WORLD HEALTH ORGANIZATION
EUROPE

NATIONAL RESPONSES TO PREVENTING VIOLENCE AND UNINTENTIONAL INJURIES

WHO EUROPEAN SURVEY

National responses to preventing violence and unintentional injuries

WHO European survey

By:
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ABSTRACT

Nearly 800 000 people in the European Region of WHO are killed annually by injuries, whether these are intentional or unintentional. Preventing and controlling unintentional injuries and violence comprises a priority for public health action requiring strong leadership from the health sector. To understand the extent of the response to date and to identify areas where more action may be needed, a European survey of national responses to the prevention of violence and unintentional injuries has been conducted. The focal persons on violence and unintentional injury prevention appointed by health ministries participated in the survey. Thirty-one of the 42 countries to which it was sent, returned the questionnaires, a response rate of 74%. The survey shows that few countries have developed an adequate structural response or devoted adequate resources to the problem. This especially applies to low- to middle-income countries in the Region, which have the highest burden of injuries. These results demonstrate that more concerted action is needed. This includes the need for advocacy, surveillance, building capacity, developing policy and mobilizing resources. The results form a useful baseline for assessing future activities and identifying country-specific areas that could be targeted for further development.

Keywords

VIOLENCE – prevention and control
WOUNDS AND INJURIES – prevention and control
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The information presented in this report has been compiled from responses provided to questionnaires between May 2004 and March 2005. As health policy may be in a dynamic state of change, the situation may have changed in some countries.

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Foreword

Nearly 800 000 people in the European Region of WHO are killed annually by injuries, whether these are intentional or unintentional. Injuries are the leading cause of death among people younger than 45 years of age. There is great inequality in the Region: the likelihood of dying from injuries is 3.6 times higher among the people living in low- to middle-income countries in the Region than among the people living in high-income countries. Despite the severity of the problem and the inequality in the Region, the policy response so far has been inconsistent compared with the challenge, and relatively little action has been taken.

The prevention of unintentional injury and violence is a public health priority and requires a strong institutional response and leadership from the health sector. To understand the extent of the response to date and to identify areas where more action may be needed, a global survey of national responses to the prevention of violence and unintentional injuries has been conducted. In the WHO European Region, the focal persons on violence and unintentional injuries appointed by health ministries participated in the survey.

The survey shows that few countries have developed an adequate structural response or devoted adequate resources to the problem. This especially applies to low- to middle-income countries in the Region, which have the highest burden of injuries. These results demonstrate that more concerted action is needed, especially targeting the countries with the least response. This includes the need for advocacy, surveillance, building capacity, developing policy and mobilizing resources. The results form a useful baseline for assessing future activities and identifying country-specific areas that could be targeted for improvement and further development.

Reducing injuries requires strong and sustained commitment across all levels of government and society. By supporting WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the WHO European Region in September 2005, Member States took an unprecedented step in this direction.

We hope that this report will prove a useful baseline for building the response to injury and violence prevention across the Region and will support policy-makers, professionals and activists in their efforts to prevent violence and unintentional injuries.

Roberto Bertollini
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Summary

Introduction

Preventing and controlling unintentional injuries and violence comprise a priority for public health action requiring strong leadership from the health sector. The ratio of injury mortality rates in the WHO European Region for low- and middle-income countries versus high-income countries is 3.6, highlighting ample margins for improvement. WHO is working to place the prevention of violence and unintentional injuries higher on the global public health agenda. As part of this process, a global survey of national responses to the prevention of violence and unintentional injuries has been conducted. In the European Region, focal persons responsible for the prevention of violence and unintentional injuries were appointed by health ministries and participated in the survey. This report presents the main results of the national response survey on the prevention of violence and unintentional injuries in the European Region.

Aims

To undertake a survey of institutional response to the prevention of violence and unintentional injuries in the WHO European Region and consider the implications of results for preventing violence and injuries in accordance with regional priorities.

Methods

The survey questionnaire was developed for a global survey and modified for the European context. It was sent to the 42 countries (of 52 total in the Region) that had appointed health ministry focal persons in 2004. A Russian translation was also sent to the focal persons who may understand Russian better than English. Two reminders were sent to improve the response.

Results

Thirty-one countries returned the questionnaires, a response rate of 74%. Of these, 15 countries are high-income countries and 16 are low- and middle-income countries (Annex 1). Twenty-eight of the 31 countries reported having a national centre collecting injury data, and these data were disaggregated by age in 26 and by sex in 25. More countries reported fatal versus nonfatal injuries and unintentional injury versus intentional injury. Fewer reported elder abuse, intimate partner abuse and youth violence. About half the countries had full-time staff working on preventing violence and unintentional injuries, but only one quarter allocated specific funds to this. Whereas 19 countries identified unintentional injuries as a priority with an official policy, only 11 did this for violence. However, only 12 countries reported specific targets for reducing unintentional injuries and 8 for reducing violence. Overall, high-income countries gave greater priority, capacity and resources to preventing violence and unintentional injuries than low- and middle-income countries.

Conclusions

Despite the high burden, few countries have developed an adequate structural response, or devoted adequate resources, to reducing unintentional injuries and violence. This applies especially to low- and middle-income countries in the European Region, which have the highest burden. More concerted action is needed, especially in these countries. This includes the need for surveillance, advocacy, policy development and capacity-building. These results form a useful baseline for assessing future activities and identifying country-specific areas that could be targeted for improvement and further development.

1. Introduction

In the European Region of WHO, unintentional injury and violence results in an estimated almost 800 000 deaths, or 8% of all recorded deaths *(1–3)*. This number is small compared with the number of survivors of injury and violence, many of whom suffer life-long health effects. Society at large and health and welfare systems in particular bear the costs of these effects *(4)*. For every death, there are an estimated 30 hospital admissions for injury and 300 hospital emergency department visits, suggesting that the human, health service and societal costs are enormous *(5)*. Whereas the societal costs of road traffic injuries have been estimated for many countries in the Region and are thought to be about 2% of national gross domestic product (GDP), those for other types of unintentional injures and violence need to be studied more closely *(6)*. For example, the costs of domestic violence in the United Kingdom comprise an estimated 2.2% of GDP *(7)*.

The 52 countries of the European Region have great diversity in languages, culture and developmental indicators *(8)*. Similarly, the burden of injuries varies greatly in the European Region. Mortality rates are highest in the eastern part of the Region, whereas some countries in western Europe have the lowest rates in the world. People living in the low- to middle-income countries of the Region are 3.6 times more likely to die from injuries than are those living in high-income countries *(1)*.

Whereas little action has been taken in the past to prevent injuries and violence, partly because they were considered an inevitable part of everyday life, the public health community now widely acknowledges that these can be prevented through organized efforts of society *(9)*. Using an evidence-based public health approach, great progress has been made in understanding the causes of injuries and violence and how to prevent them *(10,11)*. Many countries have successfully reduced mortality and disability from injuries by developing and implementing comprehensive policies with legislative, environmental, educational and institutional components *(12)*. In contrast, many countries lack comprehensive implementation of these measures *(13)*. Consequently, countries vary across the Region despite the growing body of knowledge showing that prevention works.

In recent years, WHO has placed unintentional injury and violence prevention higher on the global public health agenda. The World Health Assembly has adopted three resolutions on prevention of violence: a public health problem *(14)*; on implementing the recommendations of the *World report on violence and health (15)*; and on road safety and health *(16)*. In addition, the United Nations General Assembly has adopted a resolution on improving global road safety *(17)*, which mandates WHO to have an international coordinating role. Further, the Secretary-General of the United Nations has commissioned two global studies on violence, one on violence against children and the other on violence against women (to be published in 2006). The resolutions have all emphasized the multisectoral nature of the response to preventing injuries and violence and the strong leadership and coordinating role the health sector needs to play. One of the key components of the resolutions is the appointment of focal persons within each national health ministry for preventing violence and unintentional injuries. The WHO Regional Committee for Europe has adopted resolution EUR/RC55/R9 on the prevention of injuries in the WHO European Region *(18)*. This resolution has provided a framework for preventing unintentional injuries and violence. The key components of this resolution are: developing national plans for prevention, improving surveillance, strengthening national capacity for prevention and care, promoting evidence-based practice through networks and supporting research. In this respect, establishing a baseline of country policy frameworks, programmes, lead agencies and capacity is an important starting-point for implementing a regional or national strategy for prevention based on the resolution.

1.1 Aims

The aim of the survey on national response to preventing violence and injuries is to better understand

the policy frameworks, responsibilities, programming and infrastructure for preventing violence and unintentional injuries available to health ministries in the European Region. A subsidiary aim is to supplement information from other WHO regions in order to develop a global picture of national response.

1.2 Methods

The survey questionnaire was piloted and adapted for the local context by modifying the questionnaire used by the WHO Global Survey on National Response to Violence and Injuries *(19)*. Four broad themes were covered:

- data collection
- coordination, leadership and administration
- programme development and implementation
- public policy and legislation (Annex 2 shows the questionnaire).

It was sent to the network of national focal persons responsible for the prevention of unintentional injuries and violence appointed by health ministries. In most countries this comprised one focal person each for violence and unintentional injury, whereas in others only one has been appointed. As of January 2005, these were established in 42 (81%) of the 52 Member States of the Region, and these were surveyed. National focal persons were sent the questionnaire both electronically and by mail. The questionnaire was sent in English, and a Russian translation was also sent to the focal persons who may understand Russian better than English. Two reminders were sent, and data were collected between May 2004 and March 2005. The WHO Collaborating Centre for Policy and Practice Development in Women's Health and Gender Mainstreaming in Glasgow entered and analysed the data using Microsoft Excel. A provisional copy of the report with the results was sent to the focal persons for confirmation prior to publication. For the purposes of this survey and report, standard definitions for injury and violence have been used which are shown in Box 1.

Box 1. What is an injury?

An injury is the physical damage that results when a human body is suddenly subjected to energy in amounts that exceed the threshold of physiological tolerance or it can be the result of the lack of one or more vital elements (e.g. oxygen). This energy could be mechanical, thermal, chemical or radiant *(5)*. It is usual to define injuries by intent. The main causes of unintentional injuries are road traffic injuries, poisoning, drowning, falls and burns.

Violence is defined as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in injury, death, psychological harm, maldevelopment or deprivation *(11)*. Violence can be divided into self-directed (as in suicide or self-harm), collective (in war and by gangs), and interpersonal (child, partner, elder, acquaintance and stranger).

2. Results

2.1 Data collected for the survey

Focal persons returned completed surveys from 31countries (74%) by March 2005. Of these, two were in Russian and were translated into English. Twenty-eight respondents chose to complete and return the survey electronically. Two were returned after the closing date and are not included in this analysis. Table 1 shows the countries for which focal persons returned questionnaires classified by national income in accordance with the World Bank definition of GDP per capita *(20)*.

