WORLD HEALTH ORGANIZATION
EUROPE

PROGRESS IN PREVENTING INJURIES IN THE WHO EUROPEAN REGION

Implementing the WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region and the Recommendation of the Council of the European Union on the prevention of injury and promotion of safety

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Implementing the WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region and the Recommendation of the Council of the European Union on the prevention of injury and promotion of safety

By:

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ABSTRACT

Injuries, whether intentional or unintentional, are the third leading cause of death in Europe and pose a threat to economic and social development. This publication presents an overview of progress achieved by Member States in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injuries. A web-based database of country profiles was developed using a questionnaire survey completed by health ministry focal people for injury and violence prevention. An inventory of national policies was compiled by searching the internet. Information was provided on progress in delivering on key items of resolution EUR/RC55/R9 and on the implementation of 69 selected evidence-based programmes to prevent unintentional injury and violence. Good progress is taking place, and resolution EUR/RC55/R9 has catalysed change. Development of national policies for individual types of injury and violence varied from 86% for road safety to about one third for preventing youth violence and self-inflicted violence. Implementation of evidence-based programmes for preventing all types of injury and violence varied in countries, and the median was 56% for all these taken together. This progress report documents that the health sector needs to commit more to the widespread implementation of effective programmes both in number and coverage, and to engage with other stakeholders in a multisectoral response to prevent injuries.

Keywords

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This publication describes progress of a three-year collaborative project between WHO and the Directorate-General for Health and Consumers of the European Commission which began in April 2007 (2006WHO02 Prevention of injuries): Implementation of the Council Recommendation on the prevention of injury and promotion of safety and WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region.

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Executive summary

Injuries, whether intentional or unintentional, are the third leading cause of death in Europe and pose a threat to economic and social development. To support Member States in addressing this problem more comprehensively, WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the WHO European Region and the Recommendation of the Council of the European Union of 31 May 2007 on the prevention of injury and the promotion of safety have both placed violence and injury prevention firmly on the public health agenda and call for the reporting of national activities.

Aims and methods

This publication aims to present an overview of progress achieved by Member States in implementing resolution EUR/RC55/R9 and the European Council Recommendation. A subsidiary aim is to report on the development of web-based tools comprising a database of country profiles compiled through a questionnaire survey and an inventory of national policies.

A database of country profiles has been developed using a questionnaire survey and WHO information sources such as the Health for All database. Health ministry focal people for injury and violence prevention completed the questionnaire. Information was provided on progress in delivering on key items of resolution EUR/RC55/R9 and on the implementation of evidence-based programmes to prevent unintentional injury (road traffic, poisoning, drowning, falls and fires) and violence (youth violence, child maltreatment, intimate partner violence, elder abuse and self-directed violence). This information was analysed to provide a regional overview and country profiles. An inventory of national policies on preventing injuries and violence was collated. After being verified by focal people, the country profiles have been uploaded on the WHO Regional Office for Europe web site to act as a resource and catalyst for action. Responses on 30 countries were obtained.

Progress made

Good progress is taking place, and resolution EUR/RC55/R9 has catalysed change; 71% of responding countries stated that the resolution had placed violence and injury prevention higher on the national policy agenda and had helped to stimulate action. During the past year, progress has been made in the following items of resolution EUR/RC55/R9 and the European Council Recommendation: developing national policy in 68% of countries, surveillance in 61% and capacity-building in 56%. In terms of national policy development, 52% of countries have overall national policies for injury prevention and 23% of countries for violence prevention. Development of national policies for individual types of injury and violence varied. Whereas most countries had a national policy for road safety (86%), half or less had national policies for preventing other unintentional injuries: poisoning, fires, falls or drowning. For violence prevention, 71% of responding countries had national policies for preventing intimate partner violence, 61% for preventing child maltreatment and only about one third had policies for preventing elder abuse, youth violence and self-inflicted violence.

Of the 69 evidence-based programmes for preventing all types of injury and violence, implementation varied in countries, and the median was 56% for all these taken together. The median was 65% for preventing unintentional injuries and 55% for preventing violence. The median values for individual types of unintentional injury ranged from 80% for preventing road traffic injuries to 60% for preventing drowning, and for violence prevention this ranged from 100% for preventing child maltreatment to 50% for preventing intimate partner violence. In many countries, policies were implemented in selected geographical areas rather than nationally. This mapping exercise has shown that the health sector needs to commit to more widespread implementation of effective programmes both in number and coverage

and to engage with other stakeholders in a multisectoral response to prevent injuries.

The use of a survey is not without limitations of validity, reliability and completeness, but these findings are nevertheless an important baseline against which to measure progress for future evaluation.

How this progress has been achieved

Countries have had increased interest in working in this previously neglected area. Momentum has been gained through a combination of World Health Assembly resolutions, resolution EUR/RC55/R9 and the European Council Recommendation, which have catalysed action. The number of countries working through biennial collaborative agreements with WHO has increased to 15 in 2008–2009 compared to 5 in 2004–2005. WHO has been working with several countries in developing national policy (10 countries) and supporting injury surveillance (6 countries). A train-the-trainers workshop has been held for Russian-speaking countries, and interest has been expressed in mainstreaming WHO's TEACH-VIP curriculum into health professional training. Three European network meetings of health ministry focal people for violence and injury prevention have been held, and focal people have proven to be a conduit for the exchange of best practice and experience. Joint working has increased with other networks and with other international organizations, and in particular the collaborative project with the Directorate-General for Health and Consumers of the European Commission on implementing resolution EUR/RC55/R9 and the European Council Recommendation has proven to be an asset in facilitate reporting. The First United Nations Global Road Safety Week was effectively used to advocate for road safety among youth, and 20 countries participated by holding national events. The health systems of these countries met the challenge by working collaboratively with other sectors. The lessons learned can be used for future opportunities such as the forthcoming world and European reports on child injury prevention planned for December 2008. The current project on a global status report on road safety has ensured that national data coordinators (most often also the focal person) have worked in a multisectoral team and will also present a further opportunity to advocate for road safety.

Conclusions and way forward

Encouraging progress has been made in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injuries. These efforts need to be sustained and commitment amplified to overcome this important public health challenge. Some key steps for the way forward are suggested:

- build on current achievements with more widespread policy development and implementation of evidence-based programmes by countries;
- research and evaluation are needed to increase the body of knowledge in the WHO European Region;
- surveillance needs to be improved in some countries to make the extent, causes and consequences of the problem more visible;
- violence and injury prevention should be mainstreamed in health professional curricula and further investments made in building institutional capacity;
- the network of health ministry focal people has proven to be a great asset, and investment in this needs to be sustained;
- opportunities for working across sectors and with other networks need to be exploited; and
- the gaps identified in this report present future directions that should be taken, and health systems need to seize this opportunity to reduce the burden of injuries and violence.

1 Introduction

Injuries, whether intentional or unintentional, threaten the economic and social development of Europe.[A] Although a neglected health problem until recently, injuries and violence account for 9% of all causes of death in Europe, with about 800 000 people losing their lives to injury-related causes each year *(1,2)*. Injuries are the leading cause of death among people 5–44 years old and are responsible for 14% of all the disability-adjusted life-years (DALYs or years lost due to death or lived with disability) lost in the WHO European Region. The burden is unequally distributed both within and between countries: people living in low- and middle-income countries in the Region are nearly four times more likely to die from injuries than those in high-income countries *(3)*. Similarly, within countries there is a three-fold difference in death and hospitalization from injury when the least affluent people are compared with the most affluent people *(4–6)*.

These facts have implications for the attainment of social justice and equity in health in the Region and within countries. Within the Region, the response of countries to the problem of injuries has varied.

Many countries, particularly those in northern Europe, started addressing the problem systematically a few decades ago, whereas others have only acknowledged the extent of the problem of injuries and the ability to prevent them and started taking action in more recent years *(3,7)*.

To support Member States in addressing this problem more comprehensively, resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region (September 2005) and the European Commission Communication and European Council Recommendation on the prevention of injury and the promotion of safety (31 May 2007) have both placed violence and injury prevention firmly on the public health agenda and call for the reporting of national activities (Box 1) *(8,9)*.

Box 1. Key items of the European Council Recommendation and the WHO Regional Committee for Europe resolution

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

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

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

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

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

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

(g) to report back to the Regional Committee in 2008 on progress achieved in the implementation of this resolution by the Secretariat and the Member States.

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

In response to World Health Assembly resolution WHA56.24 on implementing the recommendations of the *World report on violence and health* and WHA57.10 on road safety and health, health ministries in 48 of the 53 European Member States have appointed at least one focal person for preventing either injury or violence or both *(10,11)*. As part of the collaboration between WHO and the European Commission, a three-year project on implementing the Council Recommendation on the prevention of injury and promotion of safety and WHO Regional Committee for Europe resolution EUR/RC55/R9 on prevention of injuries in the WHO European Region began in April 2007 *(12)*. The project aims: a) to develop resources and tools to assist countries in developing national policies and monitor and report progress in implementing resolution EUR/RC55/R9 and the Council Recommendation, b) to facilitate the exchange of experience and c) to build capacity in developing national plans, surveillance and advocacy. In this publication, the policy tools that have been developed through this collaborative project have been used to report on progress in key areas of the resolution and Recommendation.

2 Aims and methods

This publication aims to present an overview of progress achieved by Member States in implementing resolution EUR/RC55/R9 and the European Council Recommendation. A subsidiary aim is to report on the development of web-based tools comprising a database of country profiles compiled through a questionnaire survey and an inventory of national policies.

A database of country profiles has been developed using a questionnaire survey and WHO information sources such as the Health for All database *(13)*. This information was analysed to provide a regional overview and develop country assessments that will be uploaded on the WHO web site.

Questionnaire

A survey questionnaire was developed to identify progress in achieving the main items highlighted in resolution EUR/RC55/R9 on developing policies to prevent specific causes of injury and types of violence. In addition, the following factors considered favourable for policy development were assessed *(14)*: political support, easy access to surveillance information, mapping of stakeholders, multisectoral working and the presence of a funded secretariat. The questionnaire (Annex 1) was revised after consultation with health ministry focal people and an expert panel. In particular, questions were added as to whether selected evidence-based interventions and programmes for primary prevention were being implemented at the national level or in parts of the country and whether policy development had changed in the past year *(12,15,16)*. These programmes were selected from a WHO guide based on having good or promising evidence of their effectiveness as determined by systematic reviews of the literature *(16–20)*. There were 69 programmes selected for the 10 types of injury and violence. Focal people supplied information as to whether these were implemented nationally or in some areas. For the purpose of this report, both national-level implementation and implementation in some geographical areas of the country were considered as evidence of implementation.

