# Latvia

This country assessment is based on (1) the responses to a WHO Regional Office for Europe questionnaire designed to gather information on key elements of WHO Regional Committee for Europe resolution EUR/RC55/R9 and of the European Council Recommendation on the prevention of injury and promotion of safety and (2) Regional Office data and information.

## Summary of country assessment

Latvia reports implementing 61% of 99 interventions effective in preventing a range of injuries versus a European Region median score of 71% and a first quartile of 0–64%.

The country feedback was positive on some of the key areas identified, such as national policy development, multisectoral collaboration and evidence-based emergency care.

### National policies

- There is an overall national policy for preventing violence but none for preventing injuries. There are specific national policies for road safety and preventing poisoning; falls; interpersonal, youth, sexual and intimate partner violence; child maltreatment; and suicides. National policies have not highlighted socioeconomic inequality in injuries and violence as a priority.

### Implementation of effective interventions

- Latvia reported implementing 49% of selected effective interventions for preventing injuries and 74% for preventing violence. These figures are lower than the median regional scores of 70% for preventing unintentional injury and 81% for preventing violence. Table 2 shows the details of percentages for each type of injury. The list of interventions implemented for each type of injury is available separately from the country questionnaire. The proportion of reported implementation was lower than the median regional score for the interventions related to fires, drowning, falls and most of the violence-related interventions.
- Alcohol-related harm is a problem that manifests as violence and injuries. The consumption of illegal home brew, informally produced alcoholic beverages and alcohol not intended for human consumption causes much of this. Latvia reported implementing 88% of selected effective interventions on alcohol versus a median regional score of 71%. Latvia has implemented 86% of legal and fiscal interventions and all the health system–based programmes to reduce alcohol-related harm (Table 2) as part of a public health response.

### Impact of resolution EUR/RC55/R9 and of the European Council Recommendation

- Latvia acknowledged that adopting resolution EUR/RC55/R9 and the European Council Recommendation helped the Ministry of Health in raising the policy profile of the prevention of violence and injuries as a health priority. Although there is no overall national policy on preventing injuries, there is political commitment for this. Many of the key steps considered necessary for developing policy are in place, and the public health strategy for 2004–2010 includes targets on injury mortality. There has been positive progress in the past 12 months in national policy development, multisectoral collaboration and evidence-based emergency care. Some of the elements of resolution EUR/RC55/R9 have been successfully achieved, such as a commitment to develop national policies, injury surveillance and evidence-based emergency care.

### Next steps

- Greater attention needs to be given to capacity-building, exchanging evidence-based practices and implementing evidence–based interventions for preventing falls, drowning (no interventions to prevent falls and drowning are reported to have been implemented), fires, youth violence, child maltreatment and elder abuse. Several interventions (on sexual and intimate partner violence and child maltreatment) were implemented in selected regions rather than nationally, and this could be an area for future activity. Alcohol remains an important risk factor even if alcohol-related interventions are reported as being well implemented. Mortality rates for alcohol poisoning are still too high. Interventions to reduce socioeconomic inequality have not been implemented and could be an area of future activity.

## Country profile

### Table 1. Demographics

- Latvia has a population of 2.3 million. The percentage of children 0–14 years old is lower than the European Region average, and the percentage of people 65+ years old is higher than the regional average.
- Life expectancy at birth is lower than the European Region average, both for males and for females. Males and females differ greatly in life expectancy.

| Indicator (last available year) | Latvia | WHO European Region | European Union (EU27) |
|---|---|---|---|
| Mid-year population | 2.3 million | 890.9 million | 493.8 million |
| % of population aged 0–14 years | 13.9 | 17.5 | 15.7 |
| % of population aged 65+ years | 17.2 | 14.0 | 16.8 |
| Males, life expectancy at birth, in years | 65.8 | 71.4 | 76.0 |
| Females, life expectancy at birth, in years | 76.5 | 79.1 | 82.2 |

