account of these contextual differences.

There are not many differences between the EU countries and the countries of the WHO European Region as a whole. For the whole Region, this report shows sustained and increasing collaboration between EU countries, the European Commission and WHO. This has been associated with good progress in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety. These European policies have been a catalyst for change, as evidenced by 70% of the responding countries stating that this has placed the prevention of violence and injuries higher on the national policy agenda and has stimulated action. Further, this past year has witnessed encouraging progress in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and the promotion of safety: 67% of countries reported national policy development, 72% surveillance, 60% capacity-building and 84% multisectoral collaboration. Only 46% of the countries progressed on evidence-based emergency care from 2008 to 2009. Ninety-six per cent of the countries reported having favourable policy environments, with political support for formulating national policies for preventing violence and injuries and with the health sector taking a lead role in coordination, working with other sectors to achieve implementation. However, only 56% have a budget to support activities, and this needs to be improved to enhance coordination by the health sector and implementation.

A.5.1.1 Progress made in preventing unintentional injuries and remaining challenges

In terms of national policy development, 62% of countries have integrated policies for unintentional injury, and this represents an increase of 24 percentage points from 2008 in countries with comparable data. Many countries have also developed national policies for individual types of injury. Whereas most countries have a national policy for road safety (96%), only 60% of countries have national policies on fires and poisoning and half or less on falls (46%) and drowning (50%). The lack of policy is probably reflected in the fact that evidence-based interventions for these types of injuries are relatively infrequently implemented nationally. The median implementation of drowning-, poisoning- and falls-related interventions are among the lowest (about 60%); this is a cause for concern, and more action is needed. Of even greater concern is the fact that programming for preventing drowning was reported as having decreased since 2008, and improvements in programming for other types of injuries have been relatively small.

A.5.1.2 Progress made in preventing violence and remaining challenges

There are integrated policies for preventing violence in 44% of countries, an increase of 19 percentage points compared with 2008. The adoption of national policies for specific types of violence varied in the responding countries. This was quite high for child maltreatment and intimate partner violence (88% of the countries in both cases and the median implementation of intervention equal to 100%) but lower for elder abuse (44%), self-directed violence (57%) and sexual violence (64%). Youth violence is perceived as a growing problem in many countries, and more countries need to develop policies to prevent it: only two thirds of EU countries have a specific national policy. However, the median implementation rate is quite high (88%), although in most countries these programmes were implemented in some areas rather than nationwide. Several important interventions for preventing youth violence require leadership by the education and health sectors. The health sector could contribute by

playing a coordinating role, by sharing information and through evaluation. Preventing elder abuse is another challenge in the EU, especially given the demographic trends. Less than half the countries have a specific national policy, and the median implementation rate was 67%, the lowest among the violence-related interventions. Health systems can ensure that elder abuse does not happen in residential homes; other approaches involve engaging civil society and empowering older people to prevent violence. For most types of violence, the current main challenge is to expand the coverage of evidence-based programmes to the national level.

A.5.1.3 Progress made in reducing risk factors for violence and injuries and remaining challenges

The importance of alcohol as a leading risk factor for both injuries and violence is widely recognized in the EU. Encouragingly, 88% of the responding countries reported that alcohol has been identified as a risk factor in national policies for both unintentional injuries and violence, and this is higher when the Region is considered as a whole. Of the alcohol-related interventions, 76% were implemented, but alcohol-related mortality rates are high in several countries. However, 71% of fiscal and legal alcohol-related interventions and 83% of health system–based programmes were implemented, which is encouraging. However, the latter were implemented more locally than nationally, and their coverage should improve. Of particular concern is the low number of countries implementing interventions to limit alcohol sales. It is cause for concern that there are no bans for advertising on local radio and that only 4% of countries apply this for commercial television.

Only 36% of the EU countries reported that national policies highlight socioeconomic inequality in injuries and violence as a priority, and only 52% have policies targeting the reduction in socioeconomic differences in health between segments of society. There is low implementation of interventions targeting disadvantaged groups to reduce socioeconomic differences, and redressing this would be important to attain greater equity. The health sector needs to improve access to services for disadvantaged people but also work with other sectors to improve preventive and support services for the people at risk, to reduce differential exposure to risk and to reduce social stratification.

A.5.2 The way forward and next steps

The health sector and partners need sustained action to reduce the inequality in violence and injury between and within EU countries. The progress mapped in this report is encouraging and emphasizes the fact that only political and resource commitment by countries and international organizations can sustain future success. The key steps forward are listed below.

1. Build on current achievements with greater development of national policies and achieve more widespread implementation of evidence-based programmes in EU countries.
2. Reinvigorate political commitment and collaboration between WHO, the European Commission, countries and civil society to maintain the momentum that has been achieved.
3. Improve access to reliable and comparable injury surveillance information to make the extent, causes and effects of the problem more visible across the EU.
4. Use research and routine information systems to evaluate policies and programmes, with an emphasis on using outcome indicators to increase the body of knowledge in the EU.
5. Step up existing efforts in building institutional capacity and train professions from health and other sectors by mainstreaming courses such as TEACH-VIP into educational curricula.
6. Address the capacity-building needs to improve high-quality trauma care services in the EU.
7. Maintain support for the existing network of health ministry focal people for preventing violence and injuries and promote the exchange of experience and expertise at the subregional level.
8. Seek new opportunities and make better use of collaborative working with other sectors and networks, including academe and civil society organizations.

9. Conduct future evaluations using comparable policy indicators to those reported here and outcome measures.
10. Ensure that international collaboration that results in local implementation is sustained.
11. Increase investment in resources and political commitment to:
    - exploit the above opportunities to the fullest;
    - build on existing progress;
    - fill the gaps identified in this report, and
    - increase momentum in countries and in the EU.

ANNEX 2. QUESTIONNAIRE USED

World Health Organization
Regional Office for Europe

Weltgesundheitsorganisation
Regionalbüro für Europa

Organisation mondiale de la santé
Bureau régional de l'Europe

Всемирная организация здравоохранения
Европейское региональное бюро

PREVENTION OF INJURIES IN THE EUROPEAN REGION
QUESTIONNAIRE TO MONITOR THE IMPLEMENTATION OF
WHO REGIONAL COMMITTEE RESOLUTION RC55/R9

Injuries are a leading cause of death in the European Region. As a response, in 2005 the WHO Regional Committee for Europe adopted a resolution on the Prevention of injuries (EUR/RC55/R9) with strong support from Member States. Ministry of Health Focal Persons for Violence and Injury Prevention are reporting on progress in implementing the resolution by completing this questionnaire annually. It is now time to fill the questionnaire to record progress made in the last 12 months again and we would be very grateful were you to take the time needed to complete this questionnaire.

