World Health Organization

REGIONAL OFFICE FOR Europe

EUROPEAN STATUS REPORT ON PREVENTING CHILD MALTREATMENT

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European status report on preventing child maltreatment

By:
Dinesh Sethi, Yongjie Yon, Nikesh Parekh,
Thomas Anderson, Jasmine Huber,
Ivo Rakovac & Franziska Meinck

ABSTRACT

Child maltreatment is a major public health problem, affecting at least 55 million children in the WHO European Region. The impact of abuse and/or neglect in childhood is detrimental to physical, psychological and reproductive health throughout the life-course, yet the high costs to society are avoidable. There are clear risk factors for maltreatment at the level of the individual, family, community and society. This status report documents the progress that has been made by Member States in implementing the WHO *European child maltreatment prevention action plan 2015–2020* at its midpoint. The plan has a target of a 20% reduction in child maltreatment and homicides by 2020. Data were collected through a survey of government-appointed national data coordinators of 49 participating countries in the Region. Results show that good progress is being made overall towards achieving the objectives. Development of national policy for the prevention of child maltreatment has increased across the Region, with three quarters of countries reporting an action plan, but these must be informed by robust national data. Surveillance of child maltreatment remains inadequate in many countries, with information systems in low- and middle-income countries most in need of strengthening. Legislation to prevent maltreatment is widespread, but better enforcement is warranted. The implementation of child maltreatment prevention programmes, including home-visiting, parenting education, school and hospital-based initiatives, has accelerated, but evaluation of impact is needed. Child maltreatment is a societal issue that crosses sectoral boundaries, meaning a sustained, systematic, multidisciplinary and evidence-informed approach to prevention must remain a priority for governments.

Keywords

CHILD ABUSE – PREVENTION AND CONTROL
VIOLENCE – PREVENTION AND CONTROL
CHILD WELFARE
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CONTRIBUTORS

This report was written by: Dinesh Sethi and Yongjie Yon (WHO Regional Office of Europe), Nikesh Parekh (Royal Borough of Greenwich, United Kingdom), Thomas Anderson and Jasmine Huber (WHO Regional Office of Europe), Ivo Rakovac (WHO European Office for Prevention and Control of Noncommunicable Diseases) and Franziska Meinck (University of Oxford, United Kingdom).

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FOREWORD

Child maltreatment is a societal problem that exists in all countries. Children's development is fundamentally disrupted by maltreatment, conferring risk to physical, psychological and reproductive health throughout the life-course. Fifty-five million children in the WHO European Region experience abuse and/or neglect. The costs to society from reduced social cohesion, lost productivity and avoidable health-service use are substantial. This is avoidable – there are clear biological, social, cultural and economic factors that underlie the burden of child maltreatment.

Traditionally, efforts to tackle child maltreatment have been led by the social care and criminal justice systems, through a protective and punitive lens. WHO has been advocating for a shift in focus from a protection-centred approach to one of prevention. Evidence shows that this is achievable and cost–effective, with an approach driven by public health principles. This entails strategies that are population-based, multidisciplinary and evidence-informed.

Preventing child maltreatment is key to reducing health inequities in Europe and achieving the goals of Health 2020, the European health policy framework. In 2014, the WHO Regional Committee for Europe adopted resolution EUR/RC64/13, Investing in children: the European child maltreatment prevention action plan 2015–2020. *This set a target of reducing the prevalence of child maltreatment in the Region by 20% by 2020. The plan calls on Member States to achieve this through three objectives: making child maltreatment more visible with better surveillance; strengthening governance for the prevention of child maltreatment by developing national action plans; and implementing maltreatment prevention programmes.*

This European status report on preventing child maltreatment describes the progress made by governments in the Region in achieving these objectives at its midway point. The report is based on a detailed survey completed by government-appointed national data coordinators in 49 of 53 Member States in the Region. It documents the robustness of child maltreatment surveillance, the extent and scope of policy development and the implementation of evidence-informed preventive programmes. While there is no doubt that positive strides have been made in the Region as a whole to prevent child maltreatment, we highlight the considerable gaps that exist between countries. Better data, more comprehensive action plans and stronger evaluation of the impact of prevention initiatives are needed.

We at the WHO Regional Office for Europe hope this report will provide policy-makers, practitioners and activists with the information and guidance needed to continue the momentum on implementing the European child maltreatment prevention action plan. The prevention of child maltreatment is achievable. The benefits that this would bring are not only for the healthy development of children and their families, but also for society as a whole. We hope this report will act as a benchmark to help countries attain the goals of the European action plan and as a catalyst for attaining the target of Sustainable Development Goal 16.2, of eliminating violence against children by 2030.

Bente Mikkelsen
Director
Division of Noncommunicable Diseases and Promoting Health through the Life-course
WHO Regional Office for Europe

ACRONYMS

ACE	adverse childhood experience
CIS	Commonwealth of Independent States
EU	European Union
HICs	high-income countries
ISO	International Organization for Standardization
LMICs	low- and middle-income countries
NCDs	noncommunicable diseases
NFP	Nurse–Family Partnership (programme)
NGO	nongovernmental organization
OBPP	Olweus® Bullying Prevention Program
RCT	randomized controlled trial
SDG	(United Nations) Sustainable Development Goal
SDR	standardized death rate
STEEP	Steps Towards Effective Enjoyable Parenting (programme)
TEACH VIP	(WHO) Training Education Advancing Collaboration in Health, Violence and Injury Prevention (curriculum)
UNCRC	United Nations Convention on the Rights of the Child

EXECUTIVE SUMMARY

Child maltreatment is the physical, sexual and/or emotional abuse and/or neglect of children under 18 years of age. It was estimated in 2015 that 629 children died by homicide in the WHO European Region. Deaths represent just the very tip of the iceberg – for every death there are thousands of child protection referrals and hospital admissions for child maltreatment. Beneath the official statistics is a hidden pandemic of adverse childhood experiences, which are strongly related to maltreatment. It is estimated that child maltreatment affects at least 55 million children in the Region.

Biological systems are disrupted by child maltreatment during a time of major brain development, conferring serious risk to physical, psychological and reproductive health and societal attainment through the life-course. Some of the most intractable public health problems, including substance misuse, high-risk sexual activity, noncommunicable disease, mental illness and interpersonal violence, are influenced by experiencing maltreatment and other adversity in childhood. The costs to society from reduced social cohesion, lost productivity and avoidable health-service use are substantial.

Child maltreatment is preventable. Clear risk factors exist at individual, parent and caregiver, and community and society levels. Until recently, much of society's reaction has been to respond to abuse and neglect only when, and if, detected. While a child protection response is critical, evidence shows strongly that prevention is much more cost–effective. It makes more sense to safeguard children's right to a nurturing upbringing by preventing maltreatment from occurring in the first instance, rather than deal with its consequences.

The WHO Regional Office for Europe published the European report on preventing child maltreatment in 2013 to catalyse policy-makers and practitioners to take preventive action against child maltreatment. Following this, the WHO Regional Committee for Europe adopted resolution EUR/RC64/13, *Investing in children: the European child maltreatment prevention action plan 2015–2020,* in 2014. This set a target of reducing the prevalence of child maltreatment in the Region by 20% by 2020. The plan set out three main objectives for achieving this target:

1. make health risks such as child maltreatment more visible by setting up information systems in Member States;
2. strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans; and
3. reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States.

The prevention of child maltreatment also features prominently in the Sustainable Development Goals, with four targets (5.2, 5.3, 16.1 and 16.2) addressing the ending of violence against children and several more (within goals 1, 3, 4, 5, 10, 11 and 16) focusing on risk factors.

This status report describes the progress made by countries in implementing the *European child maltreatment prevention action plan 2015–2020*.

The specific aims are to:

- detail the burden of child maltreatment in countries across Europe, and highlight the scale of surveillance and data collection in the Region to inform interventions;
- examine the scale of policy and legislative commitment from countries to preventing child maltreatment;
- identify the extent of evidence-informed programmatic interventions for child maltreatment prevention;
- describe the health and social care services in place to support the early detection of, and response to, child maltreatment; and
- identify gaps that should be addressed to achieve the 2020 target in the Region.

Method

The report is based on a survey conducted with the support of government-appointed national data coordinators for each country. The method comprised a four-stage process which entailed: 1) a self-administered questionnaire

completed by representatives from government ministries and, sometimes, nongovernmental organizations; 2) a multisectoral consultation to decide which data most accurately represented the country; 3) validation of final data submitted by each participating country by WHO regional technical staff; and 4) approval from government officials to include the final data in this report.

Coverage

The report presents data from 49 countries that participated in the survey out of a total 53 Member States of the WHO European Region. This represents 98% (approximately 250 million) of the children in the Region.

Progress on Objective 1: making child maltreatment more "visible"

Child homicide has been decreasing across the Region. Projections based on trend data suggest that the Region is on track to achieve a 20% reduction by 2020. While this is welcome, inequalities persist in the Region.

Homicide rates in low- and middle-income countries are 1.6 times higher than in high-income countries (0.37 versus 0.23 per 100 000). Strong information systems and surveillance to provide good epidemiological data to inform prevention are still lacking in many countries. Less than 50% of countries could report data from child protection agencies; the 23 countries that provided such data at national level reported 550 607 new child protection contacts over a one-year period. Hospital admissions are often poorly recorded and/or inadequately coded.

National surveys that use standardized, validated instruments are necessary to determine the hidden burden of abuse. This would enable comparisons to be made between countries and support learning across the Region. The current situation is such that 45% of countries in the Region have never conducted a national child maltreatment survey using a standardized instrument, and 65% do not conduct regular surveys; this makes monitoring of trends challenging. Surveys are important in developing national policy, but 22% of countries have not completed surveys to inform their national child maltreatment prevention action plans. Countries are urged to optimize existing information systems across all sectors, share data between sectors, and develop data where lacking.

Progress on Objective 2: are countries developing national action plans to coordinate action against child maltreatment?

Substantial gains in preventing child maltreatment can be made by coordinating actors in multiple sectors and developing national policy. It is highly encouraging that the Region has seen an almost 30% increase since 2013 in the proportion of countries with a national action plan for the prevention of child maltreatment. This indicates high-level recognition of the need for child maltreatment prevention alongside protection systems.

The strength of a national action plan to comprehensively address child maltreatment and generate increased political and societal momentum depends on its content. There is substantial scope for action plans to improve by setting clear objectives with measurable targets, and ensuring plans are fully funded – only one in five and one in three respectively fulfil these criteria currently. Links should also be made with related policies to prevent violence, poverty, gender inequality and noncommunicable disease. Only 53% of countries with a prevention plan for noncommunicable disease recognized child maltreatment as a risk factor, despite extensive evidence showing how adverse childhood experiences and maltreatment are significant determinants.

Member States have a duty under the United Nations Convention on the Rights of the Child to enact and enforce legislation to protect children from violence. The Region is in a strong position in this regard, with a high proportion of countries enacting laws against child maltreatment. Countries are nevertheless encouraged to extend legislation to ban corporal punishment in all settings, as the current situation leaves settings such as home and day care with a lack of legislative clarity in four out of 10 countries. A quarter of countries are not enforcing legislation. Inevitably, the impact of any legislation will be limited by the extent of its enforcement; improvement is required in this area,

particularly in low- and middle-income countries and the Commonwealth of Independent States subregion.

Progress on Objective 3: are countries implementing prevention programmes?

The evidence base for both universal and targeted programmes that can reduce risk factors for child maltreatment is substantial. Home-visiting programmes are the most commonly implemented programmes on a large scale (57% of countries), which may reflect their potential for preventing child maltreatment and improving overall child health outcomes. Enhanced capacity in home visiting to support families to mitigate risk would potentially offer quick gains for these countries.

Various types of parenting programmes to support and train parents in developing nurturing relationships with children are being implemented across the Region, although scope for improvement remains. Parental training programmes to prevent abusive head trauma in infants are the least widely implemented, with only 10% of countries adopting them on a large scale. Less than half of the countries (43%) undertake programmes in primary school to strengthen protective factors such as recognition of abuse and harmful situations and proactive disclosure to trusted adults. Most countries implementing prevention programmes have developed their own; these may be very similar to established programmes, but countries are encouraged to evaluate them to confirm.

Gains have been made since 2013 in strengthening services to detect and respond appropriately to child maltreatment. A substantial rise in the proportion of European countries that have implemented services at large scale for prenatal assessment of risk for child maltreatment or intimate-partner violence has been seen between 2013 and 2017. This is a positive development, as health professionals providing prenatal care are well positioned to question parents about violence in the household and offer support early. The earlier supportive interventions are put in place for children, the greater the opportunity to mitigate the damaging impacts of maltreatment. Response services, however, must be adequately resourced to provide holistic, family-centred support to at-risk families through earlier detection. Greater emphasis should also be placed on training for health-care and other professionals.

Children with disabilities are at heightened risk of experiencing maltreatment and may have greater challenges in communicating harm. Countries are urged to ensure that prevention programmes are tailored to meet the needs of children with disabilities, and that the impact on safeguarding is closely monitored. Programmes also need to be adapted to reach so-called hard-to-reach groups, such as migrant and refugee children.

Conclusion

Child maltreatment has grave consequences, both immediately and in the long term. While good progress has been made, this status report shows that countries in Europe can achieve much more with population-based, multidisciplinary and evidence-informed strategies. It is hoped that the shortcomings presented here at the midpoint of the *European child maltreatment prevention action plan 2015–2020* will help countries to develop and implement more comprehensive national policies and programmes in child maltreatment prevention.

Governments across the Region are urged to build on their progress in achieving the objectives of the action plan leading to 2020. The current momentum should be used as a catalyst to step up action to end violence against children and build equitable and just societies, thereby honouring the Sustainable Development Goal targets.

EUROPEAN STATUS REPORT
ON PREVENTING
CHILD MALTREATMENT

1. Background

Background

Context

Child maltreatment affects over 55 million children in the WHO European Region *(1)*. The 2013 European report on preventing child maltreatment documented a high prevalence of child maltreatment, from 9.6% for sexual abuse, 16.3% for physical neglect, 18.4% for emotional neglect, and 22.9% for physical abuse, to 29.6% for emotional abuse *(1)*. Based on child homicide data, it is estimated that child maltreatment causes over 700 avoidable deaths a year in children under 15 in the European Region *(1,2)*. For every child death, there are between 150 and 2400 cases of significant physical abuse that are detected and come to the attention of services *(3)*.

The consequences of maltreatment are devastating to both the short- and long-term health of affected individuals *(4)* and result in substantial and avoidable health-care costs throughout the life-course *(5)*. This is not a problem that can be overcome without explicit commitment and active interventions.

In 2014, Member States of the WHO European Region adopted *Investing in children: the European child maltreatment prevention action plan 2015–2020 (6)*. Europe is the first region to develop such a plan. The problem of child maltreatment, however, is not unique to Europe; global estimates suggest that over 1 billion children suffered from violence in the past year *(7,8)*.

Investing in children: the European child maltreatment prevention action plan 2015–2020

This status report examines progress in the WHO European Region in implementing the *European child maltreatment prevention action plan for 2015–2020*. The action plan promotes activity to overcome child maltreatment and sets a voluntary target of a 20% reduction by 2020. Actions are proposed through three main objectives (Box 1).

This report is based on responses by Member States to a survey, "Countdown to 2020: implementing the European child maltreatment prevention action plan". The main section of the report describes the regional overview, followed by country profiles with key indicators of progress.

Box 1. Action plan objectives

Objective 1. Make health risks such as child maltreatment more visible by setting up information systems in Member States.

Objective 2. Strengthen governance for the prevention of child maltreatment through partnerships and multisectoral action by developing national plans.

Objective 3. Reduce risks for child maltreatment and its consequences through prevention by strengthening health systems in Member States.

Source: WHO Regional Office for Europe *(6)*.

Chapter 2 outlines the methodology for the survey. Chapter 3 focuses on the scale of the problem by first examining mortality data from child homicides followed by data from child protection agencies, hospital admission rates due to assaults and injury, and prevalence studies and community surveys of child maltreatment. The subsequent chapters focus on policy and legislative responses (Chapter 4) and preventive programmes and victim services (Chapter 5), and the report concludes with a discussion on progress made in reducing child maltreatment and proposals for a way forward (Chapter 6).

Throughout the report, the terms action plan and policy are used interchangeably to describe a written document that provides the basis for action to be taken jointly by the government and its nongovernmental partners *(9)*.

Data on bullying-prevention programmes were also collected in the survey. While bullying is a form of peer violence and not in itself child maltreatment, children who have experienced maltreatment have an increased risk of being victims and perpetrators of bullying *(10,11)*. Preventing this additional presentation of child victimization is important in reducing long-term adverse mental health in children who have experienced maltreatment *(12)*.

What is child maltreatment?

Child maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment, or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power *(13,14).* Children may be subjected to more than one type of maltreatment in their childhood.

What is violence against children?

Violence against children is defined as the intentional use of physical force or power, threatened or actual, against children under 18 years that either results in, or has a high likelihood of resulting in, injury, death, psychological harm, maldevelopment or deprivation. These acts of violence may be committed by adults, whether carers, relatives or strangers, or by peers – other children *(13,14).* Child maltreatment is a major type of violence against children.