- Injuries are the third leading cause of death. The rates for unintentional injuries and for almost all intentional injuries (except for youth violence) are higher than the European Region averages.
- Injury mortality rates rose steeply and then peaked in the mid-1990s due to the political and socioeconomic transition and are now declining (Fig. 1).
- The leading causes of unintentional injury-related deaths are road traffic injuries, poisoning, falls, drowning and fires.
- The leading causes of intentional injury-related death are suicide followed by homicide.
- The alcohol-related poisoning rate and the rate for road traffic injuries involving alcohol are much higher than the regional averages.
- The WHO Regional Office for Europe has been supporting the focal person and is collaborating with the Ministry of Health to develop a national policy on preventing violence, guidelines for detecting and referring intimate partner violence and conducting a survey of adverse childhood experiences. Latvia participated in the advocacy events of the First United Nations Global Road Safety Week, the project on a global status report on road safety and a Nordic and Baltic subregional mentoring workshop to build capacity for violence and injury prevention. TEACH-VIP, a comprehensive curriculum on preventing and controlling injuries, has been translated into Latvian and will be used to train trainers in preventing violence.

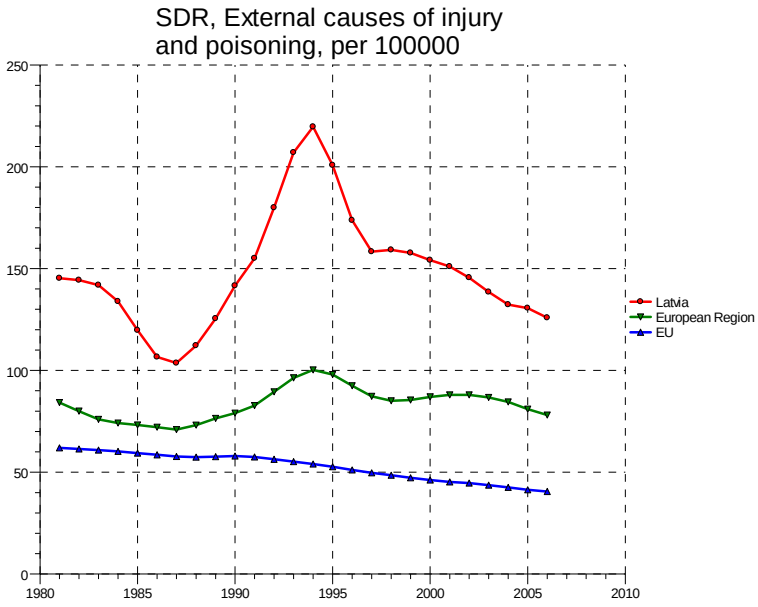


**Fig. 1. Standardized death rate (SDR) for external causes of injury and poisoning in Latvia, the WHO European Region and the European Union (EU), 1980–2008**

## Table 2. Injury burden, policy response and effective prevention measures in place

Legend: ✓ Yes ✘ No ? Not specified or no response NA Not applicable - No data

| Cause of injury | Mortality[a] (SDR per 100 000 population, all ages, last available year)[b] | | | National policy? | Intervention effectiveness (%) | |
|---|---|---|---|---|---|---|
| | Latvia | WHO European Region | European Union[c] | | Country score[d] | WHO European Region[e] |
| **All injuries** | **115.2** | **75.8** | **40.0** | **NA** | **61** | **71** |
| **Unintentional injury**[f] | **86.4** | **45.9** | **25.9** | ✘ | **49** | **70** |
| Road traffic injuries | 17.5 | 13.3 | 9.3 | ✓ | 94 | 81 |
| Fires and burns | 7.4 | 2.4 | 0.7 | ✘ | 40 | 60 |
| Poisoning | 14.4 | 10.7 | 2.3 | ✓ | 80 | 80 |
| Drowning or submersion | 10.2 | 3.4 | 1.3 | ✘ | 0 | 63 |
| Falls | 10.7 | 5.6 | 5.5 | ✓ | 0 | 75 |
| **Intentional injury** | **NA** | **NA** | **NA** | ✓ | **74** | **81** |
| Interpersonal violence[g] | 8.0 | 5.2 | 1.0 | ✓ | NA | NA |
| Youth violence[h] | 3.5 | 5.3 | 1.0 | ✓ | 72 | 86 |
| Child maltreatment[i] | 0.9 | 0.6 | 0.3 | ✓ | 80 | 100 |
| Intimate partner violence | – | – | – | ✓ | 75 | 75 |
| Elder abuse and neglect | – | – | – | ✘ | 0 | 67 |
| Self-directed violence | 17.8 | 14.0 | 10.2 | ✓ | 88 | 88 |
| **Alcohol**[j] | **NA** | **NA** | **NA** | **NA** | **88** | **71** |
| Alcohol-related poisoning | 8.3 | 2.8 | 0.9 | NA | NA | NA |
| Alcoholic liver diseases[k] | 1.7 | – | 8.6 | NA | NA | NA |
| Road traffic injuries (fatal and non-fatal) involving alcohol | 32.3 | 18.0 | 19.2 | NA | NA | NA |
| Fiscal and legal measures[l] | NA | NA | NA | NA | 86 | 71 |
| Health system–based programmes[m] | NA | NA | NA | NA | 100 | 67 |

