World Health Organization
REGIONAL OFFICE FOR Europe

European facts and the *Global status report on violence prevention 2014*

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Francesco Mitis, Dinesh Sethi, Vittoria Crispino and Gauden Galea

ABSTRACT

This regional fact sheet is published with the first *Global status report on violence prevention 2014* and assesses measures countries are taking to prevent violence. Data were collected in 41 of the 53 countries of the WHO European Region and new global, regional and national estimates of homicide were computed. The findings show that nearly 35 000 people were victims of homicides in 2012. Those most at risk are males aged 30–59 years. The non-fatal effects of violence are enormous and far-reaching and pose a strain on health systems and societies. More data-informed national plans need to be developed in the Region. Countries are investing in solutions to prevent violence, but scaling-up is urgently required. Laws to protect against violence have been widely enacted, but reported enforcement is inadequate and needs to be improved. Health systems need to take the lead on developing quality services to identify, refer, protect and support victims. Policy-makers and practitioners from different sectors need to work together to implement evidence-informed solutions that focus on equity and the life-course approach.

Keywords
Violence – prevention and control
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KEY FACTS

- Nearly 35 000 people in the WHO European Region died from homicide in 2012.
- Younger and middle-aged adults aged 30–59 years are at higher risk of being murdered.
- Males are three times more likely to be victims of homicide.
- Homicide rates vary greatly across the Region, with those in the Commonwealth of Independent States being 10 times higher than in the European Union.
- Death rates due to interpersonal violence are declining throughout the Region and there is convergence between Commonwealth of Independent States and European Union countries.
- For every homicide, 43 people are admitted to hospital and 262 attend emergency departments for treatment of violent assaults.
- Population surveys show that tens to hundreds of millions of people in the Region are affected by non-fatal interpersonal violence.
- More national action plans that are informed by data from surveys need to be developed.
- Many more countries need to undertake surveys to inform planning and evaluation.
- Countries are investing in solutions to prevent violence, but scaling-up is much needed.
- Alcohol consumption is strongly linked to violence and more fiscal and legal measures to reduce access to alcohol are required to tackle its harmful use.
- Laws to protect against violence have been widely enacted, but reported enforcement is inadequate.
- The availability of services to identify, refer, protect and support victims varies markedly and their number and quality need to be improved considerably.
- Violence prevention requires multiple sectors to work together to implement evidence-informed solutions that focus on equity and the life-course approach.

Photo: Fotolia

PART 1. BACKGROUND

PURPOSE

This regional fact sheet is published with the first *Global status report on violence prevention 2014 (1).* It aims to assess measures countries are taking to prevent violence since they committed to implementing the recommendations of the *World report on violence and health (2,3).*

Data were collected in 41[1] of the 53 countries of the WHO European Region. Of these, 25 are high-income countries (HICs) and 16 are low- and middle-income countries (LMICs); together they represent 83% of the Region's 900 million people. The rigorous methodology employed, which adopted a consensus approach involving multisectoral stakeholders, is described in the *Global status report on violence prevention 2014 (1)* (Fig. 1). This document considers 21 participating countries from the 28 European Union (EU) countries and 10 from the 12 Commonwealth of Independent States (CIS)[2] countries for subregional analyses.

Fig. 1. Methodology

Source: WHO *(1).*

The findings complement and update those from previous European regional reports on violence prevention: *Preventing injuries in Europe: from international collaboration to local implementation (4), European report on preventing violence and knife crime among young people (5), European report on preventing elder*

[1] Countries that participated in the survey are classified by income groups according to the 2012 World Bank definition. High-income countries include: Austria, Belgium, Croatia, Cyprus, Czech Republic, Estonia, Finland, Germany, Iceland, Israel, Italy, Latvia, Lithuania, Netherlands, Norway, Poland, Portugal, Russian Federation, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland and United Kingdom. Low- and middle-income countries comprise: Albania, Armenia, Azerbaijan, Belarus, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Romania, Serbia, the former Yugoslav Republic of Macedonia, Tajikistan, Turkey and Uzbekistan.

[2] This group of countries includes all the official and unofficial members as of 2006: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan – Turkmenistan and Ukraine did not participate in the survey.

maltreatment (6), and *European report on preventing child maltreatment (7).*

Interpersonal violence: a universal challenge

Violence is "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 or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" *(2).* It presents a universal challenge. This fact sheet documents Europe's status in relation to interpersonal violence between family members, friends, acquaintances and strangers. It includes child maltreatment, youth, intimate-partner and sexual violence, and elder abuse. Self-inflicted and collective violence are not part of the assessment and have been described in other reports *(2,8).*

Calls to action

Violence prevention has been a priority justice and rights issue for the United Nations since 1986, and the World Health Assembly declared violence a leading global public health problem in 1996 *(9).* The *World report on violence and health (2)* and accompanying World Health Assembly resolution WHA56.24 *(3)* asked governments to involve a range of stakeholders in developing plans for evidence-based solutions. WHO Regional Committee for Europe resolution EUR/RC5/R9 on the prevention of injuries emphasises the burden of interpersonal violence and need for action in the Region *(10).* The World Health Assembly requested a global plan of action on violence prevention in 2014 *(11)*, and the *Global status report on violence prevention 2014 (1)* will serve as a baseline measure for this. Member States of the European Region have approved the European child maltreatment prevention action plan 2015–2020 *(12)*, which is firmly rooted in the principles of equity, the life-course approach, multisectoral working and evidence-informed action that underpin the overarching WHO European policy for health and well-being, Health 2020 *(13).*

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PART 2. FINDINGS

MORTALITY

In 2012, 34 469 people in the 53 countries of the European Region[3] died from interpersonal violence: 74% (25 454) were males, in whom death rates are three times higher than in females.[4]