An assessment score was calculated for each country based on the proportion of programmes being implemented in each country of the 69 programmes addressing all the types of injury and violence. The percentage implementation of the number of prevention programmes for each type of injury and violence was calculated for each country. Median scores of percentage implementation were calculated for the Region for programmes addressing each type of injury or violence separately and collectively for the 69 programmes.

Questionnaires returned

The questionnaire was sent to the network of national health ministry focal people responsible for preventing unintentional injuries and violence. It was sent electronically in English to the focal people of the 48 European Member States that have a focal person, and a version in Russian was also sent to the 9 Russian-speaking countries with focal people. This was initiated in 2007 when there were 36 responses, and the revised version of the questionnaire was sent in 2008.

Several electronic and telephonic reminders were provided to improve response. This publication reports on the 30 revised questionnaires that were returned in 2008. Of these, 19 were received from European Union countries and, of the remaining 11, 4 were from Russian-speaking countries, which were back-translated into English.

Country assessments

Epidemiological and policy indicators were developed based on selected data from the Health for All database and from the responses of focal people to the survey questionnaire *(13)*. An overall assessment score was developed based on the proportion of 69 effective interventions that were implemented to prevent each of the types of injury or violence.

A score of one star was given if the overall score for the country was less than the lower quartile of the regional distribution (25% of the 69 interventions implemented), two stars if the implementation score was greater than 25% but less than the regional median (in this case 56%), three stars if the score was greater than the median but less than the third quartile (80% of interventions implemented) and four stars if the implementation score was greater than 80%. Salient factors from the questionnaire survey were reported on, including whether resolution EUR/RC55/R9 had made a difference in policy development or programme implementation, whether different items of the resolution were implemented or not, progress made on items of resolution EUR/RC55/R9 and the European Council Recommendation in the past 12 months (Box 1) and whether the policy environment was favourable for policy development *(14)*. Country survey summaries include this salient information as well as epidemiological indicators such as mortality rates for the different types of injury and violence. On completion, country survey summaries were sent to the focal people to check the validity and to get government approval to publish. Only the countries for which this was achieved by 18 August 2008 are included in the country information.

Inventory of national policies on violence and injury prevention

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

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

National policies identified

As of November 2007, 51 documents from 18 countries had been uploaded in the inventory. Based on the questionnaire responses, a further 53 have been identified, and policies are now available for 32 countries, of which 22 are European Union countries. Only policies written in English or German have been analysed. Analysis and uploading of new policies identified is ongoing. This inventory is a resource for policy-makers and practitioners interested in seeking more information on European national policies on injury and violence prevention *(21)*.

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

3 Results

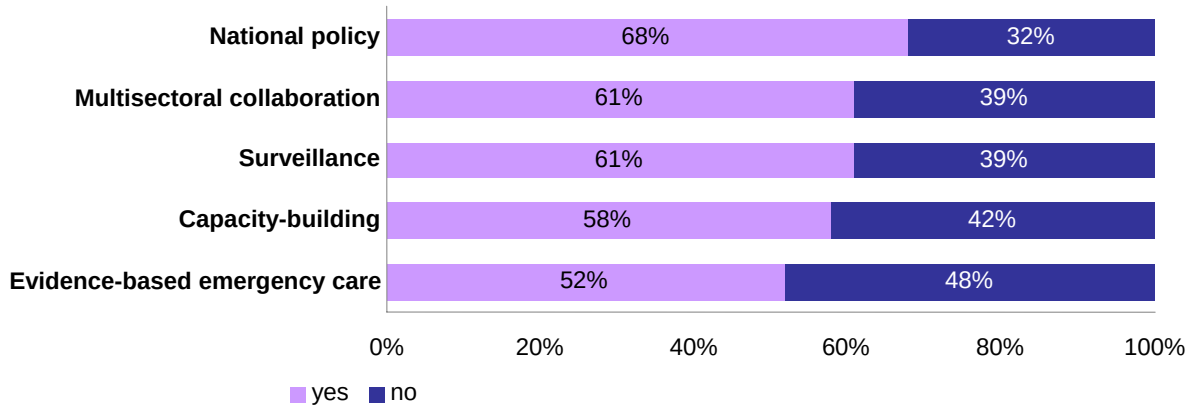
This report provides a regional overview based on the collated responses on country progress. Summaries of country assessments from among the 30 countries where clearance had been sought and obtained are uploaded on the WHO Regional Office for Europe web site *(22)*.

Regional overview of implementation of resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injuries

Developments in a 12-month period from 2007 to 2008 in delivering on resolution EUR/RC55/R9 and the European Council Recommendation

Of the respondent countries, 71% said that the resolution had placed violence and injury prevention higher on the national policy agenda and helped to catalyse action. Further, there has been encouraging progress over the past year in relation to many items of the resolution (Fig. 1). For developing national policy, progress has been achieved in 68% of responding countries, for surveillance in 61% and for capacity-building in 58%.

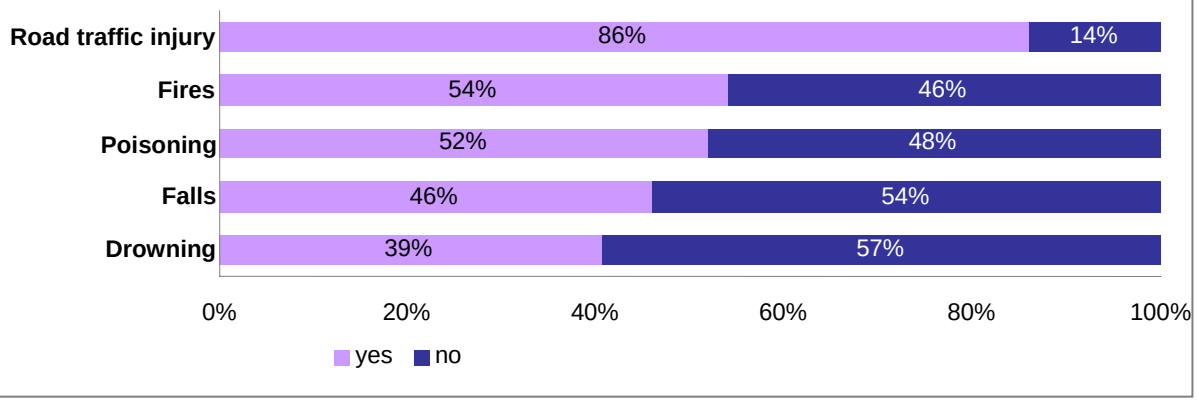
Fig. 1. Have there been any new developments in violence and injury prevention in your country over the past 12 months in any of the following areas?



Existence of policies for different causes of unintentional injuries

Whereas most countries had a national policy for road safety (86%), half or less had national policies for the other unintentional injuries, poisoning, fires, falls or drowning (Fig. 2). The priority given to these in terms of rank contrasts with the ranked leading causes of unintentional injury-related death: road traffic injury, poisoning, falls, drowning and fires *(1)*.

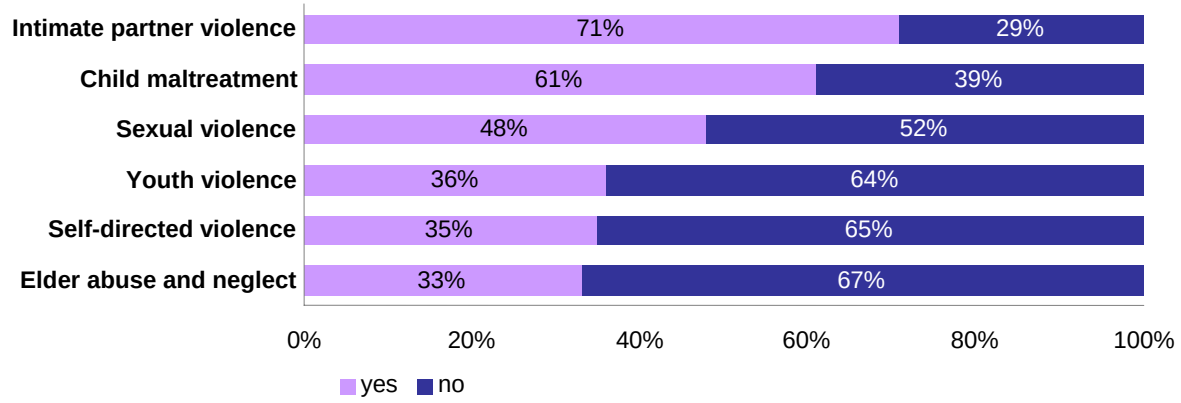
Fig. 2. Is there a policy on the prevention of any of the following categories of unintentional injuries?



Existence of policies for different types of interpersonal violence and self-directed violence

Among types of interpersonal violence, 71% of countries had national policies for intimate partner violence, but fewer had policies for elder abuse and neglect (33%) and youth violence (36%) (Fig. 3). Only 35% had policies for suicide prevention, which is the leading cause of injury-related death in the WHO European Region *(1)*.

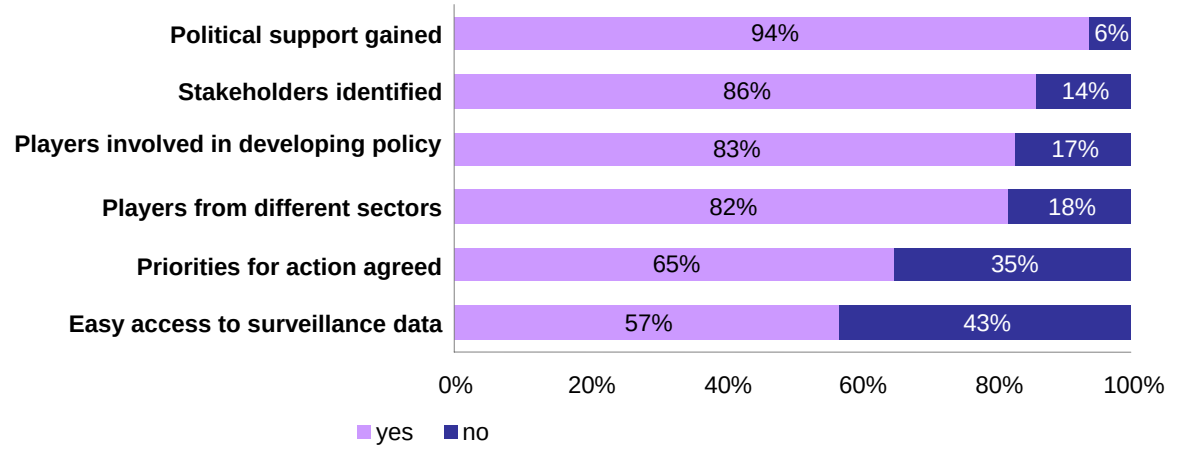
Fig. 3. Is there a policy on the prevention of any of the following categories of violence-related injuries?