What are adverse childhood experiences?

Any form of victimization in children, whether due to violence from peers or due to child maltreatment, is considered an adverse childhood experience (ACE). ACEs may also be caused by household dysfunction, such as living with someone who has a mental illness or an alcohol, drug or substance problem, or is (or has been) incarcerated, or if the child is witnessing parental separation or divorce and/or parental violence *(15).* Household dysfunction is often a risk factor and may co-occur with child maltreatment. More than one type of ACE may be experienced during childhood.

Why is child maltreatment so important?

Child maltreatment is a leading cause of health inequality and social injustice *(1).* The effect of ACEs is a cumulative increase in risk for poor health outcomes, often through the adoption of health-harming behaviours *(15).* Factors that may seem distal to long-term health are in fact key to some of the most intractable public health problems across geographies, societies and cultures *(16).*

Childhood is a period of extensive neurological, physical and emotional development. Adversity from maltreatment and household dysfunction can result in toxic stress and cognitive delay, and the adoption of health-harming behaviours such as substance misuse and risky sexual behaviour. Over the life-course, these determinants can result in the development of noncommunicable diseases (NCDs) and mental illness, and could lead to premature death, suicide and the intergenerational transmission of violence *(1,17–20).* Maltreated children and those exposed to multiple types of adversity may be at greater risk of being both victims and perpetrators of violence in later life *(19,21).* Maltreatment also exacerbates inequality because of its health and social impacts, thereby perpetuating cycles of deprivation.

Children have a right to caregiving and nurturing in childhood. Its absence, particularly in early life, may lead to toxic stress, resulting in the disruption of neural, immune, endocrine and metabolic pathways and leading to poor health outcomes through the life-course *(16,17,22,23).* Children in the first three years of life are most vulnerable to these changes in brain development; one of the greatest returns therefore can be made through investing in early child development *(24).*

Maltreatment at all ages interferes with children's educational and social achievement, constraining their potential and bringing major implications for society at large. Loss of productivity from poor health outcomes attributable to child maltreatment, alongside direct costs to health, education, welfare and criminal justice systems, imposes a global economic burden warranting urgent international action *(1).* In Germany, the annual cost to services and society of child maltreatment has been estimated to be between €11 billion and €30 billion *(25).* Total lifetime costs of new victims of child maltreatment in the United States in one year (fatal and non-fatal combined) were estimated (in 2008) at US $124 billion *(26).* Child maltreatment clearly has significant individual, societal and economic repercussions. Irrespective of the child's age, child maltreatment is also a violation of human rights *(27).*

Global and European calls to action

The United Nations Convention on the Rights of the Child (UNCRC) *(28)* emphasizes that children's right to health and

well-being throughout their development is paramount, and that they should be free from violence and other forms of adversity. Other significant policy developments globally and in the European Region have been introduced since the adoption of the UNCRC. These include the WHO *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (3)*, which emphasizes the importance of a public health approach using evidence-based prevention and response interventions.

Preventing violence and its cumulative effects on health throughout the life-course is also emphasized in the global strategy for women's, children's and adolescents' health 2016–2030. Violence prevention is given priority in the 2030 Agenda for Sustainable Development, with United Nations Sustainable Development Goal (SDG) target 16.2 calling for an end to all forms of violence against children by 2030 *(29).* Ending violence against children also features in targets 5.2, 5.3 and 16.3, and in targets within goals 1, 3, 4, 5, 10, 11 and 16, which address risk factors. Reducing violence against children is a priority of the WHO 13th Global Programme of Work 2019–2023 through the adoption of target 16, to reduce the number of children who experience violence, including physical and psychological violence by caregivers, in the previous 12 months by 20% by 2023. All these policies highlight the importance of an integrated, cross-sectoral approach to ending violence against children.

European Member States also adopted *Investing in children: the European child and adolescent health strategy (30)* in 2014. It and the action plan are framed within Health 2020, the European policy framework and strategy for the 21st century, with its guiding principles of equity, a life-course approach, a whole-of-society approach, and evidence-based prevention to improve population health outcomes.

Risk and protective factors

Multiple factors across the ecological domains of individual, family and caregivers, community and wider society influence the risk of child maltreatment (Fig. 1) *(14).* Interrelationships between the disadvantage experienced at the micro level of the individual (such as disability), surrounding family (parental substance misuse, for example) and macro structural level, such as enforcement of laws banning corporal punishment and improving welfare and labour conditions, including promoting the availability of preschool places, increasing employment opportunities and reducing poverty, will influence parenting capacity and susceptibility to violence *(31,32).* Ultimately, people and their environments influence each other: holistic approaches that recognize the interplay between risk factors at micro and macro levels are therefore pivotal to child maltreatment prevention strategies.

Individual-level factors

Children living with disability or who have behavioural problems may be at increased risk of maltreatment *(33).* Risk is also influenced by age and ethnicity *(24).* Most risk factors at individual level relate to caregiver or perpetrator characteristics. These include alcohol and substance misuse, caregivers' own history of child maltreatment or harsh discipline, mental illness, single parenthood, lack of social support, parental anger, perceiving the child as a problem and parental stress levels *(33).* The development of individual resilience through assets in the community (such as childhood friendships, opportunity to use abilities, fair treatment, a trusted adult and someone to look up to) can substantially reduce the risk of ACEs impairing health and educational achievement *(34).*

Family and caregiver relationship factors

Both parent–child interactions and family characteristics increase the risk of child maltreatment. Risk factors include poor parenting skills, parental approval of corporal punishment, poor family cohesion and functioning, financial stress, intimate-partner violence and being a child of an unplanned pregnancy *(35,36).* Protective factors include strong and nurturing attachment between parents and children, knowledge of parenting and child development, parental resilience and having strong social connections and support *(37).*

Community-level factors

The characteristics of the community in which children and

Fig. 1.

An ecological framework to represent the risk factors for child maltreatment

Source: Sethi et al. *(1).*

families live also affect the likelihood of child maltreatment. Risk factors include communities with socioeconomic disadvantage, poor social capital, limited access to child care and ease of access to alcohol. Protective factors include strong social networks and concrete support for parents and communities, such as flexible working arrangements, job stability, parental leave, high-quality day care from young age and welfare services *(38).*

Societal-level factors

Cultural and societal values that can influence the risk of child maltreatment include acceptance of physical punishment to discipline children, gender inequality, and harmful practices such as child marriage and female genital mutilation. Socioeconomic inequalities, the absence of laws protecting children, lack of services for maltreated children and their families and greater access to alcohol are also risk factors

(31,39). Protective factors include societies with egalitarian values and the presence and enforcement of laws protecting children against violence.

Preventing child maltreatment

Research shows that child maltreatment can be prevented by implementing specific programmes, including targeted support for vulnerable parents through home visiting *(40)*, universal support (including parental education) *(41)* and hospital-based training for parents to prevent infant abusive head trauma *(42,43).* The WHO publication *Implementing child maltreatment prevention programmes: what the experts say (44)* presents a collation of recommended cost-effective interventions for the prevention of child maltreatment. WHO and international partners have also developed a resource package, *INSPIRE: seven strategies to end violence against children (8)*, to deliver on the SDG targets to end violence against children. The INSPIRE package focuses on implementation and enforcement of laws to protect children, changing norms and values towards violence, creating safe environments, providing parent and caregiver support, securing incomes and economic strengthening, enhancing responses and support services, and offering children education and life skills *(8,45).* The *INSPIRE handbook: action for implementing the seven strategies for ending violence against children* and the INSPIRE indicator guidance and results framework provide support for effective implementation of the package. A multidisciplinary approach involving the health, education, justice, welfare and employment sectors, along with commerce and civil society, is essential in achieving its goals.

Additional information for the report

The report has five annexes that provide additional information:

- Annex 1 provides detailed definitions of child abuse and neglect, and child maltreatment prevention;
- Annex 2 lists national data coordinators by country;
- Annex 3 provides country listings for the subregions defined in the report;
- Annex 4 provides a summary of the legislative situation on corporal punishment in the Region;
- Annex 5 provides additional figures on: reported availability of child protection agency data by level of country income in the WHO European Region (Fig. A5.1); countries with a national child maltreatment protection plan (Fig. A5.2); the proportion of countries with laws relating to the prevention of child maltreatment (Fig. A5.3); and the proportion of countries who had laws concerning child maltreatment in 2013 and 2017 surveys (Fig. A5.4).

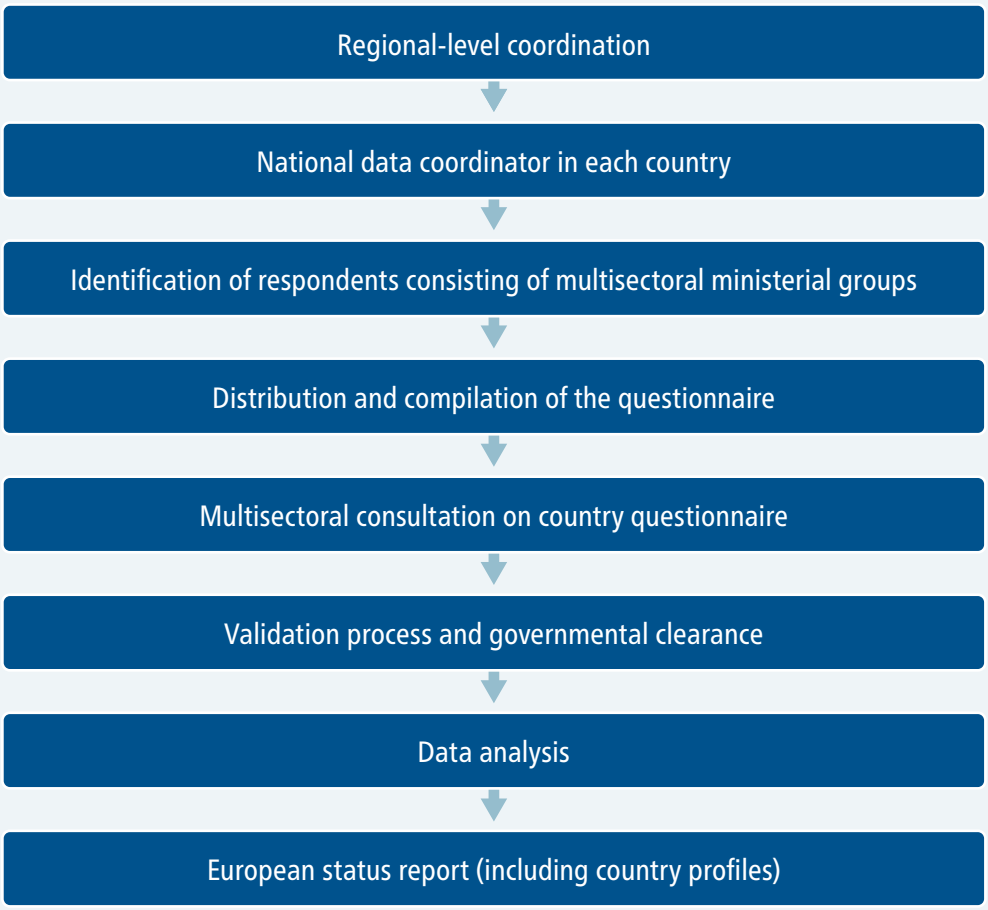
2. Methodology

Methodology

A rigorous methodology for data collection based on the *Global status report on violence prevention 2014 (46)* was used (Fig. 2). This involved systematically gathering data and other information from each participating country in a four-phase process, primarily led by a government-appointed national data coordinator. National data coordinators are listed in Annex 2.

First, a self-administered questionnaire was completed in each country by respondents from ministries including health, justice, education, welfare, law enforcement and police, social development and the interior, and, where relevant, nongovernmental organizations (NGOs). Secondly, respondents were encouraged to hold a consensus meeting and agree on the data that best represented their country. Thirdly, WHO regional technical staff validated the final data submitted for each participating country by checking them against independent databases and other sources. Lastly, approval to include the final data in this European status

Fig. 2. Flow chart of methodology used for data collection and validation



Source: Butchart et al. *(46).*

report was obtained from the national data coordinator and/or government officials.

Some data presented in this report were obtained from the Global Initiative to End All Corporal Punishment of Children *(47)*: this is clearly stated where applicable. Information on legislation against corporal punishment obtained from this source was verified with Member States prior to use.

The questionnaire is based on indicators in the action plan and the three associated handbooks *(6,44,48,49).* Content was developed in consultation with experts and is similar to that for the *Global status report on violence prevention 2014 (46).* The questionnaire focused on the three areas of the plan: surveillance, national policy development and implementation of prevention programmes. Questions covered the following areas:

- data on homicide from police and civil or vital registration systems;
- data on non-fatal violence and from hospitalizations, child protection agency contacts and national population-based surveys;
- national action plans for the prevention and protection of child maltreatment;
- government departments responsible for overseeing
- and/or coordinating child maltreatment prevention activities and mechanisms for exchange of information;
- programmes for child maltreatment prevention;
- enactment and enforcement of laws relevant to child maltreatment prevention;
- detection and response services for victims of violence in the health, social and legal sectors; and
- capacity development activities through training of professionals.

This report presents data from 49 countries that participated in the survey out of a total 53 countries of the WHO European Region. Sub-analyses by country income and subregional grouping (see Annex 3 for country and income listings) are offered to identify inequalities in the Region. Analyses by income level include 31 high-income countries (HICs) and 18 low- and middle-income countries (LMICs), as defined by the World Bank *(50).* Analyses by subregion includes 27 European Union (EU) countries and the 10 countries comprising the Commonwealth of Independent States (CIS). Together, these countries represent 98% (approximately 250 million) of children in the Region *(51).* Progress in the Region is also analysed against results from 41 Member States in a similar survey conducted in 2013.

3. Objective 1: are countries making child maltreatment more visible by measuring it?

Objective 1: are countries making child maltreatment more visible by measuring it?

Key facts 1. Make child maltreatment more visible

- There are an estimated 629 homicides every year in the Region in children aged under 15 years.
- There is a 7.9-fold difference in the country with the highest versus lowest child homicide rate.
- Health-service data relating to child maltreatment are incomplete.
- Less than half of the countries collect national child protection data systematically.
- There were more than 550 000 child protection contacts over one year in 23 reporting countries.
- Less than half of countries have conducted a child maltreatment population survey using standardized instruments.
- A minority of countries collect data and report on different subtypes of maltreatment.
- One in three countries repeats surveys at regular intervals.
- Data collection is more complete in HICs than in LMICs.

An effective public health response has its foundations in reliable data. The findings from this survey complement and update those from previous European regional reports on child maltreatment prevention *(1,52).* Child maltreatment is a hidden form of violence, and gathering comprehensive data on the burden requires the use of multiple information systems, including vital registration, hospital admissions, child protection agency contacts and community surveys (Fig. 3) *(48).*

Mortality data for homicide and undetermined intent

Official statistics of mortality from assaults and homicide remain the most available data and are used in this section as a proxy for deaths from child maltreatment in children aged 0–14 years (mortality data aggregated for the age group 15–17 years are not readily available).

Based on the WHO Global Health Estimates, there were 629 homicides in children aged 0–14 years in 2015 *(2).* Data from the European Detailed Mortality Database show a consistent decline in child homicide rates since the mid-1990s for children aged 0–14 *(53)* (Fig. 4). The most recent trend data show homicide mortality rates among children in the Region decreased by 11% (0.36 per 100 000 to 0.32) over five years (2010–2014). At subregional level, reductions of 8% in the EU (0.28 per 100 000 to 0.26) and 17% in the CIS (0.57 per 100 000 to 0.47) are seen over the same time frame. Mortality rates between CIS and EU countries converge, indicating that inequalities in child homicides are decreasing. Homicide rates in CIS countries (0.47 per 100 000) nevertheless are 1.8 times higher than in EU countries (0.26 per 100 000). Rates in LMICs (0.37 per 100 000) are 1.6 times higher than in HICs (0.23 per 100 000).