Table 1. Categorization of responding countries by GDP into low- and middle-income countries and high-income countries

Low- and middle-income countries (*n* = 16)	High-income countries (*n* = 15)
Albania	Austria
Armenia	Belgium
Belarus	Cyprus
Bulgaria	Denmark
Croatia	Finland
Czech Republic	Israel
Estonia	Italy
Georgia	Malta
Latvia	Monaco
Lithuania	Netherlands
Romania	Norway
Russian Federation	Slovenia
Slovakia	Spain
The former Yugoslav Republic of Macedonia	Switzerland
Turkey	United Kingdom
Turkmenistan	

2.2 Data collection on violence and unintentional injuries

Twenty-eight countries reported having a national centre or agency that collects health-related statistics. The three countries that did not were Armenia, Monaco and The former Yugoslav Republic of Macedonia. Eleven countries reported that a single agency coordinated health-related statistics, with the others stating that more than one agency coordinated this system. For example, Cyprus reported "Department of Research and Statistics, Traffic Police Statistics and Research Office, Fire Services Department, Medical & Public Health Services Department and Social Security Department".

Table 2 breaks down the classification schemes used to code mortality and morbidity data related to unintentional injuries and violence. Nearly half reported that they used the Tenth Revision of the International Classification of Diseases (ICD-10) or ICD-10 with other measures to augment data *(21)*. Twenty-five countries reported that data in the national health information system were disaggregated by sex and 26 reported disaggregation by age. The countries reporting not having disaggregated data were Armenia, Cyprus, Georgia (by age only), Monaco and the Russian Federation. Fig. 1 shows whether data are collected by cause on nonfatal injuries and deaths for the various causes of injury and violence. This shows that more countries collected data on injury deaths than on nonfatal injuries and that more countries collected data on the causes of unintentional injury than on types of violence. Table 3 shows the types of injury and violence data not collected in specified countries.

2.2.1 Data collection in low- and middle-income countries versus high-income countries

For data collection, more high-income countries used ICD-9 (6/15 versus 4/16 low- and middle-income countries): the Nordic Medico-Statistical Committee (NOMESCO) coding systems (2/15 versus 0/16 low- and middle-income countries) and "other" coding systems (5/15 versus 0/16 low- and middle-income countries).

Most high-income countries collected more data across a range of issues. Differences included:

- road traffic injuries (13/15 high-income countries versus 10/16 low- and middle-income countries);
- injuries due to fire or flames (13/15 high-income countries versus 9/16 low- and middle-income countries);
- drowning (9/15 high-income countries versus 8/16 low- and middle-income countries);
- falls (12/15 high-income countries versus 8/16 low- and middle-income countries);

- interpersonal violence injuries (9/15 high-income countries versus 6/16 low- and middle-income countries) and deaths (12/15 high-income countries versus 8/16 low- and middle-income countries);
- youth violence deaths (5/15 high-income countries versus 7/16 low- and middle-income countries);
- child abuse and neglect (8/15 high-income countries versus 5/16 low- and middle-income countries);
- intimate partner violence (9/15 high-income countries versus 4/16 low- and middle-income countries);
- sexual violence injuries (8/15 high-income countries versus 6/16 low- and middle-income countries);
- suicide deaths (9/15 high-income countries versus 11/16 low- and middle-income countries); and
- collective violence injuries (1/15 high-income countries versus 5/16 low- and middle-income countries) and deaths (3/15 high-income countries versus 8/16 low- and middle-income countries).

The proportions of missing or unknown data were high for some causes.

2.2.2 Access to information

Twenty-three respondents indicated that statistics on unintentional injuries and violence are made accessible in the form of printed reports: 15 on web sites and 13 on electronic databases. Low- and middle-income countries were less likely to have printed reports, web sites and databases available than high-income countries (for example, 4/16 low- and middle-income countries versus 9/15 high-income countries had databases). Thirty country responses indicated that other agencies also collect data (such as hospitals, universities and the police).

2.3 Violence and injuries – coordination, leadership and administration

2.3.1 Staff at the health ministry

Fifteen countries reported that the health ministry has staff working on preventing unintentional injuries and violence. Substantial differences were found, with staff present in 10 of 15 high-income countries and 5 of 16 low- and middle-income countries. High-income countries had proportionately more staff allocated than low- and middle-income countries. Five countries reported 1–5 staff working full time on this (high-income countries: Malta, the Netherlands and Norway; low- and middle-income countries: The former Yugoslav Republic of Macedonia and Turkmenistan); Finland reported 6–10 staff; and Romania 21 staff or more. Some countries also reported part-time staff working on this: Croatia, Cyprus, Norway, Slovakia, Slovenia and The former Yugoslav Republic of Macedonia reported 1–5 part-time staff and Spain 6–10 part-time staff.

Only 7 countries reported that specific funds are allocated within the health ministry budget for preventing unintentional injuries (5/15 high-income countries: Cyprus, Finland, the Netherlands, Slovenia and Switzerland; 2/16 low- and middle-income countries: the Czech Republic and Lithuania) and 6 reported this for preventing violence (4/15 high-income countries: Belgium, Finland, Norway and Switzerland; 2/16 low- and middle-income countries: Bulgaria and Lithuania).

2.3.2 Injuries as a priority

Nineteen countries stated that the health ministry had identified unintentional injuries as a priority area over the past five years versus only eight for preventing violence (Austria, Belgium, the Czech Republic, Estonia, Latvia, Romania, Spain and Turkey). The responses did not differ by country income. The low- and middle-income countries not giving priority to preventing unintentional injuries were Albania, Armenia, Georgia, Lithuania and the Russian Federation; the high-income countries were Belgium, Monaco, the Netherlands and Slovenia.

2.3.3 Targets

Thirteen respondents stated that their country has a national target for reducing unintentional injuries (8/16 low- and middle-income countries and 5/15 high-income countries). Targets ranged from "Reduction of fatal and serious injuries in road traffic by 30%" and "Reduction in occupational, domestic and leisure injuries by 50%" to "To decrease mortality from traffic accidents by 40% in next 5 years". Nine countries (5/16 low- and middle-income countries

Table 2. Classification schemes countries used for national health information systems

Classification	Countries
ICD-6, ICD-7 or ICD-8 (*n* = 1)	Turkey
ICD-9 (*n* = 5)	Albania, Belgium, Bulgaria, Georgia, Spain
ICD-9 and V2000 Coding Manual IPP-HLA, SINIACA-ISS (*n* = 1)	Italy
ICD-10 (*n* = 11)	Belarus, Croatia, Czech Republic, Finland, Latvia, Lithuania, Malta, Slovakia, Slovenia, Turkmenistan, United Kingdom
ICD-9 and ICD-10 (*n* = 4)	Georgia, Israel, Switzerland, The former Yugoslav Republic of Macedonia
ICD-9 and ICD-10, MDS (European) (*n* = 1)	Netherlands
ICD-10 and Nordic Medico-Statistical Committee (NOMESCO) (n = 2)	Denmark, Norway
ICD-10 and Austrian Home & Leisure Coding Manual (*n* = 1)	Austria
International Classification of External Causes of Injury (*n* = 1)	Estonia
Don't know (*n* = 2)	Bulgaria, Romania
Missing (*n* = 2)	Cyprus, Russian Federation

Fig. 1. Percentage of responding countries collecting data in their national health information systems on deaths and injuries caused by violence and unintentional injuries

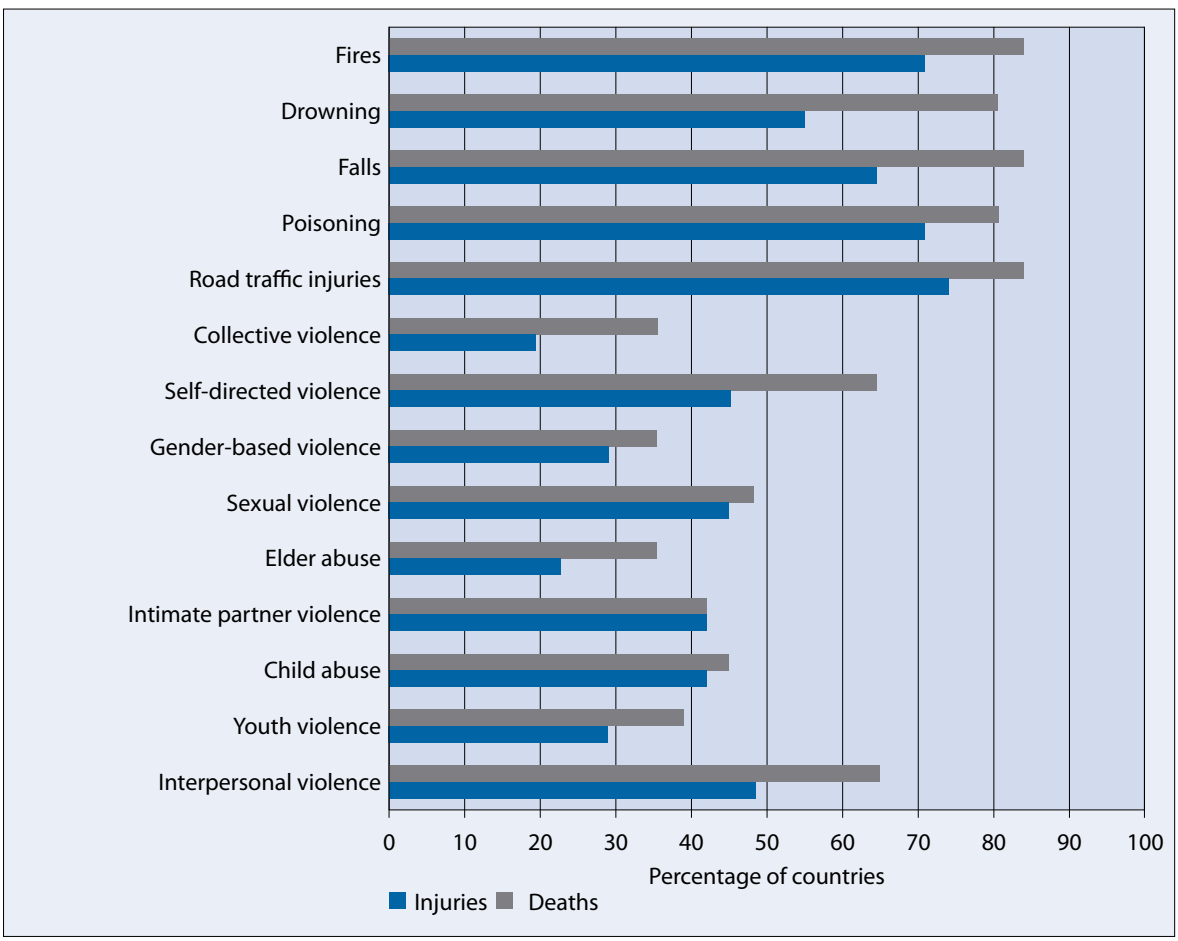


Table 3. Types of injury and violence data not collected in specific countries (X denotes data items not collected)

Country	Road accidents		Accidents caused by fire and flames		Accidental drowning and submersion	
	Injuries	Deaths	Injuries	Deaths	Nonfatal	Deaths
Albania						
Armenia	X	X	X	X	X	X
Austria						
Belarus			X		X	
Belgium		X		X		X
Bulgaria	X					
Cyprus		X			X	
Croatia						
Czech Republic						
Denmark						
Estonia						
Finland						
Georgia	X		X		X	
Israel					X	X
Italy						
Latvia						
Lithuania					X	
Malta	X				X	
Monaco	X		X	X	X	
Netherlands						
Norway						
Romania						
Russian Federation	X	X	X	X	X	X
Slovakia						
Slovenia						
Spain			X		X	
Switzerland						
The former Yugoslav Republic of Macedonia						
Turkey			X		X	
Turkmenistan	X	X	X			
United Kingdom						

and 4/15 high-income countries) reported a national target for reducing mortality from violence. Targets varied between countries, such as "Reduction of fatal and serious injuries by 25%" and "Total number of homicides to be under 100/year from 2007 forward". Tables 4 and 5 show the targets for unintentional injuries and violence.