Leadership and coordination and the policy-making process

Of the reporting countries, 94% said there was political support for preventing violence and injuries, and 80% had a budget to support activities (Fig. 4). A further 86% said that, in responding to the questionnaire, they had to build consensus with stakeholders from other sectors. Only 57% said they had easy access to injury surveillance data. There was an intersectoral injury prevention committee in 67% of countries, of which 47% had a secretariat and, in 54% of these, the focal person was the secretariat. Only 52% had an overall national policy for injury prevention and only 23% for violence prevention. Most countries have gone through the necessary steps for the initial stages of developing a national policy such as ensuring there was political commitment to developing plans, defining the extent of the problem and assessing and documenting existing policies and interventions *(14)*. Priorities for action have been agreed on in 65% of responding countries.

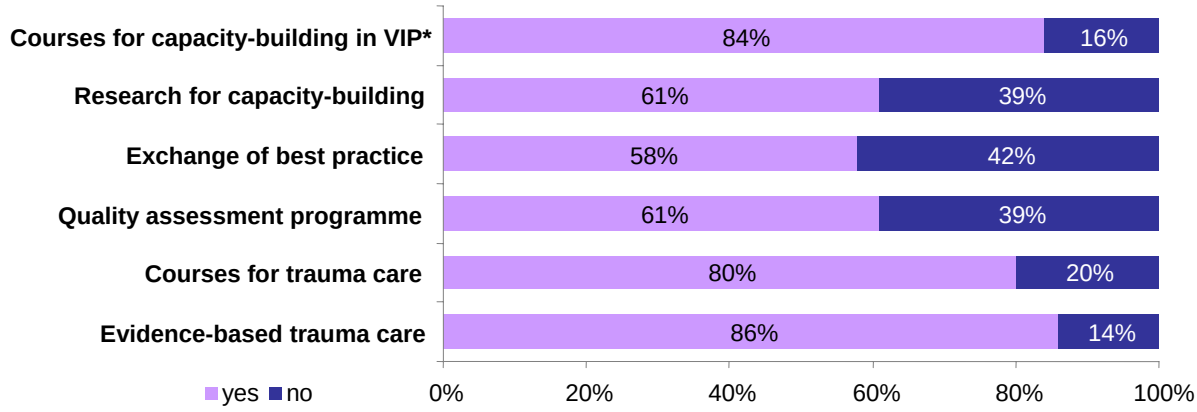
Fig. 4. Have the following processes in policy-making been achieved?



Capacity-building for violence and injury prevention and trauma care

Having adequate capacity is a critical factor in the development of a commensurate health system response to the injury burden, both for prevention and cure. Capacity-building activities were quite widespread in the Region, but two areas for improvement are the exchange of best practice for violence and injury prevention and the introduction of quality assessment programmes in emergency departments for improving trauma care (Fig. 5).

Fig. 5. Do you have the following capacity-building measures in place?



(*VIP = violence and injury prevention)

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

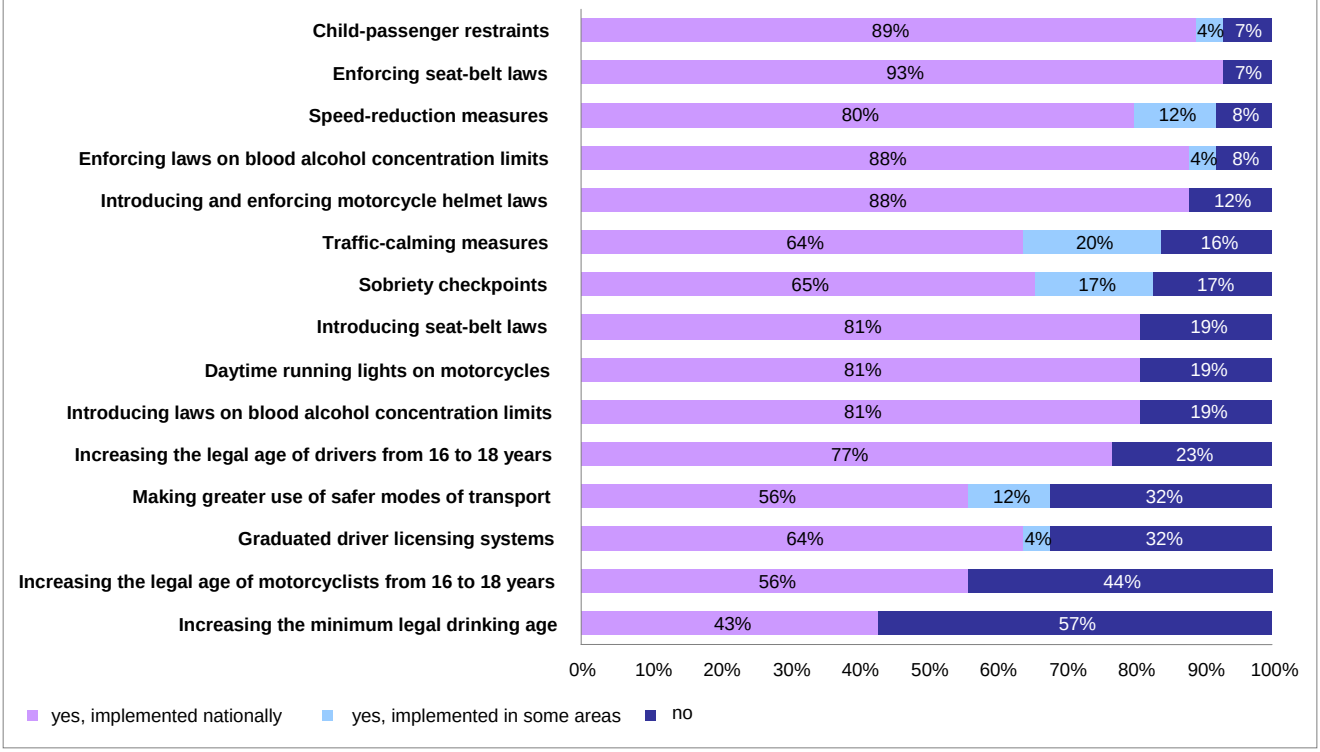
This section attempts to define the extent of implementation at the regional level of a selection of evidence-based interventions and programmes by each type of injury and violence. It helps to identify gaps that health systems and other sectors should fill to bridge policy deficits and take appropriate action at the national level. Many of the responses are intersectoral, and the role of the health sector may be in a leadership or coordinating role or as a key stakeholder, depending on the type of injury or violence and the nature of the preventive programme.

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

The median percentage implementation for all road safety programmes is 80% for responding countries. These evidence-based measures to prevent road traffic injuries were implemented in most countries at the national level, although some measures were only enacted locally rather than nationwide (Fig. 6). Among the least implemented were those effective in targeting young drivers and motorcyclists. More widespread implementation on these is needed, as road traffic injuries are the leading cause of death among young road users *(23)*. Similarly, only 56% of countries reported greater use of safer means of transport, such as public transport.

This is another priority area of action considering the risks to health due to noise and air pollution, decreased physical activity, climate change etc. incurred from excessive reliance on private car transport *(20)*.

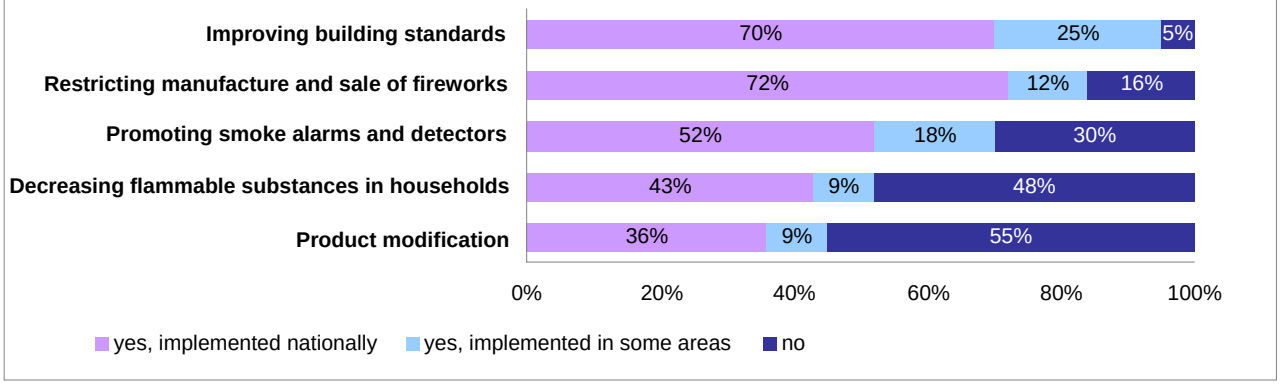
Fig. 6. Do you have in place any of the following programmes for the prevention of road traffic injuries?



Programmes and interventions for preventing fires and burns

The median percentage of implementation of programmes for the prevention of fires and burns was 60%. Most implementation had occurred in making building standards safer (70%) and restricting the manufacture and sale of fireworks (72%) (Fig. 7). Least action had occurred in reducing the storage of flammable substances (43%) at home and modifying household products such as cookers, stoves and candleholders to make them safer, so that fires were less likely to start (36%).