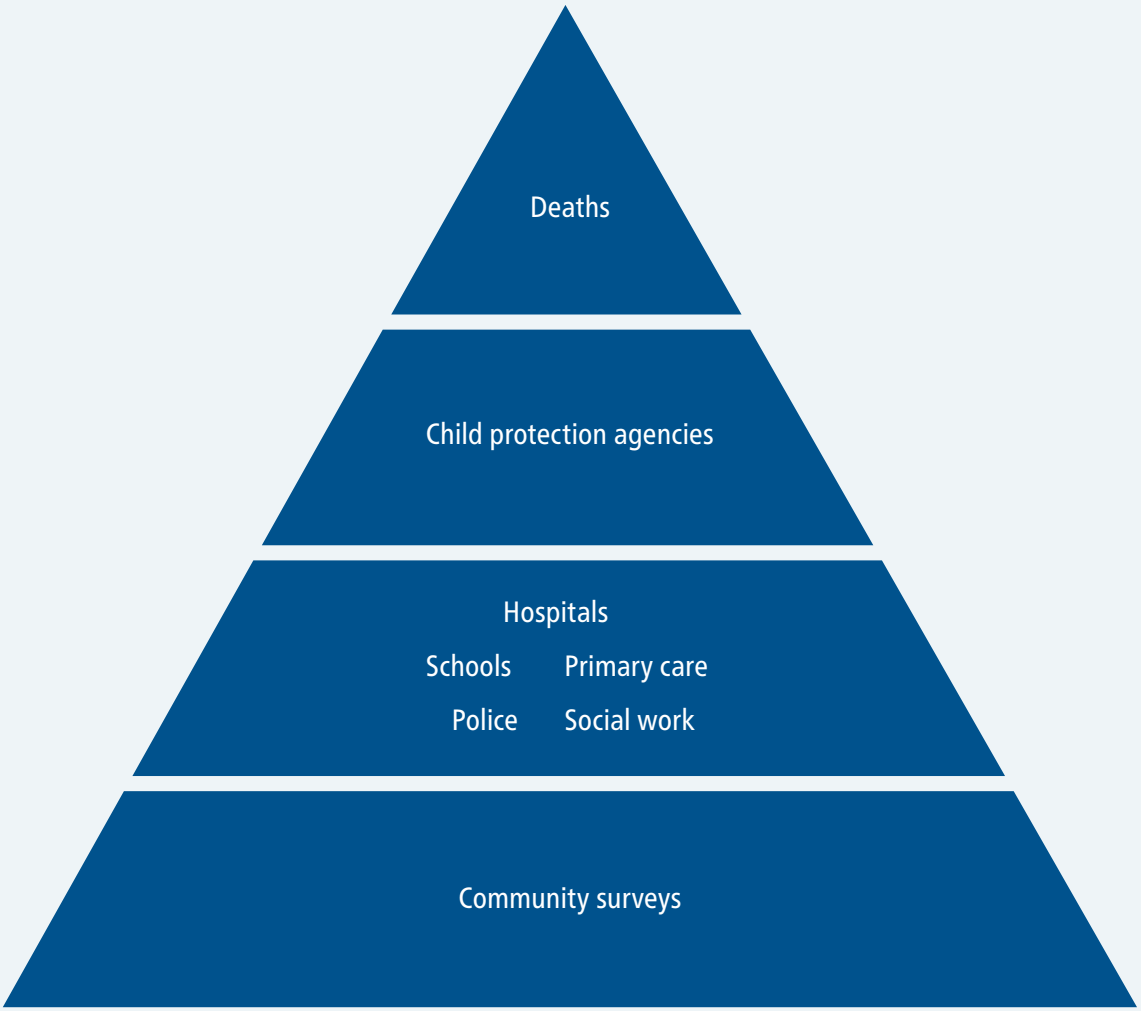
A high proportion of deaths from undetermined intent are thought to be due to violence *(54).* There was a 13% reduction in the combined rate of homicides and deaths from undetermined intent over the five-year period from 2010 to 2014, from 0.82 per 100 000 to 0.71 (Fig. 5). The most significant decline at subregional level has been seen in the countries that joined the EU in May 2004, with a reduction of 32%.

Projections based on these trend data suggest that the Region is on track to reach the target of a 20% reduction in mortality rates by 2020. When country-level data are compared using five-year averages in standardized death rates (SDR) from homicide in children aged under 15 years, a 7.9-fold difference is seen between the country with the highest rate and one of those with the lowest (Fig. 6).

Data from child protection agencies

Data from child protection agencies on children who come into contact with services for child maltreatment were collated in the survey. Twenty-three countries reported

Fig. 3. Sources of data for child maltreatment



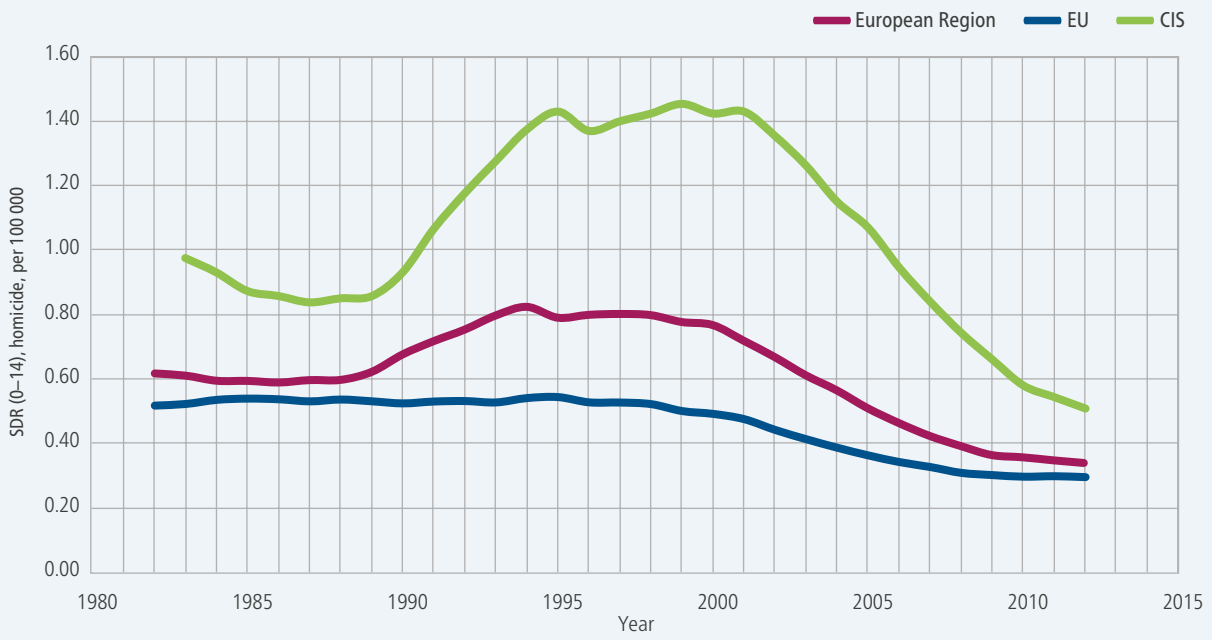
Source: Sethi et al. *(1).*

national data, totalling 550 607 new child protection contacts over a one-year period. As threshold definitions for referral and service provision vary between countries, these data cannot be used to make comparisons. Child protection agency data may be influenced by factors other than incidence of child maltreatment, such as changes in case thresholds, increases in workforce resource and capacity, and greater awareness of child maltreatment. The data nevertheless are useful for monitoring child protection cases within countries. Individual country data can be found in the country profiles after the main report.

For the Region as a whole, the results show that 47% (n = 23) of countries have national child protection data and 18% (n = 9) have subnational data (Annex 5, Fig. A5.1). The proportion of countries with national data was higher in HICs (53%) than in LMICs (37%). These data suggest that efforts to collect national child protection

Fig. 4.

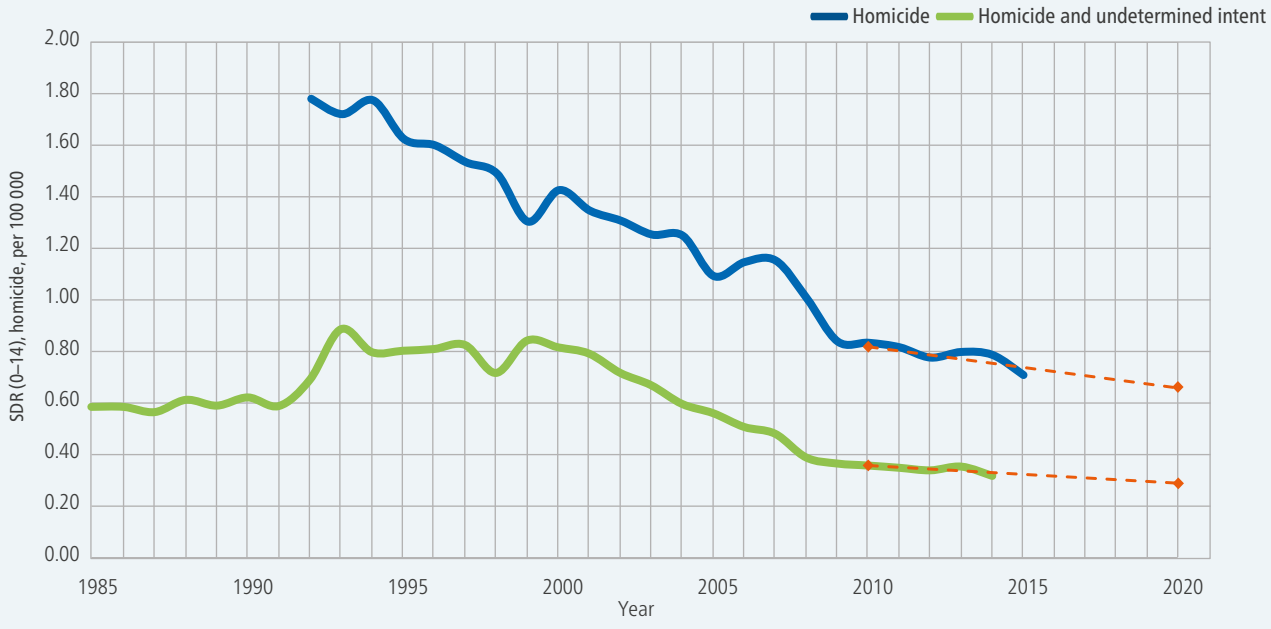
Trends in SDR per 100 000 children aged 0–14 years from homicide, by subregion (five-year moving averages)



Source: WHO Regional Office for Europe *(53)*.

Fig. 5.

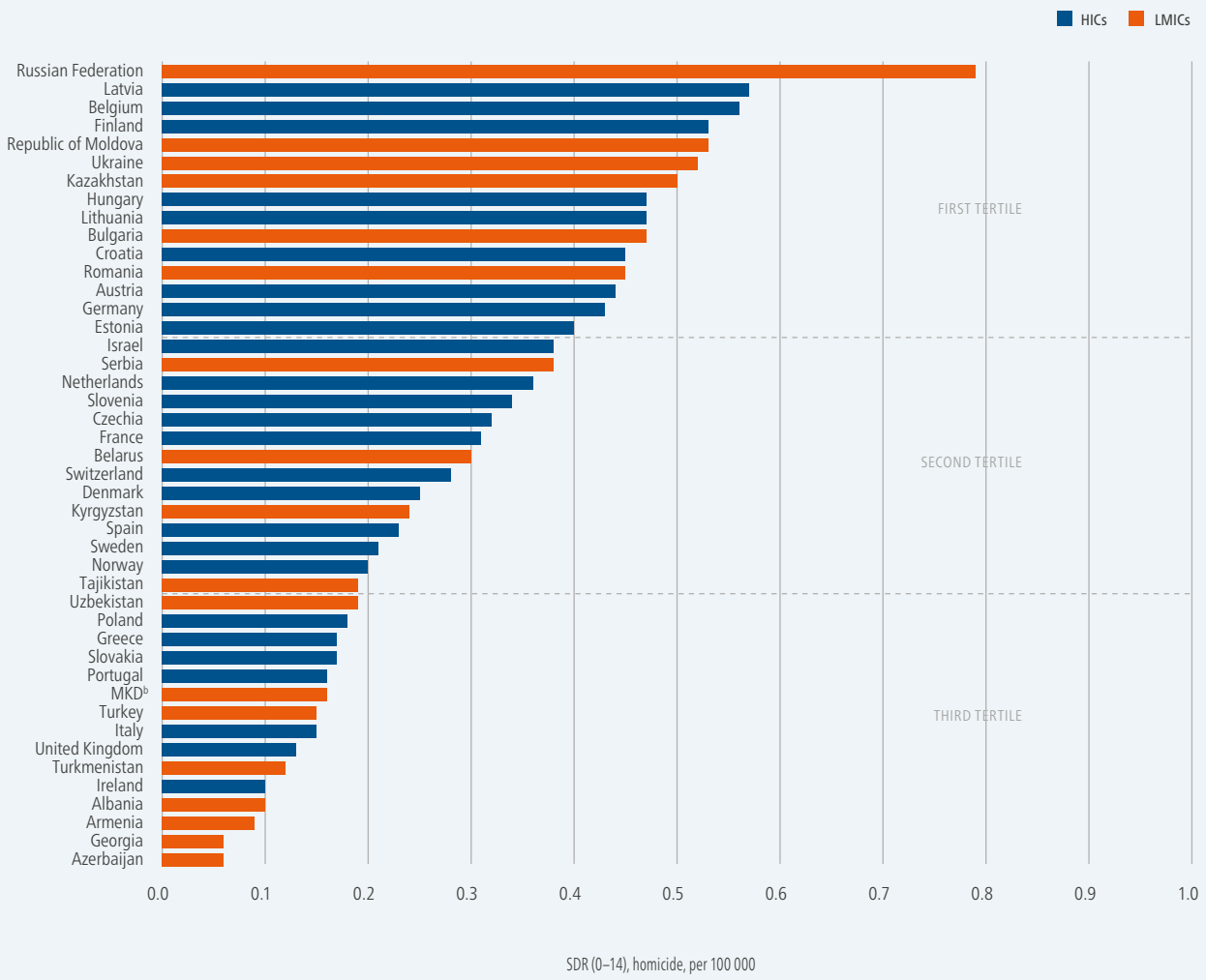
Trends in SDR per 100 000 children aged 0–14 years in the WHO European Region from homicide and undetermined intent, with projections to the 20% reduction target in 2020



Source: WHO Regional Office for Europe *(53)*.

Fig. 6.

Homicide rates per 100 000 children aged 0–14 years in the WHO European Region (average for last available five years)[a]



[a] Excluded are countries with populations of less than 1 million: Andorra, Cyprus, Iceland, Luxembourg, Malta, Monaco, Montenegro and San Marino. Data were unavailable for Bosnia and Herzegovina, and Monaco.
[b] The former Yugoslav Republic of Macedonia ((MKD) is an abbreviation of the International Organization for Standardization (ISO)). *Source:* WHO Regional Office for Europe *(53)*.

data needs improvement across the Region, but more so in LMICs.

Hospital admission data on assaults

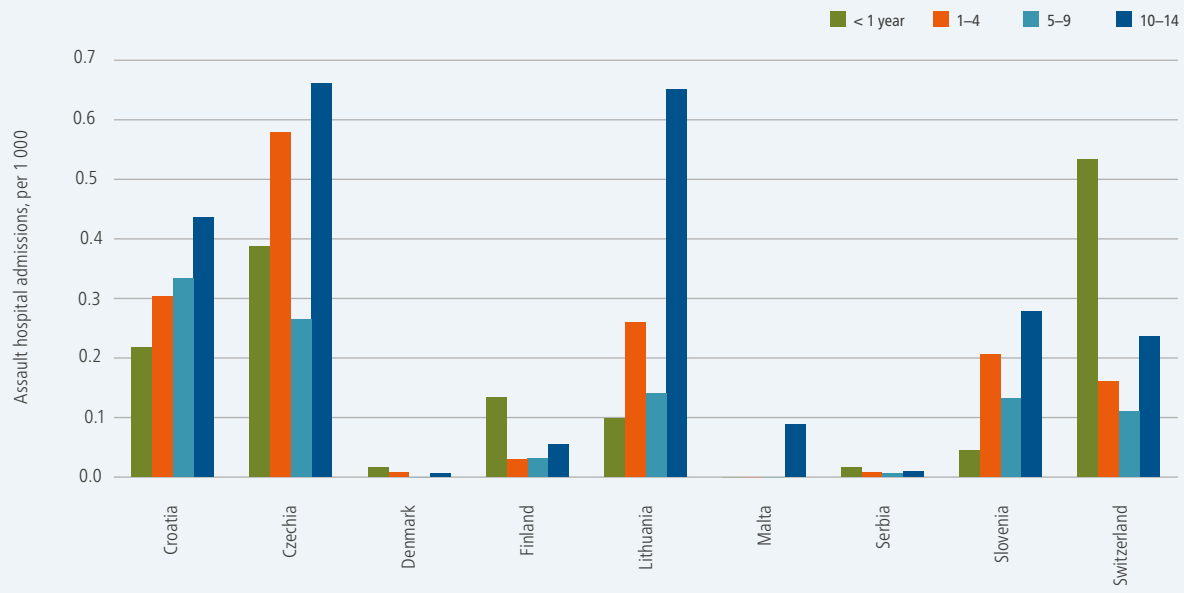
Hospital admission rates due to assaults can provide additional useful sources of information on violence against children. These are not routinely available in the Region for most countries. Data disaggregated by age are shown for nine countries with hospital admission data for assaults (ICD-10 codes X85-Y09) available on the European Hospital Morbidity Database (Fig. 7). Data quality issues, such as completeness and accuracy of coding of assaults, variation in admission policies, health-system infrastructure and access to services, limit comparability between countries.

Population surveys

Community-based population surveys offer crucial information for establishing the true size of the problem of child maltreatment. Surveys provide the only method of identifying child maltreatment that is not captured from homicide data, hospital admissions and child protection agencies, and would otherwise remain unrecorded and hidden *(38,44–46)*. They can be self-report or informant (health professional, for instance) studies, but self-

Fig. 7.