[a] Unless otherwise specified.
[b] Sources for mortality data: European Health for All database and European Health for All mortality database [online databases]. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/hfadb, accessed 15 January 2010).
[c] The 27 European Union countries.
[d] Calculated as the proportion of effective interventions in place in the country. This is based on WHO list of effective interventions published in: *Preventing injuries and violence: a guide for ministries of health*. Geneva, World Health Organization, 2007 (http://www.who.int/violence_injury_prevention/publications/injury_policy_planning/prevention_moh/en, accessed 15 January 2010). For the full range of interventions and responses, please consult the country questionnaire.
[e] Median of the proportion of effective interventions in place in countries in the WHO European Region.
[f] Standardized death rates (SDR) from accidents.
[g] Proxy for mortality: mortality from homicide and assault, all ages.
[h] Proxy for mortality: mortality from homicide and assault, 15–29 years.
[i] Proxy for mortality: mortality from homicide and assault 0–14 years.
[j] This score was calculated from 17 alcohol-related interventions.
[k] The EU average was calculated based on 20 countries. Data retrieved from: European detailed mortality database [online database]. Copenhagen, WHO Regional Office for Europe, 2009 (http://www.euro.who.int/InformationSources/Data/20070615_2, accessed 15 January 2010).
[l] This score was calculated from 14 interventions on access to alcohol (availability, restrictions and bans).
[m] This score was calculated from three interventions on health systems-based programmes to reduce alcohol-related harm.

**Table 3. Key elements of policy development in preventing injury and violence**

Legend: ✓ Yes ✘ No ? Not specified or no response

| | |
|---|---|
| **National policies** | |
| • Overall national policy on injury prevention | ✘ |
| • Overall national policy on violence prevention | ✓ |
| • Commitment to develop national policy | ✓ |
| • Alcohol identified as a risk factor for injuries | ✓ |
| • Alcohol identified as a risk factor for violence | ✓ |
| • Policies targeted to reduce socioeconomic differences in health | ✘ |
| • National policies highlight socioeconomic inequality as a priority | ✘ |
| **Political support for the agenda for injury and violence prevention** | ✓ |
| **Easy access to surveillance data** | ✓ |
| **Intersectoral collaboration** | |
| • Key stakeholders identified | ✓ |
| • Secretariat to support the intersectoral committee | ✘ |
| • Questionnaire answered in consensus with other sectors and stakeholders | ✓ |
| • Can WHO help to achieve intersectoral collaboration in the country? | ✓ |
| **Capacity-building** | |
| • Process in place | ✘ |
| • Exchange of evidence-based practice as part of this process | ✘ |
| • Promotion of research as part of this process | ✘ |
| **Emergency care** | |
| • Evidence-based approach | ✓ |
| • Quality assessment programme | ✘ |
| • Process to build capacity identified | ✓ |
| **EUR/RC55/R9 influenced the agenda for injury and violence prevention** | ✓ |
| **Recent developments in injury and violence prevention (during the past 12 months)** | |
| • National policy | ✓ |
| • Surveillance | ✘ |
| • Multisectoral collaboration | ✓ |
| • Capacity-building | ✘ |
| • Evidence-based emergency care | ✓ |