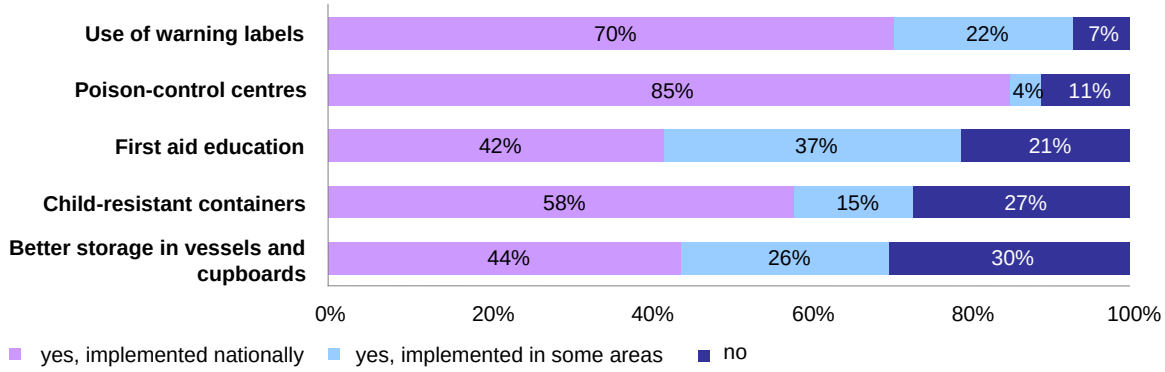
Fig. 7. Do you have in place any of the following programmes for the prevention of fires or burns?



Programmes and interventions to prevent unintentional poisoning

The median percentage implementation of all measures to prevent poisoning was 80% for responding countries. There is widespread availability of poison control centres (85%). Although 70% of countries have clear warning labels for toxic products, these are only effective if parents practise safe storage, particularly for preventing child poisoning (Fig. 8). Only 58% of countries implement containers with child-resistant closures, one of the most effective interventions. The European Commission mandates the enforcement of this measure for dangerous products (such as toxic and corrosive chemicals), and this simple measure greatly needs to be extended throughout the Region, thereby ensuring a degree of passive protection to all children in Europe.

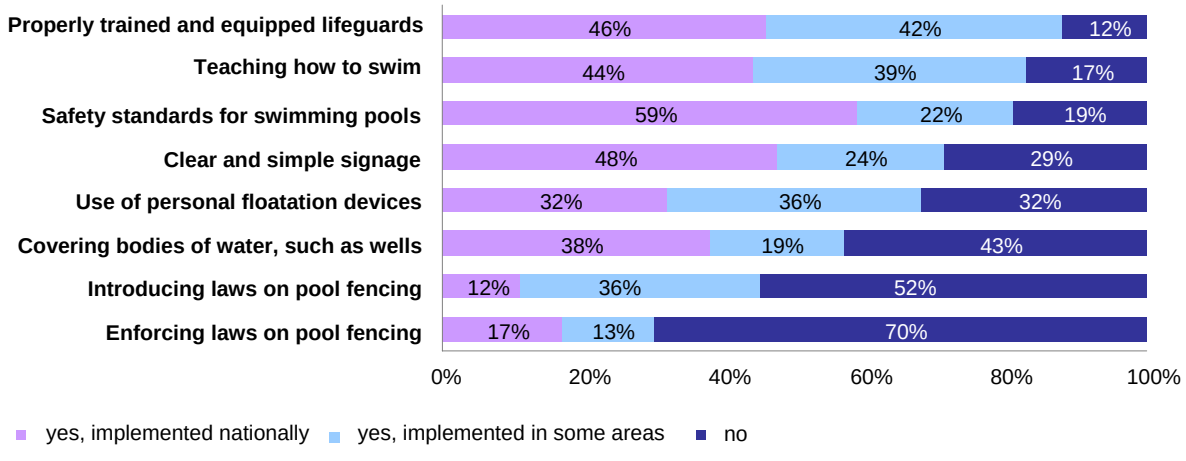
Fig. 8. Do you have in place any of the following programmes for the prevention of unintentional poisoning?



Programmes and interventions for preventing drowning or submersion

The median percentage implementation of measures to prevent drowning is 63%. Drowning is the second leading cause of unintentional injury-related death among children in the Region. However, some of the most effective measures for preventing drowning, such as using floatation devices, implementing pool fencing and teaching people how to swim, were among the least frequently implemented (Fig. 9). This insufficient uptake reflects the lack of national policy development. Much of the implementation was at the local level, and coverage in many countries needs to be extended nationwide.

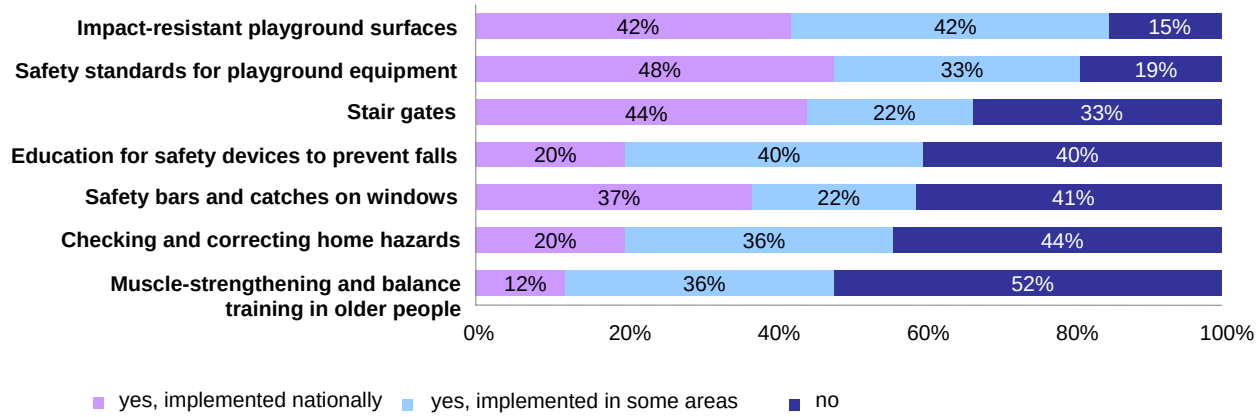
Fig. 9. Do you have in place any of the following programmes for the prevention of drowning or submersion?



Programmes and interventions to prevent unintentional falls

The median percentage of implementation of measures to prevent fall injuries is 71% for responding countries. Children and older people are the age groups most vulnerable to this injury cause. Falls are an important cause of injury among children, where they are associated with a large burden and also in older people, where fatality is high *(1)*. Home safety checks and implementation of safety measures for children are not widely practised, with implementation rates ranging from 37% to 48% at the national level, although for many countries this refers to local rather than national-level activities, suggesting the importance of more widespread local implementation by local authorities to achieve national coverage (Fig. 10). For older people at high risk, checking and modification of potential hazards in the home is limited (20%). Educational programmes to promote safety devices to prevent falls also have low implementation (20%), as do muscle-strengthening exercises and balance training among older people (12%).

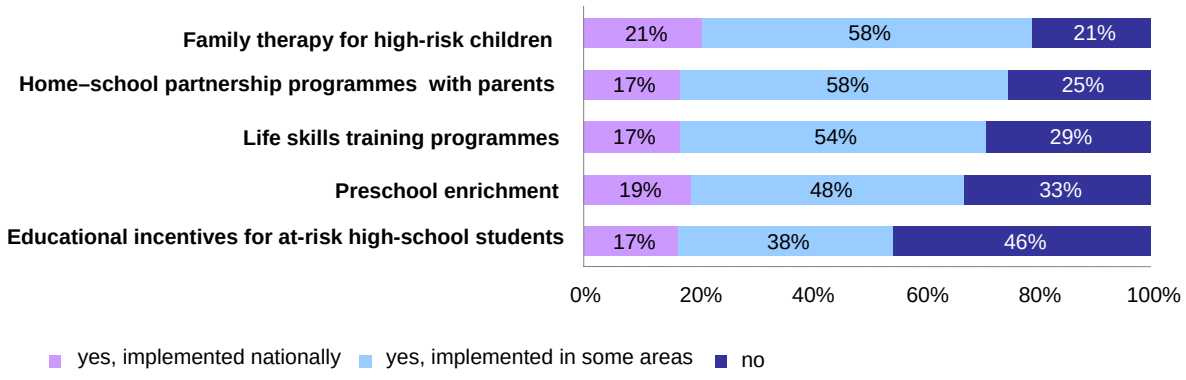
Fig. 10. Do you have in place any of the following programmes for the prevention of unintentional falls?



Programmes and intervention to prevent youth violence

The median percentage of implementation of programmes to prevent youth violence is 60% for responding countries in the Region. The implementation of programmes in many countries was patchy and only covered the whole country from 17% to 21% (Fig. 11). Much more could be done to achieve coverage on a wider scale, and this stresses the importance of cooperation with local educational authorities. Youth violence is perceived as a growing problem in many countries, and greater action is needed *(17)*.

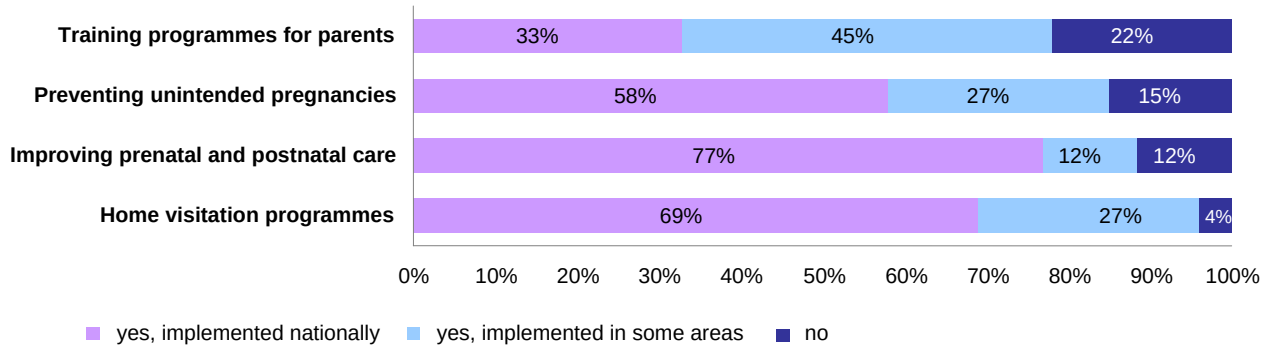
Fig. 11. Do you have in place any of the following programmes for the prevention of youth violence?



Programmes and interventions to prevent child maltreatment

Whereas the median percentage of implementation of programmes for child maltreatment prevention is 100%, many countries had implemented these programmes only locally as opposed to nationally, and more widespread coverage is a way forward in these countries. For example, home visitation programmes were implemented nationally in 69% of responding countries, but only 33% implemented training programmes for parents at the national level (Fig. 12).