Age-specific hospital admission rates for assaults on children in selected European countries



Source: WHO Regional Office for Europe *(55)*.

report surveys are crucial: a meta-analysis of global prevalence data on child sexual abuse showed a 30-fold difference between the prevalence of reported abuse in self-report (127 per 1000 children) and informant (four per 1000 children) surveys *(56)*. The WHO Regional Office for Europe has developed *Measuring and monitoring national prevalence of child maltreatment: a practical handbook* for Member States who wish to use standardized approaches *(48)*.

Fig. 8 shows countries in the Region that have conducted surveys. Although 71% (n = 35) reported having nationally representative survey data on child maltreatment, only half (n = 27, 55%) collected data based on standardized instruments, and 21 (43%) provided data on child maltreatment by subtype of abuse and neglect. Variation in prevalence periods (from past year to lifetime, for instance) and age groups (such as from under 1 to 20 years) are evident. It is recommended that prevalence is measured for the past year as this enables trends in prevalence to be monitored with consecutive surveys *(48)*. Over a third of countries (38%, or n = 20/53) conduct regular surveys *(47)*. To assess trends in data, consecutive surveys that repeat the same question to similar populations are necessary, and it is recommended that these are performed every four to seven years *(48)*.

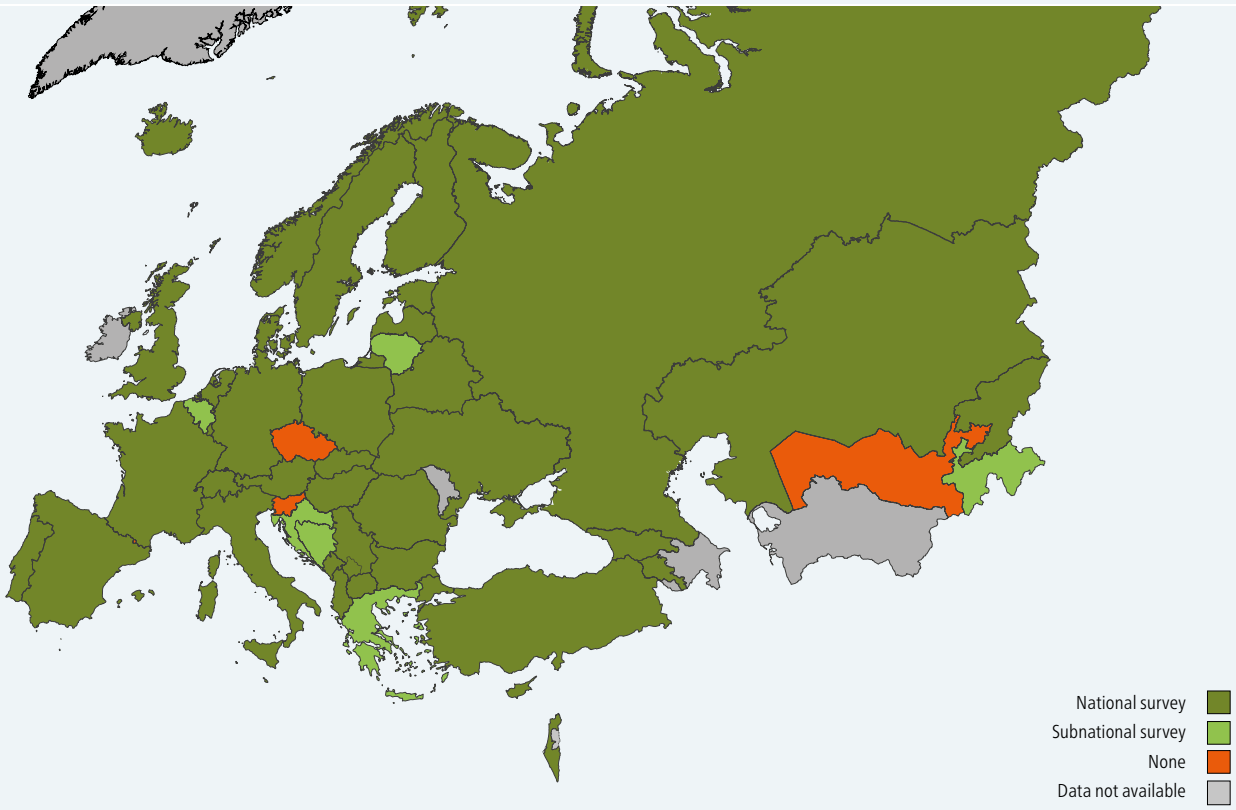
Surveys of ACEs have been undertaken in many European countries to highlight the scale of the problem and advocate for policy and programmatic action at policy dialogues *(57–71)* (Box 2–4).

Surveys of children's mental health

Capturing data on the mental health and well-being of children can provide valuable insights into the impact of child maltreatment and other ACEs. Child maltreatment can have a profound negative impact on mental health and well-being of children and throughout the life-course *(4,72,73)*. Twenty-six countries (53%) reported in the survey that they have regular monitoring on child mental well-being, commonly using a school-based survey.

Fig. 8.

Countries that reported survey data on child maltreatment



Box 2. Surveys of ACEs in Europe

Surveys of ACEs have been undertaken in young people (18–25 years) in higher education in 13 countries, including Albania, Czechia *(57,58)*, Latvia, Lithuania, Montenegro *(59,60)*, Poland *(61)*, Romania *(60,62)*, the Republic of Moldova *(63)*, the Russian Federation *(64)*, Serbia *(65)*, the former Yugoslav Republic of Macedonia *(60,66)*, Turkey *(67)* and Ukraine *(68)*. These surveys were conducted with support from the WHO Regional Office for Europe, and multisectoral policy dialogues were held to disseminate results and recommend next steps for preventive action.

Results demonstrate that the prevalence of child maltreatment and other adversities in childhood is high. Half of respondents (48.5%) across all 13 countries reported at least one ACE, with 6.3% reporting four or more. ACEs reported included physical, emotional and sexual abuse, neglect, and witnessing intimate-partner violence and a household member with alcohol misuse, drug abuse, mental illness and/or incarceration. Strong associations with health-harming behaviours were found, which inevitably leads to poor individual health outcomes and has negative societal impacts. These surveys have been used to underscore the policy advantage of ensuring violence-free, nurturing and caring childhoods *(60,69)*. Similar surveys have been conducted in other countries, including Sweden *(70)* and the United Kingdom *(60,71)*.

Box 3. Garnering multi-agency commitment to prevent ACEs in United Kingdom (Wales) using national data

National data have been powerful advocacy tools to drive multi-agency action to prevent and respond to ACEs in United Kingdom (Wales). Data on the extent and impact of ACEs in Wales to advocate for the multi-agency action required to prevent and respond to them using evidence-based approaches were lacking prior to 2015. Public Health Wales then undertook a national ACE study among the general adult population. This found that 47% of adults surveyed had experienced at least one ACE, and 14% had suffered four *(71).* The more ACEs people had suffered, the more likely they were to engage in health-harming and antisocial behaviours, develop chronic health conditions and require health treatment. The survey also demonstrated the gains to health and well-being that could be made if ACEs were prevented *(71).* The findings were widely disseminated alongside information explaining how ACEs affect behaviour and health. An animated film based on the data was also produced to support awareness-raising.

This work generated significant multi-agency attention and drove changes to health and social policy in Wales, supporting a shift towards investment in prevention of ACEs and better support for vulnerable children. The Welsh Government prioritized support for families to reduce ACEs and committed to developing ACE-informed public services, including building childhood resilience in their national strategy. An ACE hub was established to share learning and knowledge across the country and ACE-informed practice is emerging among health, social care, education and justice sectors. A second national ACE survey was undertaken in 2017, identifying the value of childhood community resilience assets in reducing the extent of poor childhood health *(34).*

Box 4. Preventing child maltreatment in the former Yugoslav Republic of Macedonia

The ACE study in the former Yugoslav Republic of Macedonia found that one in five (21%) of university and high-school students had been exposed to physical abuse, 30% to psychological neglect, 11% to psychological abuse, and 13% to sexual abuse in childhood. Approximately two in three participants (65%) had been exposed to an ACE, with 35% experiencing multiple ACEs *(66).*

Evidence on the scope of the problem and three awareness-raising campaigns helped set the national policy and legal landscape for child maltreatment prevention actions.

The national action plan for prevention and combating child abuse and neglect, adopted in 2013, addressed child maltreatment, strategically in the country for the first time. Other linked policies for reducing poverty and social exclusion, improving children's rights, tackling children on the streets, and prevention and protection of sexual abuse and paedophilia, also reflected the importance of child maltreatment prevention.

The WHO Training Education Advancing Collaboration in Health, Violence and Injury Prevention (TEACH VIP) modular training curriculum on violence prevention and control has been introduced to address capacity-building needs. Around 2390 general practitioners, emergency medicine doctors, paediatricians, gynaecologists, psychiatrists and nurses completed training between 2010 and 2012. Sixty university professors from faculties of medicine, psychology, social work, gender studies, pedagogy, law and the police academy became trainers of trainers on TEACH VIP workshops between 2009 and 2010.

Despite the enormous progress made in child maltreatment prevention and safety promotion, further strategic efforts are needed in the years ahead to reduce violence using evidence-based preventive programmes and reinforce the legal and policy framework. Clear budget allocations from all relevant ministries and more defined indicators for reducing child mortality and burden of child maltreatment will be addressed in an upcoming national action plan on preventing ACEs.

4. Objective 2: have countries developed national action plans to coordinate action to reduce child maltreatment?

Objective 2: have countries developed national action plans to coordinate action to reduce child maltreatment?

Key facts 2. Are there comprehensive national policies to reduce child maltreatment and laws against it?

- Three out of four countries have national action plans for child maltreatment prevention.
- The proportion of countries with national action plans for child maltreatment prevention has increased substantially (by 29%) since 2013.
- Eighty-six per cent of countries have multisectoral lead agencies to coordinate child maltreatment prevention activities.
- One in four national action plans have not been informed by a national survey.
- A minority of action plans in LMICs have quantifiable targets, or are fully funded.
- National action plans to tackle NCDs exist in most countries, but only half recognize child maltreatment as a risk factor.
- Only six out of 10 countries have comprehensive laws banning corporal punishment in all settings.
- Twenty-four per cent of countries with a ban on corporal punishment do not fully enforce the legislation.
- Most countries in the Region have laws against statutory rape (96%), female genital mutilation (76%) and child marriage (98%).

National policy development

In line with the UNCRC, society has a moral and legal obligation to protect children from harm. Policy development is a significant step in knowledge transfer from research to practice and legislation *(9),* and government plays a pivotal role in developing an organized and systematic action plan to prevent child maltreatment.

Recognizing the difference between policy development for child maltreatment *prevention* and that for *protection* is crucial. Child *protection* is focused on safeguarding children at high risk and those who are experiencing maltreatment, but the focus of child maltreatment *prevention* is to stop these adversities occurring in the first place.

Countries were asked if they perceive child maltreatment as a problem in their country, and 43% (n = 21) saw it as a very big or big problem. Thirty-seven countries in the survey reported having a national action plan (76%) for preventing child maltreatment (Fig. 9). Comparing results of the 41 countries that participated in the surveys in 2013 and 2017, a substantial increase in the development of child maltreatment action plans (83% of countries in 2017 compared to 54% in 2013) can be seen (Fig. 10). This increase in policy attention for child maltreatment prevention is a welcome success story in the Region.

Twenty-two per cent of the prevention plans, however, have not been informed by a national survey, and in many instances, surveys have not been undertaken regularly. Clearly, more work needs to be done to collect good epidemiological data on child maltreatment to inform, monitor and evaluate the success of policy and programmatic intervention.

In contrast, 71% (n = 35) of countries in the 2017 survey reported having a national action plan for child protection (Annex 5, Fig. A5.2). Based on the 41 countries that also participated in the 2013 survey, there has been a 22% increase in the number of countries reporting national child maltreatment protection plans (Fig. 10).

Setting measurable, time-limited and realistic targets for national action plans is important *(49)*, but only seven countries among the 37 that reported having a national child maltreatment prevention action plan in place (19%) have set measurable targets (Fig. 11). Full funding for implementation is available in only 13 countries (35%), with an additional 20 (54%) reporting partial funding.

Fig. 9.

Countries that reported an action plan for child maltreatment prevention

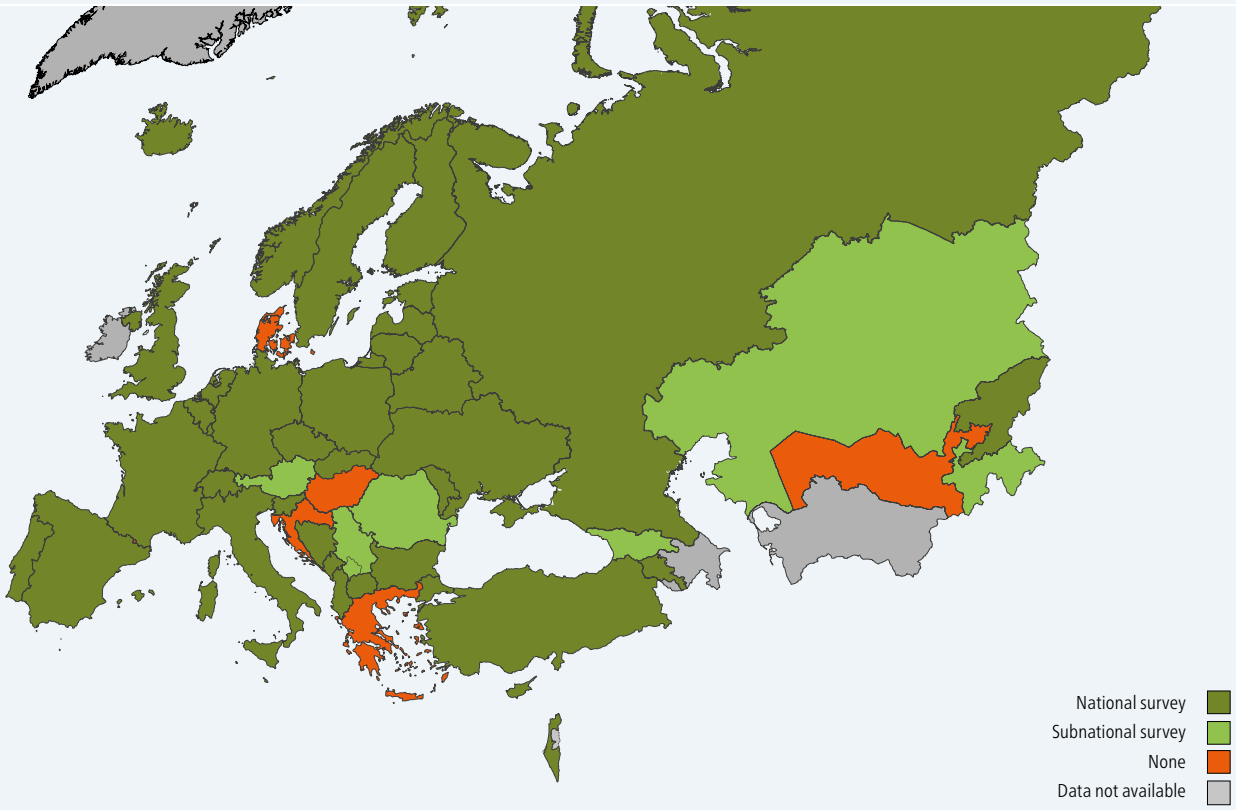
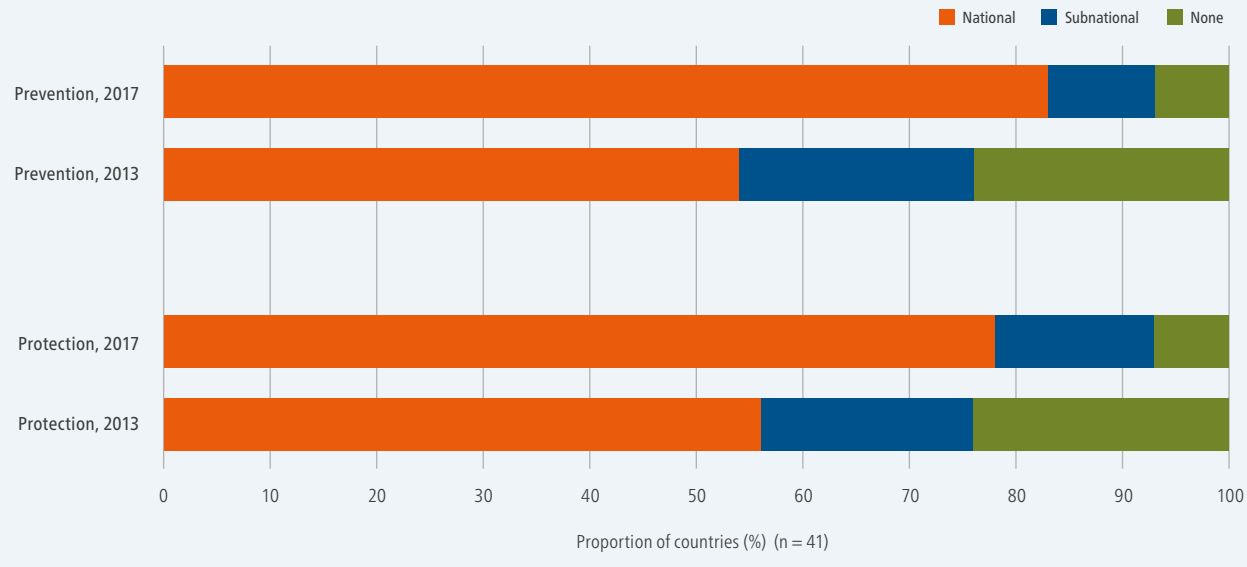


Fig. 10.