The questionnaire is almost identical to the one filled last year but has additional questions on programmes for alcohol control policies (45-53) and social determinants of injuries (54-59). These have been included in response to requests made at the 4th focal persons meeting in Helsinki on 10-11 November 2008. These additional questions have been placed at the end of the questionnaire.

Questions 1-9 concern key items of the Regional Committee Resolution and are expected to provide a useful update as to how well implementation is going. Questions 10-15 are meant to help us to identify national policies in the various areas of injury prevention (e.g. road safety) and violence prevention (e.g. youth violence). Question 16 is concerned with new developments in the past 12 months. Questions 17-41 enquire about whether evidence-based injury and violence prevention programmes exist in your country for different mechanisms of injury and types of violence, and questions 42-44 are about the processes involved. As stated above, new questions have been added in 2009: questions 45-53 on alcohol control measures, and questions 54-59 on socioeconomic determinants. The responses to the questionnaires will be entered onto a database and the information made available to focal persons as a resource through a web based tool.

INSTRUCTIONS TO FILL THE QUESTIONNAIRE

Please assist us by ticking the appropriate answer and providing as much additional information to enable us to undertake this important assignment. If you do not know the answers to questions yourself, please try and obtain the information by contacting relevant departments or organisations in your country.

- If you already filled the questionnaire in 2008, then some of the answers to questions 1-44 may need to be updated in view of policy developments in your country. Please note that some minor changes have been made to questions 2, 4, 10, 17, 19, 23, 27, 29, 31 and 43. This is to incorporate new evidence which has emerged. You may refer to your previous responses but please answer all the questions.

- If you have not filled the questionnaire in 2008, then please answer **all** the questions.

To allow time to complete the report, we would be grateful if you could fill the questionnaire and send it by 31st May, 2009. We will be sharing the results of the Regional response to injuries and violence with yourselves at the next focal persons meeting in autumn 2009.

Please e-mail it to:
violenceinjury@ecr.euro.who.int

Country: Select your country from the list

Date of reporting:

Name of respondent:

Title of respondent:

Email address:

Postal address:

Telephone number:

Q1a) Is there a commitment to develop national plans or policies for injury and violence prevention?

○ YES ○ NO

Q1x) Please provide more details if available:

If you answered YES to Q1a, as part of this have the following activities been undertaken:

Q1b) a definition of the size of the injury and violence problem:

○ YES ○ NO

Q1xi) Please provide more details if available:

Q1c) an assessment of existing policy response (e.g. a national plan or policy)?

○ YES ○ NO

Q1xii) Please provide more details if available:

Q1d) an assessment of the interventions in place?

○ YES ○ NO

Q1xiii) Please provide more details if available:

Q2a) Do you have easy access to surveillance data on the different types of injuries and violence, which could help you to prioritize in formulating a plan and to monitor its progress?

○ YES ○ NO

Q2x) If you answered YES to Q2a, please provide more details on the overall data quality:

Q2b) If you answered YES to Q2a, are injury data available by smaller geographical sub-national areas?

○ YES ○ NO

Q2c) If you answered YES to Q2b, please specify if this is available by (tick all that apply):

Region ☐
Province ☐
District ☐
Municipality ☐
Electoral ward/ Neighbourhood ☐

Q3a) Has political support been gained for the injury and violence prevention agenda?

○ YES ○ NO

Q3x) Please illustrate your answer with examples. Examples include presidential support, inter-ministerial support, ministerial support, director support, public statements by political leaders, etc

Q4a) Has the process of identifying key stakeholders been undertaken?

◯ YES ◯ NO

Q4x) If you answered YES to Q4a, please provide details on which stakeholders have been identified and list stakeholders separately for injuries and violence

Q4b) If you answered YES to Q4a, has a list of key players from different sectors been drawn up?

◯ YES ◯ NO

Q4xi) Please provide more details if available:

4c) If you answered YES to Q4a, have the different stakeholders been already involved in the proposed policy development?

◯ YES ◯ NO

Q4xii) Please provide more details if available:

Q5a) Is there an intersectoral committee that meets regularly to take the injury and violence prevention agenda forward?

◯ YES ◯ NO

Q5x) If you answered YES to Q5a, please provide more details if available:

Q5b) Is there a secretariat to support the injury prevention committee?

◯ YES ◯ NO

Q5c) If you answered YES to Q5b, is this secretariat in the form of focal persons?

◯ YES ◯ NO

Q5d) Is there a budget to support activities?

◯ YES ◯ NO

Q5xi) Are there other resources made available to help it deliver its function such as meeting rooms, administrative support, printing, communication?

Q6a) Have outcomes and priorities for action in injury and violence prevention been agreed upon by key stakeholders?

◯ YES ◯ NO

Q6x) If you answered YES to Q6a, are steps being undertaken to formulate these into action? Please provide more details if available.

Q7a) Are there specific programmes or courses dedicated to building capacity in injury and violence prevention?

◯ YES ◯ NO

Q7x) Please provide more details if available:

Q7b) Is the promotion and exchange of evidence-based practice part of this process?

◯ YES ◯ NO

Q7xi) Please provide more details if available:

Q7c) Is the promotion of research to fill local gaps in knowledge part of this process?

◯ YES ◯ NO

Q7xii) Please provide more details if available:

Q8a) Is there an evidence-based approach to emergency trauma care?

◯ YES ◯ NO

Q8x) Please provide more details if available:

Q8b) Is there a quality assessment programme to improve the quality of care?

○ YES ○ NO

Q8xi) Please provide more details if available:

Q8c) Are there programmes or courses to build capacity in emergency trauma care?

○ YES ○ NO

Q8xii) Please provide more details if available:

Q9a) Has the adoption of resolution RC55/R9 contributed to catalyze change with respect to the prevention of violence and injuries in your country?

○ YES ○ NO

Q9x) If you answered YES to Q9a, please briefly describe the changes that have been prompted/facilitated by the Resolution

PLEASE ANSWER QUESTIONS 10-12 IF YOU WORK IN THE AREA OF INJURY PREVENTION

Q10) Is there an overall national policy on injury prevention?