2.3.4 Multisectoral approach: main actors

Three focal persons (from Cyprus, Finland and Switzerland) reported that their country has a national coalition or committee for injury prevention. Sixteen countries have a national road safety council (10/15 high-income countries versus 6/16 low- and middle-income countries). Six countries (4/15 high-income countries versus 2/16 low- and middle-income countries) have a national committee on domestic violence or violence against women. Fifteen countries (8/15 high-income countries versus 7/16 low- and middle-income countries) reported that other relevant national institutions were involved in this work. These institutions included "Finland: the

Accidental falls		Accidental poisoning		Interpersonal violence		Youth violence	
Injuries	Deaths	Injuries	Deaths	Nonfatal	Homicide	Injuries	Deaths
				X	X	X	X
X	X	X	X	X	X	X	X
						X	X
	X			X		X	
X		X		X		X	X
	X		X	X		X	
				X	X	X	X
			X			X	X
X		X		X		X	
X			X	X	X	X	X
				X	X	X	
	X		X	X		X	
X	X	X	X	X		X	X
						X	X
							X
				X	X	X	X
X	X	X	X	X	X	X	X
						X	X
	X						
X						X	X
				X	X	X	X

Committee of Occupational Safety" and the "Danish Crime Prevention Council".

Most focal persons reported a range of ministries being involved in conducting activities to prevent unintentional injury and violence in their country. The health ministry was mentioned most frequently (28 countries); the three exceptions were Armenia, Monaco and the Russian Federation. Other ministries involved were transport (25 countries), education (21 countries), social welfare or social services (23) justice (17), domestic affairs (16), labour (15), finance, trade or commerce (7) and others (12). High-income countries reported higher proportions than low- and middle-income countries of involvement of the finance, trade or commerce ministry (5/15 high-income countries versus 2/16 low- and middle-income countries) and the labour ministry (9/15 high-income countries versus 6/16 low- and middle-income countries); whereas low- and middle-income countries reported a slightly higher rate for a domestic affairs ministry (7/15 high-income countries versus 9/16 low- and middle-income countries).

Table 3. (contd)

Country	Child abuse and neglect		Intimate partner violence		Abuse and neglect of older people	
	Injuries	Deaths	Injuries	Deaths	Injuries	Deaths
Albania	X	X	X	X	X	X
Armenia	X	X	X	X	X	X
Austria						X
Belarus	X	X	X	X	X	X
Belgium		X		X		
Bulgaria	X		X		X	
Cyprus					X	
Croatia	X	X	X	X	X	X
Czech Republic			X	X		
Denmark					X	
Estonia						
Finland						
Georgia	X		X		X	
Israel	X	X	X	X	X	X
Italy	X	X	X	X	X	X
Latvia			X			
Lithuania			X	X	X	X
Malta	X				X	
Monaco	X	X	X	X	X	X
Netherlands					X	X
Norway		X			X	X
Romania	X	X	X		X	
Russian Federation	X	X	X	X	X	X
Slovakia						
Slovenia					X	X
Spain					X	X
Switzerland			X	X	X	X
The former Yugoslav Republic of Macedonia						
Turkey	X	X	X	X	X	X
Turkmenistan	X	X	X	X	X	X
United Kingdom						

Twenty-nine countries reported a lead agency for preventing road traffic injuries. Twenty-one countries reported a lead agency for preventing violence (12/16 low- and middle-income countries versus 9/15 high-income countries) and 21 a lead agency for preventing other unintentional injuries (12/15 high-income countries versus 9/16 low- and middle-income countries).

Twenty-three countries reported that non-governmental organizations are currently focusing on unintentional injuries and violence (such as road safety, intimate partner violence, child abuse and neglect, child safety and adolescent suicide). More high-income countries reported the existence of nongovernmental organizations (13/15 high-income countries versus 10/16 low- and middle-income countries).

In addition, 19 countries reported that universities or research bodies were currently focusing on injuries, with negative responses from the low- and middle-income countries Albania, Armenia, Latvia, Romania and Slovakia and the high-income countries Cyprus,

Sexual violence		Self-directed violence		Collective violence		Gender-based violence	
Injuries	Deaths	Injuries	Deaths	Injuries	Deaths	Injuries	Deaths
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X
				X	X	X	X
X		X		X		X	
	X		X	X	X	X	X
X				X		X	
		X		X		X	X
X	X	X		X	X	X	X
X	X			X	X	X	X
				X	X	X	X
X		X		X		X	
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X
		X		X		X	X
		X		X		X	X
X	X	X	X	X	X	X	X
X	X			X	X	X	X
	X	X		X	X		X
X	X	X	X	X	X	X	X
X	X			X	X	X	X
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X

Italy and Malta. Twenty-three countries reported that the media regard unintentional injuries and violence as a social and health problem (negative responses: Armenia, Belgium, Monaco, the Netherlands, Romania and Spain).

2.4 Developing and implementing programmes on violence and unintentional injuries

More countries had implemented preventive interventions for causes of unintentional injuries versus types of violence (Fig. 2). For example, countries tended to report more interventions and agency involvement for road traffic injuries than, for example, self-directed violence. Other agencies than the health ministry led most interventions. This shows that intersectoral work is already occurring and how the health sector has a partnership role. The interventions ranged from public awareness campaigns and national strategies to peer education programmes. A list of organizations when the health ministry is not the lead agency, types of programmes

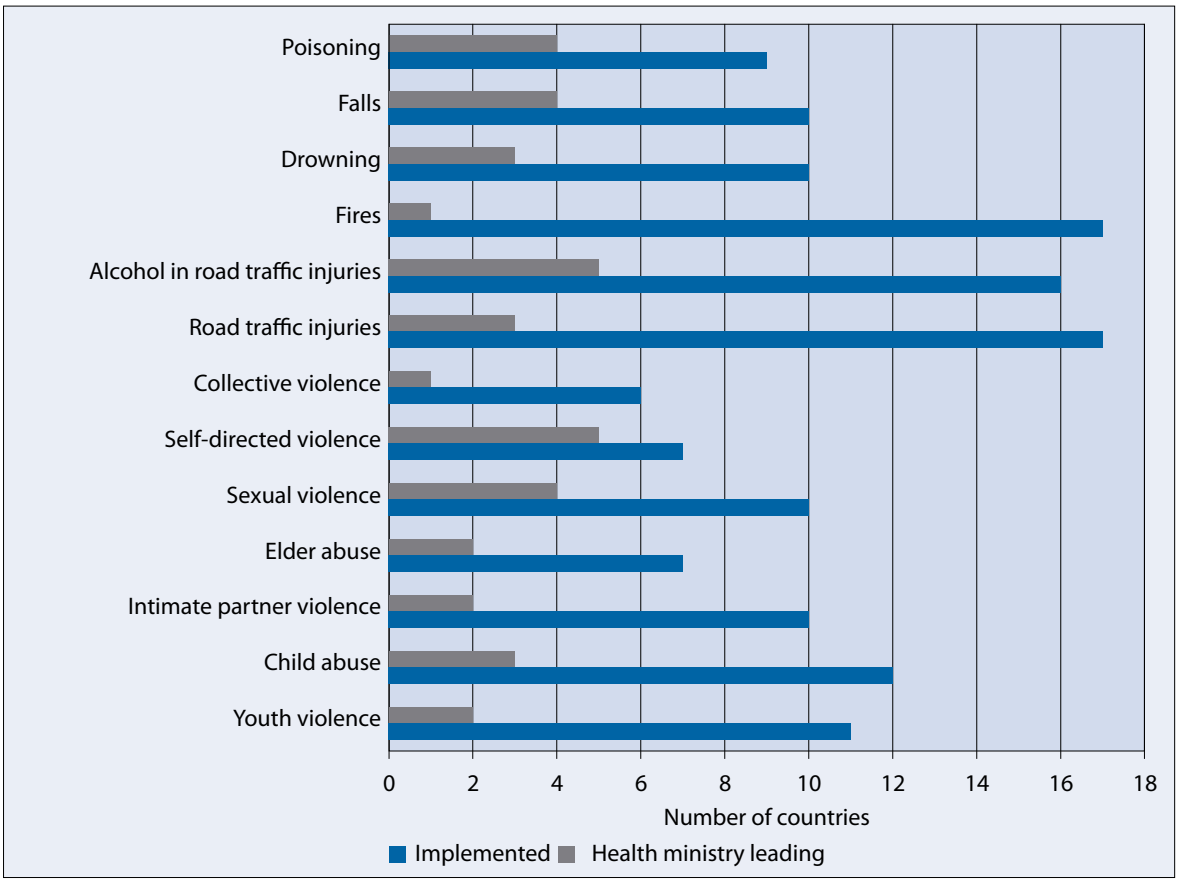
Table 4. Targets for reducing mortality for unintentional injuries

Country	Target
Belarus	Decline in injury mortality by 10% by 2012
Czech Republic	Reduction of fatal and serious injuries in road traffic by 30% Reduction in occupational, domestic and leisure injuries by 50%
Estonia	Reduction in road traffic injury mortality by 30% by 2012
Latvia	Target No. 10 of the Public Health Strategy: reducing health disorders from violence and accidents. It is planned to reduce the disability and mortality from all work, domestic and leisure accidents by at least 30%
Malta	Reduction of road accident injury by 50% by 2014
Netherlands	30% reduction in road traffic injury mortality in 2010
Romania	Reduction in traffic injury mortality and morbidity by 20% by 2005
Slovenia	Road traffic injury mortality by 50% by 2005 (reference year is 1995)
Spain	To decrease mortality from traffic accidents by 40% in next five years
The former Yugoslav Republic of Macedonia	Draft strategy for improvement of health protection of the population in The former Yugoslav Republic of Macedonia, 2001. This document is still under discussion and was not officially enacted. Target 9: By 2010 there should be a significant reduction in injuries, disability and death as a result of accidents or violence. Reduction of mortality and disability as a result of traffic accidents by at least 30%, i.e. mortality rate of 5 per 100 000 population by 2010 Reduction of mortality and disability from all types of injuries by at least 50%, i.e. mortality rate from all injuries of 16 per 100 000 population by 2010
Turkey	50% reduction in home accident mortality (40% reduction for children) 50% reduction in occupational accidents 30% reduction in road accidents mortality