Proportion of countries that had national or subnational action plans for child maltreatment prevention and child maltreatment protection in 2013 and 2017 surveys (%) (n = 41)



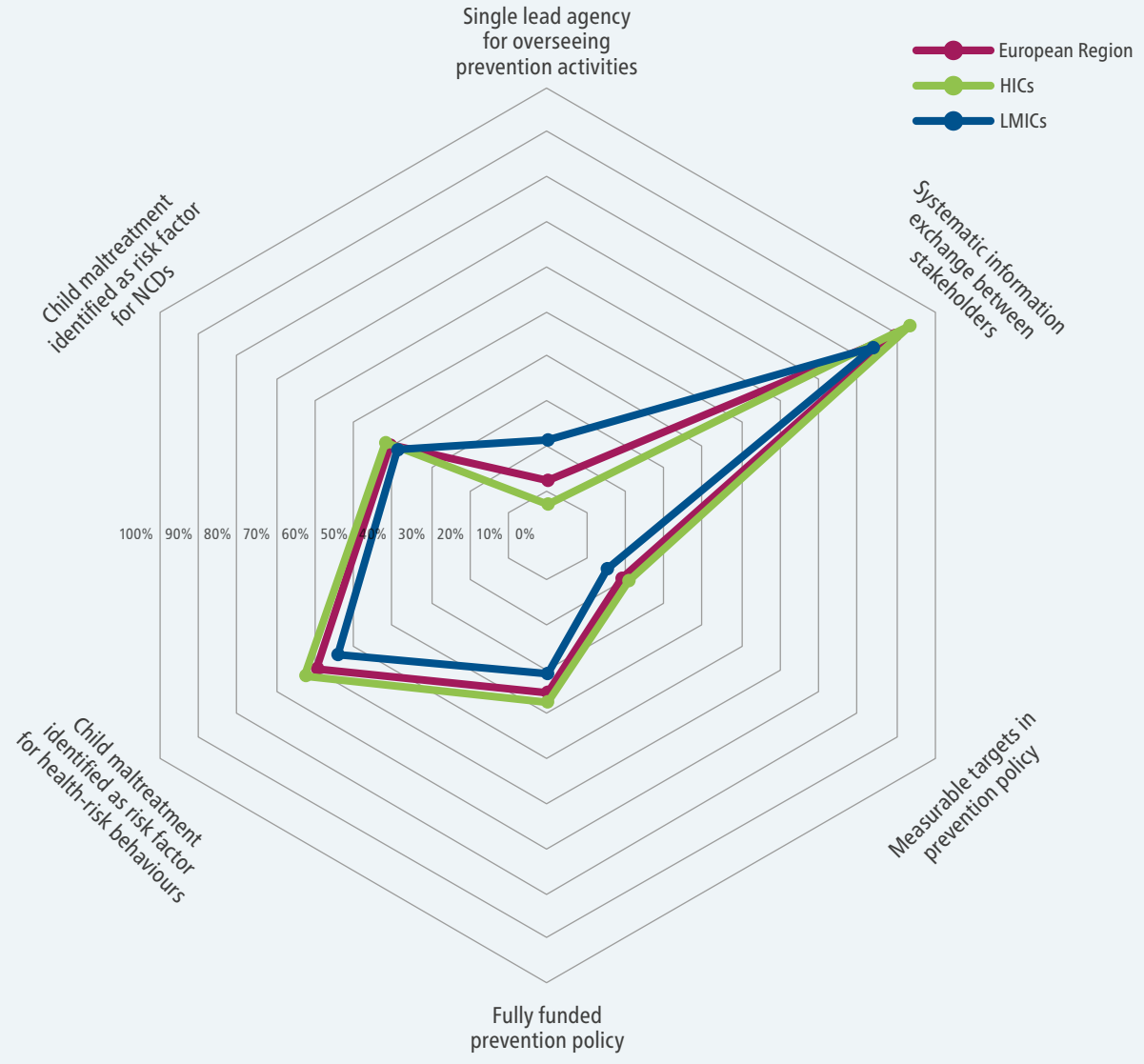
Source: WHO Regional Office for Europe *(55)*.

Given the complexity and cross-sectoral responsibility for preventing and protecting children from maltreatment, a national action plan should be developed with engagement of key stakeholders, but with a lead agency that holds oversight for its implementation *(49)*. Few countries (n = 6, 12%) reported a lead government agency/department that had responsibility for overseeing child maltreatment prevention activities. Most (n = 42, 86%) reported that multiple government agencies hold responsibility for overseeing prevention activities. Almost all surveyed countries reported a system in place for regular exchange of information among sectors and stakeholders on child maltreatment prevention (n = 44, 90%).

Child maltreatment and NCDs

Seventy-six per cent (n = 28) of the 37 countries reporting a national child maltreatment prevention action plan recognize in their plan that child maltreatment may coexist with other ACEs. Twenty-two countries (59%) explicitly recognize child maltreatment as a risk factor for the development of health-

Fig. 11. Policy landscape to prevent child maltreatment across the WHO European Region[a]



[a] Four indicators were based on 37 countries that reported a national action plan for child maltreatment prevention: measurable targets in prevention policy; fully funded prevention policy; child maltreatment identified as a risk factor for health-risk behaviours; and child maltreatment identified as risk factor for NCDs.

risk behaviours (such as alcohol misuse, cigarette smoking, physical inactivity and overeating), but only 41% (n = 15) of countries explicitly recognize that child maltreatment is a risk factor for the development of NCDs.

It is notable that 78% (n = 38) of surveyed countries have a national action plan for the prevention of NCDs, but only about half (n = 20, 53%) identify child maltreatment as a risk factor for NCDs in the action plan. This suggests insufficient recognition at policy level of the long-term harms of diabetes, heart disease and cancers associated with child maltreatment *(22)*.

Legislation to protect children against maltreatment

Given its devastating impact, protecting children from abuse and neglect is a core function of governments. In addition to action plans, governments have important roles in regulating the safeguarding of children by enacting and enforcing legislation to prevent child maltreatment and protect children's rights. Legislation can be used to direct a range of actions relating to child maltreatment, including the banning of corporal punishment, statutory rape, child marriage and female genital mutilation. The survey collected information on legislation and levels of enforcement from the participating countries. Information on the extent of law enforcement is an important indicator of progress in child maltreatment prevention.

The Region is in a strong position, with a high proportion of countries enacting laws against child marriage (98%, n = 48), statutory rape (96%, n = 47) and female genital mutilation (76%, n= 37) (Fig. 12). All countries report having legislation that bans corporal punishment, but based on data from the Global Initiative to End All Corporal Punishment of Children, the legislation is applicable to all settings (home, day care, alternative care settings, school and penal institutions) in only 66% (n = 35/53) of countries (Fig. 13). A summary of the legislative situation on corporal punishment in the Region is presented in Annex 4.

Despite widespread enactment of laws relevant to child maltreatment, their reported enforcement is suboptimal. As Fig. 12 shows, of those countries with national laws, 87% report full enforcement of the law against statutory rape, 65% against child marriage, 86% against female genital mutilation and 76% against corporal punishment. Actions for strengthening laws and their enforcement and providing support services can also be conducted at municipal level (Box 5).

Fig. 12.

Proportion of countries with laws related to child maltreatment and the extent to which these laws are fully enforced (%) (n = 49)

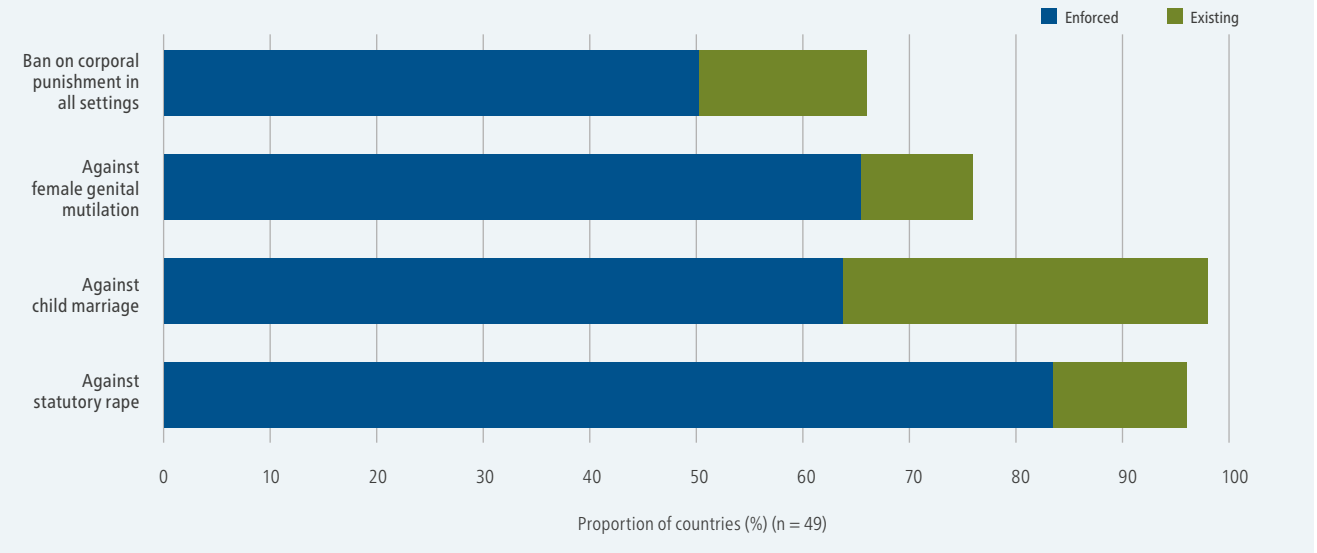
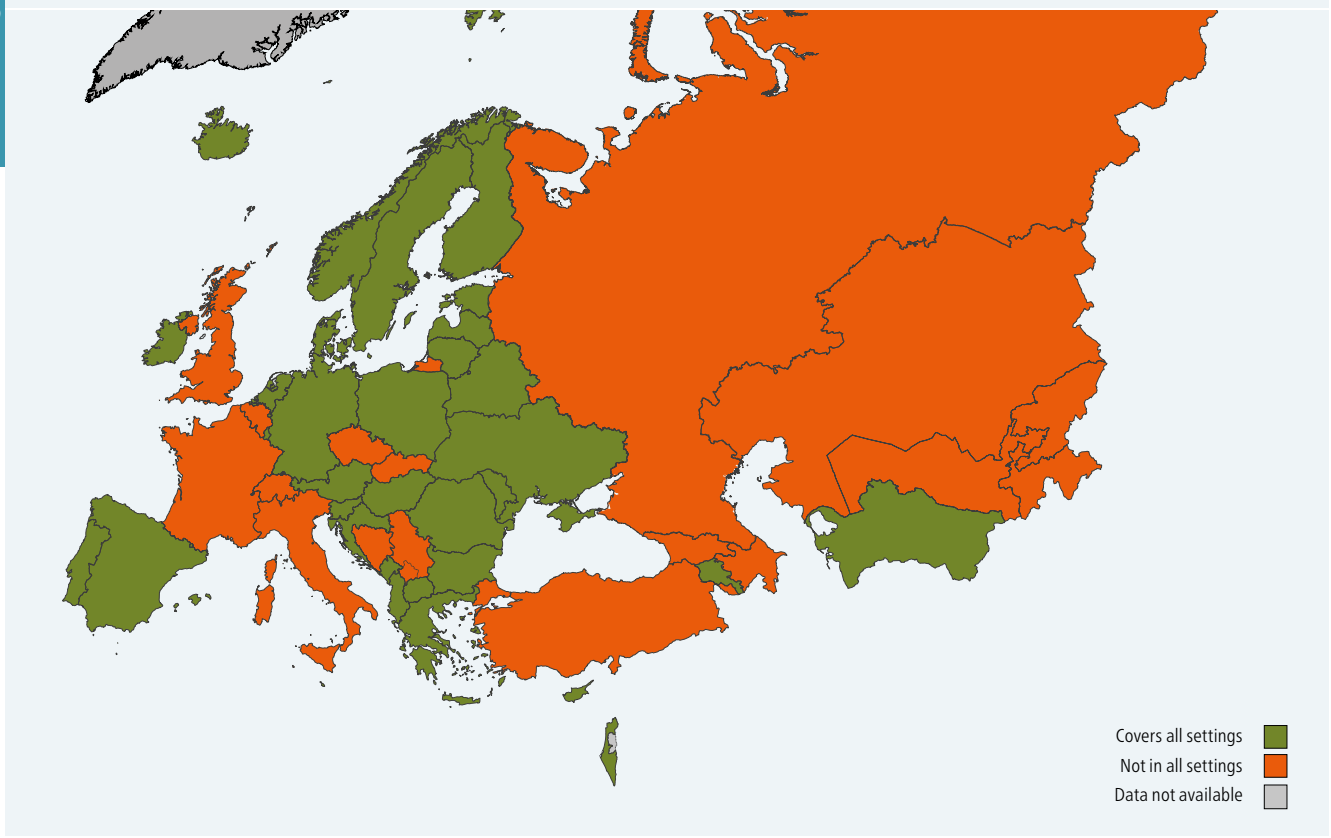


Fig. 13. Countries that have banned corporal punishment of children in all settings



Based on reports from the 41 Member States who took part in consecutive surveys in 2013 and 2017, the number of countries enacting laws to prevent child maltreatment since 2013 has increased (Annex 4, Table. A4.1; Annex 5, Fig. A5.4). Increases in laws against child marriage (90% in 2013 to 98% in 2017), statutory rape (90% to 98%) and female genital mutilation (50% to 78%) have also been seen (see below).

Corporal punishment

Corporal punishment involves the deliberate infliction of pain to discipline children, and is an important risk factor for child maltreatment *(75)*. The legality of corporal punishment in some countries represents a violation of children's rights of equal protection under the UNCRC *(27,76)*.

Corporal punishment not only has physical implications, but also adversely affects mental health and well-being *(77)*. Legislation banning corporal punishment effectively reduces violence against children *(75,78,79)*; Member States are encouraged to extend legislation to ban corporal punishment in all settings, and good progress is being made in enacting comprehensive legislation. It is now banned in all settings in 66% of countries in the Region, an improvement from 47% in 2013 *(1,37)*.

All countries in the Region have banned corporal punishment from schools and 98% have banned it from penal institutions. Efforts need to focus on banning corporal punishment in the home, alternative care settings and day-care centres, as only 66% (n = 35), 72% (n = 38) and 74% (n = 39) of countries do so, respectively. Most EU countries have a comprehensive ban on corporal punishment (n = 22, 79%), but this is not the case for CIS countries (n = 5, 42%).

Substantial differences in the extent of enforcement of legislation also exist, with 40% of CIS countries reporting full enforcement compared with 67% of EU countries.

Box 5. Multisectoral programme to tackle wide-ranging abuse and adverse health experiences of street children in St Petersburg, Russian Federation

In the 1990s, following the dissolution of the Soviet Union and difficult socioeconomic circumstances, adverse conditions in homes and orphanages led to an increase in children living on the street. A 2006 survey of young people (aged 15–19 years) living on the street in St Petersburg found a high prevalence of lifetime physical or sexual abuse (38%), lifetime exchange of sex for goods (10%), lifetime diagnosis of sexually transmitted infections (34%), lifetime injecting drug use (51%), excess alcohol use (72%) and current HIV infection (37%).

In response, the city government adopted a comprehensive five-year multisectoral plan in collaboration with multiple NGOs to tackle the situation by addressing upstream risk factors, such as promoting noninstitutionalized care and restricting access to opioids, and more downstream issues, including outreach work and increased health and social service provision for at-risk families. The plan also included strengthening of justice and education sector responses to the problem. Special boarding schools were created, and increased foster-care placements for children lacking parental support were put in place. A repeat municipal survey was conducted in 2012 among a new cohort of 311 young people living on the street to assess the impact of the five-year multisectoral response *(74)*. The reported prevalence by street children of experiencing violence and other adverse health conditions had decreased dramatically since the 2006 survey: physical or sexual abuse had reduced from 38% to 26% ($p = 0.05$), lifetime exchange of sex for goods from 10% to 4% ($p < 0.01$), lifetime diagnosis of sexually transmitted infections from 34% to 8% ($p < 0.01$), lifetime injecting drug use from 51% to 15% ($p < 0.01$), excess alcohol consumption from 72% to 34% ($p < 0.01$) and HIV infection from 37% to 10% ($p < 0.01$).

This coordinated, multisectoral and multicomponent approach for high-risk children and families has gained countrywide recognition. Its work continues to confront upstream and downstream risk factors using family-strengthening initiatives, improved health and social service provision, and enforcement of child protection laws.