For the purpose of this survey, an injury prevention policy is a document that sets out the main principles and defines goals, objectives, prioritised actions and coordination mechanisms, for preventing injuries and reducing their health consequences

○ YES ○ NO

Q10a) If you answered YES to Q10, and this is not for all age or risk groups, then please specify age or risk groups this applies to:

Q10b) If you answered YES to Q10, have targets been set as part of the national policy or plans (e.g. to reduce injury mortality by 20% by 2010)?

◯ YES ◯ NO

Q10x) Please provide more details if available:

10c) If you answered YES to Q10, is there a budget for the implementation of the national policy or plans?

◯ YES ◯ NO

Q10xi) Please provide more details if available:

Q11) Is there a policy on the prevention of any of the following categories of unintentional injuries?

Category	**Response**
Q11a) Road safety/traffic injuries	◯ YES ◯ NO
Q11x) If yes, please provide title and web-link:	
Q11b) Accidental falls	◯ YES ◯ NO
Q11xi) If yes, please provide title and web-link:	
Q11c) Accidental drowning and submersion	◯ YES ◯ NO
Q11xii) If yes, please provide title and web-link:	
Q11d) Accidental poisoning	◯ YES ◯ NO
Q11xiii) If yes, please provide title and web-link:	
Q11e) Accidents caused by smoke, fire and flames	◯ YES ◯ NO
Q11xiv) If yes, please provide title and web-link:	

Q12) If any of these policies exist and are not available on the web, are they available as:

Q12a) Electronic copies	○ YES ○ NO
Q12b) Hard copies	○ YES ○ NO

Please provide us with copies of these policies if you have answered YES to question 12.

PLEASE ANSWER QUESTIONS 13-15 IF YOU WORK IN THE AREA OF VIOLENCE PREVENTION

Q13) Is there an overall national policy on violence prevention?
For the purpose of this survey, a violence-related injury prevention policy is a document that sets out the main principles and defines goals, objectives, prioritised actions and coordination mechanisms, for preventing violence and reducing the health consequences.

○ YES ○ NO

Q14) Is there a policy on the prevention of any of the following categories of violence-related injuries?

Category	**Response**
Q14a) Interpersonal violence	○ YES ○ NO
Q14x) If yes, please provide title and web-link:	
Q14b) Youth violence	○ YES ○ NO
Q14xi) If yes, please provide title and web-link:	
Q14c) Child abuse and neglect	○ YES ○ NO
Q14xii) If yes, please provide title and web-link:	
Q14d) Intimate partner or domestic violence	○ YES ○ NO
Q14xiii) If yes, please provide title and web-link:	
Q14e) Elder abuse and neglect	○ YES ○ NO
Q14xiv) If yes, please provide title and web-link:	
Q14f) Sexual violence	○ YES ○ NO
Q14xv) If yes, please provide title and web-link:	
Q14g) Self-directed violence	○ YES ○ NO
Q14xvi) If yes, please provide title and web-link:	

Q15) If any of these policies exist and are not available on the web, are they available as:

Q15a) Electronic copies	○ YES ○ NO
Q15b) Hard copies	○ YES ○ NO

Please provide us with copies of these policies if you have answered YES to question 15.

Q16) Have there been any new developments in violence and injury prevention in your country over the past twelve (12) months in any of the following areas? You may wish to refer to your responses to questions 1-8 in answering these.

Q16a) National policy

○ YES ○ NO

Q16x) If YES, please briefly describe these developments

Q16b) Surveillance

○ YES ○ NO

Q16xi) If YES, please briefly describe these developments

Q16c) Multisectoral collaboration

○ YES ○ NO

Q16xii) If YES, please briefly describe these developments

Q16d) Capacity building

○ YES ○ NO

Q16xiii) If YES, please briefly describe these developments

Q16e) Evidence-based emergency care

○ YES	○ NO

Q16xiv) If YES, please briefly describe these developments

Q17) Do you have in place any of the following programmes for the prevention of road traffic injuries? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q17a) Increasing the legal age of motorcyclists from 16 to 18 years	○ NO	○ Some areas	○ Nationally
Q17b) Increasing the legal age of drivers from 16 to 18 years	○ NO	○ Some areas	○ Nationally
Q17c) Introducing laws on blood alcohol concentration limits	○ NO	○ Some areas	○ Nationally
Q17d) Enforcing laws on blood alcohol concentration limits	○ NO	○ Some areas	○ Nationally
Q17e) Graduated driver licensing systems	○ NO	○ Some areas	○ Nationally
Q17f) Traffic-calming measures	○ NO	○ Some areas	○ Nationally
Q17g) Daytime running lights on motorcycles	○ NO	○ Some areas	○ Nationally
Q17h) Introducing seat-belt laws	○ NO	○ Some areas	○ Nationally
Q17i) Enforcing seat-belt laws	○ NO	○ Some areas	○ Nationally
Q17j) Child-passenger restraints	○ NO	○ Some areas	○ Nationally
Q17k) Introducing and enforcing motorcycle helmet laws	○ NO	○ Some areas	○ Nationally
Q17l) Speed-reduction measures	○ NO	○ Some areas	○ Nationally
Q17m) Making greater use of safer modes of transport	○ NO	○ Some areas	○ Nationally
Q17n) Sobriety checkpoints	○ NO	○ Some areas	○ Nationally
Q17o) Increasing the minimum legal drinking age	○ NO	○ Some areas	○ Nationally
Q17p) Separating different types of road user	○ NO	○ Some areas	○ Nationally

Q18) Please provide information on any other programmes in place for the prevention of road traffic injuries not listed in Q17

Q19) Do you have in place any of the following programmes for the prevention of fires or burns? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q19a) Restricting the manufacture and sale of fireworks	○ NO	○ Some areas	○ Nationally
Q19b) Reducing storage of flammable substances in households	○ NO	○ Some areas	○ Nationally
Q19c) Improving building standards	○ NO	○ Some areas	○ Nationally
Q19d) Modifying products – for example, kerosene stoves, cooking vessels and candle holders	○ NO	○ Some areas	○ Nationally
Q19e) Setting (and enforcing) laws on the implementation of smoke alarms and detectors	○ NO	○ Some areas	○ Nationally
Q19f) Setting laws on hot-water temperature and educating the public	○ NO	○ Some areas	○ Nationally
Q19g) Treating patients at dedicated burns centres	○ NO	○ Some areas	○ Nationally
Q19h) Setting a standard for child-resistant lighters	○ NO	○ Some areas	○ Nationally
Q19i) Developing standards and codes for fire retardant garments	○ NO	○ Some areas	○ Nationally
Q19j) Providing first aid for scalds – "cool the burn"	○ NO	○ Some areas	○ Nationally