Table 5. Country targets for reducing mortality from violence

Country	Target
Czech Republic	Reduction of fatal and serious injuries by 25%
Denmark	As part of the government's effort against violence, to reduce the number of cases of aggravated violence that results in homicide
Finland	Health 2015 programme. Total number of homicides to be under 100 per year from 2007 forward
Latvia	Target No. 10 of the Public Health Strategy: reducing health disorders from violence and accidents. It is planned to reduce the incidence of all kinds of violence and its health consequences by at least 10%
Malta	Child abuse: preventing violence against children with the aim of reducing their number, consequences and fatalities
Romania	Reduction of domestic violence by 25% by 2010 Reduction of family violence by 20% by 2010
Spain	To decrease in the first instance and to eradicate the violent acts and to help the victims overcome the effects that the abuse might have had on them
The former Yugoslav Republic of Macedonia	Draft strategy for improvement of health protection of the population in The former Yugoslav Republic of Macedonia – Macedonia Academy of Sciences and Arts and Ministry of Health, Skopje, 2001. This document is still under discussion and was not officially enacted. Target 9: By 2010 there should be a significant reduction in injuries, disability and death as a result of accidents or violence. Reduction of mortality and disability as a result of traffic accidents by at least 30%, i.e. mortality rate of 5 per 100 000 population by 2010 Reduction of mortality and disability from all types of injuries by at least 50%, i.e. mortality rate from all injuries of 16 per 100 000 population by 2010
Turkey	By 2020, 25% reduction in mortality from domestic, gender and collective violence
United Kingdom	Public service agreements: reduce mortality from suicide by 20% by 2010

Fig. 2. Number of countries in which the health sector is implementing and leading programmes by types of violence and unintentional injuries



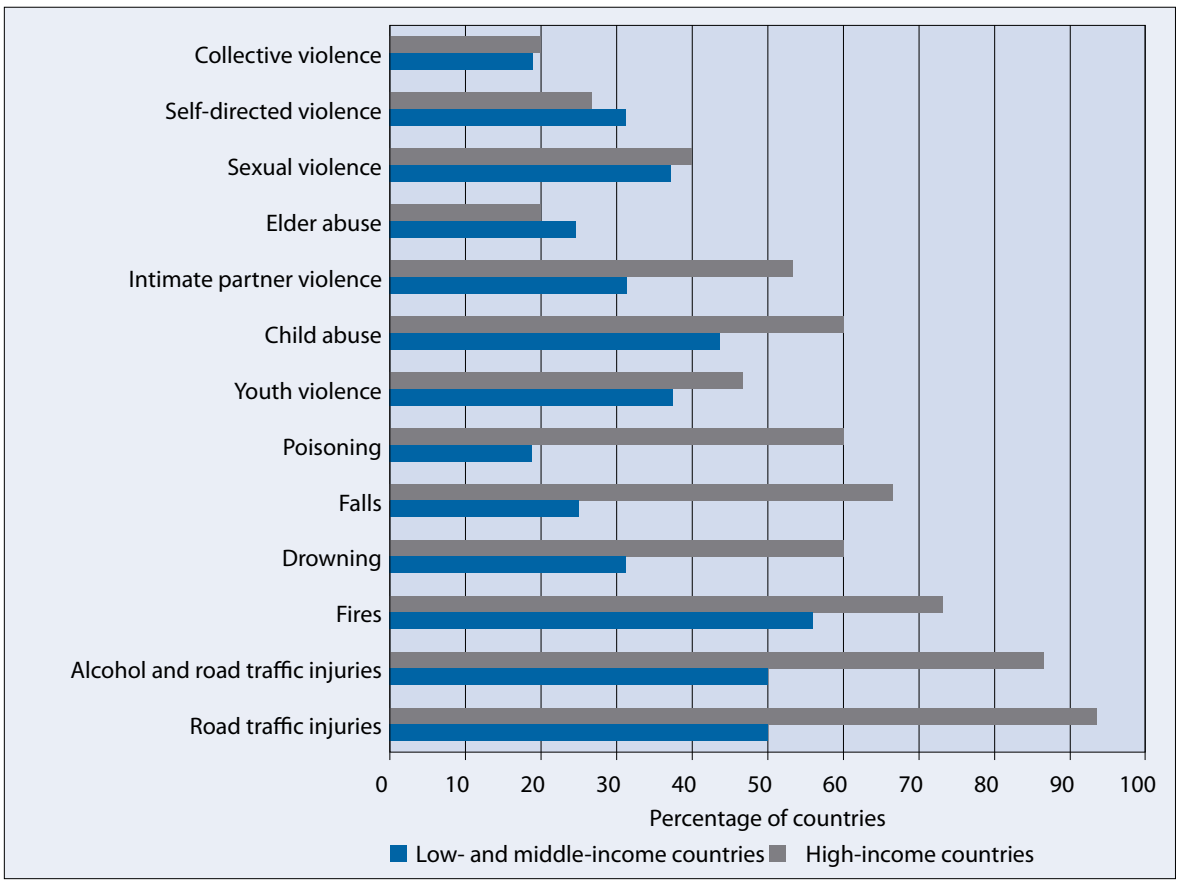
and partner agencies was also reported. For road traffic injuries, the lead organizations included the transport ministry and the interior or justice ministry or rescue services ministry for fire safety, whereas for preventing violence, lead organizations tended to be the interior or justice ministry and the social affairs ministry. Some countries had a national agency or campaign for preventing family violence.

Countries with limited or no programme development and implementation on the variety of issues were the high-income countries Austria, Belgium and Monaco and the low- and middle-income countries Albania, Armenia, Belarus, the Czech Republic, Georgia, Latvia, Lithuania, the Russian Federation, Romania, Slovakia, Turkey and Turkmenistan. Fig. 3 compares low- and middle-income countries and high-income countries and shows that high-income countries have greater programme development and implementation for most types of unintentional injuries and violence. Table 6 provides the types of injuries and violence lacking programme development and implementation for each country. For some issues such as collective violence, a substantial proportion of data were missing.

2.5 Public policy and legislation on violence and unintentional injuries

Eighteen focal persons reported that their country has an official policy on preventing and controlling unintentional injuries, with substantial differences between high-income countries (12/15) and low- and middle-income countries (6/16). In five countries, the health ministry had led in developing the official policy, in six the health ministry had done this with another ministry and in five the health ministry had no involvement. Those without such policies are the high-income countries Israel and Malta and the low- and middle-income countries Albania, Armenia,

Fig. 3. Comparison of programme development and implementation in low- and middle-income countries and high-income countries by cause of unintentional injury and violence



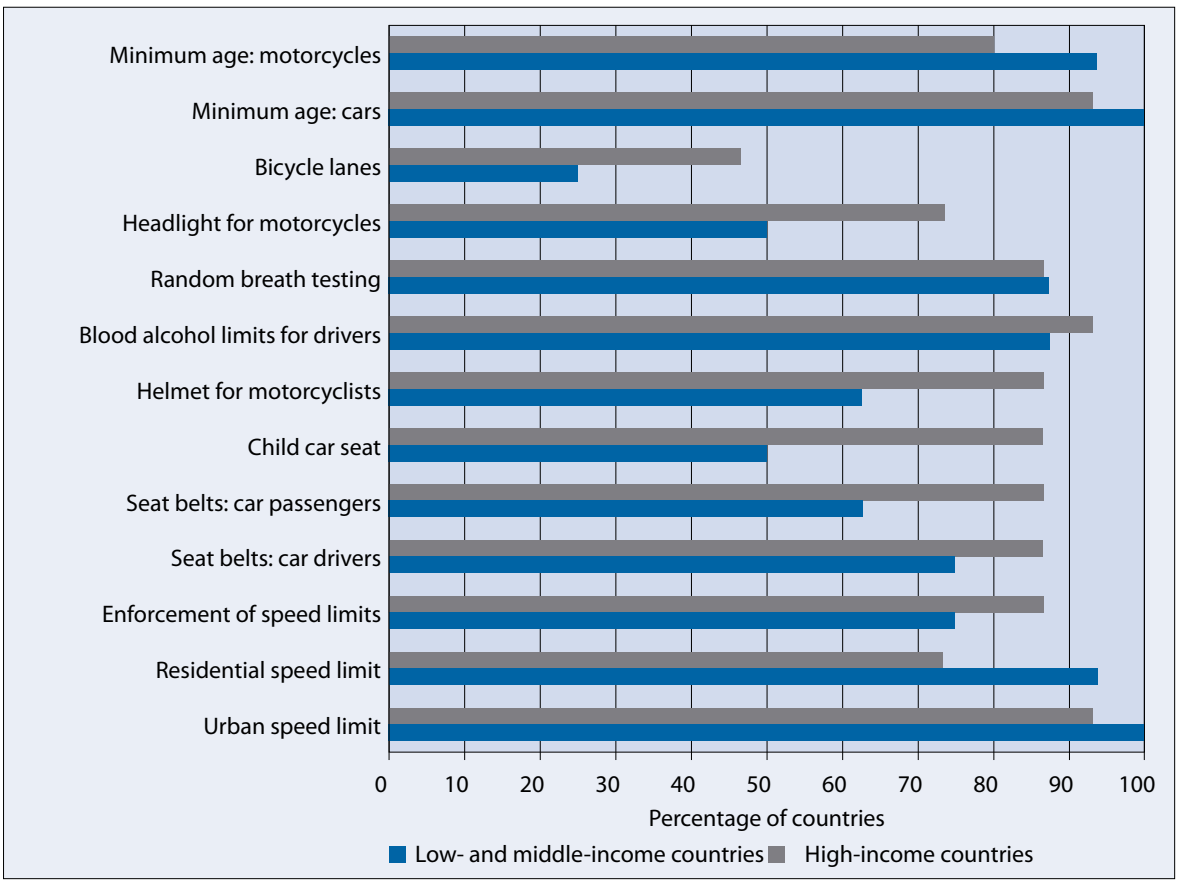
Bulgaria, the Czech Republic, Estonia, Georgia and Turkey. In terms of policy implementation, four countries reported that the health ministry led on this; in eight the health ministry did this partnered with another ministry; and four reported no health ministry involvement. With policy evaluation, four reported that the health ministry led on this; six that the health ministry did this with another ministry; and four that the health ministry had no involvement.

Eleven respondents reported that their country has an official policy on preventing and controlling violence, with similar proportions in high-income countries and low- and middle-income countries. Those with no such policy were the high-income countries Austria, Cyprus, Israel, Italy, Malta, Slovenia and the United Kingdom and the low- and middle-income countries Albania, Armenia, Bulgaria, the Czech Republic, Estonia, Georgia, Lithuania, Monaco, the Russian Federation, Turkey and Turkmenistan. Three countries indicated that the health ministry led in developing the official policy; six that the health ministry did this with another ministry; and in three the health ministry had no involvement in implementing policy. The distributions for implementation and evaluation were similar.

Sixteen countries reported having an official gender policy: 11/15 high-income countries versus 5/16 low- and middle-income countries. Those with no policy were the high-income country Israel and the low- and middle-income countries Armenia, the Russian Federation, The former Yugoslav Republic of Macedonia and Turkey. In 12 countries the health ministry had a gender policy, and in 7 countries this was related to injury and violence prevention.

Most countries reported having laws for preventing road traffic injuries, with a similar pattern for low- and middle-income countries and high-income countries (Fig. 4).