Inequalities persist in the European Region

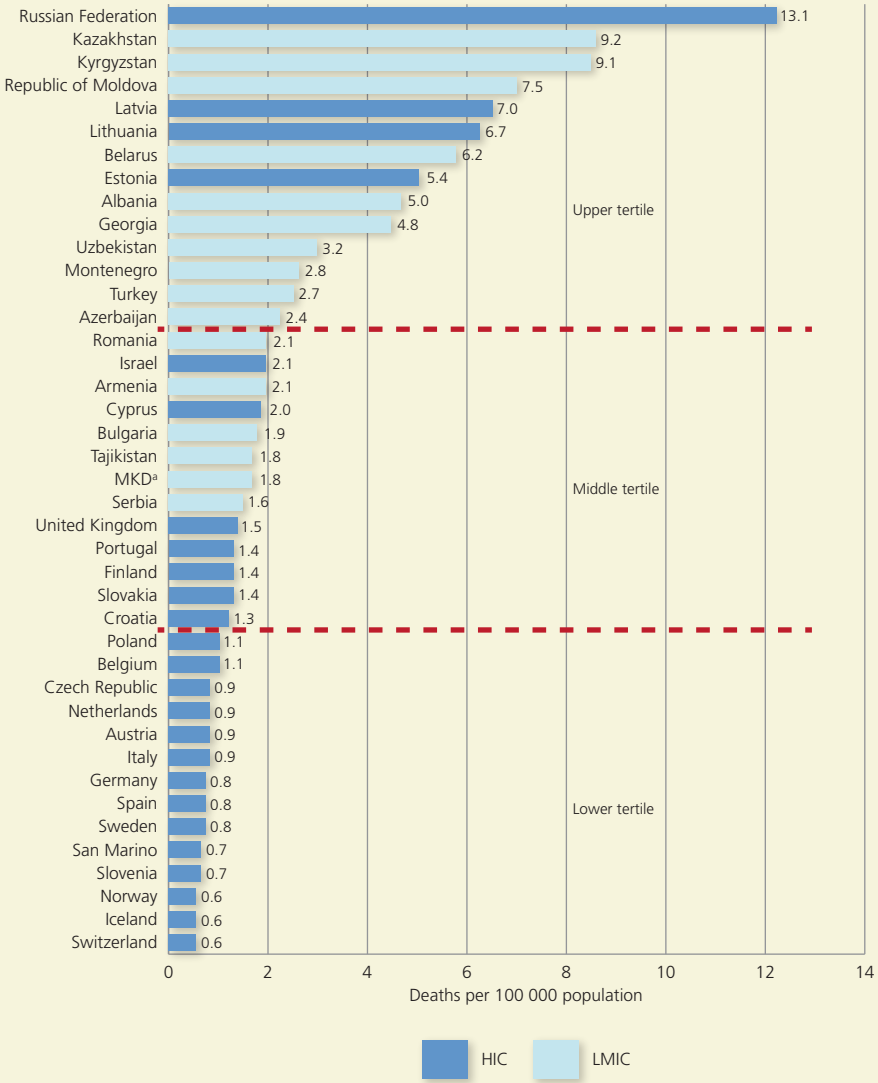
Homicide rates differ greatly in the Region, as shown in Fig. 2. The lowest rates are in HICs that occupy the lowest third (or tertile), with more LMICs seen in the highest tertile. The Russian Federation had the highest death rate in the Region (13.1 per 100 000) and experienced more than 50% of total deaths (18 780), a rate 22 times higher than in the safest countries (0.6 per 100 000 in Norway and Switzerland). The Russian Federation is a HIC: as is the case with the Baltic states of Estonia, Latvia and Lithuania (which have also recently

[3] Number of deaths and mortality rates have been estimated for each country of the Region taking into consideration mortality data provided by: (i) health data held by WHO; (ii) criminal justice statistics held by the United Nations Office on Drugs and Crime; and (iii) data collected through the *Global status report on violence prevention 2014* by national data coordinators (health and police sources) and predictors such as Gini index, corruption index, unemployment rate, gender inequality index and guns per capita. Details on the methodology and its limitations can be found in the full report *(1)*.

[4] When not referenced, findings are based on computations of data collected for the *Global status report on violence prevention 2014 (1)* for the European Region.

Photo: Fotolia

Fig. 2. Mortality rates due to interpersonal violence in the European Region by income levels, 2012



[a] The former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the International Organization for Standardization.

transitioned into the HIC bracket), its high homicide rate suggests that multiple factors other than country income govern fatal violence. Greater wealth, reduced inequalities and increased social capital and social justice are associated with reduced levels of violence at macroeconomic level, and future analyses need to take these social determinants into account *(14)*.

Younger and middle-aged adults bear much of the burden of violent deaths

Sixty per cent of homicides are perpetrated on people aged 30–59 years. The highest death rates are in adults aged 30–44 followed by those aged 45–59: this contrasts with other global regions, where the highest rates are in young people in the 15–29 range. Mortality is higher among males for all age groups. The lowest mortality rates are observed in children aged 5–14 years, where the lowest disparity between the sexes is also seen (Fig. 3).

When taken as a whole, 29% of violent deaths in the European Region are due to sharp force, 27% to firearms, and 44% to other causes (Fig. 4).

Fig. 3. Age- and gender-specific mortality rates due to interpersonal violence in the European Region, 2012