Q20) Please provide information on any other programmes in place for the prevention of fire or burns not listed in Q19

Q21) Do you have in place any of the following programmes for the prevention of accidental poisoning? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q21a) Child-resistant containers for medicines and toxins	○ NO	○ Some areas	○ Nationally
Q21b) Poison-control centres	○ NO	○ Some areas	○ Nationally
Q21c) Locking away medicines and other toxic substances	○ NO	○ Some areas	○ Nationally
Q21d) Packaging drugs in non-lethal quantities	○ NO	○ Some areas	○ Nationally
Q21e) Removing the toxic agent	○ NO	○ Some areas	○ Nationally

Q22) Please provide information on any other programmes in place for the prevention of accidental poisoning not listed in Q21

Q23) Do you have in place any of the following programmes for the prevention of drowning or submersion? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q23a) Use of personal floatation devices	○ NO	○ Some areas	○ Nationally
Q23b) Introducing laws on 4-sided pool fencing	○ NO	○ Some areas	○ Nationally
Q23c) Enforcing laws on 4-sided pool fencing	○ NO	○ Some areas	○ Nationally
Q23d) Removing or covering bodies of water, such as wells	○ NO	○ Some areas	○ Nationally
Q23e) Properly trained and equipped lifeguards	○ NO	○ Some areas	○ Nationally
Q23f) Safety standards for swimming pools	○ NO	○ Some areas	○ Nationally
Q23g) Conducting targeted awareness-raising on drowning	○ NO	○ Some areas	○ Nationally
Q23h) Ensuring immediate resuscitation	○ NO	○ Some areas	○ Nationally

Q24) Please provide information on any other programmes in place for the prevention of drowning or submersion not listed in Q23

Q25) Do you have in place any of the following programmes for the prevention of accidental falls? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q25a) Safety mechanisms on windows, such as window bars in high-rise buildings	○ NO	○ Some areas	○ Nationally
Q25b) Stair gates and guard rails	○ NO	○ Some areas	○ Nationally
Q25c) Impact-resistant surfacing material on playgrounds	○ NO	○ Some areas	○ Nationally
Q25d) Safety standards for playground equipment	○ NO	○ Some areas	○ Nationally
Q25e) Muscle-strengthening exercises and balance training for older adults	○ NO	○ Some areas	○ Nationally
Q25f) Checking and if necessary modifying potential hazards in the home, where there are individuals at high risk	○ NO	○ Some areas	○ Nationally
Q25g) Educational programmes encouraging safety devices to prevent falls	○ NO	○ Some areas	○ Nationally
Q25h) Redesigning nursery furniture and other products	○ NO	○ Some areas	○ Nationally

Q26) Please provide information on any other programmes in place for the prevention of accidental falls not listed in Q25

Q27) Do you have in place any of the following programmes for the prevention of youth violence? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q27a) Life skills training programmes	○ NO	○ Some areas	○ Nationally
Q27b) Preschool enrichment, to strengthen bonds to school, raise achievement and improve self-esteem	○ NO	○ Some areas	○ Nationally
Q27c) Family therapy for children and adolescents at high risk	○ NO	○ Some areas	○ Nationally
Q27d) Home–school partnership programmes promoting the involvement of parents	○ NO	○ Some areas	○ Nationally
Q27e) Educational incentives for at-risk high-school students	○ NO	○ Some areas	○ Nationally
Q27f) Interventions to identify and treat conduct and emotional disorders in early childhood	○ NO	○ Some areas	○ Nationally
Q27g) Psychological interventions for children and adolescents exposed to child maltreatment and intimate partner violence	○ NO	○ Some areas	○ Nationally

28) Please provide information on any other programmes in place for the prevention of youth violence not listed in Q27

Q29) Do you have in place any of the following programmes for the prevention of child abuse or neglect? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q29a) Improving the quality of and access to prenatal and postnatal care	○ NO	○ Some areas	○ Nationally
Q29b) Home visitation programmes	○ NO	○ Some areas	○ Nationally
Q29c) Training programmes for parents	○ NO	○ Some areas	○ Nationally
Q29d) Preventing unintended pregnancies	○ NO	○ Some areas	○ Nationally
Q29e) Training children to recognize and avoid potentially abusive situations	○ NO	○ Some areas	○ Nationally

Q30) Please provide information on any other programmes in place for the prevention of child abuse or neglect not listed in Q29

Q31) Do you have in place any of the following programmes for the prevention of intimate partner violence or domestic violence? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q31a) School-based programmes to prevent violence in dating relationships	○ NO	○ Some areas	○ Nationally
Q31b) Training health-care providers to detect intimate partner violence and to refer cases	○ NO	○ Some areas	○ Nationally
Q31c) Changing norms to gender inequality	○ NO	○ Some areas	○ Nationally
Q31d) Changing cultural norms that support intimate partner and sexual violence	○ NO	○ Some areas	○ Nationally

Q32) Please provide information on any other programmes in place for the prevention of intimate partner violence or domestic violence not listed in Q31

Q33) Do you have in place any of the following programmes for the prevention of elder abuse or neglect? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q33a) Building social networks of older people	○ NO	○ Some areas	○ Nationally
Q33b) Training older people to serve as visitors and companions to individuals at high risk of victimization	○ NO	○ Some areas	○ Nationally
Q33c) Developing policies and programmes to improve the organizational, social and physical environment of residential institutions for the elderly	○ NO	○ Some areas	○ Nationally

Q34) Please provide information on any other programmes in place for the prevention of elder abuse or neglect not listed in Q33

Q35) Do you have in place any of the following programmes for the prevention of sexual violence? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q35a) School-based programmes to prevent violence in dating relationships	○ NO	○ Some areas	○ Nationally

Q36) Please provide information on any other programmes in place for the prevention of sexual violence not listed in Q35