Fig. 4. Percentage of countries with laws for preventing road traffic injuries in low- and middle-income countries and high-income countries



Both high-income countries and low- and middle-income countries had laws for preventing violence in the community in force (Fig. 5). However, those for preventing violence in the family seemed to be more prevalent in high-income countries than in low- and middle-income countries, such as establishing special services for victims of sexual assault and intimate partner violence (12/15 high-income countries versus 11/16 low- and middle-income countries); and prosecution of perpetrator of child abuse and neglect (13/15 high-income countries versus 9/16 low- and middle-income countries).

2.6 Comments by respondents

Twelve focal persons responded with other comments on the activity and capacity for preventing unintentional injury and violence within their country. Of these, nine identified areas of development for their own country: Albania, Croatia, Czech Republic, Finland, the Netherlands, Russian Federation, Slovakia, Slovenia and The former Yugoslav Republic of Macedonia. Four main themes arose: more resources; the need for improved systems including data collection systems; more national coordination; and more WHO support. For example, The former Yugoslav Republic of Macedonia stated:

> There is a need to increase the unintentional injury and violence prevention to a higher level since this is a serious global public health problem with high priority. There is a need to increase the awareness about unintentional injury and violence among the general population and specific vulnerable groups. It is necessary to prepare a national strategy for unintentional injury and violence prevention. Develop a national health information system with incorporated subsystem for injuries and violence. Establishment of a national committee for injury and violence.

Table 6. Types of injuries and violence for which there is no programme development or implementation in specific countries (X denotes no activity)

Country	Road accidents	Accidents caused by fire and flames	Accidental drowning and submersion	Accidental falls	Accidental poisoning
Albania	X	X	X	X	X
Armenia	X			X	X
Austria					
Belarus	X	X	X	X	X
Belgium		X	X	X	X
Bulgaria					
Cyprus				X	
Croatia					X
Czech Republic		X	X		X
Denmark				X	X
Estonia					
Finland					
Georgia	X	X	X	X	X
Israel		X	X		X
Italy					
Latvia	X	X	X		X
Lithuania		X	X	X	X
Malta					X
Monaco	X	X	X	X	X
Netherlands					
Norway					
Romania	X	X	X	X	X
Russian Federation	X	X	X	X	X
Slovakia				X	X
Slovenia					
Spain					
Switzerland					
The former Yugoslav Republic of Macedonia	X	X	X		X
Turkey			X		X
Turkmenistan					
United Kingdom					

Three countries provided more detail about activity in their own country: Cyprus, the Netherlands and Slovakia. Regarding how WHO could contribute to preventing unintentional injuries and violence in their countries, the main themes were liaison with health ministries and financial and technical support for development activity (Armenia, Croatia, the Czech Republic, Romania, the Russian Federation, Slovakia, Slovenia and The former Yugoslav Republic of Macedonia). Support was requested for injury surveillance, capacity-building and developing networks. These themes are illustrated by Israel's response:

> There are many ways in which WHO can contribute to injury and violence prevention in Israel. First of all the ability to lean on the knowledge, experience and reputation of WHO will strengthen any attempt to implement an intervention or

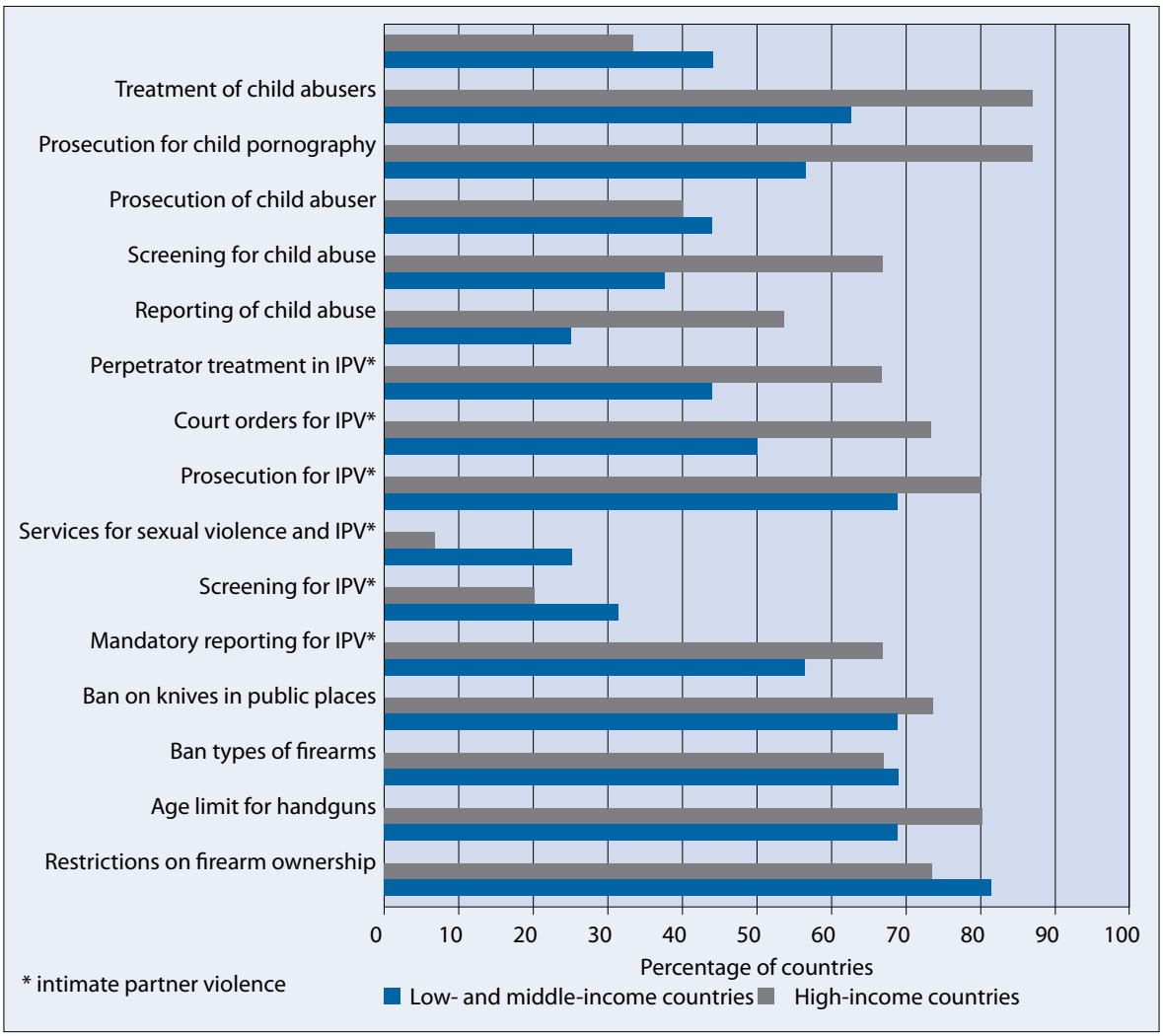
Inter-personal violence	Youth violence	Child abuse and neglect	Intimate partner violence	Abuse and neglect of older people	Sexual violence	Self-directed violence	Collective violence
X	X		X	X	X	X	X
X		X	X	X	X	X	X
	X			X	X		X
X	X	X	X	X	X	X	X
						X	X
							X
					X	X	X
X			X			X	X
X	X	X	X	X	X	X	X
				X			
				X			X
X							
X	X	X	X	X	X	X	X
				X	X	X	X
	X	X	X	X	X		X
X	X	X	X	X	X	X	X
X				X			X
X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X
				X		X	X
	X			X			X
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X
X	X	X	X	X	X	X	X
		X	X	X	X		
				X		X	
						X	X
X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X

prevention programme. Secondly, one of the major problems in Israel is obtaining funding for such actions. Resources are very limited in our country, and they are often directed to more acute areas of care, leaving no funds for prevention. WHO support for projects may significantly change this situation and improve safety and health. Furthermore, we believe that once such programmes are shown to be beneficial, it will encourage local sources to contribute funds for future actions in these areas.

Others requested from WHO the dissemination of good practice, the development of standardized approaches, organizing international conferences and developing a European network on preventing violence and injuries. The Netherlands also commented on:

> Using "Injury" as a concept including all causes from accidents, whether traffic, occupational, home and leisure, and from violence.

Fig. 5. Percentage of countries with laws for preventing violence in high-income countries and low- and middle-income countries



3. Limitations

Despite the overall high response and completeness of information, the survey may be subject to respondent bias because it depends on self-reported information. The questionnaires had many items and required intensive work and information gathering by respondents. Thus, the completeness and accuracy may have varied given the breadth of the subject matter. A large proportion of responses were "don't know", and policies or programmes might actually exist. The authors hope that this may have been minimized, given that the focal persons for violence and injury prevention sought information from more than one source. This may also reflect the fact that the health sector has not yet engaged in that particular area. The method is further limited by the fact that it is a cross-sectional snapshot in time and is therefore not likely to include past policies or activities *(22)*. Those pertaining to environmental, product or behavioural modification may have longstanding effects. Further recall bias is more likely to influence older interventions than more recent initiatives.

Similarly, some interventions require a long period of time before their effects can be measurably shown. Even though this would be reflected as a current priority in the questionnaire, formulated policy may not be effectively implemented and enforced for some years. Further, some countries with a low burden may place injuries lower on the policy agenda than other emerging conditions, although the infrastructural and environmental changes may already be in place. Another important limitation of surveys is that, although inferences can be drawn about associations, this does not apply to conclusions about causality *(23)*. The limitations of the responses to questions on policy development, enactment of laws and programme development are that, although they may be reported as affirmative, they may not yet be implemented or enforced. Whether legislation exists or not hides some complex issues, such as the time taken for enactment, the range of institutions involved in getting measures adopted or enforced and the political system of the country, whether unitary or federal *(22)*. The enactment and enforcement of laws may vary in different parts of a country. Law enforcement requires good governance, and there are concerns about this in many countries. The remit of this survey did not include measuring these. Which measures are selected, when legislation was introduced and how it is enforced are difficult to compare internationally.

4. Discussion

This report summarizes findings from a WHO survey of European countries on the prevention of violence and unintentional injuries and the related policy activities and structures. The key findings are as follows.

- Throughout the survey themes, a clear pattern emerged that **more development** is required within the European Region on prevention of violence and unintentional injuries. This especially applied to low- and middle-income countries, although some high-income countries reported that they did not know whether their country was involved in certain aspects of work the survey covered. There were also reasonable proportions of missing data for certain survey items.
- There is strong support for an **increased role for WHO** as an advocate to national governments on more comprehensive resourcing of these topics and as an arbiter on sharing examples of good practice.
- Although most countries reported national coordination of health-related statistics, only half the countries collected **violence-related statistics** nationally. This was more frequent in low- and middle-income countries than high-income countries. However, almost all countries reported that local agencies (such as hospitals, universities and the police) collect data. Data are not always easily accessible because of limited dissemination.
- Only a quarter of countries reported specific funds allocated within health ministry budgets for activities to prevent unintentional injuries and violence. Preventing unintentional injuries was more likely to have been given priority in the past five years than preventing violence, with more national structures evident to underpin this activity such as national road safety councils.
- Interventions ranged from public awareness campaigns and national strategies to peer education programmes. More **programmes** had been developed and implemented for preventing unintentional injuries than for preventing violence. However, the prevention of unintentional injury tended to focus on road traffic injuries, and the role of alcohol in these, and injuries from fire and flames.
- About two thirds of countries report **national policies** for preventing and controlling injury in relation to gender. Half the countries reported policies on preventing and controlling violence. **Laws** intended to prevent unintentional injury were more common than laws intended to prevent violence. For example, 25 countries reported road safety laws, whereas only 7 countries reported mandatory reporting of domestic violence.