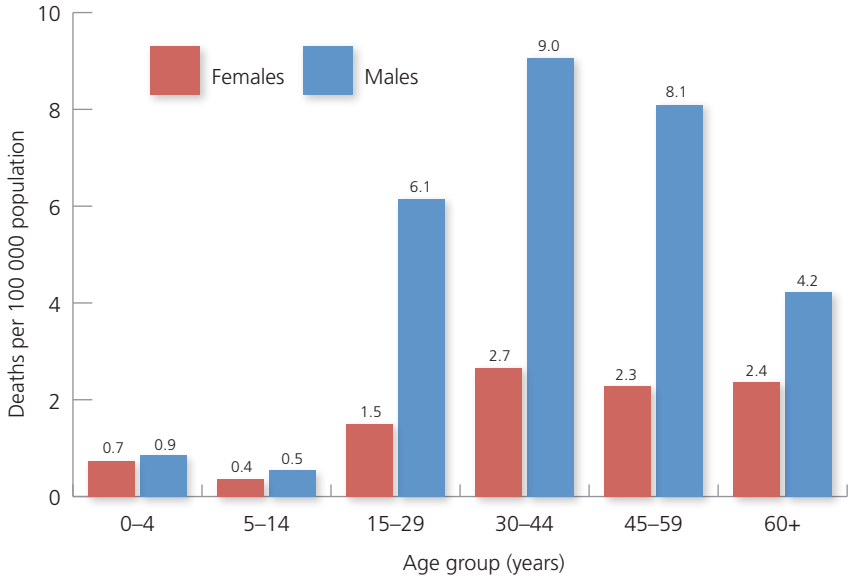
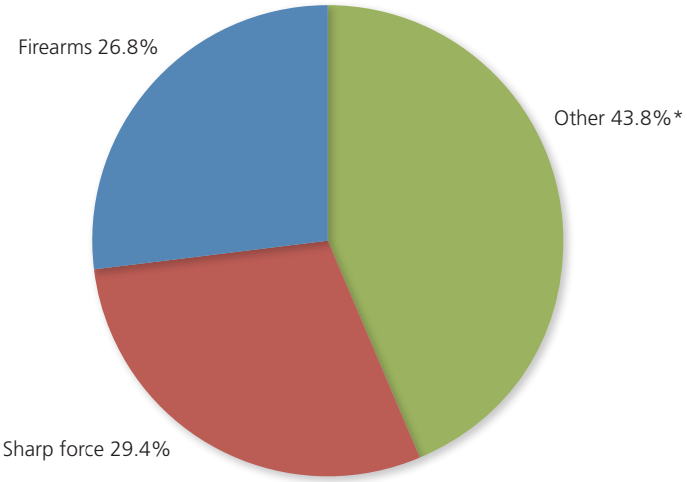


Fig. 4. Mortality due to interpersonal violence by mechanism in the European Region, 2012



* The category "other" includes blunt force, strangulation, burns, other intentional injuries and unknown mechanism.

Homicides are declining throughout the Region

Homicide rates in the Region are declining, falling nearly three-fold (2.75 times) between 1994 and 2010. Peaks in CIS countries in 1994 and 2002 are attributed to periods of political, economic and social transition. Mortality rates are still 10 times higher in the CIS than in the EU (Fig. 5). Some convergence is apparent, however, and rates have fallen faster in the CIS (2.75 times over this period) than in the EU (2.33 times).

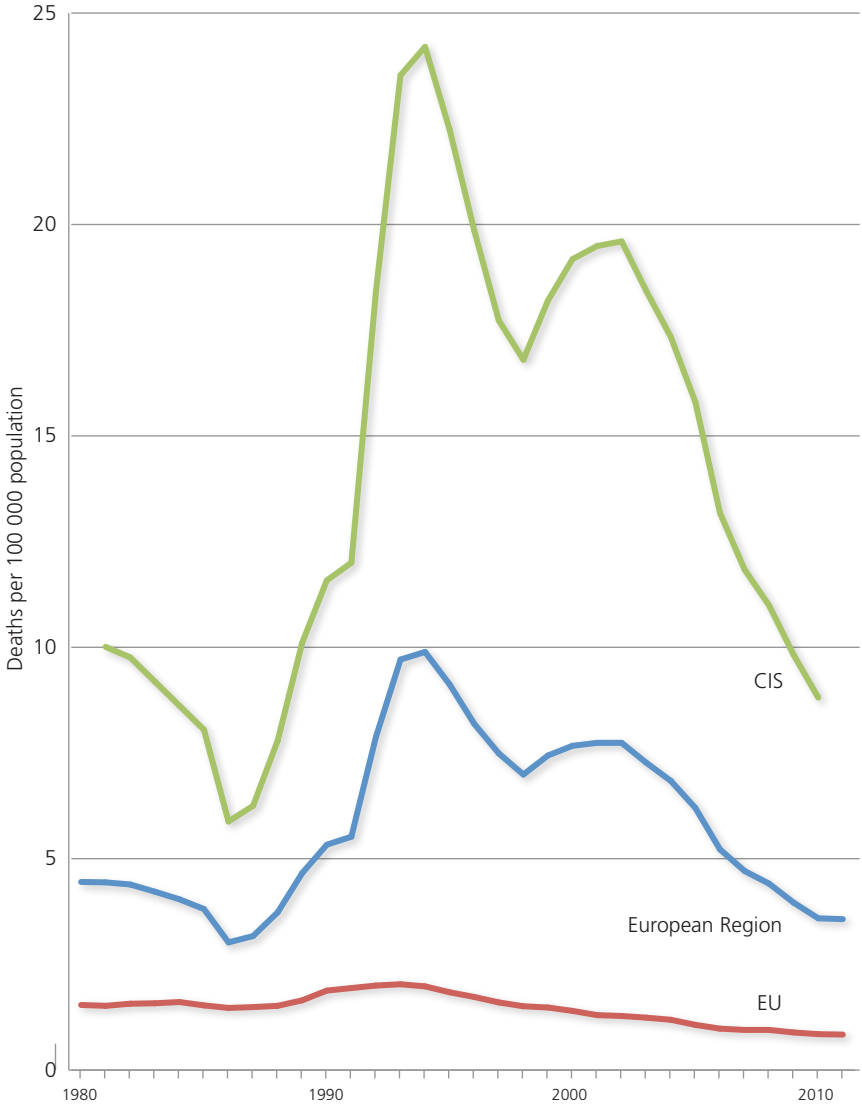
Data quality on violent deaths could be improved

Reliable mortality data are the mainstay of monitoring policy and population health.

Availability of homicide data across the Region is generally good, but data quality could be improved. Police data on homicide numbers were provided by 96% of HICs and 94% of LMICs. Vital-registration data on homicides were provided by 92% of HICs but only 81% of LMICs. Seven countries (17%) reported that police homicide data do not use a standard definition (the United Nations Office on Drugs and Crime's International Classification of Crime for Statistical Purposes[5]) to classify homicides, and two do not use a standard definition for vital-registration sources (International Classification of Diseases (ICD–10) external cause of injury codes).

[5] Intentional homicide is defined as unlawful death purposefully inflicted on a person by another person.

Fig. 5. Trends in standardized mortality rates due to homicides in the European Region, EU and CIS



Source: WHO Regional Office for Europe *(15)*.