Q37) Do you have in place any of the following programmes for the prevention of self-directed violence? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q37a) Restricting access to pesticides	○ NO	○ Some areas	○ Nationally
Q37b) Restricting access to medications	○ NO	○ Some areas	○ Nationally
Q37c) Restricting access to unprotected heights	○ NO	○ Some areas	○ Nationally
Q37d) Preventing depression	○ NO	○ Some areas	○ Nationally
Q37e) Treating depression	○ NO	○ Some areas	○ Nationally
Q37f) Preventing alcohol and substance abuse	○ NO	○ Some areas	○ Nationally
Q37g) Treating alcohol and substance abuse	○ NO	○ Some areas	○ Nationally
Q37h) School-based interventions focusing on crisis management, the enhancement of self-esteem, and coping skills	○ NO	○ Some areas	○ Nationally

Q38) Please provide information on any other programmes in place for the prevention of self-directed violence not listed in Q37

Q39) Do you have in place any of the following programmes for the prevention of intentional and unintentional injuries? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q39a) Reducing the availability of alcohol during high-risk periods (e.g., on saturday night, after discos)	○ NO	○ Some areas	○ Nationally
Q39b) Reducing economic inequalities	○ NO	○ Some areas	○ Nationally
Q39c) Strengthening social security systems	○ NO	○ Some areas	○ Nationally
Q39d) Reducing the availability of drugs	○ NO	○ Some areas	○ Nationally

Q40) Please provide information on any other programmes in place for the prevention of of intentional and unintentional injuries not listed in Q39

Q41) Do you have in place any of the following programmes for the prevention of all types of violence? (Please tick the most applicable responses)

Programme	NO	YES, implemented in	
Q41a) Reducing demand for firearms	○ NO	○ Some areas	○ Nationally
Q41b) Reducing the availability of firearms	○ NO	○ Some areas	○ Nationally
Q41c) Sustained, multimedia prevention campaigns aimed at changing cultural norms that promote violence	○ NO	○ Some areas	○ Nationally

Q42) Please provide information on any other programmes in place for the prevention of all types of violence not listed in Q41

Q42a) Please list the constraining factors in the implementation of violence and injury prevention activities within your country

Q42b) Please list the enabling factors to the implementation of violence and injury prevention activities within your country

Q43a) In answering this questionnaire, did you build consensus with other sectors/stakeholders involved in VIP?

○ YES ○ NO

Q43b) If YES, please provide details

Q43c) Please specify the sectors/stakeholders you consulted (tick all that apply)

- Ministry of Health ☐
- Ministry of Education ☐
- Ministry of Justice ☐
- Ministry of Transportation ☐
- Ministry of Social Welfare/Social Services ☐
- Ministry of Finance/Trade/Commerce ☐
- Ministry of Labour ☐
- Ministry of Infrastructure ☐
- Ministry of Domestic Affairs ☐
- Ministry of Professional bodies ☐
- Institutes of public health ☐
- NGOs ☐
- Other (please specify) ☐

Q44a) Multisectoral collaboration is an integral part of successful action in violence and injury prevention. Do you think WHO can provide support to achieve this in your country?

○ YES ○ NO

Q44x) If YES, please describe how WHO can provide support to achieve this in your country.

THE FOLLOWING QUESTIONS HAVE BEEN ADDED IN 2009

Questions 45-53 are concerned with alcohol as a risk factor for injuries and violence.

Q45a) Has alcohol been identified as a risk factor for violence in your national plan or policy?

○ YES ○ NO

Q45b) Has alcohol been identified as a risk factor for unintentional injuries in your national plan or policy?

○ YES ○ NO

Q46) Alcohol availability (Please tick the most applicable responses)

	NO	YES, implemented in	
Q46a) In order to control alcohol availability, is there a law restricting sale of alcohol to juniors?	○ NO	○ Some areas	○ Nationally

Q46x) If YES, please specify age limit:

Q46xi) If YES, how would you score the level of enforcement with a scale from 1 to 10 (from 1=not enforced, to 10=fully enforced)? Please select the appropriate number from the box below.

Select the level

	NO	YES, implemented in	
Q46b) In order to control alcohol availability, are there recommendations by the government on restricting sale of alcohol to juniors?	○ NO	○ Some areas	○ Nationally
Q46c) Is there a minimum drinking age in your country?	○ NO	○ Some areas	○ Nationally

Q46xii) If YES, please specify what age:

*Q46d) In order to control alcohol availability, are there any laws which limit the time periods when alcohol can be sold for **on** licensed premises (e.g. bars)?*	○ NO	○ Some areas	○ Nationally

Q46xiii) If YES, please provide details:

*Q46e) In order to control alcohol availability, are there any laws which limit the time periods when alcohol can be sold for **off** licensed premises? (e.g shops selling alcohol)*	○ NO	○ Some areas	○ Nationally

Q46xiv) If YES, please provide details:

Q47) If YES, how would you score the level of enforcement with a scale from 1 to 10 (from 1=not enforced, to 10=fully enforced)? Please select the appropriate number from the box below.

Select the level

Q48) Alcohol use/restrictions (Please tick the most applicable responses)

	NO	YES, implemented in	
Q48a) In order to control alcohol use, are fiscal measures such as increasing taxes (and, subsequently, prices) on alcoholic drinks implemented (e.g., excise duty tax, value added tax (VAT))?	○ NO	○ Some areas	○ Nationally
Q48b) In order to control alcohol use, are there any measures which reduce the number of retail outlets selling alcohol?	○ NO	○ Some areas	○ Nationally
Q48c) Are there any restrictions on alcohol sales at specific events (such as football games)?	○ NO	○ Some areas	○ Nationally
Q48d) Are there any policies which aim to control public alcohol sales in pubs and clubs, such as server and staff training (e.g., in denying alcohol service to those that are already intoxicated or underage)?	○ NO	○ Some areas	○ Nationally
Q48e) Are there any national rules in your country to prevent illegal production and sales of home- or informally produced alcoholic	○ NO	○ Some areas	○ Nationally

Q49a) In your country, are there legally binding regulations on alcohol advertising? (Please tick the most applicable responses)

NO	YES, implemented in	
○ NO	○ Some areas	○ Nationally

Q49b) If YES, please specify the type of media where advertising is regulated:

Q49x) Public service/national TV — Select the option

Q49xi) Commercial/private TV

Q49xii) National radio

Q49xiii) Local radio

Note: "Partial statutory restriction" means that the restriction applies during a certain time of day or to some events, programmes, magazines, films, etc…

Q50) Please provide information on any other measure in place in order to control alcohol availability/use not listed in questions 45-46 and 48-49.

Q51) Is the consumption of illegal home- or informally produced alcoholic beverages causing problems in your country?