The absence of structural protection may contribute to inequalities in child maltreatment deaths in the Region. Evidence suggests that corporal punishment in the home is more socially acceptable in some CIS countries *(80)*. Societal attitudes need to be shifted to discourage the use of violent discipline and reinforce the benefits of nonviolent approaches. Universal campaigns can positively shift population attitudes away from physical punishment and other risk factors for child maltreatment *(81,82)*. Changing norms and values away from the use of violent discipline is key to garnering widespread support for legislation against child maltreatment *(8)* (Box 6).

Statutory rape

Statutory rape is sexual intercourse or other sexual relations with a person under the legal age of consent. Having legislation against statutory rape is important in safeguarding children. Sexual violence may occur in many settings and more often affects older children and teenagers.

Safeguarding against statutory rape can be achieved by enforcement of laws, but also through changing societal attitudes and recognizing and promoting gender equality throughout societal structures. In the Region, 96% ($n = 47$) of countries have a national law against statutory rape, but this is only enforced (largely) in 87%.

Child marriage

Forced marriage of children is a harmful traditional practice that violates human rights. Child brides are at increased risk of intimate-partner violence, sexual abuse and poorer sexual and reproductive health outcomes *(83)*. All responding countries in the Region have a law against child marriage (98%, or 48 countries, have a national law, one country has

Box 6. Success in banning corporal punishment in Lithuania

Corporal punishment was lawful in the home and other care settings in Lithuania until 14 February 2017, when the Government adopted a ban on all forms of physical punishment of children. Achieving this took a strong and coordinated effort requiring societal will, media support and political consensus-building. The trigger for an escalation of efforts was the tragic death of a 4-year-old boy at the hands of his mother and stepfather. NGOs took the lead in coordinating nationwide campaigns with slogans such as "Let's protect children" and "Childhood without abuse". The campaign involved academic debates, media engagement and a petition to Parliament signed by 32 253 people and 68 organizations, entitled "Let's guarantee safe childhood for each child!" The law was passed by the Parliament, partly in response to the public outcry, and despite a previously unsuccessful attempt to pass such a law.

The next steps in preventing child maltreatment in Lithuania include conducting social marketing campaigns to change attitudes more widely. Moves are underway to reform and strengthen child protection systems. There is also a need to increase the emphasis on prevention mechanisms, including education activities for parents and professionals, a telephone helpline for parents and increased family support. The need for monitoring and evaluation to ensure that prevention and protection responses are effective is recognized.

a subnational law), but this is enforced effectively in only one third of countries.

Female genital mutilation

Female genital mutilation is a harmful traditional practice with severe sexual and reproductive health implications, including complications in childbirth and even neonatal death *(84)*. The practice is mostly carried out on young girls between infancy and age 15 *(84)*. Legislation banning female genital mutilation is crucial in safeguarding young girls.

Seventy-six per cent (n = 37) of countries in the Region have a national law against female genital mutilation. This is an improvement since 2013, when 55% of 41 countries surveyed reported having such a law. Many countries report that female genital mutilation is not an issue in their country as it is not part of their cultural traditions, so they do not have specific legislation against the practice. More work needs to be done, however, with co-called hard-to-reach populations that condone the practice on cultural grounds.

5. Objective 3: are countries implementing prevention and response programmes to reduce child maltreatment?

Objective 3: are countries implementing prevention and response programmes to reduce child maltreatment?

Key facts 3. Are countries implementing prevention and response programmes?

- Implementation of child maltreatment prevention programmes is unequal in Europe.
- Adoptions of home-visiting, parent education and primary school programmes, and parent training to prevent abusive head trauma, have increased since 2013.
- Home-visiting programmes have been the most widely implemented intervention, with 89% of countries reporting some implementation and 57% large-scale implementation.
- The potential to scale up and focus prevention programmes needs to be tapped.
- Only one in 10 countries in the Region reports large-scale implementation of parental training to prevent abusive head trauma.
- Most countries have developed their own prevention programmes instead of adopting established programmes – evidence to measure their impact is needed.
- Health-service provision for risk assessment and response to child maltreatment has increased since 2013.
- Large-scale systematic implementation of services to prevent and respond to child maltreatment is less common in LMICs than in HICs.
- An opportunity exists to increase evidence-based prevention and response services throughout the Region.

Tackling child maltreatment and its health-harming effects, and breaking the vicious cycle of intergenerational violence associated with maltreatment, requires that prevention, for which a firm evidence base of cost-effective interventions exists, be given high priority. This chapter assesses whether countries are investing and implementing primary prevention programmes, and implementing detection and response services.

Prevention programmes

Safe, nurturing relationships with parents and other caregivers, including in schools, are crucial determinants of a child's healthy development and future well-being *(85)*. The earlier the supportive interventions are put in place for children, the greater the opportunity to prevent violence. Interventions should be underpinned by evidence, monitored and evaluated for impact.

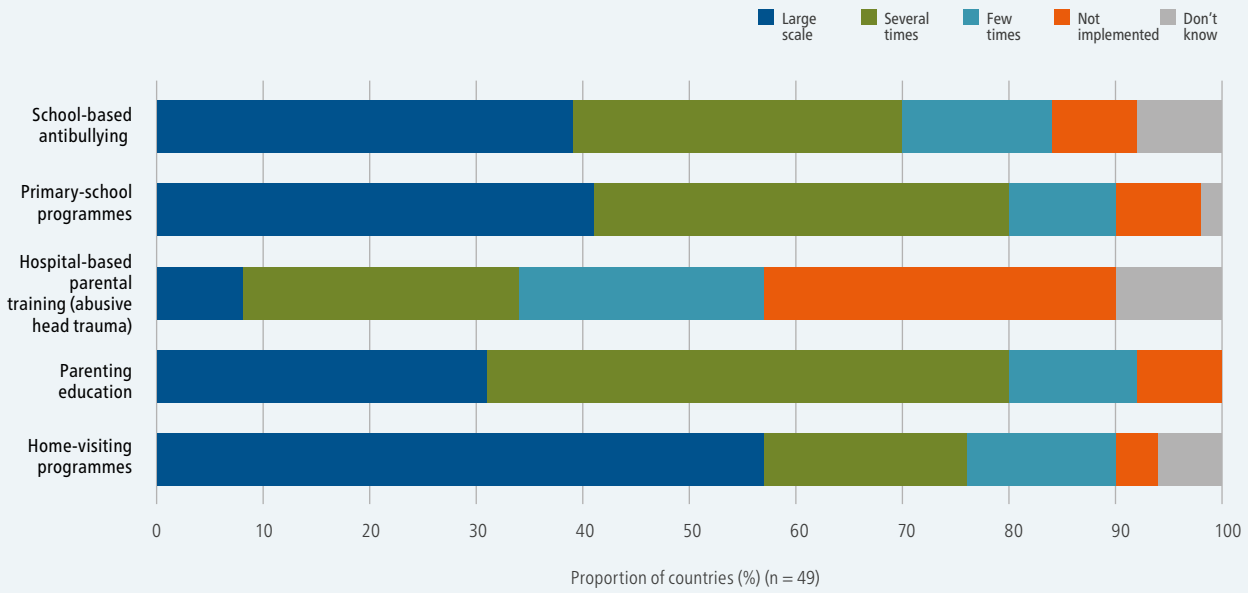
Evidence of benefit exists for a wide-ranging set of programmes, including parental training, home visiting, hospital-based education, and school-based interventions. These clearly can reduce known risk factors for child maltreatment, and the evidence base identifying programmes that reduce the incidence of child maltreatment cases is growing *(8,86)*, although more research is needed.

Measuring change in actual cases of child maltreatment as a primary outcome of research trials and in the evaluation of prevention programmes is crucial to firmly establishing the most effective interventions. Of course, this requires countries to have strong surveillance systems that can provide robust child maltreatment data. There is also a need to understand what specific components of prevention programmes are transferable to different settings. As ongoing research furthers knowledge of what works to reduce the incidence of child maltreatment in the Region, policy-makers can focus on addressing known risk factors with programmes that promote caring family environments, safe schools and vigilant and supportive communities.

A range of child maltreatment prevention programmes currently is being implemented in parts of the Region, although generally, the Region has significant room for improvement (Fig. 14). Home-visiting programmes are the most commonly implemented on a large scale in the Region (57% of countries), which may reflect a long-established resource base for their potential value in the

Fig. 14.

Extent of implementation of child maltreatment primary prevention programmes (%) (n = 49)



prevention of child maltreatment and overall improved child health outcomes *(81–83)*. Programmes of parental training to prevent abusive head trauma in infants (so-called shaken baby syndrome) are the least widely implemented intervention, with 10% of countries adopting them on a large scale (Fig. 15).

In general, similar proportions of HICs and LMICs reported implementation of child maltreatment prevention programmes. There is, however, a four-fold difference in the proportion of HICs (approximately 40%) implementing large-scale antibullying programmes in comparison to LMICs (approximately 10%) (Fig. 15). While antibullying programmes are not child maltreatment programmes, children who experience maltreatment are known to have an increased risk of experiencing bullying *(11)*. Preventing this further victimization is important in reducing long-term adverse effects on mental health in adulthood *(12)*.

Home-visiting programmes

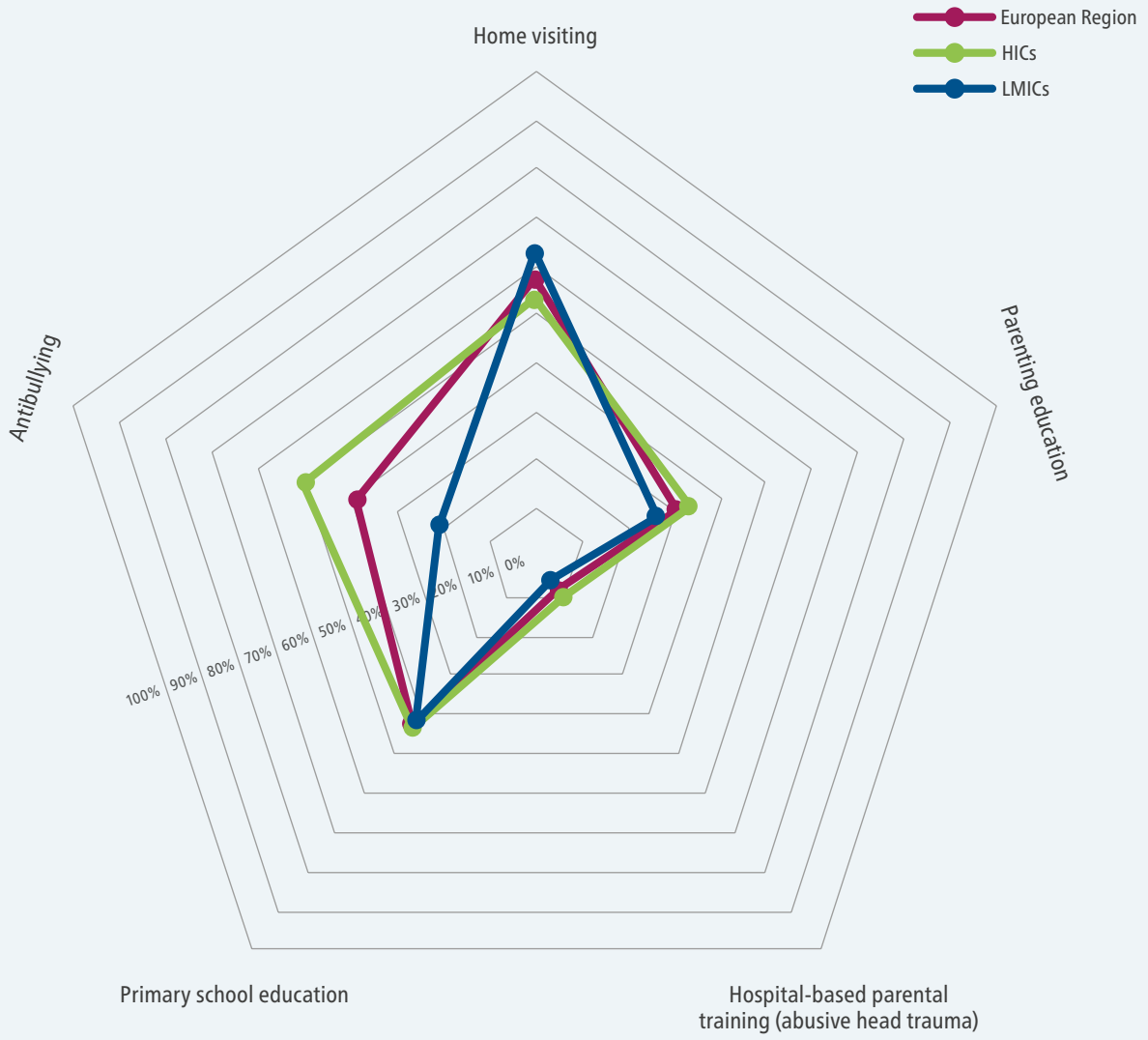
Home-visiting programmes generally provide parenting, health and social support to new parents in their own homes, and are usually delivered by trained nurses *(87)*. They can be implemented universally in low intensity as a routine aspect of maternal and child health services, as is the case in many European countries, or targeted intensively at vulnerable families.

The components and intensity of the programmes, whether targeted or universal, can vary considerably *(88)*. Collectively, however, trials comparing the incidence of child maltreatment in families that have participated in home-visiting programmes compared with controls trend towards the intervention reducing the risk of maltreatment *(89)*. Interestingly, the proportion of LMICs that implement home-visiting programmes is higher than in HICs. The potential exists to ensure these programmes have stronger maltreatment-prevention and parental-support components.

Evidence-based home-visiting programmes are underpinned by different theoretical frameworks for improving child health outcomes *(87)*. The widely implemented Nurse–Family Partnership (NFP) programme is a psychoeducational approach that focuses on parenting skills, social support and stress management for first-time low-income mothers *(90)* (Box 7). In contrast, the Steps Towards Effective Enjoyable Parenting (STEEP)

Fig. 15.

Large-scale systematic implementation of primary prevention programmes for child maltreatment in the WHO European Region, by income classification[a]

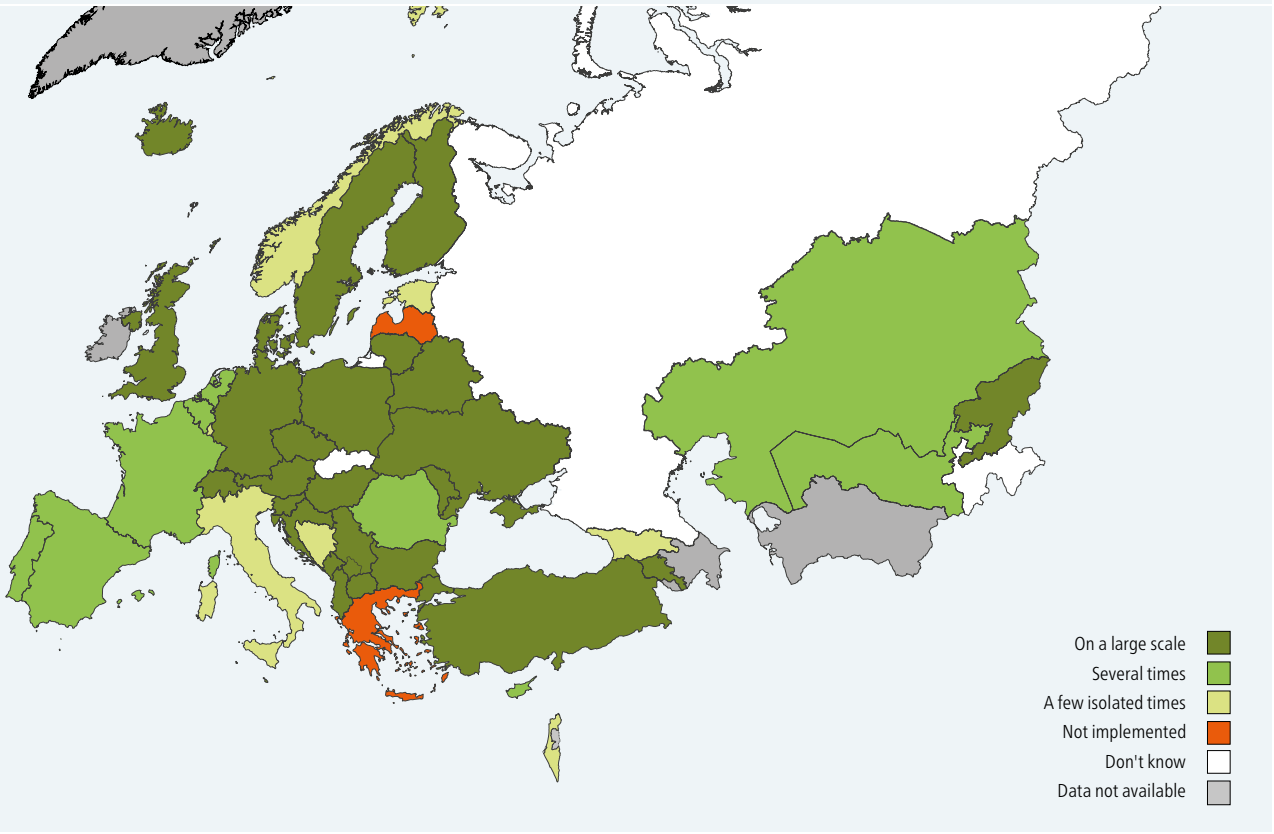


[a] Five indicators were based on 49 countries that reported large-scale systematic implementation of primary prevention programmes for child maltreatment: home visiting; parenting education; hospital-based parental training (abusive head trauma); primary school education; and antibullying.

programme, also targeted at vulnerable mothers, is based on infant–mother attachment theory and puts emphasis on increasing maternal sensitivity, exploring the effect of prior relationships on maternal representations of attachment and optimizing social support *(86)*. Another established home-visiting programme for first-time low-income families is Early Head Start. This intensive programme, developed in the United States, focuses on supporting child development and using parental education to enable parents to optimally fulfil their roles.