4.1 Encouraging research

Despite the high burden, few countries seem to have devoted adequate resources to preventing unintentional injuries and violence. This is particularly the case for low- and middle-income countries in the Region, which have the highest burden, with injury mortality 3.6 times higher than in high-income countries. Although this survey shows overall that the high-income countries have greater capacity and activity to prevent unintentional injuries than the low- and middle-income countries, this difference is not as marked as might have been expected. The methods used here have shortcomings, as discussed in the section on limitations, and other contextual factors need to be taken into account. Which measures are selected, when legislation was introduced and how it is enforced are difficult to compare internationally *(21,22)*. More research is needed to understand these and other contextual factors.

4.2 Advocating increased resources

The respondents generally agreed that more effort is required to encourage activities to prevent unintentional injuries and violence and for WHO involvement within this. By considering individual country and subregional profiles as well as broader implications, WHO could work with countries on a more targeted and efficient basis. For example, funding was a consistent theme. WHO could advocate more strongly increased national and international funding for these activities. The approaches of

different countries may often necessarily differ. For example, some countries need support for setting up a wide range of infrastructure such as national data systems, policies and laws, whereas others need to strengthen capacity development and programme implementation and evaluation.

4.3 Improving information systems

More specific issues also need to be considered in relation to the four main themes of data systems, coordination, programme development and implementation and public policy and legislation. In relation to data systems, several specific issues need to be considered. Information should be seen as a building-block for planning policy and the development of services. The countries that do not nationally coordinate injury-related data may wish to consider this as a priority. Several international initiatives could lend support. For example, the International Classification of External Causes of Injury *(24)* and WHO's guidelines on injury surveillance *(5)* should aid European countries in further developing national data systems. Further, some countries need to work on related web sites and databases. This would allow greater access to such data by researchers, nongovernmental organizations and other members of civil society in order to raise the prevention of injuries higher on the policy agenda *(13)*. Debate within the European Region on standardizing data classification schemes would also be useful.

4.4 Establishing priorities

The findings of the survey have provided a useful baseline both at the regional level and the country level for the priorities outlined in WHO Regional Committee for Europe resolution RC55/R9 *(18)* (Box 2) and, as highlighted above, are an important starting-point for national and collaborative action.

4.5 Developing a multisectoral approach

In terms of coordination, WHO considers health ministries as key agents in developing the agenda for preventing unintentional injuries and violence. However, this survey shows that health ministries are not the lead agency for many of the activities documented. Nevertheless, they often work in partnership with other ministries and may play a key role in coordinating preventive strategies. This coordinating role needs to be expanded, as recommended by the World Health Assembly resolutions on preventing violence *(15)* and on road safety and health *(16)* as well as by the resolution of the WHO Regional Committee for Europe *(18)*.

Many respondents identified other lead agencies for preventing road traffic injuries, violence and other unintentional injuries. Many countries have activities for preventing road traffic injuries; this suggests that preventive activities could be expanded to other injury causes with a great burden. In addition, many countries reported that health ministry staff members are working on preventing unintentional injury and violence, showing existing commitment in the Region. Further development of national injury prevention committees and national committees on violence prevention could ensure better coordination of the various activities and greater involvement of stakeholders from different sectors and would

Box 2. Essential elements of the WHO framework for preventing unintentional injuries and violence in the European Region

- Developing national action plans for the prevention of violence and unintentional injuries
- Forming a lead multisectoral body to coordinate injury prevention activities across different sectors
- Developing injury surveillance to better define the burden, causes and consequences of injuries, for advocacy and for monitoring and evaluation
- Strengthening technical and institutional capacity for primary prevention and care
- Promoting the implementation of evidence-based approaches towards prevention and care
- Supporting the activities of the network of national focal persons for the prevention of unintentional injuries and violence
- Increasing research and development to overcome current gaps in knowledge
- Allocating adequate resources to implement the above actions

ensure that various ministries and agencies give higher priority to preventing injuries and violence. In addition, large proportions reported a variety of nongovernmental, university, research and media activities in relation to these topics. This expertise needs to be engaged in developing this agenda at the national and regional levels *(13,25)*.

4.6 Enhancing the role of the health sector

Similarly to overall coordination, not all health ministries led on existing programme development and implementation or public policy and legislation for this agenda. WHO may wish to consider this in advocating for a greater role for the health sector, capacity-building and promoting national links for development work. Less than half the countries had implemented work in areas related to preventing violence. Similarly, for drowning, falls and poisoning, few had programmes for implementing prevention. In contrast, programmes for preventing road traffic injuries were much more common. Besides advocacy, WHO could provide specific guidance on what the health sector can do to better fulfil its pivotal role in preventing violence and injury. Several reports and guidelines from WHO could be used to aid European countries in developing a more systematic approach to prevention and development work, ranging from developing policy on injury prevention to preventing road traffic injuries and violence *(10,11,26–28)*. Further, in terms of developing capacity, a curriculum to teach injury epidemiology, advocacy and policy development *(29)* has become available and could be used to enhance national capacity.

4.7 Addressing inequality

Addressing the prevention of injuries and violence requires tackling structural, socioeconomic and gender inequality *(30–32)*. It is encouraging that many countries reported such policies, and work on gender mainstreaming is an example of commitment to address structural inequality *(33)*.

4.8 Using policy and legislative synergy

Synergy is created in tackling violence and unintentional injuries together in terms of laws, risk factors and behaviour *(9)*. An example is alcohol, in which laws, enforcement, access and drinking behaviour influence the incidence and severity of both violence and unintentional injuries. Interestingly, more countries had laws controlling violence in the community, whereas fewer had legislation and services for hidden forms of violence such as intimate partner violence and child abuse.

4.9 The way forward

This survey in the European Region is part of a larger WHO Global Survey of National Responses to Violence and Injuries project *(19)*. It is the first step for WHO in improving the design and planning of its support for efforts to prevent violence and unintentional injuries at the global level. National and regional profiles of activities and policies for preventing violence and unintentional injuries will be documented and used to identify areas requiring greater effort. Such information could also be used to call for resources to tackle violence and injuries and for international bodies such as WHO to support governments by targeting technical assistance (such as capacity-building, methods and analysis) in accordance with local needs.

It is an opportunity for WHO to work in partnership with Member States to build the next steps in the public health approach to preventing violence and injuries, in accordance with the resolution of the WHO Regional Committee for Europe. The survey results can be used as a baseline, and progress towards the goals set out in the resolution can be measured by repeating the survey again in subsequent years.

4.10 Conclusion

This survey provides useful baseline information upon which to build future activity and has indicated a number of areas for development. These include insufficient programmes and laws for preventing violence, falls, drowning and poisoning. Low- and middle-income countries seemed to have fewer initiatives than high-income countries. This report echoes the comments made by individual countries on the need for more resources, improved surveillance, coordination and WHO support. The fact that countries have identified these issues themselves and have indicated a desire to develop this work further gives good impetus for further change.

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Annex 1. Respondents to the WHO European survey on national response to the prevention of unintentional violence and injuries

Country	Respondents
Albania	Silvana Novi, Gezim Licaj, Boris Miska, Margarita Caci
Armenia	Ruzanna Yuzbashyan
Austria	Mathilde Sector, Rupert Kisser
Belarus	Alexander Mukhlia
Belgium	Christiane Hauzeur-Vermeulen
Bulgaria	Fanka Lazarova Koycheva, Galia Krumova Tsolova, Maxim Gaydev, Boriana Maximova, Alexi Kesiakov
Croatia	Vlasta Hrabaxk-Zerjavic, Milena Car, Ines Sprem, Milena Koren
Cyprus	Christodoulos Kaisis, Olga Kalakouta, Stala Kioupi
Czech Republic	Veronika Benesova, Iva Truellova
Denmark	Ministry of the Interior and Health
Estonia	Aidula-Taie Kaasik, Lenno Uusküla
Finland	Merja Soderholm
Georgia	Giorgadze Tea, Saldadze Temur
Israel	Kobi Peleg, Berlowitz Itzhak
Italy	Alessi Mariano, Pitidis Alessio
Latvia	Jautrite Karaskevica
Lithuania	Ramune Meiziene, Ausrute Armonaviciene
Malta	Miriam Camilleri, Maria Attard, Renzo Pace-Asciak, Chiara Borg
Monaco	Anne Negre
Netherlands	Loek J.W. Hesemans
Norway	Ellinor F. Major, Bent Olav Olsen
Romania	Loti Popescu, Daniel Verman
Russian Federation	Larisa Mylnikova
Slovakia	Maria Chmelova, Maria Konecna, Zuzana Vranova, Hana Bartova
Slovenia	Mateja Rok Simon, Barbara Mihevc Ponikvar, Mojca Gruntar Cinc
Spain	Teresa Robledo De Dois
Switzerland	Walter Weiss, Monique Aeschbacher, Lukas Matti, Bernard Perisset, Jean-Marie Bouverat, Roland Allenbach
The former Yugoslav Republic of Macedonia	Tozija Fimka, Snezana Cicevalieva, Jovanov Aleksandar, Spirkoski Vlado, Jovanka Karadzinska Aleksej Duma, Mira Dojcinovska, Marika Karanfilova
Turkey	Tahir Soydal, Nihal Babaliogu, Toker Erguder
Turkmenistan	Begklych Ovezklychev
United Kingdom	Clare McVeigh, Karen Hughes, Mark A. Bellis, John A. Ashton

Annex 2. Questionnaire for the WHO European survey on national response to the prevention of unintentional violence and injuries

Department of Injuries and Violence Prevention
Noncommunicable Diseases and Mental Health

World Health Organization
Organisation Mondiale de la Santé

WHO Global Survey on National Response to Violence and Injuries EUROPEAN REGION

It is estimated that in the European Region almost one million deaths – about 10% of all recorded deaths – result from unintentional injury and violence. This number is small compared to the number of survivors of injury and violence, many of whom suffer life-long health consequences, whose costs are borne by society at large, and by health and welfare systems in particular.

Whereas great progress has been made in understanding the causes of injuries and violence and how to prevent them, there are still numerous deficits in the implementation of this knowledge. In recent years, unintentional injury and violence prevention and control have been promoted as a priority public health area for action, requiring strong leadership from the health sector. WHO is working to place unintentional injury and violence prevention higher on the global public health agenda. As a first step, there is a need to document the policy frameworks, programmes and lead agencies in relation to unintentional injury and violence prevention activities.

This survey of the European Region is part of the WHO Global Survey on National Responses to Violence and Injuries project. It is the first step in the development of an information system to support global violence and unintentional injury prevention efforts. The survey will allow WHO to develop national and regional profiles of violence and unintentional injury prevention activities and policies. It will, therefore, identify areas where more efforts are needed. WHO and its partners will be able to use these profiles to advocate for increased resources to tackle violence and injuries as a public health problem and to share examples of best practice. In addition, WHO will be in a better position to support ministries of health by providing technical assistance (e.g. capacity building, methods, analyses) that better responds to local needs for the implementation and support of violence and injury prevention activities. In addition, WHO will develop a Global Atlas of National Response to Violence and Injuries, describing the results of the survey on a regional and national level, which we will share with the ministries of health. With your permission, country profiles will be published on the WHO web site.