MORBIDITY

Non-fatal assaults present a major challenge to health systems

Comprehensive information from health systems contributes to monitoring service responses to violence.

Violent deaths tell only part of the story. Data on non-fatal assaults are not readily available. It is estimated that for every death in Europe, about 43 people are admitted to hospital and 262 attend an emergency department for treatment of assaults *(16)*.[6] This suggests that in addition to the 34 469 deaths in 2012, there were roughly 1.5 million hospital admissions and 90 million emergency department attendances, representing a considerable challenge to health systems and emergency services.

Surveys provide essential information on burden and risk for planning and monitoring

Many acts of violence do not come to the attention of the police, protection agencies, social services or health authorities. These agencies typically provide information on use of services, but the true extent of interpersonal violence can only be understood through population-based surveys that also provide information on type of violence, extent, severity, gender, risk factors, socioeconomic status and outcomes *(17)*.

A combined analysis of surveys of child maltreatment in Europe shows that 13.4% of girls and 5.7% of boys have been sexually abused, 22.9% of children have been physically abused and 29.1% emotionally abused. When scaling-up to the child population in the Region aged under 18 years, estimates suggest that almost 18 million have been sexually abused, more than 43 million physically abused and over 55 million emotionally abused *(7)*. This far exceeds the annual loss due to 900 child homicides and demonstrates the importance of surveys to increasing understanding of scale.

Few surveys of youth violence have been undertaken in countries, but those carried out suggest that about 10–15% of young males and 3–5% of young females have experienced violent assault. The Health Behaviour in School-aged Children (HBSC) survey provides some information on bullying, fighting and weapon-carrying *(5,18)*. Combined analyses for intimate-partner violence and sexual violence among women suggest that the lifetime prevalence of intimate-partner violence (physical or sexual) is 25.4% in LMICs and about 23% in HICs *(19)*; for non-partner sexual violence, this is thought to be 5.2% and 12.6% respectively.

Elder abuse estimates suggest that the prevalence of physical abuse experienced by older people during the previous year is 2.7%, 0.7% for sexual abuse, 19.4% for emotional abuse and 3.8% for financial abuse *(6)*.

[6] Emergency department attendance is based on information reflecting the entire national caseload of 12 countries in Europe and a sample of hospitals in nine.

POLICY RESPONSE: REGULATIONS, SERVICES, INTERVENTIONS

Action plans are not always informed by data

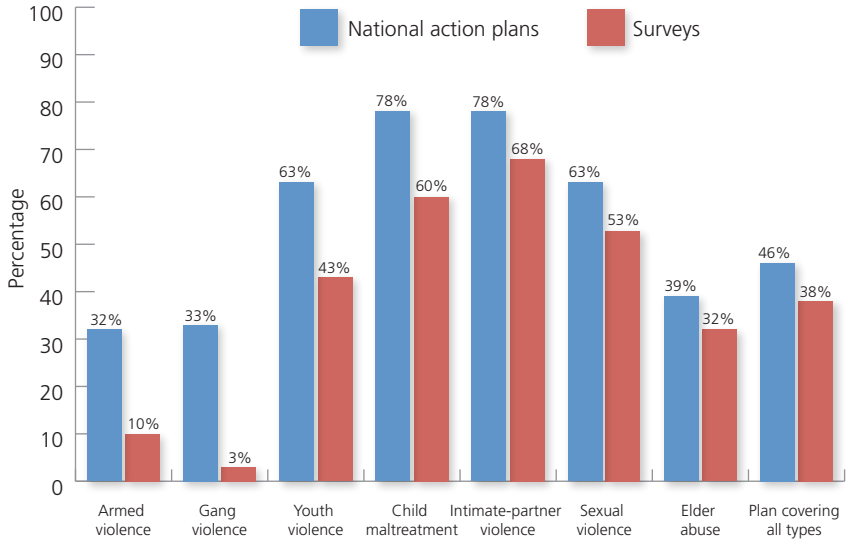
Developing an action plan is a key step toward effective and coordinated violence prevention.

Integrated plans that encompass all types of interpersonal violence (which were found in 46% of the countries) are less common than those for specific types of violence. Many countries have action plans for the prevention of child maltreatment (78%), intimate-partner violence (78%), youth violence (63%) and sexual violence (63%) (Fig. 6), but violence-prevention activities in almost all the countries are spread across multiple agencies, with no lead agency identified for accountability and monitoring purposes.

Good epidemiological data are needed to build realistic action plans, set quantified targets with a timeline and monitor implementation. Action plans are more commonly found than population-based surveys.

Seventy-eight per cent of the countries have developed an action plan for child maltreatment, but only 60% have survey data: the respective figures for elder abuse are 39% and 32% (Fig. 6).

Fig. 6. Proportion of countries with national survey data and National action plans, by type of violence



Seventy-eight per cent of the countries (20 HICs and 12 LMICs) have a system in place for regular exchange of information among agencies, sectors and actors involved in violence prevention. Such exchange is an essential component in coordinated multisectoral responses to violence *(2,5)*.

Countries are investing in prevention, but not at a level commensurate with the scale and severity of the problem

Numerous options for preventing violence are available. Using systematic reviews of the evidence *(2,5–7,20)*, 18 prevention programmes supported by evidence of effectiveness were selected to cover the different types of interpersonal violence.