Eighty-nine per cent (n = 44) of countries now implement a home-visiting programme (Fig. 16 shows the implementing countries); 57% are implemented systematically and at large scale, with the remainder implementing programmes at a less substantial scale; 18% of countries responded that

Fig. 16. Countries that reported implementation of home-visiting programmes



they implement a home-visiting programme several times, and 14% a few isolated times.

In the Region, 41% (n = 18) of countries have implemented NFP, 9% (n = 4) STEEP and 5% (n = 2) Early Head Start. While each programme has evidence of support for improved child health outcomes and a reduction in risk factors for child maltreatment, the NFP has been shown in the largest number of trials (predominantly from the United States) to protect children against the incidence of child maltreatment *(87,90,91)*. A large proportion of countries (61%, n = 27/44) nevertheless are implementing alternative home-visiting programmes that may have similar principles, objectives and programme components: indeed, NFP may not necessarily represent better value above existing universal provision of home-visiting services, as is the case in some European countries *(92)*. The impact of any programmes should be monitored and evaluated, ideally with a control group, with measurement of incident child maltreatment cases as the primary outcome.

A 10% increase in adoption of home-visiting programmes is seen among the 41 countries surveyed in both 2013 and 2017 (Fig. 17).

Parenting education programmes

Parenting is shaped by a combination of parents' personal psychological resources, the so-called goodness-of-fit between child and parent characteristics, and the contextual sources of stress and support, including intimate-partner relationships, social networks and employment *(97)*. These factors are key features that determine risk for maltreatment around a child and families' need for support.

Parenting education programmes have been shown in meta-analyses to be effective in preventing child maltreatment and its risk factors *(98–100)* through improving parents' knowledge of child development, building parenting skills and strengthening parent–child relationships. The evidence that improvement in positive parenting is the key

Box 7. Implementation and outcomes of the NFP in Europe: from the Netherlands to Bulgaria

NFP is arguably the most well-established home-visiting programme. The intervention targets low-income, young first-time mothers to improve pregnancy-related, child health and child development outcomes in the short and longer term *(93,94)*. Crucially, the programme has been shown to prevent actual cases of child maltreatment *(38,93)*. The RAND Corporation estimates that for every US $1 spent on NFP, the return is US $5.70.

The intervention starts prenatally, as early as the first trimester, and involves regular, structured, nurse-led home visits from ages 0–2 years. This continuity of care builds a trusting relationship and enables a broad range of support to be delivered, including information provision, parental instruction on child care, provision of emotional support, early identification of developmental problems, and facilitation of social and medical care for the family.

Following evidence from three randomized controlled trials (RCTs) of the programme that showed the effectiveness of NFP in protecting children in the United States from harm and developmental problems, NFP was tested in an RCT for the first time in a European setting in the Netherlands *(95)*. The programme involved 10 home visits during pregnancy, with 20 in the first year and 20 in the second year.

The study showed that compared to standard care, NFP effectively reduces the risk of child maltreatment reports (RR 0.91, p = 0.04) and leads to a more nurturing home environment with positive child development at two-year follow up. In contrast to these positive findings, an RCT of NFP in United Kingdom (England) found no benefit over usual care for outcomes of smoking in late pregnancy, birth weight or all-cause unplanned hospital care at two-year follow up *(96)*. This study, however, did not assess child maltreatment or child development outcomes.

NFP is now implemented across other western European countries, and implementation has recently progressed in the eastern part of the Region in Bulgaria. NFP programme fidelity and outcomes should be monitored and reported to support learning across LMICs in the Region.

factor mediating change in problematic child behaviour is strong. Reduction in harsh and negative parenting is an important, but not sufficient, condition for improvement, but evidence suggests that positive parenting is an absolutely necessary change *(101)*. Evidence also suggests that parenting education programmes can successfully be transported to new countries without extensive adaptation *(95)*.

Parenting education programmes are usually delivered in group sessions (a key distinction from home-visiting programmes) and may be implemented universally or targeted at high-risk families *(1)*. They can differ greatly in their focus, from being predominantly about health and welfare support to improve family functioning, to providing structured parental training to build skills, optimize parenting and build resilience in children *(86)*. The latter type has a stronger evidence base for the prevention of child maltreatment *(86)*.

The vast majority of countries (80%, n = 45) surveyed in 2017 have implemented parenting education programmes on a large scale (31%, n = 15) or several times (49%, n = 24). Other countries reported implementation a few isolated times (n = 6, 12%). Based on the 41 countries surveyed in 2013 and 2017, the Region has seen a 12% increase in the number of countries implementing parenting education programmes.

Various evidence-based parenting education programmes are being implemented in countries across the Region (Boxes 8–10 show examples of implementation in Europe): Triple P (Positive Parenting Programme) (n = 19, 42%), The Incredible Years (n = 8, 18%), ACT (Adults and Children Together Against Violence) (n = 4, 9%), Parenting for Lifelong Health (n = 1, 2%), and Safe Environment for Every Kid (n = 1, 2%) *(41,102–106)*. Most responding countries (n = 31, 69%) nevertheless reported use of other parenting education programmes. Many of the components may overlap with evidence-based programmes, but it is

Box 8. Nationwide implementation of The Incredible Years programme in Norway

Children with challenging behaviour are at increased risk of experiencing child maltreatment. The Incredible Years basic parenting programme is a group-based intervention that targets children (up to 12 years of age) with behavioural issues, with the focus on the parent–child relationship and developing parenting skills *(107)*. Videotaped vignettes and role play demonstrating helpful skills are core features of the intervention.

The Incredible Years has been implemented nationally in Norway following results of an RCT involving children aged 4–8 years with behavioural difficulty. The RCT showed reduced use of harsh discipline, reduced stress of mothers and increased use of positive parenting strategies *(108)*. The programme is now being implemented throughout the general population. Nationwide implementation is supported by the Ministry of Health, and the coordinating hub for programme implementation is a steering group at the University of Tromso. A small number of mentors from the steering group train group leaders and then monitor implementation of the programme to ensure fidelity.

Some of the key elements behind the success of The Incredible Years in Norway are long-term government support (including financial), professional support and inclusion of the programme in official plans and strategic documents. Having a clear national provider of the programme, with key accredited professionals (the mentors) knowing the content of the programme and the art of successful implementation, is also beneficial. Identified challenges in nationwide implementation are group leaders having insufficient time and resources to deliver the programme with fidelity and attend for consultations, changes in leadership and turnover, and the process of translation of materials. A strong European network links providers of The Incredible Years, enabling collaborative learning to overcome challenges and sharing of successes in implementation, evaluation and research.

Box 9. Mellow Parenting Programme in the Republic of Moldova

The number of children institutionalized due to abandonment by parents has declined in the Republic of Moldova over the last decade. The Government's child protection strategy (2014–2020) includes development of prevention services and support for high-risk families, and promotes increased responsibility of parents, families and communities for the safe care of children. To support this national agenda, the evidence-based Mellow Parenting Programme, developed in United Kingdom (Scotland) *(109)*, was introduced to the Republic of Moldova in 2016 through a collaborative project involving the Ministry for Labour, Social Protection and Family, and the NGO Partnership for Every Child.

The programme, which is for children under 5 years, is based on social attachment theory and targets vulnerable families whose children are at risk of abandonment. These families are socioeconomically disadvantaged, with high rates of substance abuse, domestic violence and physical punishment of children. Thirty practitioners have been trained by experts, and seven groups across six regions of the country were evaluated in a pilot implementation *(110)*. Results showed improvements in self-reported parental well-being and stress and the children's Strengths and Difficulties Questionnaire. Dropout from the groups was very low (10%), demonstrating high user acceptability. A widened rollout is now underway.

Contributing to the successful adoption of the programme in a new setting are its low demand on literacy and cultural sensitivity, and relatively low cost. Having high-level political commitment and a central coordinating hub has facilitated smooth training, delivery and evaluation. Evaluation results measuring changes in child maltreatment are awaited.

Box 10. Parenting for Lifelong Health – the Adapt, Optimize, Test, and Extend (RISE) project in south-eastern Europe

Despite evidence from HICs for the effectiveness of some parenting interventions in reducing child maltreatment, LMICs face challenges of generalizability and affordability of importing the programmes. Parenting for Lifelong Health is a suite of parenting programmes developed through collaboration involving WHO, the United Nations Children's Fund, universities in South Africa and the United Kingdom, and NGOs. Its purpose is to develop and test low-cost evidence-based parenting interventions that can be integrated within LMICs' existing service delivery systems.

The programme comprises a 12-session, group-based parenting intervention grounded in collaborative social learning behavioural change techniques to build a nurturing and supportive home *(111)*. It engages parents in positive parenting strategies to improve parent–child relationships and reduce harsh discipline, and uses non-didactic methods such as group discussions, illustrated stories of parent–child interactions, role plays to practise parenting skills, home activity assignments, and collective problem-solving.

The RISE project, funded by the EU, is using the Multiphase Optimization Strategy *(112)* to effectively widen the reach of the Parenting for Lifelong Health programme for young children (aged 2–9 years) to eastern Europe (the Republic of Moldova and the former Yugoslav Republic of Macedonia). This entails three distinct phases: preparation, by conducting a small-scale feasibility study; optimization, through a study to determine the most impactful programme components across settings; and evaluation, with a randomized trial to investigate the programme's success. Evaluation of programme success is based on: 1) demonstrated effectiveness in reducing the risk of violence against children using RCTs; 2) integration within existing service delivery systems; 3) feasibility to deliver the programme with fidelity by paraprofessionals; 4) cultural acceptability within the setting of implementation; and 5) scalability with respect to affordability, replicability and sustainability.

The RISE project aims to report results on phase 1 (feasibility) in late 2018.

important that the effectiveness of such programmes is monitored and evaluated.

Hospital-based parental training programmes to prevent abusive head trauma

Abusive head trauma (so-called shaken baby syndrome) is one of the most severe forms of child maltreatment and is a leading cause of death from maltreatment in infants *(113)*. Hospital-based programmes target new parents following the birth of a child, prior to discharge, educating them on the dangers of infant shaking and positive strategies to deal with challenging situations, such as persistent infant crying. These programmes are usually delivered by health and/or social care professionals and have good evidence for increasing parental knowledge and awareness of the dangers of infant shaking *(42)*.

Only 8% (n = 4) of countries in the Region have implemented these programmes on a large scale, all of which are HICs. Other countries have indicated that they have implemented hospital-based programmes several times (and) in multiple areas (n = 12, 24%), and 22% (n = 11) have implemented programmes a few isolated times. A high proportion of countries (n = 16, 33%) do not have any hospital-based programmes to prevent shaken baby syndrome.

The number of countries reporting adoption of hospital-based programmes for the prevention of shaken baby syndrome has increased by 4% between the 2013 and 2017 surveys. Given the early opportunity for intervention and wide coverage of new parents in the hospital setting, countries without existing programmes may consider which evidence-based interventions could reduce risk of shaken baby syndrome in their settings *(114,115)*.

Primary school-based programmes

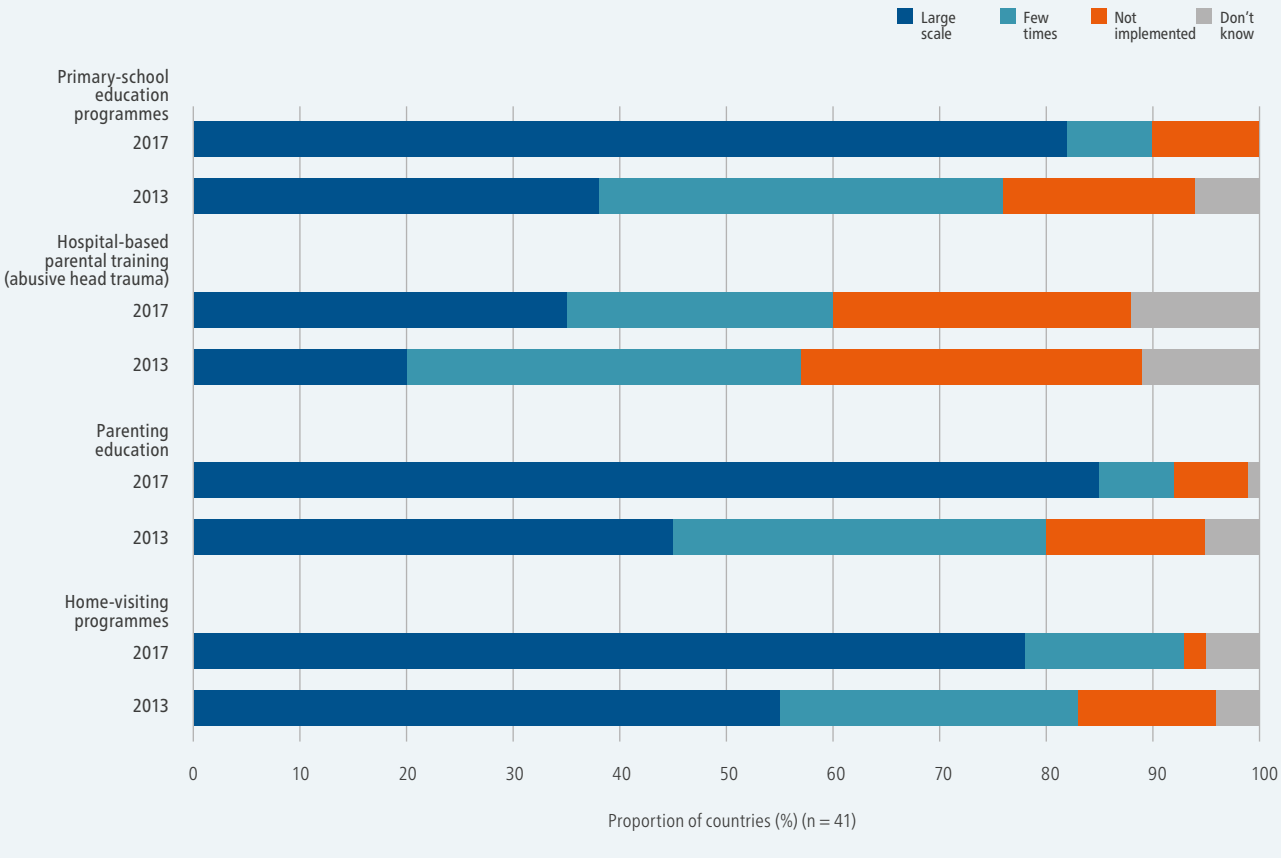
Schools are a logical setting in which to educate and empower children to avoid and report situations of abuse without

stigmatizing high-risk individuals, given their universal reach and primary duty to educate *(116,117).* Many school-based programmes to prevent child abuse focus exclusively on prevention of sexual violence *(116)*, while others are designed also to prevent other types of violence against children, including bullying *(117).*

Primary school-based programmes aim to strengthen protective factors, such as knowledge of abuse, dealing with strangers, recognition of harmful situations and inappropriate close contact, and proactive disclosure to trusted adults *(28,44,116,117).* Kidpower and Stay Safe are programmes for primary schools that have shown improvements in safety knowledge, self-esteem and self-protective behaviours, and which may improve disclosure *(118,119).* Stay Safe has also been adapted to enable the curriculum to be taught to children with a wide range of special needs *(117).* Given the higher risk of abuse in children with special needs, adaptation of prevention programmes to meet the learning capacity of all children is of the utmost importance.

Primary school-based prevention programmes are widely implemented in the WHO European Region (Box 11 provides an example of a combined civil society and government approach), but most have not been evaluated. The survey found that 43% (n = 21) of countries have implemented programmes on a large scale, 37% (n = 18) have implemented them several times (and) in multiple areas, and 10% (n = 5) have implemented them a few isolated times. Based on the 41 countries for which survey data were available in 2013, the proportion of countries in the Region adopting primary school-based prevention programmes has increased by 14% (n = 5) (Fig. 17).

Fig. 17. Proportion of countries with child maltreatment prevention programmes in 2013 and 2017 surveys (%) (n = 41)



Box 11. "I am my own" storybook for the prevention of child sexual abuse in Estonia

A story book, "I am my own" ["Mina olen enda oma" in Estonian and "Ja prinadlezu sebe" in Russian] has been distributed universally to kindergartens and schools for children up to 10 years of age since September 2017. Children can relate to the two main characters in the storybook, which aims to educate and empower children on how to avoid and deal with situations that may be sexually abusive. The stories are written by a popular Estonian author, Juhani Püttsepp, and have been informed by parental focus groups and the input of two psychotherapists.