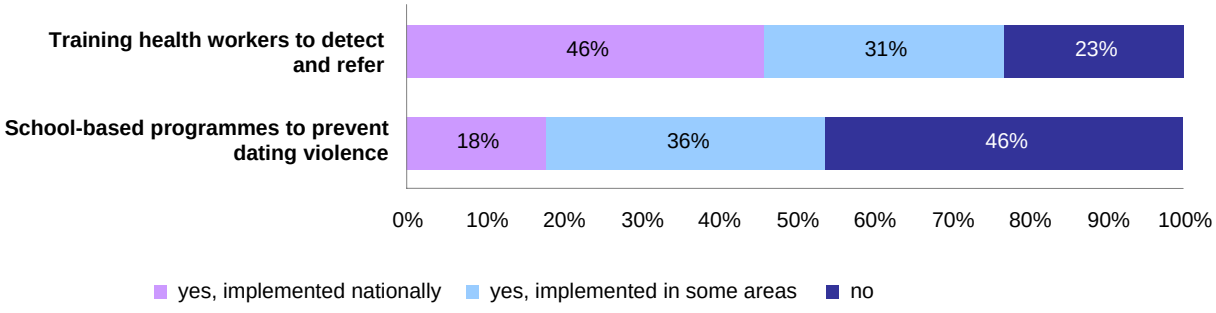
Fig. 12. Do you have in place any of the following programmes for the prevention of child maltreatment?



Programmes and interventions to prevent intimate partner violence

The median percentage of implementation for programmes to prevent intimate partner violence was 50% for responding countries. There was training for health care workers to detect and refer cases of intimate partner violence in 46% of responding countries nationally, with local coverage in a further 31% (Fig. 13). Only 18% of countries had school-based programmes to prevent dating violence nationally, with 36% reporting only local coverage. Programmes could be broadened to the national level and uptake increased in more countries. These measures also show promise for preventing sexual violence.

Fig. 13. Do you have in place any of the following programmes for the prevention of intimate partner violence?

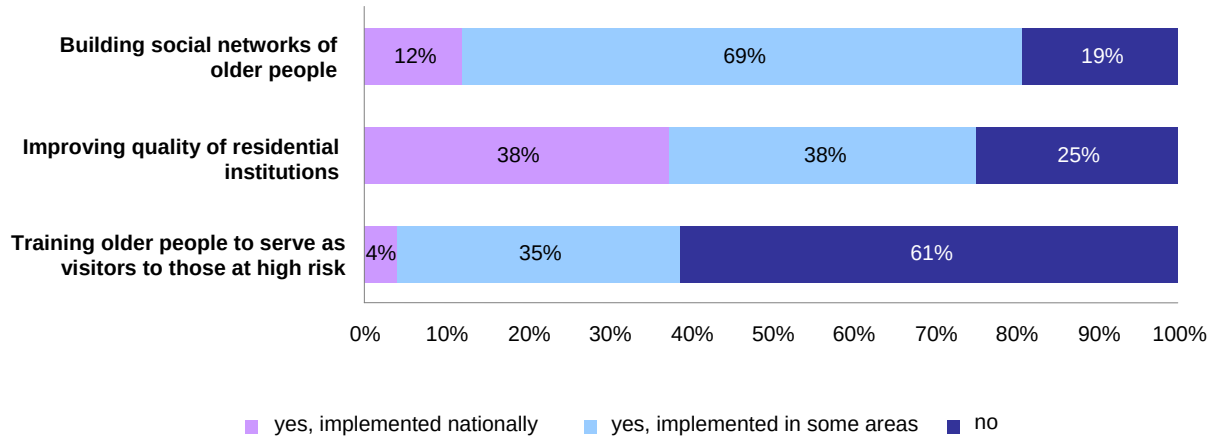


Programmes and interventions to prevent elder abuse

The median percentage of implementation of measures to prevent elder abuse was 67% for responding countries. Developing policies and programmes to improve the organizational, social and physical environment of residential institutions for older people is an obvious area for health systems to intervene to prevent elder abuse but was only practised nationally in 38% of countries (Fig. 14). Other approaches that engage civil society and involve empowering older people to prevent violence, such as training older people to serve as visitors and companions to individuals at high risk of victimization (4%) and building social networks of older people (12%), showed particularly low uptake. This area of violence prevention requires greater attention, especially given the demographic

pressures of an ageing society in the Region. Uptake needs to be augmented both within and between countries.

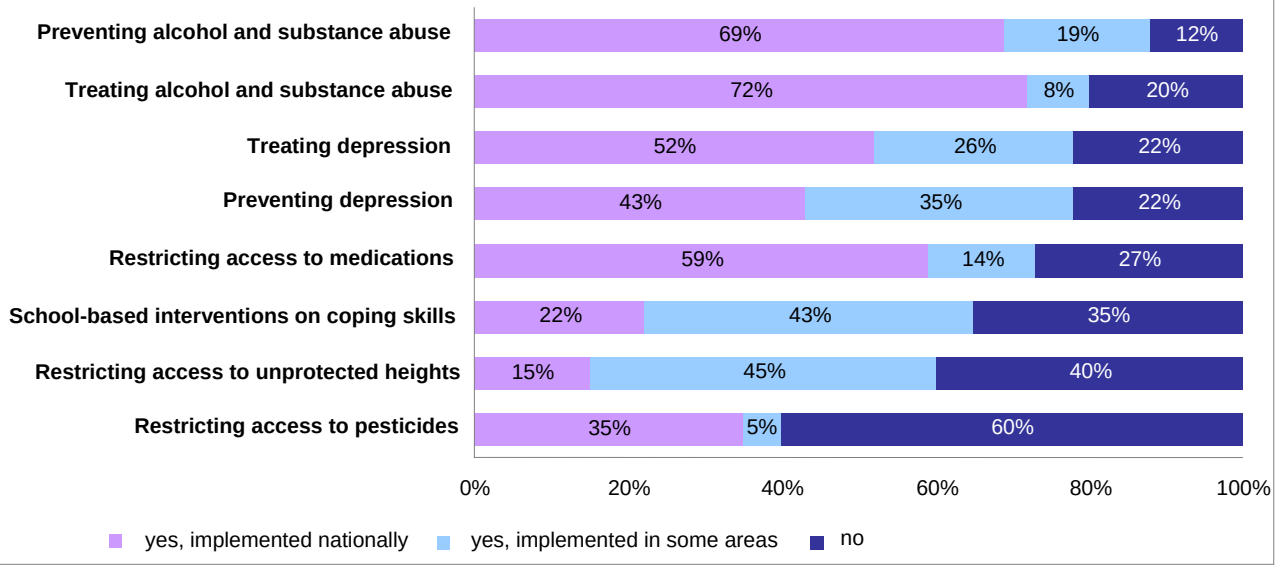
Fig. 14. Do you have in place any of the following programmes for the prevention of elder abuse?



Programmes and interventions to prevent self-directed violence

The median percentage of implementation of measures to prevent self-directed violence for responding countries is 63%. The highest percentage implementation is for those interventions where the health sector has a lead, such as preventing and treating alcohol and substance abuse (69–72%), preventing and treating depression (43–52%) and restricting access to medications (59%) (Fig. 15). Other interventions that require intersectoral work, such as school-based interventions focusing on crisis management, the enhancement of self-esteem and coping skills (22%) and restricting access to pesticides (35%), have substantially lower uptake. Suicide is the leading cause of injury-related death in most countries in the Region, and substantially better performance is needed.

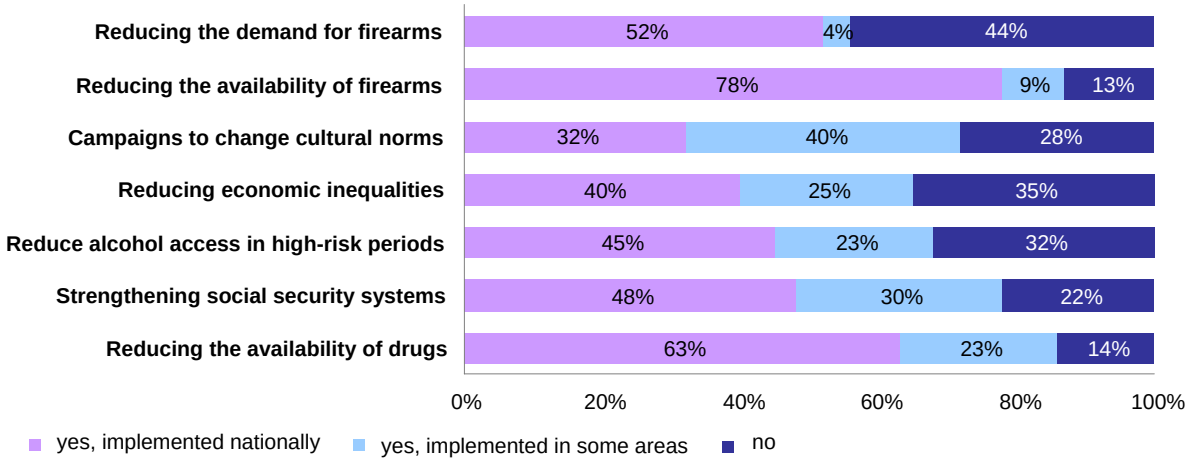
Fig. 15. Do you have in place any of the following programmes for the prevention of self-directed violence?



Programmes and interventions targeting the societal level to reduce unintentional injuries and violence

There are also societal interventions targeting reducing risk factors that are common for more than one type of unintentional injury or violence. These require more widespread uptake in the Region, both within and between countries (Fig. 16). Reducing economic inequality (40% of countries implement this nationally), decreasing the access to and availability of alcohol in high-risk periods (45% of countries implement this nationwide) and reducing the availability of drugs (63% implement nationwide) are thought to be effective in preventing most types of unintentional and intentional injuries. In contrast, other programmes such as sustained, multimedia prevention campaigns aimed at changing cultural norms that promote violence (32% nationwide implementation) and reducing the availability of firearms (78% nationwide implementation) focus on reducing risk factors to prevent different types of violence.

Fig. 16. Do you have in place any of the following programmes for the prevention of injuries and violence?



How was progress achieved in preventing violence and injury?

Increased activity and interest by countries in taking up the challenge to reduce the burden of injuries has been catalysed through World Health Assembly resolutions, the WHO Regional Committee for Europe resolution and the European Council Recommendation *(8–11)*.

Work through biennial collaborative agreements

Countries have increasingly recognized the severity of the problem, with increasing demand for collaboration with WHO through biennial collaborative agreements. These have steadily increased from 5 in 2004–2005 to 9 in 2006–2007 and to 15 in 2008–2009. The activities undertaken within the biennial collaborative agreement framework focus on four priority areas: preventing road traffic injury, preventing violence, capacity-building and surveillance.