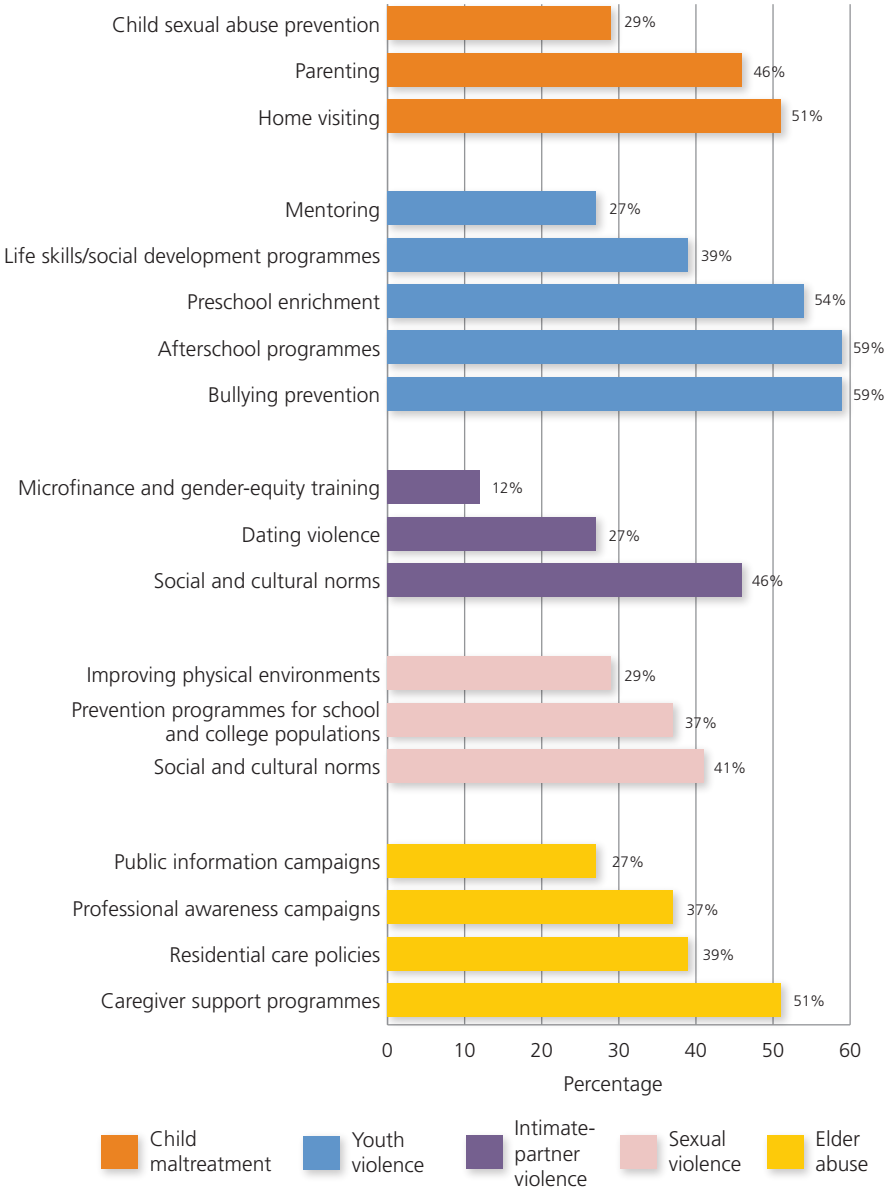
Many countries report investing in these preventive actions rather than merely reacting to violence and its consequences. Overall, countries are implementing on average 41% of the interventions on a larger scale[7] (median value 33%). This suggests considerable room for improvement. The Region shows great variation for all types of interpersonal violence-prevention programmes (Fig. 7).

In keeping with the life-course approach, more attention is being devoted to violence prevention among children and young people. Home visiting and parenting programmes aim

[7] Larger-scale implementation is defined as covering at least 30% of the population; limited applies to less than 30% (see Table 1).

Photo: Fotolia

Fig. 7. Proportion of countries implementing violence-prevention programmes on a larger scale, by type of programme



to provide safe, stable, nurturing home environments by training parents in childrearing and are cost–effective in reducing child maltreatment. School-based programmes empower children to recognize and prevent sexual abuse *(7).* About half the countries have larger-scale programmes on implementing home visitation (51%) and positive parenting (46%), but fewer (29%) have child sexual abuse prevention programmes.

Many effective violence-prevention programmes for young people involve working with the education sector to provide preschool training, safe school environments, life and social skills training and afterschool programmes *(5)*. Over half the countries are implementing bullying prevention initiatives, afterschool programmes and preschool enrichment on a larger scale.

Most of the interventions on intimate-partner and sexual violence are not widely implemented. More countries are taking action to change social and cultural norms that lead to intimate-partner and sexual violence, but less is being done on school- and college-based prevention programmes.

Caregiver support for elder abuse prevention has been taken up by half the countries, though residential care policies and professional awareness campaigns are lagging behind.

Many countries are implementing interventions in a limited way rather than widely. Larger-scale implementation is more common in EU countries than in the CIS, but an opportunity exists in many countries to scale-up interventions that currently are implemented only on a limited scale (Table 1).

Photo: Fotolia

Table 1. Proportion of countries implementing different types of programmes, by type of programme and breadth of population covered, CIS, EU and European Region

Prevention programmes	CIS		EU		European Region	
	Larger-scale (%)	Limited (%)	Larger-scale (%)	Limited (%)	Larger-scale (%)	Limited (%)
Child maltreatment						
Home visiting	40	40	67	24	51	34
Parenting education	30	30	62	38	46	41
Child sexual abuse prevention	20	50	33	67	29	59
Youth violence						
Preschool enrichment	60	20	52	33	54	29
Life skills/social development programmes	50	50	29	19	63	32
Mentoring	20	60	38	48	27	54
Afterschool programmes	60	20	76	14	59	22
Bullying prevention	30	20	67	33	59	29
Intimate-partner violence						
Dating violence	20	20	38	38	27	39
Microfinance with gender-equity training	20	30	10	33	12	34
Social and cultural norms	30	60	48	48	46	49
Sexual violence						
Prevention programmes for schools and college populations	20	30	52	38	37	39
Improving physical environment	30	60	33	33	29	41
Social and cultural norms	30	50	52	38	41	49
Elder abuse						
Professional awareness campaigns	30	40	48	24	37	34
Public information campaigns	30	40	29	48	27	49
Caregiver support programmes	40	10	57	33	51	29
Residential care policies and procedures	30	30	38	38	39	37

Social and education policy measures to mitigate some of the key risk factors for violence should be more widely implemented

Many of the key determinants of violence, such as employment, education, welfare and housing, are governed by sectors other than health.