○ YES ○ NO

Q52) Is the use of alcohol which is not intended for human consumption (i.e. surrogate alcohol, such as industrial alcohol, aftershave, or antifreeze) causing violence and injury in your country?

○ YES ○ NO

Q53) In your country are there any of the following health systems based programmes to reduce alcohol related harm. (Please tick the most applicable responses)

	NO	**YES, introduced in**	
Q53a) Screening and brief counseling interventions in primary care for alcohol-related harm?	○ NO	○ Some areas	○ Nationally
Q53b) Physician counselling provided in emergency rooms for adolescents with alcohol–related injuries using a motivational interview?	○ NO	○ Some areas	○ Nationally
Q53c) Training of health professionals at a regular basis in screening and brief interventions for alcohol problems?	○ NO	○ Some areas	○ Nationally

QUESTIONS 54-59 are concerned with socioeconomic determinants as risk factors for injuries and violence.

Q54a) Are health or mortality data available in your country disaggregated by indicators of socioeconomic class?

○ YES ○ NO

Q54x) If YES, please specify which kind of indicator is used to define socioeconomic class and/or to characterize material deprivation (e.g. socioeconomic deprivation index based on multiple variables, educational level, occupational status, income, ownershio of material goods, etc…)

Q55) If you answered YES to Q54a, please select from the list below the geographical levels or areas that data on socioeconomic indicators might be available (tick all that apply):

Region ☐

Province ☐

District ☐

Municipality ☐

Electoral ward/ Neighbourhood ☐

	NO	YES, implemented in	
Q56a) Have there been any policies targeted to reduce socioeconomic differences in health between segments of society in your country over the past twelve months?	○ NO	○ Some areas	○ Nationally

Q56x) If YES, please specify which:

Q57a) Have socioeconomic inequalities (or variations) in injures and violence been highlighted as a priority in national policy?

○ YES ○ NO

Q57x) If YES, please specify how:

	NO	YES, implemented in	
Q58a) Have any specific interventions been introduced to reduce socioeconomic inequality in injuries and violence? (Please tick the most applicable responses)	○ NO	○ Some areas	○ Nationally

Q58x) If YES, please specify which:

Q59) Are there any specific interventions which have been introduced to reduce socioeconomic disparity in injuries and violence which target the following groups? (Please tick the most applicable responses)

	NO	YES, introduced in	
Q59a) Social disadvantaged groups in general	○ NO	○ Some areas	○ Nationally
Q59b) Ethnic minorities	○ NO	○ Some areas	○ Nationally
Q59c) Specific groups such as asylum seekers	○ NO	○ Some areas	○ Nationally
Q59x) Other, if possible specify:	○ NO	○ Some areas	○ Nationally

Please send the completed questionnaire by 31 May 2009 by e-mail to: violenceinjury@ecr.euro.who.int

ANNEX 3. LIST OF FOCAL PEOPLE WHO RESPONDED

No.	Country	Respondent	
		Violence	Unintentional injuries
1	Albania	Gentiana Qirjako *Public Health Department*	Maksim Bozo *Ministry of Health*
2	Armenia	Ruzanna Yuzbashyan *Ministry of Health*	Lilit Avetisyan *State Hygienic and Antiepidemic Inspectorate*
3	Austria	Rupert Kisser *Kuratorium für Verkehrssicherheit*	
4	Azerbaijan	Rustam Talishinskiy *Traumatology Centre, Baku*	Vagif Verdiev *National Research Institute of Traumatology and Orthopaedics*
5	Belarus	Ivan Pikirenia *Ministry of Health*	
6	Belgium	Christiane Hauzeur *Federal Ministry of Public Health*	Martine Bantuelle *Centre d'Education à la Santé*
7	Bosnia and Herzegovina	Federation of Bosnia and Herzegovina: Jasmina Cosic *Federal Ministry of Health* Republic of Srpska: Jasminka Vuckovic *Ministry of Health and Social Welfare*	Federation of Bosnia and Herzegovina: Jasminka Kovacevic Republic of Srpska: Alen Seranic *Ministry of Health and Social Welfare*
8	Bulgaria	Fanka Koycheva *National Center for Public Health Protection*	Maksim Gaidev *Ministry of Health*
9	Croatia	Melita Jekavic and Ivana Brkic Bilos *Croatian National Institute of Public Health*	
10	Cyprus	Myrto Azina-Chronidou *Ministry of Health*	Olga Poyiadji-Kalakouta *Ministry of Health*
11	Czech Republic	Iva Truellova *Ministry of Health*	Veronika Benešová *Centre of Epidemiology and Prevention of Children's Injuries*
12	Denmark	Karin Helweg-Larsen *National Institute of Public Health* Helle Engslund Krarup *Ministry of the Interior and Health*	Karin Helweg-Larsen *National Institute of Public Health* Margit Ulmer *Ministry of Health and Prevention*
13	Estonia	Ülla-Karin Nurm *Ministry of Social Affairs*	
14	Finland	Helena Ewalds *National Research and Development Centre for Welfare and Health (STAKES)*	Merja Söderholm *Ministry of Social Affairs and Health*

No.	Country	Respondent	
		Violence	Unintentional injuries
15	France	Pierre Arwidson *Institut national de prévention et d'éducation pour la santé* Delphine Girard *Institut national de prévention et d'éducation pour la santé*	
16	Georgia	David Pavliashvili *Ministry of Labour, Health and Social Affairs*	Kakha Kheladze *Ministry of Labour, Health and Social Affairs*
17	Germany	Elke Metz *Federal Ministry of Health*	Elke Metz *Federal Ministry of Health* *Horst Peretzki* *Bundesvereinigung Prävention und Gesundheitsförderung, Kooperation in der Prävention*
18	Greece	Dimitrios Efthymiadis *National Centre for Emergency Health Care*	
19	Hungary	Maria Herczog *Eszterházy Károly College*	Maria Bényi *National Centre for Healthcare Audit and Inspection*
20	Iceland	Gunnar Alexander Olafsson *Ministry of Health*	Rosa Thorsteinsdottir *Public Health Institute of Iceland*
21	Ireland	Robbie Breen *Department of Health and Children*	
22	Israel	Yitzhak Berlovitz *Ministry of Health*	Kobi Peleg *Gertner Institute for Epidemiology and Health Policy Research*
23	Italy	Maria Giuseppina Lecce *Ministry of Health*	
24	Kyrgyzstan	Samat Toymatov *Ministry of Health*	
25	Latvia	Jana Feldmane *Ministry of Health*	
26	Lithuania	Robertas Povilaitis *Head of Childline*	Ramune Meiziene *Ministry of Health*
27	Malta	Taygeta Firman *General Directorate for Health*	Marianne Massa *Health Promotion Department*
28	Montenegro	Svetlana Stojanovic *Ministry of Health*	
29	Netherlands	Loek J.W. Hesemans *Ministry of Health, Welfare and Sport*	
30	Norway	Freja Ulvestad Kärki *Norwegian Directorate for Health*	Jakob Linhave *Norwegian Directorate for Health*
31	Poland	Wojciech Klosinski *Ministry of Health*	
32	Portugal	Maria João Quintela *Ministry of Health*	Gregória Paixão von Amann *Ministry of Health*