Developing national policies

Specific support has been given for developing national policies for violence and injury prevention in 10 countries (Austria, Belarus, Czech Republic, Cyprus, Germany, Latvia, Romania, Russian Federation, the former Yugoslav Republic of Macedonia and Turkey). This ranged from advocacy to active involvement in the policy development process.

Capacity-building

Much work has also gone to strengthen the capacity of national health systems to respond to injuries, emphasizing surveillance, evidence-based practice and evaluation. A

capacity-building workshop for violence and injury prevention focal people has been held with the aim of developing the stewardship role of the health sector in mounting a multisectoral response to injury prevention. This has been achieved by using WHO's TEACH-VIP curriculum, which was developed by WHO headquarters and has been translated into Russian *(24)*. The first train-the-trainer workshop in the Region was held in September 2007 with Russian-speaking participants. This was favourably received, and plans are underway to expand this so that the curriculum can be adapted for local use and mainstreamed for health professional training. TEACH-VIP is being translated and adapted locally in Belarus, Czech Republic, Latvia, Romania, the Russian Federation, Spain, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan and the United Kingdom.

A mentoring programme (MENTOR-VIP), coordinated by WHO headquarters, which aims to impart both knowledge and skills for violence and injury prevention, has also been initiated with mentors and mentees from European countries participating *(25)*.

Improving injury surveillance

Hospital-based injury surveillance activities are being implemented in countries such as Lithuania and the Russian Federation, and a community survey of injuries has been undertaken in the former Yugoslav Republic of Macedonia using guidelines developed by WHO. In addition, WHO is on the advisory committee for injury registries in countries such as the Czech Republic, Hungary and Slovakia and for the European Commission-funded project to develop a European Injury Database. In the 2008–2009, further community surveys will be taking place to assess the scale of the interpersonal violence problem in Latvia, Romania and the former Yugoslav Republic of Macedonia.

Supporting the network of national focal people

Three European network meetings have been held, hosted by the health ministries of the Netherlands (2005), Austria (2006) and Portugal (2007) *(15,26,27)*. All three meetings have centred around key items of resolution EUR/RC55/R9, such as building capacity, surveillance and advocacy. At one of the meetings, a training workshop was held using the WHO TEACH-VIP curriculum *(24)* to familiarize focal people with the public health approach to injury and violence prevention and to promote the use of the curriculum to build capacity in countries. In addition, two global meetings of focal people have been held in conjunction with the 8th World Conference on Injury Prevention and Safety Promotion in Durban, South Africa (2006) and the 9th Conference in Merida, Mexico (2008), both including strong representation from European countries. These meetings have promoted the exchange of best practice and experience among focal people from diverse countries. A fourth European meeting of focal people is planned for 10–11 November 2008 and is being hosted by the Ministry of Health and Welfare of Finland.

Technical support on best practice

As well as providing input to specific collaborative projects, a steady flow of publications, policy briefings and fact sheets has brought together state-of-the-art knowledge on the burden and evidence-based solutions to address violence and injuries in the Region. These have been disseminated widely to the focal people and a broader audience of other policy-makers, practitioners and scientists so that best practices can be shared and implemented through the network of violence and injury prevention focal people and other networks. Annex 2 provides a list. Currently a European report on child injury prevention is being developed and is planned to be launched with the world report on child injury prevention on 10 December 2008.

Developing collaboration with other networks and partnerships

Collaboration has also been developed with other injury prevention networks, such as the European Association for Injury Prevention and Safety Promotion (EuroSafe); the European Child Safety Alliance, the EuroSafe initiative of the Child Safety Action Plan; Public Health Action for a Safer Europe; Best Practice Measures in Road Safety; the European Alcohol Policy Network; and the

South-eastern Europe Injury Prevention Network. Partnerships have also been developed with the European Commission Directorate-General for Health and Consumers and Directorate-General for Transport and Energy. Collaboration is also ongoing with other international bodies such as the United Nations Children's Fund; the Organisation for Economic Co-operation and Development; the United Nations Economic Commission for Europe; the Council of Europe; the European Transport and Safety Council; and the International Transport Forum. The Scottish Executive hosted the Meeting on Third Milestones of a Global Campaign for Violence Prevention in Scotland in 2007 *(28,29)* with over 200 international participants, many from European countries. There is also exchange of technical expertise with the network of WHO collaborating centres.

Technical assistance to improve care for victims

The Government of Italy hosted a regional consultation on the preparation of a world report on disability and rehabilitation in June 2008 organized in close collaboration with WHO headquarters. Guidelines on essential trauma care, prehospital trauma care and for medico-legal care for victims of sexual violence *(30–32)* have been disseminated. Plans are underway for translating them into Russian and disseminating them.

Advocacy for road safety

Support was also provided through the First United Nations Global Road Safety Week (23–29 April 2007), a successful global advocacy event led by WHO headquarters, which raised the profile of youth and road safety as a priority *(33)*. In the European Region, active support to 20 countries, in close cooperation with WHO country offices, helped health ministries to engage with other sectors in mounting an advocacy response in promoting road safety. In addition, collaboration was established with the European Commission Directorate-General for Transport and Energy for an event to mark the first European Road Safety Day in 2007 and the second European Road Safety Day on 13 October 2008 in Paris.

Global status report on road safety

A new activity initiated during 2007 to provide support for road safety is the Global status report on road safety *(34)*. The Bloomberg Philanthropies is funding this project and WHO headquarters is coordinating it. Close collaboration is taking place with the 49 countries that have appointed national data coordinators and where national surveys are being undertaken as part of the project implementation. Global and regional reports will be prepared and presented at the Global Ministerial Conference on Road Safety to be hosted by the Russian Federation in autumn 2009. Many of the focal people have taken the lead as national data coordinators.

4 Conclusions and way forward

Progress made and remaining challenges

Good progress is taking place in countries with the implementation of resolution EUR/RC55/R9 and the European Council Recommendation. Resolution EUR/RC55/R9 has been a catalyst for change, as evidenced by 71% of Member States agreeing that it had placed violence and injury prevention higher on the national policy agenda and had helped to catalyse action. Further, this past year has witnessed encouraging progress regarding many items of the resolution: national policy development has taken place in 68% of countries, surveillance in 61% and capacity-building in 58%. To enable this, many countries had favourable policy environments, with political support for formulating national policies for violence and injury prevention and with the health sector taking a lead role in coordination, working with other sectors and implementation. A web-based inventory of European national policies for injury and violence prevention has been developed as a resource for policy-makers and practitioners interested in seeking more information. More than 100 policies have been identified, and this number is expected to increase.

In terms of national policy development, there are integrated policies for unintentional injury prevention in 52% of countries and for violence prevention in 23%. However, many countries have developed national policies for individual types of injury. This varied: whereas most countries have a national policy for road safety (86%), half or less have national policies for other types of unintentional injury: poisoning, fires, falls or drowning. The transport sector has shown leadership in developing road safety policies, and this is reflected in widespread implementation of effective measures by many countries. However, least has been done to reduce road traffic injuries among youth, for whom road crashes are the leading cause of death *(23)*. Further, alternative, safer forms of transport should be developed to ensure a reduction in health risks (such as pollution and lack of physical activity) arising from the current dependence on private cars *(20)*.

The lack of national policy development for preventing drowning, falls and poisoning is reflected in countries reporting implementation of only about two thirds of the evidence-based measures. This is of concern, because drowning is the leading cause of unintentional injury-related death among children 1–5 years old, and falls affect children and older people more seriously than people in other age groups *(1)*. Implementation of programmes to prevent poisoning, the leading cause of injury-related death in some countries, is also low. An important way forward is the more widespread implementation of measures to reduce child poisoning such as the use of child-resistant closures *(1)*. A large proportion of poisoning deaths among adults are linked to acute alcohol intoxication *(1,35)*. Measures such as fiscal and regulatory controls with taxation and enforcement, brief counselling in emergency departments and by physicians need to be practised more widely *(3,36,37)*.

Countries varied in the development of policies for preventing the different types of violence. For example, 71% of countries had national policies for preventing intimate partner violence and 61% for preventing child maltreatment. However, only about one third had policies for preventing elder abuse, youth violence and self-inflicted violence. Suicide is the leading cause of injury-related death in most countries in the Region, and the health sector needs to pay much better attention to policy development and implementation of evidence-based programmes *(1)*. Youth violence is perceived as a growing problem in many countries, and more countries need to develop policies to prevent it *(17)*. The median percentage of implementation of programmes to prevent youth violence in the Region was 60% among the responding countries. Several important interventions for preventing youth violence require leadership by the justice and education sectors, and for these the health sector could contribute by sharing information and evaluation. Others such as early developmental interventions and preventing alcohol and substance misuse are the remit of the health sector. Preventing child

maltreatment should be a priority given the evidence that it is closely linked to cycles of violence and has long-term health consequences *(17,19)*. The prevention of elder abuse is another challenge in the Region, particularly given the demographic trends. Health systems can ensure that this does not happen in residential homes, and other approaches involve engaging civil society and empowering older people to prevent violence *(17)*. In most types of violence, the current challenge faced is improving the coverage of evidence-based programmes to the national level.

Reducing injuries and violence also requires societal responses. Cross-cutting risk factors such as social deprivation and alcohol are linked to all types of injury and violence. Some countries have developed social policies that target overcoming economic inequality, and others target the availability of alcohol in high-risk periods and reducing the availability of drugs. Other programmes such as sustained, multimedia prevention campaigns aimed at changing cultural norms that promote violence and reducing the availability of firearms are more focused on preventing violence. These societal interventions require more widespread uptake in the Region. The health sector could lead and advocate for these changes *(16)*.

Three previous European assessments of injury prevention have taken place using a combination of policy and outcome indicators. Whereas one has focused on all types of violence and injury at all ages *(7)*, the European Environmental Health Indicators project *(38)* and the Child Safety Action Plan project *(39)*, have focused specifically on unintentional injury in children. These assessments have been successful in drawing attention to a previously neglected area of public health, increasing the calls for action and for monitoring policy development. This report has documented the favourable progress being made in policy development and implementation following resolution EUR/RC55/R9 and the European Council Recommendation. There is a need to continue synergy between these different initiatives to optimise the use of resources and create a critical mass in the Region *(38,39)*.