Policy actions in some of these areas that may reduce inequalities were examined. Twenty-nine countries (71%) (15 HICs and 14 LMICs) have a national policy that provides incentives for young people at high risk of violence to complete secondary schooling, but only nine (22%) (two HICs and seven LMICs) have national housing policies specifically to reduce concentrations of poverty in urban areas with a view to preventing violence. Most countries have legislation requiring employers to provide paid maternity and/or paternity leave to care for newborn or adopted children: these policies would contribute to better parenting across all social strata if universally applied and well enforced.

Patterns of risky alcohol-drinking behaviour remain high

The harmful use of alcohol is a strong risk factor for all forms of violence. Excessive alcohol use has a direct effect on physical and cognitive functions, which in turn affect self-control and ultimately increase the likelihood of being a victim or perpetrator of violence *(2).* Fiscal and legal measures such as taxation on alcoholic beverages, limiting the availability of alcohol and enacting age limits have been successful in reducing harmful use of alcohol *(21).*

Alcohol intake in the European Region, where two out of three adults drink regularly, is the highest in the world. Accordingly, more than 65% of Member States have medium- or higher-risk patterns of alcohol consumption *(21)* and consumption patterns in some are among the most risky in the world. More needs to be done in these countries to curb high-risk patterns of alcohol consumption and misuse.[8]

Nearly all Member States report having taxes on spirits and beer, but nine (21%) do not have a wine excise tax. All have legal age limits for off- and on-premises sales of alcohol, the most commonly applied being 18 years (30 countries (75%)), with nine stipulating 16 years (22%) and one 17.

Nearly all countries have measures to regulate access to firearms

Supply of, access to and use of firearms are directly linked to violent episodes and outcomes *(2).*

All countries in the survey have laws to regulate civilian access to firearms, control purchases with background

[8] Patterns of alcohol consumption are classified according to patterns-of-drinking scores, measured on a scale from 1 (least-risky pattern of drinking) to 5 (most risky). According to the scale, a medium risk corresponds to a value of 3.

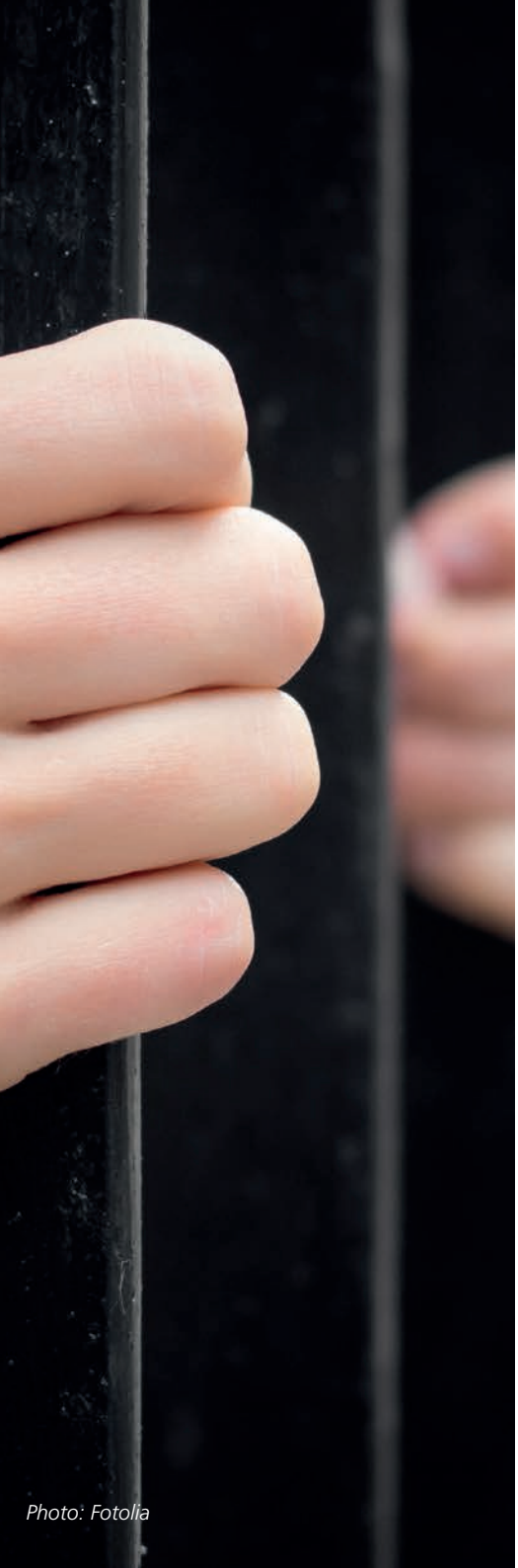


Photo: Fotolia

checks and restrict access to rifles and the carrying of firearms in public. With few exceptions, Member States also restrict access to automatic firearms and handguns. The nature, extent and enforcement of these restrictions vary widely across the Region.