No.	Country	Respondent	
		Violence	Unintentional injuries
33	Republic of Moldova	Anatolie Nacu *Ministry of Health*	Gheorghe Ciobanu *National Emergency Care Centre*
34	Romania	Daniel Verman *Ministry of Health*	
35	Russian Federation	Margarita A. Kachaeva *Centre for Social and Forensic Psychiatry*	Sergey Bagnenko *Research Institute of Emergency*
36	San Marino	Andrea Gualtieri *Authority of Public Health*	
37	Serbia	Milena Paunovic *Institute of Public Health of the City of Belgrade*	
38	Slovakia	Martin Smrek *University Children's Hospital*	
39	Slovenia	Barbara Mihevc *Institute for Public Health*	Mateja Rok Simon *Institute for Public Health*
40	Spain	Begoña Merino *Ministry of Health and Social Policy*	Vicenta Mª Lizarbe Alonso *Ministry of Health and Social Policy*
41	Switzerland	Marie-Claude Hofner *University Institute for Legal Medicine*	Roland Allenbach *Council for Accident Prevention*
42	Tajikistan	Asurova Gulbakhor *Department of Organization of Medical Services*	
43	The former Yugoslav Republic of Macedonia	Marija Raleva *Clinical Centre Skopje*	Fimka Tozija *Ministry of Health*
44	Turkey	Fehmi Aydinli *General Directorate of Primary Health Care*	Fazil Inan *General Directorate of Primary Health Care*
45	Turkmenistan	Beglych Ovezklychev *Ministry of Health and Medical Industry*	
46	United Kingdom	Mark Bellis and Karen Hughes *Liverpool John Moores University*	
47	Uzbekistan	Mirkhakim Zhavkharovich Azizov *Ministry of Health*	

ANNEX 4. COUNTRIES RESPONDING IN 2008 AND 2009

	2008	2009
1	Albania	Albania
2	Armenia	Armenia
3	Austria	Austria
4	Azerbaijan	Azerbaijan
5	Belgium	Belgium
6	Belarus	Belarus
7	Bulgaria	Bosnia and Herzegovina
8	Croatia	Bulgaria
9	Cyprus	Croatia
10	Czech Republic	Cyprus
11	Denmark	Czech Republic
12	Finland	Denmark
13	Greece	Estonia
14	Hungary	Finland
15	Iceland	France
16	Ireland	Georgia
17	Israel	Germany
18	Latvia	Greece
19	Lithuania	Hungary
20	Malta	Iceland
21	Netherlands	Ireland
22	Norway	Israel
23	Poland	Italy
24	Portugal	Kyrgyzstan
25	Republic of Moldova	Latvia

	2008	2009
26	Romania	Lithuania
27	Russian Federation	Malta
28	San Marino	Montenegro
29	Serbia	Netherlands
30	Slovakia	Norway
31	Slovenia	Poland
32	Spain	Portugal
33	Switzerland	Republic of Moldova
34	The former Yugoslav Republic of Macedonia	Romania
35	Turkey	Russian Federation
36	United Kingdom	San Marino
37	Uzbekistan	Serbia
38		Slovakia
39		Slovenia
40		Spain
41		Switzerland
42		Tajikistan
43		The former Yugoslav Republic of Macedonia
44		Turkey
45		Turkmenistan
46		United Kingdom
47		Uzbekistan

ANNEX 5. RELEVANT PUBLICATIONS ON PREVENTING VIOLENCE AND INJURIES

Technical reports

Butchart A et al. *Preventing child maltreatment: a guide to tacking action and generating evidence*. Geneva, World Health Organization and International Society for Prevention of Child Abuse and Neglect, 2006 (http://www.who.int/violence_injury_prevention/violence/activities/child_maltreatment/en/index.html).

European status report on road safety. Towards safer roads and healthier transport choices. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/violenceinjury/injuries/20080229_1)

Global Status Report on Road Safety. Geneva, World Health Organization, 2009 (http://www.who.int/violence_injury_prevention/road_safety_status/2009/en/index.html)

Injuries and violence in Europe – why they matter and what can be done. Summary. Copenhagen, WHO Regional Office for Europe, 2005 (http://www.euro.who.int/document/e87321.pdf).

Peden M et al. *World report on child injury prevention*. Geneva, World Health Organization and UNICEF, 2009 (http://www.who.int/violence_injury_prevention/child/injury/world_report/en/index.html).

Road safety performance – national peer review: Russian Federation. Paris, Organisation for Economic Co-operation and Development, 2006 (http://www.cemt.org/topics/safety/safepub.htm).

Sethi D et al. *Injuries and violence in Europe. Why they matter and what can be done*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/E88037.pdf).

Sethi D et al. *European report on child injury prevention*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/violenceinjury/injuries/20081205_2).

Sethi D et al. *Progress in preventing injuries in the WHO European Region*. Copenhagen, WHO Regional Office for Europe 2008 (http://www.euro.who.int/InformationSources/Publications/Catalogue/20080912_1).

Sethi D, Racioppi F, Mitis F. *Youth and road safety in Europe*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/document/e90142.pdf).

Shields N et al. *National responses to preventing violence and unintentional injuries. WHO European survey*. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/e89258.pdf).

Violence prevention: the evidence. Geneva, World Health Organization, 2009 (http://www.who.int/violence_injury_prevention/violence4th_milestones_meeting/publications/en/index.html).

Policy briefings

Alcohol and interpersonal violence. Copenhagen, WHO Regional Office for Europe, 2005 (http://www.euro.who.int/Document/E87347.pdf).