Limitations

This assessment was carried out using a questionnaire survey of national focal people. As with all surveys, limitations include issues of reliability and validity *(7)*. Injury and violence prevention activities are diverse, and not all relevant activities may have been recorded. To allow for this, focal people were given an opportunity to verify country profiles before these were published. Nevertheless, some of the issues of validity might remain unresolved. For example, for preventing child maltreatment, interventions such as health visitation to support high-risk families may have been of a general supportive nature rather than those tailored specifically to prevent child maltreatment *(19)*. As stated previously, the purpose of the survey is to stimulate further action by providing baseline information not only for evaluating future action but also to make more in-depth queries about the nature of national and local interventions.

The level of detail presented in this report, which provides summary information, is also limited. For example, the responses to questions on national policy development are presented as frequencies. However, rich contextual information and specific details of policy are available in the country questionnaires, and this can be studied further by examining the web sites where questionnaires and policies have been uploaded *(21,22)*. The definition of national policy used in this survey was broad: in some countries this may include strategic national plans to ensure implementation, but in others these may be a missing but necessary next step between policy development and action to implement programmes *(14)*. Similarly, focal people were not asked to quantify existing investment in injury and violence prevention; the extra resources needed in the Region to scale up efforts cannot therefore be estimated, except that these need to be considerable. Another limitation of this survey is that it did not include all injury prevention interventions and programmes; selected ones were included from among those regarded as effective, and this list may have some omissions *(16)*.

Further policy development is a dynamic process, and more recent policy initiatives or the very old ones may not have the same visibility *(7,40)*. Given this constraint, focal people will have an opportunity to update developments annually, and it is hoped that some of this dynamism will be captured. Gathering and publishing such information may not necessarily catalyse action. However, it can be used successfully to advocate for action, as demonstrated in the Child Safety Action Plan project *(39)* and the European Environmental Health Indicators *(38)*. Country reports that overestimate the national implementation of programmes (for example for preventing child maltreatment) may lead to complacency. These qualitative policy indicators, which are useful for advocating action and for benchmarking, are not a substitute for outcome indicators, and long-term evaluation needs to be conducted using mortality and morbidity data on a defined time scale. Whereas this would have been desirable, it will only be possible to do this in the future because of the 2- to 3-year time lag required for preparing mortality datasets and the longer periods of data collection needed before national policy development can be shown to affect outcomes. This has not been feasible for the current report, as the period of observation has been too short since resolution EUR/RC55/R9 was adopted in 2005 and the European Council Recommendation in 2007. Future evaluations should be able to overcome this limitation.

Opportunities for action

The following opportunities have been identified for health systems in responding to this leading cause of death and disability in the WHO European Region.

- A critical mass of policy-makers, focal people and practitioners has developed over the last decade in the area of violence and injury prevention in Europe in response to international scientific and policy developments. These networks are gaining momentum in developing and implementing public health policy and represent an investment for the future.
- Networks such as the health ministry focal people represent an opportunity to exchange and disseminate evidence-based practice and experience.
- The body of evidence is growing, and this report has mapped the extent to which this is being implemented in the Region. Country assessments have been uploaded on the WHO Regional Office for Europe web site. This mapping exercise represents an initial step in documenting the public health response to the burden of injuries and serves as a baseline for evaluating future progress at the regional and country levels.
- The country assessments together with the inventory of national policies on injury and violence prevention represent a resource of accessible information that can be used for reference and action. There is an opportunity to use these resources to advocate for greater commitment and action.
- Many programmes are being implemented at the local level geographically, and there is an opportunity to use such programmes as champions to advocate for national policy development and to provide lessons for further implementation.
- Initiatives have been started to build human resource capacity in violence and injury prevention using the WHO curriculum TEACH-VIP, and there is an opportunity to mainstream this into the syllabus for health professional training.
- There is an opportunity to raise awareness of the justice and education sectors and other sectors about the benefits of using cost-effective interventions in early violence prevention and engaging them as leaders and partners.
- Health systems have an opportunity to fulfil their stewardship role by providing leadership and coordinating a multi-sectoral response for the types of injury and violence for which there is no ownership, such as preventing drowning, falls and poisoning (unintentional injury) and preventing child maltreatment, intimate partner violence, elder abuse and self-inflicted violence. Similarly, there is an opportunity to advocate for evidence-based action in areas such as preventing fire and youth violence, where other sectors have a lead.

- For some areas, there is an opportunity for synergistic action within health systems for injury and violence prevention practitioners, such as with the mental health and alcohol policy networks for violence prevention *(35)*.

Way forward and next steps

The health sector and partners need sustained action to decrease the inequality in violence and injury between and within countries of the Region. The progress mapped in this report is not a reason for complacency. Future success require sustained political and resource commitment by countries and international organizations. The key steps forward include:

- building on current achievements with greater development of national policies and more widespread implementation of evidence-based programmes in countries in the Region (Table 1);
- using research and routine information systems to evaluate programmes using outcome indicators to increase the body of knowledge in the Region;
- improving access to injury surveillance information in some countries to make the extent, causes and consequences of the problem more visible;
- stepping up existing efforts in building institutional capacity and training and mainstreaming the prevention and care of injuries and violence into the curricula of health professions;
- maintaining support for the existing network of health ministry focal people for violence and injury prevention;
- identifying and making better use of opportunities for collaborative working with other sectors and networks;
- conducting future evaluations using policy indicators and outcome measures; and
- increasing investment in resources and political commitment:
  - to exploit the above opportunities to the fullest;
  - to build on existing progress;
  - to fill the gaps identified in this report, and
  - to increase momentum in Member States and the Region.

Table 1. Future actions needed to decrease the burden of injuries and violence in the WHO European Region and the role of health systems

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

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Annex 1. Questionnaire

Monitoring the implementation of the WHO Regional Committee for Europe Resolution RC55/R9 and the Council Recommendation

Injuries are a leading cause of death in the European region. As a response, in 2005 the WHO Regional Committee for Europe adopted a Resolution on the Prevention of injuries (EUR/RC55/R9). There was strong support for the resolution by the Ministries of Health and WHO is expected to feedback on the implementation of RC55/R9 to the Regional Committee in 2008.

In preparation of this, we are collating information on national policies on injury and violence prevention and documenting progress made by Member States in implementing RC55/R9. This questionnaire is designed to document this progress. At their third meeting on 21-22 of November, 2007 in Lisbon, Violence and Injury Prevention Focal Persons endorsed the use of this questionnaire to assess country progress and to use the information for the preparation of a report for the Regional Committee in 2008. The questionnaire has been then modified in response to the comments received at the meeting. Questions 1-15 are identical to the previous version, and additional questions have been added (questions 16-44).

Questions 1-9 concern key items of the Regional Committee Resolution and are expected to provide a useful update to information from the Focal Persons meeting in 2006.

Questions 10-15 are meant to help us to identify national policies in the various areas of injury prevention (e.g. road safety) and violence prevention (e.g. domestic violence).

Questions 16-44 have been added in 2008. Question 16 is concerned with new developments in the past 12 months. Questions 17-41 enquire about whether evidence-based injury and violence prevention programmes exist in your country for different mechanisms of injury and types of violence, and questions 42-44 are about the processes involved. The responses to the questionnaires will be entered in a database and the information made available to focal persons as a resource through a web based tool.

Instructions to fill the questionnaire

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

For those focal persons who have already returned a filled questionnaire in 2007, you need only to fill in questions 16-44. Otherwise please fill in the whole questionnaire.

To allow time to complete the report, we would be grateful if you could fill the questionnaire and send it by 21st February, 2008 to violenceinjury@ecr.euro.who.int.

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ
ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Country:

Name of respondent:
Title of respondent:
E-mail address:
Postal address:
Telephone number:

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

IF YOU HAVE ALREADY ANSWERED AN EARLIER VERSION OF THIS QUESTIONNAIRE IN 2007 PLEASE GO DIRECTLY TO QUESTIONS 16–46.

1a) Is there a commitment to develop national plans or policies for injury and violence prevention?

YES ☐ NO ☐

1x. Please provide more details if available:

If YES, as part of this have the following activities been undertaken:

1b) The size of the injury and violence problem has been defined?

YES ☐ NO ☐

1xi. Please provide more details if available:

1c) An assessment of existing policy response (e.g. a national plan or policy)?

YES ☐ NO ☐

1xii. Please provide more details if available:

1d) An assessment of the interventions in place?

YES ☐ NO ☐

1xiii. Please provide more details if available:

2a) Do you have easy access to surveillance data on the different types of injuries and violence which could help you to prioritize in formulating a plan and to monitor its progress?

YES ☐ NO ☐

2x. Please provide more details if available:

3a) Has political support been gained for the injury and violence prevention agenda?

YES ☐ NO ☐

3x. Please illustrate your answer with examples. Examples include presidential support, inter-ministerial support, ministerial support, director support, public statements by political leaders, etc.

4a) Has the process of identifying key stakeholders been undertaken?

YES ☐ NO ☐

4x. Please provide more details if available:

4b. If YES, has a list of key players from different sectors been drawn up?

YES ☐ NO ☐

4xi. Please provide more details if available:

4c. If YES, have the different stakeholders been already involved in the proposed policy development?

YES ☐ NO ☐

4xii. Please provide more details if available:

5a) Is there an intersectoral committee that meets regularly to take the injury and violence prevention agenda forward?

YES ☐ NO ☐

5x. Please provide more details if available:

5b. Is there a secretariat to support the injury prevention committee?

YES ☐ NO ☐

5c. If YES, is this secretariat in the form of focal persons?

YES ☐ NO ☐

5d. Is there a budget to support activities?

YES ☐ NO ☐

5xi. Are there other resources made available to help it deliver its function such as meeting rooms, administrative support, printing, communication?

6a) Have outcomes and priorities for action in injury and violence prevention been agreed upon by key stakeholders?

YES ☐ NO ☐

6x. If YES, are steps being undertaken to formulate these into action?

7a) Are there specific programmes or courses dedicated to building capacity in injury and violence prevention?

YES ☐ NO ☐

7x. Please provide more details if available:

7b.Is the promotion and exchange of evidence-based practice part of this process?

YES ☐ NO ☐

7xi. Please provide more details if available:

7c. Is the promotion of research to fill local gaps in knowledge part of this process?

YES ☐ NO ☐

7xii. Please provide more details if available:

8a) Is there an evidence-based approach to emergency trauma care?

YES ☐ NO ☐

8x. Please provide more details if available:

8b. Is there a quality assessment programme to improve the quality of care?

YES ☐ NO ☐

8xii. Please provide more details if available:

8c. Are there programmes or courses to build capacity in emergency trauma care?