Thank you for taking the time to complete this questionnaire. The questionnaire has 4 sections:

I. Data collection,
II. Coordination, leadership and administration,
III. Programme development and implementation, and
IV. Public policy and legislation.

Please note there is a list of definitions in Annex 3 at the end of the questionnaire.

Country Name:

Respondent 1:
(name and title)
E-mail address:
Postal address:
Telephone number:
Facsimile number:
Date:

Respondent 2:
(name and title)
E-mail address:
Postal address:
Telephone number:
Facsimile number:
Date:

Respondent 3:
(name and title)
E-mail address:
Postal address:
Telephone number:
Facsimile number:
Date:

Respondent 4:
(name and title)
E-mail address:
Postal address:
Telephone number:
Facsimile number:
Date:

If we have questions or require clarification, may we contact you:

☐ Yes

☐ No

How do you prefer we contact you?

☐ E-mail

☐ Telephone

☐ Fax

☐ Post

Please return this questionnaire to:

Dr Dinesh Sethi
Technical Officer
Accidents, Transport and Health

European Centre for Environmental Health
Via Francesco Crispi 10
I-00187 Rome
Italy

Tel.: +39 064877526
Fax: +39 064877599
E-mail: DIN@ecr.euro.who.int

WHO use CODE	Q

I. Data Collection

1. Are there **national** centres / organizations / agencies that collect health-related statistics? For example, a national centre for health statistics or national health information system.

National health information system refers to a nation-wide system that collects data on the occurrence of various health conditions, such as a vital registration system.

Y/N/D 1a ☐ Yes

A single agency (please specify): _____

More than one agency (please specify): _____

_____

☐ No → skip to question 6
☐ Don't know → skip to question 6

2. What classification scheme does the national health information system use to code **unintentional** injury- and violence-related mortality and morbidity data? (Choose those that apply and please indicate, in the space provided, for which type of data this coding is used)

Y/N 2a ☐ ICD 6, 7, or 8 _____

Y/N 2b ☐ ICD 9 _____

Y/N 2c ☐ ICD 10 _____

Y/N 2d ☐ ICECI (International Classification of External Causes of Injury) _____

_____

Y/N 2e ☐ NOMESCO (Nordic Medico-Statistical Committee) _____

NA 2x ☐ Other (specify) _____

Y/N 2g ☐ Don't know

Y/N **3.** Is data collected by the national health information system disaggregated by sex?

3a ☐ Yes
☐ No
Y/N ☐ Don't know

Is data collected by the national health information system disaggregated by age?

3b ☐ Yes
☐ No
☐ Don't know

4. Please describe in more detail the **unintentional injury- and violence-related** data that are collected by this system(s).

WHO use CODE	Q	Category		Is data collected?
Y/N/D	4a	Motor vehicle traffic accidents	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4b		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4c	Accidents caused by fire and flames	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4d		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4e	Accidental drowning and submersion	Near drowning (non-fatal)	☐Yes ☐No ☐Don't know
Y/N/D	4f		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4g	Accidental falls	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4h		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4i	Accidental poisoning	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4j		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4k	Interpersonal violence	Non-fatal assaults	☐Yes ☐No ☐Don't know
Y/N/D	4l		Homicide	☐Yes ☐No ☐Don't know
Y/N/D	4m	Youth violence	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4n		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4o	Child abuse and neglect	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4p		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4q	Intimate partner violence	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4r		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4s	Abuse and neglect of older people	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4t		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4u	Sexual violence	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4v		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4w	Self-directed violence	Non-fatal attempts	☐Yes ☐No ☐Don't know
Y/N/D	4aa		Suicide deaths	☐Yes ☐No ☐Don't know
Y/N/D	4ab	Collective violence	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4ac		Deaths	☐Yes ☐No ☐Don't know
Y/N/D	4ad	Gender-based violence	Injuries	☐Yes ☐No ☐Don't know
Y/N/D	4ae		Deaths	☐Yes ☐No ☐Don't know

WHO use CODE	Q
Y/N	5a
Y/N	5b
Y/N	5c
NA	5x

5. How are **unintentional** injury and violence statistics made accessible? (check all that apply)

☐ Printed reports

☐ Web site (please specify web address): _____

☐ Electronic database (please specify who maintains this): _____

_____

☐ Other (specify: _____

_____

Y/N/D	6a
NA	6x

6. To your knowledge, are there other ministries, institutions/organizations who collect unintentional injury- and violence-related data?
For example, hospitals, universities, NGOs, police, etc.
If yes, please specify.

☐ Yes _____

_____

☐ No

☐ Don't know

II. Coordination, Leadership and Administration

7. In the **Ministry of Health** are there staff working in unintentional injury and violence prevention?

Y/N/D	7a

☐ Yes

☐ No → skip to question 8

☐ Don't know → skip to question 8

If yes, approximately how many staff work on unintentional injury and violence prevention activities? Please **exclude** personnel working in clinical activities.

Clinical activities refer to any activity involving direct medical care of an injured person.

Staff working full-time

Y/N	7aa
Y/N	7ab
Y/N	7ac
Y/N	7ad
Y/N	7ae

☐ 1–5

☐ 6–10

☐ 11–15

☐ 16–20

☐ 21 or more

Staff working part-time (<20 hours per week)

Y/N	7af
Y/N	7ag
Y/N	7ah
Y/N	7ai
Y/N	7aj

☐ 1–5

☐ 6–10

☐ 11–15

☐ 16–20

☐ 21 or more

WHO use CODE	Q

8. Within the Ministry of Health budget, are funds allocated **specifically** for **unintentional injury** (road traffic injuries, drowning, burns, falls and poisoning) prevention?

Y/N/D 8a

☐ Yes
☐ No
☐ Don't know

9. Within the Ministry of Health budget, are funds allocated **specifically** for **violence** (e.g. homicide, non-fatal assault, sexual violence, intimate partner violence, youth violence, suicide, etc.) prevention?

Y/N/D 9a

☐ Yes
☐ No
☐ Don't know

10. To your knowledge, has the Ministry of Health in your country identified unintentional injuries and/or violence prevention as a priority area over the past 5 years?

Unintentional injuries

Y/N/D 10a

☐ Yes, year: _____
☐ No
☐ Don't know

Violence

Y/N/D 10b

☐ Yes, year: _____
☐ No
☐ Don't know

If yes, does your country have national targets for the reduction **of unintentional injury** mortality?

Y/N/D 10c

☐ Yes
☐ No
☐ Don't know

If yes, please specify what this target is (Please provide full details, including the type of injury, the reduction aimed for and the time period e.g. reduction in road traffic injury mortality by 50% by the year 2012)

Y/N/D 10x

_____
_____
_____

If yes, does your country have national targets for the reduction of **violence** mortality?

10d

☐ Yes
☐ No
☐ Don't know

If yes, please specify what this target is? (Please provide full details, including the reduction aimed for, the type of injury, and the time period e.g. 10% reduction in homicides by the year 2010)

10xi

_____
_____
_____

WHO use CODE	Q
Y/N	11a
Y/N	11b
Y/N	11c
Y/N	11x

11. In your country, are there any national councils and/or committees that focus on unintentional injury and violence prevention?

☐ National Injury Prevention Coalition/Committee
☐ National Road Safety Council
☐ National Committee on Domestic Violence or Violence Against Women
☐ Other:

_____
_____
_____
_____

NA 11e ☐ Don't know

12. Which of the following ministries is/are conducting unintentional injury and violence prevention activities in your country? (tick all that apply)

Y/N 12a ☐ Ministry of Health
Y/N 12b ☐ Ministry of Education
Y/N 12c ☐ Ministry of Justice
Y/N 12d ☐ Ministry of Transportation
Y/N 12e ☐ Ministry of Social Welfare/Social Services
Y/N 12f ☐ Ministry of Finance/Trade/Commerce
Y/N 12g ☐ Ministry of Labour
Y/N 12h ☐ Ministry of Infrastructure
Y/N 12i ☐ Ministry of Domestic Affairs
Y/N 12x ☐ Other (please specify) _____

_____
_____
_____

13. Is there an agency/ministry which is regarded as the **lead** agency/ministry for **road traffic injury** prevention in your country? If yes, please provide details

Y/N/D 13a ☐ Yes

_____
_____
_____
_____

NA 13x ☐ No
☐ Don't know

14. Is there an agency/ministry which is regarded as the **lead** agency/ministry for **interpersonal violence** (e.g. homicide, non-fatal assault, sexual violence, child abuse and neglect, intimate partner violence, youth violence, suicide, etc.) prevention in your country? If yes, please provide details

Y/N/D 14a ☐ Yes

_____
_____
_____

NA 14x ☐ No
☐ Don't know

WHO use CODE	Q
Y/N/D	15a
NA	15x

15. Is there an agency/ministry which is regarded as the **lead** agency/ministry for **other unintentional injuries** (drowning, falls, poisoning, burns) prevention in your country? If yes, please provide details

☐ Yes

_____

_____

_____

_____

☐ No

☐ Don't know

16. In the preceding questions you identified the ministries in which unintentional injury and violence prevention and control activities are occurring in your country. Do you know of individuals/units/departments in these ministries whom we may contact for further information? Please provide us with contact information.

Y/N	16a
NA	16x

Name/Title _____

Ministry/Department _____

Postal Address _____

City/Country _____

E-mail _____

Telephone _____

Fax _____

NA	16x

Name/Title _____

Ministry/Department _____

Postal Address _____

City/Country _____

E-mail _____

Telephone _____

Fax _____

NA	16xii

Name/Title _____

Ministry/Department _____

Postal Address _____

City/Country _____

E-mail _____

Telephone _____

Fax _____

WHO use CODE	Q
Y/N/D	17a
NA	17x

17. Are there any nongovernmental organizations currently focusing upon any type of injuries as their prime concern: e.g. traffic safety, intimate partner violence, child abuse, child safety, adolescent suicide etc.? If yes, please list the organizations, their concerns and contact details

☐ Yes

☐ No

☐ Don't know

WHO use CODE	Q
Y/N/D	18a
NA	18x

18. Are there any universities or research bodies which are currently focusing upon any type of injuries as research interest: e.g. traffic safety, intimate partner violence, child abuse, child safety, adolescent suicide etc.? If yes, please list the institutes, their concerns and contact details

☐ Yes

☐ No

☐ Don't know

WHO use	
CODE	Q
Y/N/D	19a
NA	19x

19. Has the media indicated any interest in injuries as a social and health problem? If yes, can you cite examples?

☐ Yes

☐ No

☐ Don't know

III. Programme development and implementation

20. This question is intended to explore specific interventions for the **prevention of unintentional injury and/or violence** implemented in your country, whether the Ministry of Health has served as the implementing agency and asks you to identify if partner agencies or organizations are co-sponsors or co-implementers. The column on the left lists the unintentional injury/injury risk area. In the next column (column 1), check "yes" or "no" depending on whether or not a given intervention is in place in your country. In column 2 indicate whether the Ministry of Health is the lead organization. In column 3, indicate whether other agencies or organizations have partnered with the Ministry of Health to implement the intervention. If the Ministry of Health is **not** the lead organization, then provide the name of this organization in column 4. In column 5, please indicate the type(s) of intervention; an *example* is given. In column 6, please identify the partner agency with whom the Ministry of Health collaborates; an *example* is given.