Bauer R, Kisser R. *Injury surveillance: a health policy priority*. Brussels, European Commission, 2009 (Apollo policy briefing number 7).

Breaking the cycle: public health perspectives on interpersonal violence in the Russian Federation. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/e89855.pdf).

Interpersonal violence and alcohol in the Russian Federation. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/Document/E88757.pdf).

Preventing child maltreatment in Europe: a public health approach. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/document/E90618.pdf).

Laflamme L et al. *Addressing the socioeconomic safety divide: a policy briefing*. Copenhagen, WHO Regional Office for Europe 2009 (http://www.euro.who.int/Document/E92197.pdf).

Sethi D. *The role of public health in injury prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 1; http://www.euro.who.int/document/VIP/policy_briefing_1.pdf).

Sethi D. *Developing national policy for injury prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 2).

Sethi D. *Inequality in injury risks*. Brussels, European Commission, 2007 (Apollo policy briefing number 3).

Sethi D. *Road traffic injuries among vulnerable road users*. Brussels, European Commission, 2008 (Apollo policy briefing number 4; http://www.euro.who.int/Document/VIP/polbrief_road_injuries.pdf).

Sethi D, Mitis F. *Alcohol and injuries*. Brussels, European Commission, 2009 (Apollo policy briefing number 5; http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/0/D733D6539AF7F643C12573A8003761DC/$file/Policy%20briefing%205%20-Alcohol%20and%20Injuries.pdf).

Sethi D, Bie H, Frerick B. *Youth violence prevention*. Brussels, European Commission, 2007 (Apollo policy briefing number 6; http://www.childsafetyeurope.org/csi/eurosafe2006.nsf/0/D87464685E9DFA75C125754D0030BE96/$file/Policy%20briefing%206%20-%20Youth%20violence.pdf).

Sethi D, Mitis F. *Using advocacy for injury prevention*. Brussels, European Commission, 2009 (Apollo policy briefing number 8; http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/0/D87464685E9DFA75C125754D0030BE96/$file/Policy%20briefing%208%20-%20Using%20advocacy%20for%20injury%20prevention.pdf).

The cycles of violence: the relationship between childhood maltreatment and the risk of later becoming a victim or perpetrator of violence: key facts. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/E90619.pdf).

Scientific articles

Racioppi F, Sethi D. *Prima Settimana Mondiale delle Nazioni Unite sulla Sicurezza Stradale: riflettori puntati sulla principale causa di morte per i giovani Europei [The first United Nations Road Safety Week: addressing the leading cause of death in young Europeans]*. Rome, L'altra Via, 2007.

Racioppi F, Sethi D. The First United Nations Global Road Safety Week: addressing the leading cause of death in young Europeans. *European Journal of Public Health*, 2007, 17:232–234 (http://eurpub.oxfordjournals.org/cgi/content/full/17/2/232).

Racioppi F, Sethi D. Shaping comprehensive policies for injury prevention in Europe. *International Journal of Injury Control and Safety Promotion* (in press).

Racioppi F, Sethi D, Baumgarten I. Stepping up the effort to reduce violence and unintentional injuries in Europe. *European Journal of Public Health*, 2006, 16:337–338 (http://eurpub.oxfordjournals.org/cgi/reprint/16/3/336).

Sethi D, Racioppi F. The role of public health in injury prevention in the WHO European Region. *International Journal of Injury Control and Safety Promotion*, 14:271–273.

Sethi D, Racioppi F, Bertollini R. Preventing the leading cause of death in young people in Europe. *Journal of Epidemiology and Community Health*, 2007, 61:842–843.

Sethi D et al. Reducing inequalities in injuries in Europe. *Lancet*, 2006, 368:2243–2250.

Sethi D, Waxweiler R, Racioppi F. Developing a national policy for injury and violence prevention. *International Journal of Injury Control and Safety Promotion*, 15:53–55.

Suarez Garcia I, Sethi D, Hutchings A. Mortality due to injuries by place of occurrence in the European region: analysis of data quality in the WHO mortality database. *Injury Prevention*, 2009,15:275–277.

Chapters in books

Sethi D, Butchart A. Violence/intentional injuries: prevention and control. In: Heggenhougen HK, Quah SR, eds. *International encyclopedia of public health, volume 6*. San Diego, Academic Press, 2008:508–518.

Sethi D, Racioppi F. Road traffic injury prevention in children and young people in the European Region. In: Tellnes G, ed. *Urbanisation and health*. Oslo, Oslo Academic Press, 2005.

Focal people meeting reports

Report on a VIP meeting: "WHO Ministry of Health, Welfare and Sport, Netherlands – joint meeting of the European national focal points for violence and injury prevention", Noordwijkerhout, 17 and 18 November 2005. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/document/VIP/FPs_%20meeting_%20report_FINAL_edited.pdf).

Workshop on strengthening capacity for violence and injury prevention: 2nd VIP focal persons meeting. Reports on: "Workshop on Strengthening Capacity for Violence and Injury Prevention", Salzburg (Austria), 21–23 June 2006 and "Second Meeting of the Violence and Injury Prevention Focal Persons for WHO Europe", Salzburg (Austria), 23–24 June 2006. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/Document/VIP/2nd_VIP_FocalPerMtg.pdf).

WHO meeting report – Third Annual European Meeting of Violence and Injury Prevention National Focal Persons of the Ministries of Health: report of a joint meeting of the WHO and the High Commissariat of Health at the Ministry of Health, Portugal, Lisbon, 21–22 November 2007. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/document/VIP/3rd_vip_focalpermtg.pdf).

Fourth annual European meeting of violence and injury prevention national focal persons of the Ministries of Health. Report of a joint meeting of the WHO and the Ministry of Social Affairs and Health of Finland, Helsinki, 10 and 11 November 2008. Copenhagen, WHO Regional Office for Europe, 2009.

Regional Office for Europe

Health Organization (WHO)
lized agency of the United
eated in 1948 with the primary
lity for international health matters
health. The WHO Regional Office
is one of six regional offices
t the world, each with its own
e geared to the particular health
of the countries it serves.

States

n

d Herzegovina

ublic

an
n

rg

ro
ds

f Moldova

ederation
o

d

r Yugoslav
c of Macedonia

tan

gdom
n

92-890-4196-6
nglish

World Health Organization
Regional Office for Europe
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17. Fax: +45 39 17 18 18.
E-mail: postmaster@euro.who.int
Web site: www.euro.who.int

ISBN 978-92-890-4196-6