YES ☐ NO ☐

8xiii. Please provide more details if available:

9a) Has the adoption of resolution RC55/R9 contributed to catalysing change with respect to the prevention of violence and injuries in your country?

YES ☐ NO ☐

9x. If YES, please briefly describe the changes that have been prompted/facilitated by the resolution

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

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

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

YES ☐ NO ☐

10 a. If yes, and this is not for all age or risk groups, then please specify age groups this applies to.

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

Category		Response		
11a. Road safety/traffic injuries	YES	☐	NO	☐
11x. If yes, please provide title and web-link …..……				
11b. Accidental falls	YES	☐	NO	☐
11xii. If yes, please provide title and web-link …..……				
11c. Accidental drowning and submersion	YES	☐	NO	☐
11xiii. If yes, please provide title and web-link …..……				
11d. Accidental poisoning	YES	☐	NO	☐
11xiv. If yes, please provide title and web-link …..……				
11e. Accidents caused by fire and flames	YES	☐	NO	☐
11xv. If yes, please provide title and web-link …..……				

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

12a. Electronic copies	YES	☐	NO	☐
or				
12b. Hard copies	YES	☐	NO	☐

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

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

13) Is there an overall national policy on violence prevention?

For the purpose of this survey, a violence-related injury prevention policy is a document that sets out the main principles and defines goals, objectives, prioritized actions and coordination mechanisms for preventing violence and reducing the health consequences.

YES ☐ NO ☐

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

Category		Response		
14a. Interpersonal violence	YES	☐	NO	☐
14x. If yes, please provide title and web-link……				
14b. Youth violence	YES	☐	NO	☐
14xi. If yes, please provide title and web-link……				
14c. Child abuse and neglect	YES	☐	NO	☐
14xii. If yes, please provide title and web-link……				
14d. Intimate partner or domestic violence	YES	☐	NO	☐
14xiii. If yes, please provide title and web-link……				
14e. Elder abuse and neglect	YES	☐	NO	☐
14xiv. If yes, please provide title and web-link……				
14f. Sexual violence	YES	☐	NO	☐
14xv. If yes, please provide title and web-link……				
14g. Self-directed violence	YES	☐	NO	☐
14xvi. If yes, please provide title and web-link……				

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

15a. Electronic copies	YES	☐	NO	☐
or				
15b. Hard copies	YES	☐	NO	☐

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

QUESTIONS 16–46 WERE ADDED IN 2008 AND SHOULD BE FILLED BY ALL RESPONDENTS

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

ai. National policy

YES ☐ NO ☐

bi. Surveillance

YES ☐ NO ☐

bii) If YES, please briefly describe these developments

ci. Multisectoral collaboration

YES ☐ NO ☐

cii) If YES, please briefly describe these developments

di. Capacity-building

YES ☐ NO ☐

dii) If YES, please briefly describe these developments

ei. Evidence-based emergency care

YES ☐ NO ☐

eii) If YES, please briefly describe these developments

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Increasing the legal age of motorcyclists from 16 to 18 years			
b. Increasing the legal age of drivers from 16 to 18 years			
c. Introducing laws on blood alcohol concentration limits			
d. Enforcing laws on blood alcohol concentration limits			
e. Graduated driver licensing systems			
f. Traffic-calming measures			
g. Daytime running lights on motorcycles			
h. Introducing seat-belt laws			
i. Enforcing seat-belt laws			
j. Child-passenger restraints			
k. Introducing and enforcing motorcycle helmet laws			
l. Speed-reduction measures			
m. Making greater use of safer modes of transport			
n. Sobriety checkpoints			
o. Increasing the minimum legal drinking age			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Restricting the manufacture and sale of fireworks			
b. Reducing storage of flammable substances in households			
c. Promoting implementation of smoke alarms and detectors			
d. Improving building standards			
e. Modifying products – for example, kerosene stoves, cooking vessels and candle holders			

20. Please provide information on any other programmes in place for the prevention of fires or burns not listed in Q19

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Child-resistant containers			
b. Poison-control centres			
c. Better methods of storage, relating both to the nature of storage vessels and where they are placed			
d. Use of warning labels			
e. First aid education			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Use of personal floatation devices			
b. Introducing laws on pool fencing			
c. Enforcing laws on pool fencing			
d. Teaching how to swim			
e. Covering bodies of water, such as wells			
f. Safety standards for swimming pools			
g. Clear and simple signage			
h. Properly trained and equipped lifeguards			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Safety mechanisms on windows, such as window bars in high-rise buildings			
b. Stair gates			
c. Impact-resistant surfacing material on playgrounds			
d. Safety standards for playground equipment			
e. Muscle-strengthening exercises and balance training for older adults			
f. Checking and if necessary modifying potential hazards in the home where there are individuals at high risk			
g. Educational programmes encouraging safety devices to prevent falls			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Life skills training programmes			
b. Preschool enrichment, to strengthen bonds to school, raise achievement and improve self-esteem			
c. Family therapy for children and adolescents at high risk			
d. Home–school partnership programmes promoting the involvement of parents			
e. Educational incentives for at-risk high-school students			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Improving the quality of and access to prenatal and postnatal care			
b. Home visitation programmes			
c. Training programmes for parents			
d. Preventing unintended pregnancies			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. School-based programmes to prevent violence in dating relationships			
b. Training health-care providers to detect intimate partner violence and to refer cases			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Building social networks of older people			
b. Training older people to serve as visitors and companions to individuals at high risk of victimization			
c. Developing policies and programmes to improve the organizational, social and physical environment of residential institutions for the elderly			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
School-based programmes to prevent violence in dating relationships			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Restricting access to pesticides			
b. Restricting access to medications			
c. Restricting access to unprotected heights			
d. Preventing depression			
e. Treating depression			
f. Preventing alcohol and substance abuse			
g. Treating alcohol and substance abuse			
h. School-based interventions focusing on crisis management, the enhancement of self-esteem, and coping skills			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Reducing the availability of alcohol during high-risk periods			
b. Reducing economic inequalities			
c. Strengthening social security systems			
d. Reducing the availability of drugs			

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

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

Programmes	No	Yes, implemented in:	
		some areas	nationally
a. Reducing demand for firearms			
b. Reducing the availability of firearms			
c. Sustained, multimedia prevention campaigns aimed at changing cultural norms that promote violence			

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

42a) Please list the constraining factors in the implementation of violence and injury prevention activities within your country

42b) Please list the enabling factors to the implementation of violence and injury prevention activities within your country

43) In answering this questionnaire, did you build consensus with other sectors/stakeholders involved in violence and injury prevention?

YES ☐ NO ☐

b) If Yes, please provide details

c) Please specify the sectors/stakeholders you consulted

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

YES ☐ NO ☐

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

Thank you for taking the time to fill this in.

Please send the completed questionnaire by 21 February 2008 by e-mail to violenceinjury@ecr.euro.who.int

or by mail to:

Violence and Injury Prevention
WHO European Centre for Environment and Health
Via F. Crispi 10
Rome 00187
Italy

Annex 2. Relevant publications on preventing violence and injuries

Technical reports

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

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

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

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

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

Policy briefings

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

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

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

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

Sethi D. *Developing national policy for injury and violence prevention*. Amsterdam, EuroSafe, 2006 (http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/0/D733D6539AF7F643C12573A8003761DC/$file/Policy%20briefing%202.pdf).

Sethi D. *Inequality in injury risks*. Amsterdam, EuroSafe, 2006 (http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/0/D733D6539AF7F643C12573A8003761DC/$file/Policy%20briefing%203.pdf).

Sethi D. *The role of public health in injury prevention in the WHO European Region*. Amsterdam, EuroSafe, 2006 (http://www.euro.who.int/document/VIP/policy_briefing_1.pdf).

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

Scientific articles

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

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

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

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

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

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

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

Chapters in books

Sethi D, Butchart A. Violence/intentional injuries: prevention and control. In: *Elsevier encylopaedia of public health*. Amsterdam, Elsevier (in press).

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

Focal people meeting reports

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

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

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

Annex 3. List of respondents

No.	Country	Respondent(s)
1.	Albania	Maksim Bozo, Ministry of Health Gentiana Qirjako, Public Health Department
2.	Armenia	Lilit Avetisyan, State Hygienic and Antiepidemic Inspectorate Ruzanna Yuzbashyan, Ministry of Health
3.	Austria	Rupert Kisser, Kuratorium für Verkehrssicherheit
4.	Azerbaijan	Rustam Talishinskiy, Traumatology Centre Baku Vagif Verdiev, Ministry of Health
5.	Belarus	Ivan Pikirenya, Ministry of Health
6.	Belgium	Martine Bantuelle, Centre d'Education à la Santé Christiane Hauzeur, Ministry of Public Health
7.	Bulgaria	Maksim Gaidev, Ministry of Health Fanka Koycheva, National Center of Public Health Prevention
8.	Croatia	Ivana Brkic and Vlasta Zerjavic, National Institute of Public Health
9.	Cyprus	Myrto Azina-Chronidou and Olga Poyiadji-Kalakouta, Ministry of Health
10.	Czech Republic	Veronika Benešová, Charles University Jarmila Razova and Iva Truellova, Ministry of Health
11.	Denmark	Margit Ulmer, Ministry of Health and Prevention
12.	Finland	Helena Ewalds, National Research and Development Centre for Welfare and Health Merja Söderholm, Ministry of Social Affairs and Health
13.	Greece	Dimitrios Efthymiadis, National Center for Emergency Health Care
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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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Injuries, whether intentional or unintentional, are the third leading cause of death in Europe and pose a threat to economic and social development. This publication presents an overview of progress achieved by Member States in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injuries. A web-based database of country profiles was developed using a questionnaire survey completed by health ministry focal people for injury and violence prevention. An inventory of national policies was compiled by searching the internet. Information was provided on progress in delivering on key items of resolution EUR/RC55/R9 and on the implementation of 69 selected evidence-based programmes to prevent unintentional injury and violence. Good progress is taking place, and resolution EUR/RC55/R9 has catalysed change. Development of national policies for individual types of injury and violence varied from 86% for road safety to about one third for preventing youth violence and self-inflicted violence. Implementation of evidence-based programmes for preventing all types of injury and violence varied in countries, and the median was 56% for all these taken together. This progress report documents that the health sector needs to commit more to the widespread implementation of effective programmes both in number and coverage, and to engage with other stakeholders in a multisectoral response to prevent injuries.

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