WHO use					
CODE	Q		INTERVENTIONS for the prevention of unintentional injury and/or violence	Implemented	Is the MoH the leading organization
Y/N Y/N Y/N Comment Comment	Ai aii aiii axi axii		Motor vehicle traffic accidents	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Bi bii biii bxi bxii		Alcohol in road traffic injuries	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Ci cii ciii cxi cxii		Accidents caused by fire and flames	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Di dii diii dxi dxii		Accidental drowning and submersion	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Ei eii eiii exi exii		Accidental falls	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Fi fii fiii fxi fxii		Accidental poisoning	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Hi hii hiii hxi hxii		Youth violence	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Jai jii jiii jxi jxii		Child abuse & neglect	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Ki kii kiii kxi kxii		Intimate partner violence	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Li lii liii lxi lxii		Elder abuse and neglect	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Mi mii miii mxi mxii		Sexual violence	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Ni nii niii nxi nxii		Self-directed violence	☐Yes ☐No	☐Yes ☐No
Y/N Y/N Y/N Comment Comment	Oi oii oiii oxi oxii		Collective violence	☐Yes ☐No	☐Yes ☐No

	Is there a partner agency	Leading organization, if different from MoH	Type of program e.g. Pedestrian awareness campaign	Partner name e.g. Citizens' Safety Council
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

WHO use CODE Q

IV. Public Policy and Legislation

21. Does your country have an official injury prevention & control policy?

For the purpose of this survey, an official injury prevention and control policy refers to a written document endorsed by the government and/or parliament, which includes a set of statements and decisions defining responsibilities, principles, goals, priorities and main directions for attaining the goals.

Y/N/D 21a

☐ Yes
☐ No
☐ Don't know

If yes, please use the table below to describe the role of the Ministry of Health in the development, implementation, and evaluation of the national injury prevention policy: (check a box for each level of involvement)

Ministry of Health had involvement in:	**The Ministry of Health contributed in which manner?**		
	Lead	Partnered with other ministry	No involvement
Development of the policy			
Implementation of the policy			
Evaluation of the policy			

Y/N 21aa
Y/N 21ab
Y/N 21ac
Y/N 21ad
Y/N 21ae
Y/N 21af
Y/N 21ag
Y/N 21ah
Y/N 21ai

22. Does your country have an official violence prevention & control policy?

For the purpose of this survey, an official violence prevention and control policy refers to a written document endorsed by the government and/or parliament, which includes a set of statements and decisions defining responsibilities, principles, goals, priorities and main directions for attaining the goals.

Y/N/D 22a

☐ Yes
☐ No
☐ Don't know

If yes, please use the table below to describe the role of the Ministry of Health in the development, implementation, and evaluation of the national injury prevention policy: (check a box for each level of involvement)

Ministry of Health had involvement in:	**The Ministry of Health contributed in which manner?**		
	Lead	Partnered with other ministry	No involvement
Development of the policy			
Implementation of the policy			
Evaluation of the policy			

Y/N 22aa
Y/N 22ab
Y/N 22ac
Y/N 22ad
Y/N 22ae
Y/N 22af
Y/N 22ag
Y/N 22ah
Y/N 22ai

WHO use CODE	Q	
		23. Does your country have an official Gender Policy? *For definition of an official policy please see q 22 above and or annex.*
Y/N/D	23a	☐ Yes ☐ No ☐ Don't know
		If yes, does the Ministry of Health have a Gender Policy?
Y/N/D	23b	☐ Yes ☐ No ☐ Don't know
		If yes, is the Gender Policy mentioned in injury- and violence-related policy?
Y/N/D	23c	☐ Yes ☐ No ☐ Don't know
		24. In your country, have national laws been enacted related to the following areas: (check all that apply)
Y/N	24a	☐ Maximum speed limit for urban areas (specify in kph _____
Y/N	24b	☐ Maximum speed limit for residential areas (specify in kph _____
Y/N	24c	☐ Enforcement of the speed limit with the use of speed cameras or radar guns
Y/N	24d	☐ Mandatory safety belt use for **all** drivers of motor vehicles
Y/N	24e	☐ Mandatory safety belt use for passengers in motor vehicles
Y/N	24f	☐ Mandatory child safety seat use in motor vehicles
Y/N	24g	☐ Mandatory helmet use while riding on motorcycle or scooter
Y/N	24h	☐ Maximum blood alcohol concentration for drivers of motor vehicles (specify level and units, e.g. g/dl : _____
Y/N	24i	☐ Enforcement of this by **random** alcohol breath tests by the police
Y/N	24j	☐ Mandatory use of headlights during daytime for motorbikes and scooters
Y/N	24k	☐ Bicycle lanes to separate bicycles from other traffic
Y/N	24l	☐ Minimum legal age to obtain licence for driving cars (specify age in years: _____
Y/N	24m	☐ Minimum legal age to obtain licence to drive motorbikes (specify age in years: _____
Y/N	24n	☐ Minimum legal drinking age (specify age in years: _____
Y/N	24o	☐ Legal restrictions that apply to ownership of firearms
Y/N	24p	☐ Minimum legal age to obtain licence to use handguns (specify age in years: _____
Y/N	24q	☐ Specific **types** of firearms are nationally and/or regionally banned (i.e. no person apart from police or military authorities are legally entitled to purchase or own these weapons).
Y/N	24r	☐ Legal restrictions that apply to carrying knives in public places
Y/N	24s	☐ Mandatory reporting of domestic violence or intimate partner violence
Y/N	24t	☐ Screening for intimate partner or domestic violence within the health sector
Y/N	24u	☐ Establishing special services for victims of sexual and / or domestic violence (e.g. crisis centres, emergency care, shelters)
Y/N	24v	☐ Prosecution of intimate partner or domestic violence
Y/N	24w	☐ Court protection orders to prevent proximity of violent partner
Y/N	24aa	☐ Treatment of perpetrators of intimate partner or domestic violence
Y/N	24ab	☐ Mandatory reporting of child abuse and neglect

WHO use CODE	Q	
Y/N	24ac	☐ Screening for child abuse and neglect within the health sector
Y/N	24ad	☐ Prosecution of perpetrator of child abuse and neglect
Y/N	24ae	☐ Prosecution for child pornography
Y/N	24af	☐ Mandatory treatment of child abuse offenders
Y/N	24x	☐ Other:

_____

_____

Y/N 25a **25.** Do you have any other comments on unintentional injury and violence prevention activity and capacity in your country.

NA 25x

_____

_____

_____

_____

Y/N 26a **26.** How can the World Health Organization contribute to unintentional injury and violence prevention work in your country?

NA 26x

_____

_____

_____

_____

Thank you

Annex 3. Definitions

Here are some definitions of the terms referred to in the survey. The unintentional injury definitions are taken from various sources, as noted after each definition, and the violence definitions are taken from the *World report on violence and health*.

Motor vehicle accidents: Accidents included are those: a) which occurred or originated on a way or street open to public traffic; b) which resulted in one or more persons being killed or injured and c) in which at least one moving vehicle was involved. These accidents therefore include collisions between vehicles, between vehicles and pedestrians, and between vehicles and animals of fixed obstacles. Singe vehicle accidents, in which one vehicle alone (and no other road users) was involved, are included. Multi vehicle collisions are counted as only one accident provided that the successive collisions happen at very short intervals. (United Nations Economic Commission for Europe, *Statistics of road traffic accidents in Europe and North America, 2001*, United Nations New York and Geneva 2001)

Accidents caused by fire and flames: According to the International Society for Burn Injuries, a burn occurs when some or all of the different layers of cells in the skin are destroyed by a hot liquid (scald), a hot solid (contact burns) or a flame (flame burns). Skin injuries due to ultraviolet radiation, radioactivity, electricity or chemicals, as well as respiratory damage resulting from smoke inhalation, are also considered to be burns.

Accidental drowning and submersion: Drowning is the process of experiencing respiratory impairment from submersion/immersion in liquid. Drowning outcomes are classified as death, morbidity and no morbidity. Agreed terminology is essential to describe the problem and to allow effective comparisons of drowning trends (definition adopted by the 2002 World Congress on Drowning).

Accidental falls: A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Within the WHO database, fall-related deaths and non-fatal injuries exclude those due to assault and intentional self-harm. Falls from animals, burning buildings and transport vehicles, and falls into fire, water and machinery are also excluded.

Accidental poisoning: All unintentional poisoning-related deaths and non-fatal outcomes caused by exposure to noxious substances. Those which are intentional or for which the intent is undetermined as well as those resulting from reactions to drugs are excluded from this definition (*International Statistical Classification of Diseases and Related Health Problems*, tenth revision. Volume 1: tabular list, Geneva, WHO, 1992)

Child abuse: Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship or responsibility, trust or power.

Collective violence: the instrumental use of violence by people who identify themselves as members of a group – whether this group is transitory or has a more permanent identity – against another group or set of individuals, in order to achieve political, economic or social objectives.

Elder abuse: a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. Such abuse is generally divided into the following categories: physical abuse, psychological or emotional abuse, financial or material abuse, sexual abuse, and neglect.

Gender-based violence: refers to violence against women and includes two main public health problems of intimate partner violence (or domestic violence) and sexual violence.

Interpersonal violence: includes homicide and non-fatal physical assaults.

Intimate partner violence: any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Also referred to as domestic violence. Such behaviours include acts of aggression, psychological abuse, forced intercourse or other forms of sexual coercion, and various controlling behaviours. (The overwhelming burden of partner violence is borne by women at the hands of men.)

Official policy: refers to a written document endorsed by the government and/or parliament, which includes a set of statements and decisions defining responsibilities, principles, goals, priorities and main directions for attaining the goals.

Self-directed violence: includes suicide and self-mutilation.

Sexual violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Youth violence: includes violence in gangs, in schools and by young people on the streets (young people in the *World report on violence and health* are defined as 10–29 years of age).

Nearly 800 000 people in the European Region of WHO are killed annually by injuries, whether these are intentional or unintentional. Preventing and controlling unintentional injuries and violence comprises a priority for public health action requiring strong leadership from the health sector. To understand the extent of the response to date and to identify areas where more action may be needed, a European survey of national responses to the prevention of violence and unintentional injuries has been conducted. The focal persons on violence and unintentional injury prevention appointed by health ministries participated in the survey. Thirty-one of the 42 countries to which it was sent, returned the questionnaires, a response rate of 74%. The survey shows that few countries have developed an adequate structural response or devoted adequate resources to the problem. This especially applies to low- to middle-income countries in the Region, which have the highest burden of injuries. These results demonstrate that more concerted action is needed. This includes the need for advocacy, surveillance, building capacity, developing policy and mobilizing resources. The results form a useful baseline for assessing future activities and identifying country-specific areas that could be targeted for further development.

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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