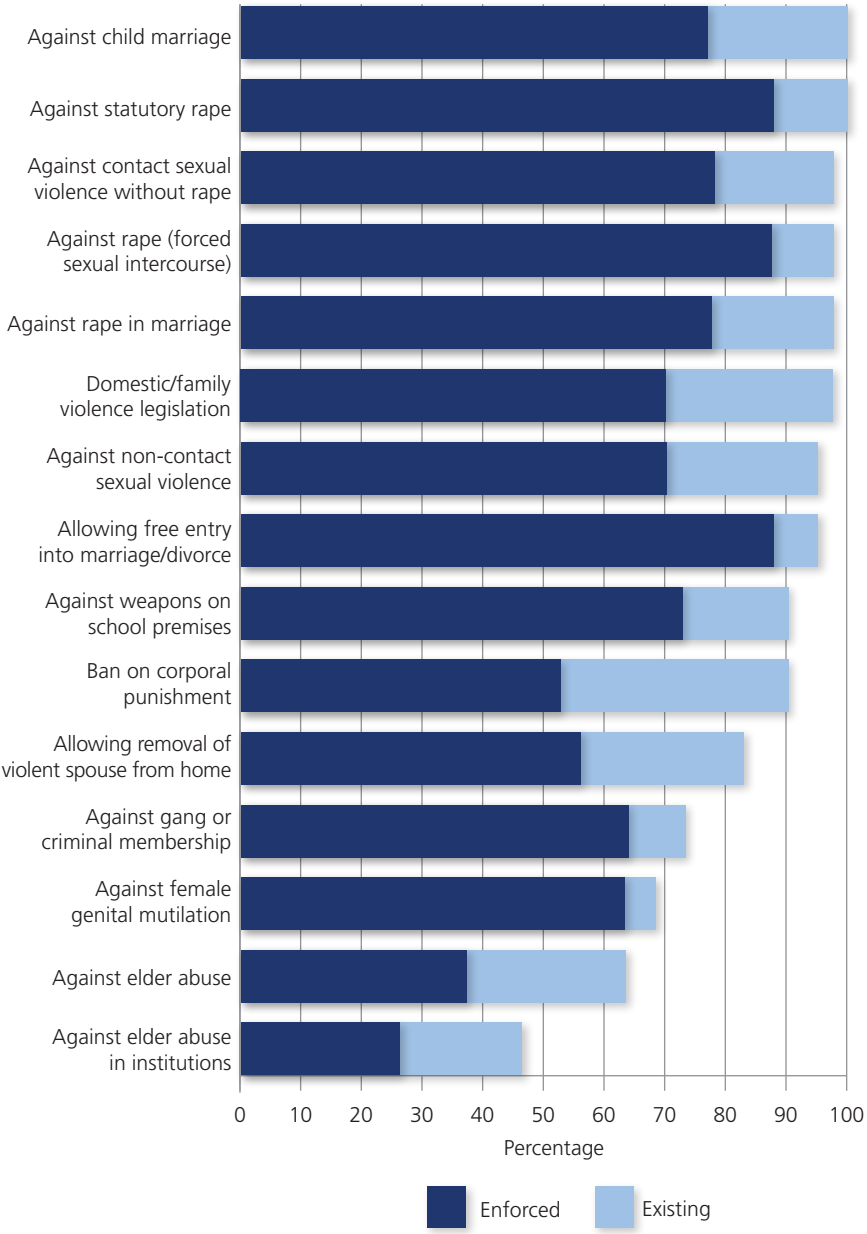
Laws relevant to violence have been enacted widely but reported enforcement is inadequate

Having and enforcing comprehensive laws is critical to protecting children and adults against violence.

Most of the laws to prevent specific kinds of violence are present in at least 90% of the countries. Almost all have laws to protect citizens from child maltreatment and intimate-partner and sexual violence, but few report laws to prevent elder abuse in domestic or institutional settings (Fig. 8).

National expert panels assessed the levels of enforcement of all laws in their countries. Overall in the Region, the average proportion of countries in which each of the laws existed was 86%, but the average proportion in which each of the laws was fully enforced was 77%. Children were least protected by the enforcement of laws to ban corporal punishment (a difference of 38%). Enforcement of laws against elder abuse was also reported as inadequate. The smallest gap (of 5%) was between the existence and enforcement of laws against female genital mutilation.

Fig. 8. Proportion of countries with laws to prevent violence and the extent to which these laws are fully enforced

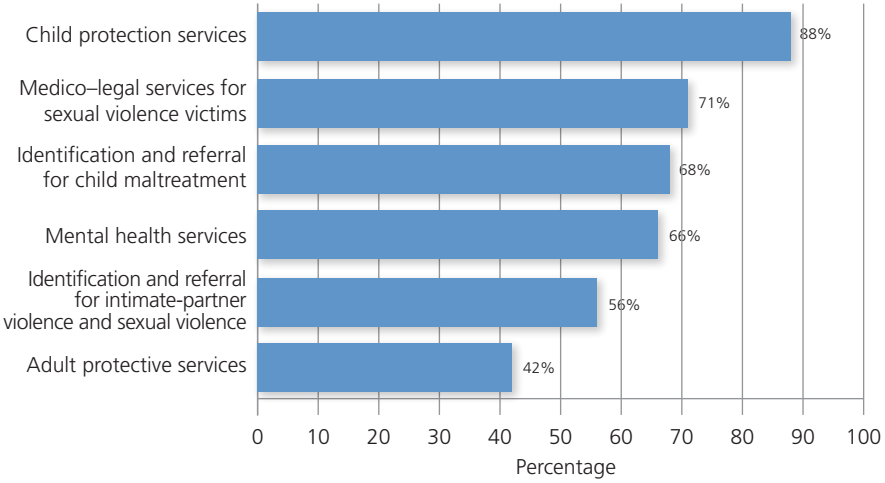


Availability of services to identify, refer, protect and support victims varies markedly

Providing high-quality protection, care and support services to victims is important in stopping further violence and lessening mental and physical trauma, helping victims heal and enabling their full reintegration into society *(7)*.

Child protection services are the most widely available of all services across the Region (88%), but adult protective services exist only in 40% of countries. Referral and support services for victims of intimate-partner and sexual violence are available in 56%, mental health services in 66% and medico–legal services for victims of sexual violence in 71% (Fig. 9).

Fig. 9. Proportion of countries with identification, referral and support services widely available, by type of service, on larger scale



PART 3. THE WAY FORWARD

CONCLUSIONS AND ACTIONS

This fact sheet shows that interpersonal violence remains an important public health problem in the European Region. Almost 35 000 people are killed by homicide every year, many tens of millions are affected by non-fatal violence and large inequalities exist.

Baseline indicators have been measured and form the foundation for preventive action and future monitoring. Although some countries are making good progress, others need to accelerate the pace of change for preventing violence and mitigating its grave and far-reaching consequences. The following actions are proposed to intensify the response in Europe.

1. **Countries should strengthen data collection to show and monitor the extent of the problem.**
   Good police and vital registration data are available in the Region but their quality needs to be improved. Data on deaths need to be supplemented by information on non-fatal violence collected through health and other authorities and by regular population surveys. More countries need to undertake population surveys to underpin national planning and evaluation. Surveys for child maltreatment have been conducted in only 60% and for elder abuse in 32%. Survey data are essential to inform planning.

2. **Countries should develop comprehensive national action plans for violence prevention.**
   Many more countries need to develop national action plans, involving actors from multiple sectors and identifying a lead agency for accountability and monitoring. A starting point would be to review existing plans and policies to ensure they cover all types of violence. Plans need to be data-led and have quantified targets with set timelines for implementation and reporting.

3. **Countries should integrate violence prevention into other health platforms.**
   An opportunity exists to exploit synergies with other health areas and integrate violence prevention into child health, home visitation, midwifery and mental health services. Violence is an unwanted outcome of risky alcohol consumption and synergies with alcohol-reduction programmes need to be reinforced.

4. **Countries should implement evidence-informed programmes.**
   Action plans need to contain the 18 solutions for violence prevention selected by scientists. Most of these strengthen people's resilience and are cost–effective, but when taken together across the Region, a median of only six are being implemented by countries on a larger scale. This suggests that many governments need to improve their performance for violence prevention. There is an opportunity to scaleup and achieve better coverage of these programmes in many countries.

5. **Countries should upgrade the quality of services for victims.**
   The number and quality of services to identify and support victims of violence need to be improved. Child and adult protection services in many countries need increased capacity for detection, care, support and rehabilitation of victims.

6. **Countries should improve the enforcement and quality of existing laws.**
   Laws that protect against different types of violence have been widely enacted, but enforcement could be improved. For example, 90% of countries have banned corporal punishment of children, but only about half enforce the law. The enactment of laws against elder abuse also needs to be improved, especially in view of the changing demographic profile in Europe and its ageing population. Social marketing campaigns strengthen public understanding of, and support for, these laws.

7. **Countries should build health-systems capacity for violence prevention.**
   National planning, surveillance and programming require health-systems strengthening, and support needs to be provided to the workforce.

8. **Countries should focus on equity and the life course.**
   Violence prevention in the Region requires multiple sectors to work together to implement evidence-based solutions that focus on equity and a life-course approach. As early-life violence affects mental and physical health and social attainment across the life course, investing in preventing violence on children should be a priority. These principles are enshrined in Health 2020 *(13)* and offer countries an opportunity to prioritize violence prevention.

REFERENCES

1. Global status report on violence prevention 2014. Geneva: World Health Organization; 2014.

2. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, R Lozano. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/hq/2002/9241545615.pdf, accessed 12 November 2014).

3. World Health Assembly resolution WHA56.24 on implementing the recommendations of the World report on violence and health. Geneva: World Health Organization; 2003 (http://apps.who.int/gb/archive/pdf_files/WHA56/ea5624.pdf, accessed 12 November 2014).

4. Sethi D, Mitis F, Racioppi F. Preventing injuries in Europe. From international collaboration to local implementation. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0011/96455/E93567.pdf, accessed 12 November 2014).

5. Sethi D, Hughes K, Bellis M, Mitis F, Racioppi F. European report on preventing violence and knife crime among young people. Copenhagen: WHO Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf, accessed 12 November 2014).

6. Sethi D, Wood S, Mitis F, Bellis M, Penhale B, Iborra Marmolejo I et al., editors. European report on preventing elder maltreatment. Copenhagen: WHO Regional Office for Europe; 2011 (http://www.euro.who.int/__data/assets/pdf_file/0010/144676/e95110.pdf, accessed 12 November 2014).

7. Sethi D, Bellis M, Hughes K, Gilbert R, Mitis F, Galea G, editors. European report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-Child-Maltreatment.pdf, accessed 12 November 2014).

8. Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1, accessed 12 November 2014).

9. World Health Assembly resolution WHA49.25 on prevention of violence: a public

health priority. Geneva: World Health Organization; 1996 (http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_eng.pdf, accessed 12 November 2014).

10. WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2005 (http://www.euro.who.int/__data/assets/pdf_file/0017/88100/RC55_eres09.pdf, accessed 12 November 2014).

11. World Health Assembly resolution WHA67.22. Addressing the global challenge of violence, in particular against women and girls, and against children. Geneva: World Health Organization; 2014 (http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_22-en.pdf, accessed 12 November 2014).

12. WHO Regional Committee for Europe resolution EUR/RC64/R6. Investing in children: the European child and adolescent health strategy 2015–2020 and the European child maltreatment prevention action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0019/259210/64rs06e_InvestChildren_140731.pdf?ua=1, accessed 12 November 2014).

13. Health 2020: a European policy framework supporting action across government and society for health and well-being. Copenhagen: WHO Regional Office for Europe; 2012 (EUR/RC62/9; http://www.euro.who.int/__data/assets/pdf_file/0009/169803/RC62wd09-Eng.pdf, accessed 12 November 2014).

14. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/, accessed 12 November 2014).

15. Mortality indicators by 67 causes of death, age and sex (HFA-MDB) [online database]. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/en/data-and-evidence/databases/mortality-indicator-database-mortality-indicators-by-67-causes-of-death, -age-and-sex-hfa-mdb/, accessed 12 November 2014).

16. Injuries in the European Union. Summary of injury statistics for the years 2008–2010. Amsterdam: Eurosafe; 2013 (Issue 4; http://ec.europa.eu/health/data_collection/docs/idb_report_2013_en.pdf, accessed 12 November 2014).

17. Bellis MA, Hughes K, Leckenby N, Jones L, Baban A, Kachaeva M et al. Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. Bull World Health Organ. 2014;92(9):641–55.

18. Currie C, Roberts C, Morgan A, Smith R, Settertobulte W, Samdal O et al., editors. Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey. Copenhagen: WHO Regional Office for Europe; 2004 (Health Policy for Children and Adolescents, No. 4; http://www.euro.who.int/en/publications/abstracts/young-peoples-health-in-context.-health-behaviour-in-school-aged-children-hbsc-study-international-report-from-the-20012002-survey, accessed 12 November 2014).

19. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf, accessed 12 November 2014).

20. WHO, Liverpool John Moores University. Violence prevention: the evidence. Series of briefings on violence prevention. Geneva: World Health Organization; 2009 (http://apps.who.int/iris/bitstream/10665/77936/1/9789241500845_eng.pdf?ua=1, accessed 12 November 2014).

21. European action plan to reduce the harmful use of alcohol 2012–2020. Progress report 2014. Copenhagen: WHO Regional Office for Europe; 2014. (http://www.euro.who.int/__data/assets/pdf_file/0008/253889/64wd19e_ProgressReports_NoParma_140422.pdf?ua=1)

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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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