The storybook provides positive scenarios to teach children to inform someone about uncomfortable situations and educates adults with a guidebook on recognizing, discussing and responding to children's concerns. Examples of stories include "This wasn't a hug", "First swimming suit" and "The ugly word". The book is available in Estonian and Russian language and in hard copy, as an online version and as an audiobook to optimize accessibility. Acceptability among children, parents and teachers has been high, stimulating a second edition of the book.

The project is led by the NGO Estonian Union Child Welfare and funded by the Ministry of Justice. More information is available at the Estonian Union Child Welfare website *(120)*.

Eleven per cent (n = 5) of countries have implemented Kidpower and 7% (n = 3) Stay Safe. Most responding countries (86% n = 38) have implemented other primary school-based programmes, 35% (n = 13/37) of which include sexual abuse prevention. Evaluating and assessing these programmes in local contexts is recommended to support countries' efforts in preventing child maltreatment.

School-based antibullying programmes

Bullying is a common form of violence experienced by children, predominantly within the school environment. It is associated with wide-ranging adverse health outcomes, including sleep disturbance, headaches, abdominal pain and poor mental well-being *(121,122)*. While some of the child abuse prevention programmes in primary schools have antibullying components (as described above), many are specific to tackling bullying in schools *(122,123)*.

The Olweus® Bullying Prevention Program (OBPP) *(124)* and KiVa *(125)* are well-researched primary and secondary school programmes with a strong evidence base for the prevention of bullying in children. The OBPP, developed in Norway and implemented widely in countries such as Sweden, Iceland and Lithuania, involves a multilevel approach to prevent bullying which includes the development and enforcement of antibullying policies, staff training, classroom discussions, and provision of individual support to victims and bullies, with parental engagement *(124)*. The KiVa programme, developed in Finland, centres on classroom education, between-lesson activities to consolidate learning, and targeted support for victims and perpetrators of bullying *(126)*.

Thirty-nine per cent (n = 19) of countries in the Region have implemented antibullying programmes systematically on a large scale, 31% (n = 15) have implemented them several times (and) in multiple areas, while 14% (n = 7) have implemented such programmes a few isolated times. The OBPP is implemented across nine countries in the Region (22%), and KiVa was reported in the survey to be implemented across eight countries (20%). Other countries (56%, n = 23) reported the development or adoption of other programmes that have had less extensive research to assess effectiveness.

Health and social services

Health and social services have a crucial role in preventing, detecting and responding to child maltreatment. Strengthening health systems and service provision to provide family-centred care can help reduce recurrence of child maltreatment, prevent new cases, and improve long-term physical and mental health outcomes.

Detection of child maltreatment

Early detection and response to child maltreatment can prevent ongoing harm and adverse health outcomes. Prenatal services not only have an important role in helping parents develop sensitivity to their infants, but also do valuable work in detecting intimate-partner violence and families at high risk of child maltreatment. Women who experience intimate-partner violence during pregnancy are at increased risk of delivering preterm and low-birth-weight babies. Abusive relationships can also result in, or coexist with, maltreatment of children in the family *(127,128).*

As Fig. 18 shows, 76% (n = 37) of countries in the Region have prenatal services that detect intimate-partner violence (47% (23) of countries at systematic large-scale level and 29% (14) once or a few isolated times). Most countries (73%, n = 36) also detect risk factors for child maltreatment within prenatal services (45% (22) of countries at systematic large-scale level and 29% (14) once or a few isolated times). There has been a substantial rise between 2013 and 2017 in the proportion of countries that have widely implemented services to prenatally detect child maltreatment or intimate-partner violence (27% in 2013, to 51% in 2017) (Fig. 19).

Inequalities by income persist in the Region. The results of the survey showed that 74% (n = 23) of HICs prenatally detect risk of child maltreatment, compared to 72% (n = 13) of LMICs. When only large-scale implementation of detection services is considered, around 61% of HICs and less than 20% of LMICs have these services. Eighty-one per cent (n = 25) of HICs and 67% (n = 12) of LMICs report detection of intimate-partner violence during pregnancy to some extent (Fig. 20).

Fig. 18. Proportion of countries with health, social and legal services in place for child maltreatment (%) (n = 49)

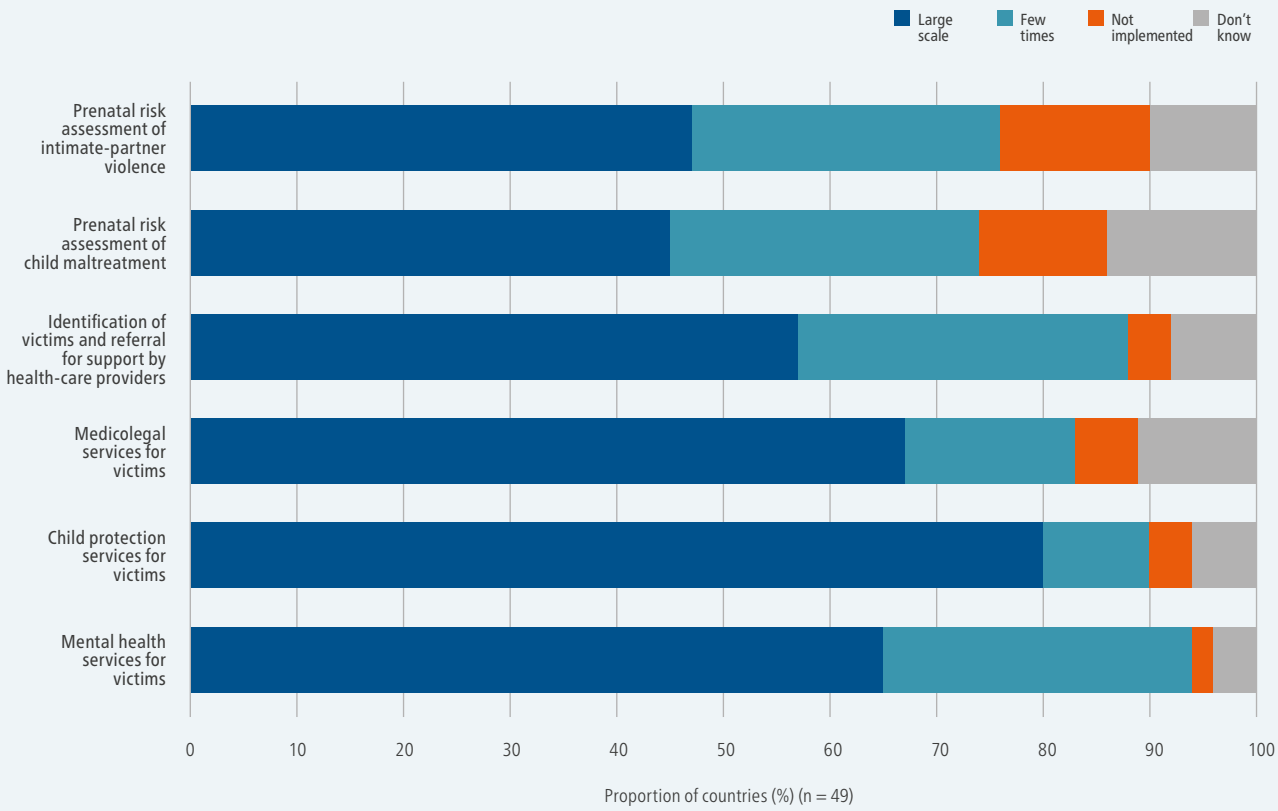
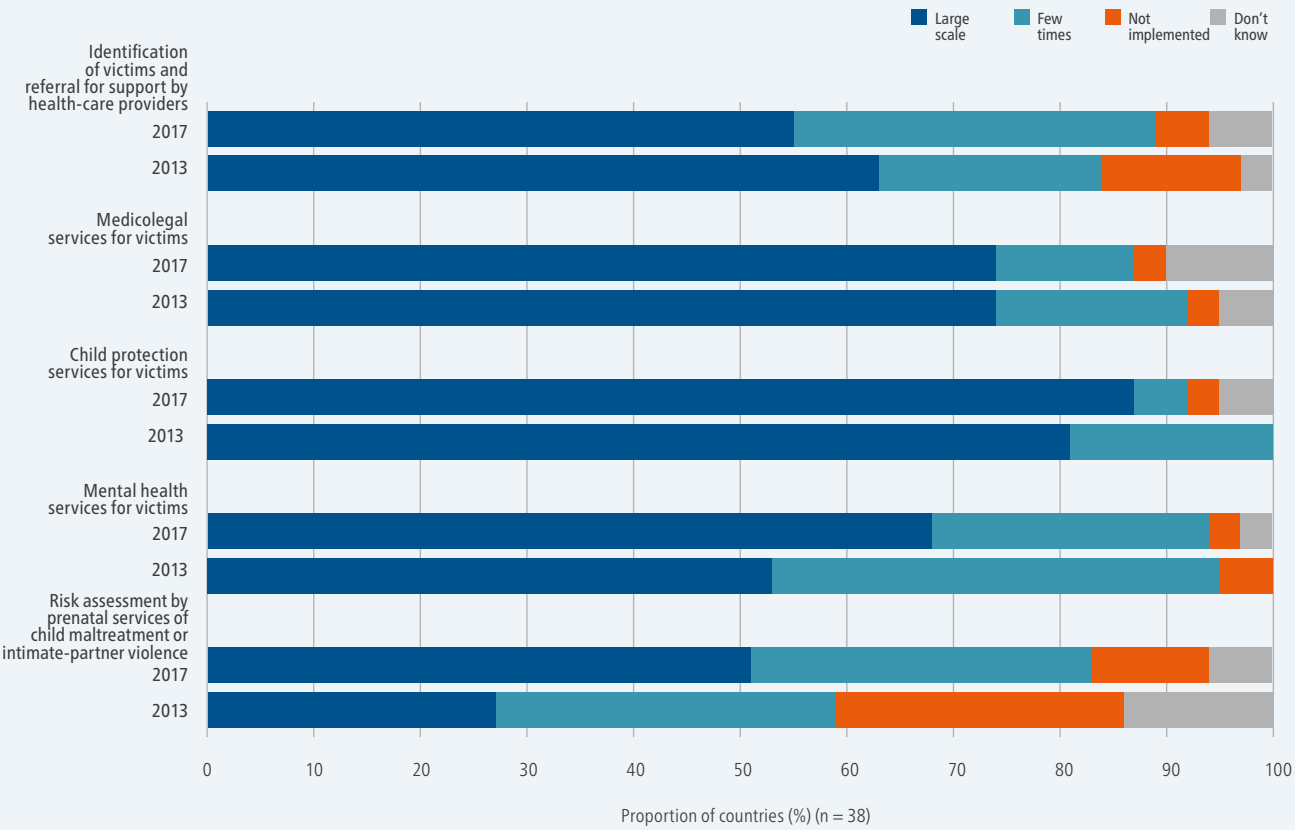


Fig. 19. Proportion of countries who have health and social services in place for child maltreatment in 2013 and 2017 surveys



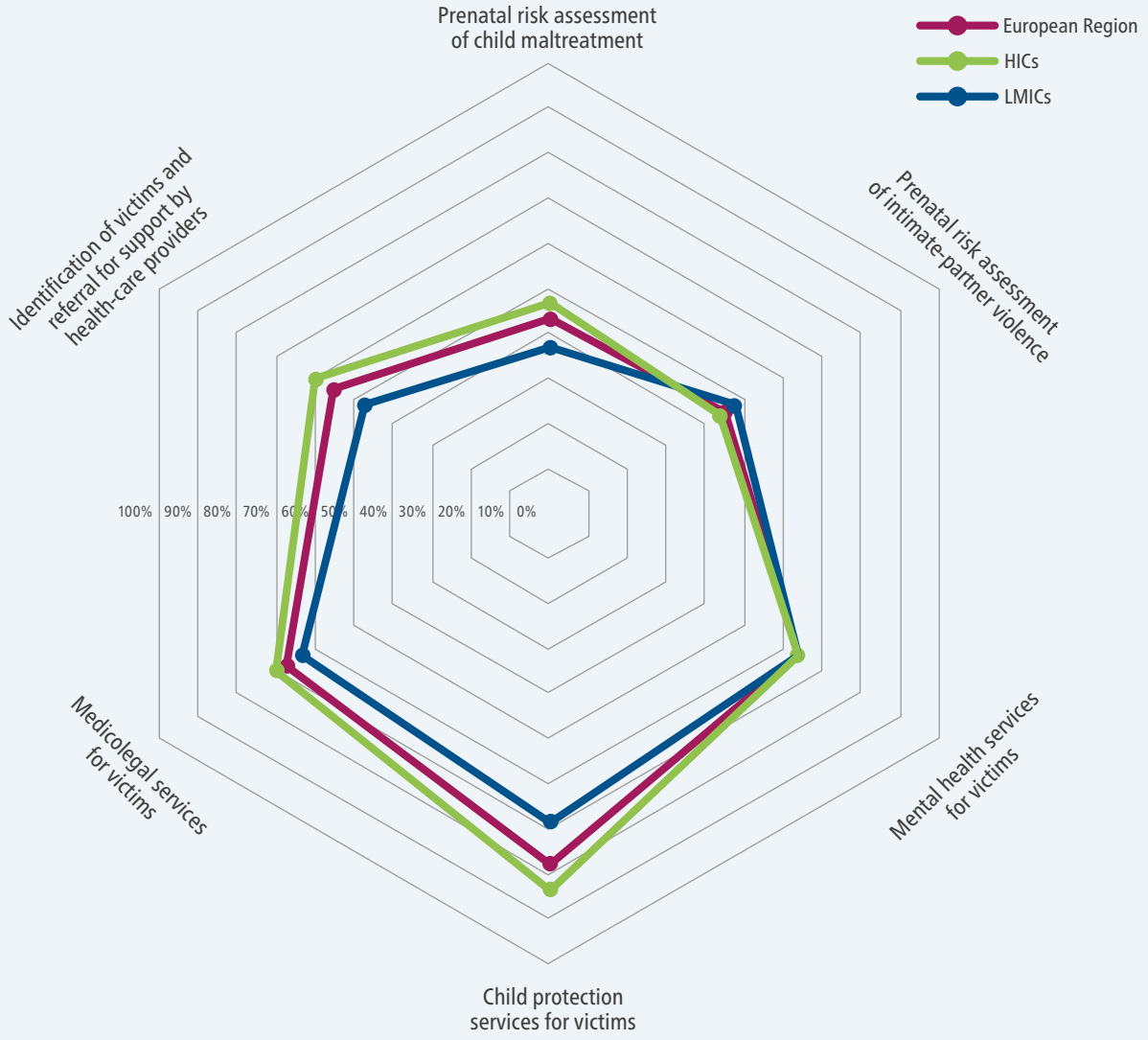
Health-care providers are in a unique position to identify child maltreatment and refer to appropriate services *(129)*. Making every contact count with health services from the earliest stages of a child's life by strengthening detection and referral processes is therefore vital. Most countries (88%, n = 43) report having a process of systematic identification and referral of victims of child maltreatment (57% (n = 28) on a large scale and 31% (n = 15) once or a few isolated times). Income inequalities exist in the systematic identification and referral of victims of child maltreatment, with 50% LMICs reporting systematic and large-scale implementation of these services (in contrast to 61% of HICs) (Fig. 20).

Although WHO does not recommend mandatory reporting laws for suspected cases of child maltreatment, such legislation is widespread. Forty-two countries (86%) in the WHO European Region have a national law mandating certain groups of professionals to report suspected child maltreatment. The evidence for benefit over harm to children and vulnerable families is unclear *(130,131)*. Underestimation of child maltreatment is largely due to low levels of disclosure among affected children. Reporting may be reduced if children and/or family members perceive the consequences of reporting to be threatening or harmful.

Circumstances in which groups of professionals and individuals fail to record and report child maltreatment suspicions include inadequate training and lack of understanding of the signs, symptoms, and outcomes of child maltreatment, fears of damaging professional–client relationships, and perception that reporting may do more harm than good *(132)*. Professionals in primary care and paediatrics, schools, social services and law enforcement play an important role in detecting and reporting child

Fig. 20.

Large-scale systematic implementation of services to prevent and respond to child maltreatment, by income classification[a]



[a] Five indicators were based on 49 countries that reported large-scale systematic implementation of services to prevent and respond to child maltreatment: prenatal risk assessment of child maltreatment; prenatal risk assessment of intimate-partner violence; mental health services for victims; child protection services for victims; medicolegal services for victims; and identification of victims and referral for support by health-care providers.

play an important role in detecting and reporting child maltreatment, as they encounter children in their daily work *(133)*. Having professional groups reporting suspected child maltreatment can help to develop understanding of the scope of the problem and potentially lead to earlier instigation of safeguarding measures.

Further research on the effectiveness of mandatory reporting is urgently needed. In those countries that have mandatory reporting through legislation, it is important that sufficient resources are available for response services to manage increased referrals and target supportive, rather than punitive, family measures.

Child protection and responding to child maltreatment

A sensitive, swift and effective response to detection of child maltreatment is essential to prevent further abuse

victims. In general, child protection services have been implemented widely across the Region, but many cases of child maltreatment remain hidden from child protection services *(134)*. Availability of child protection services for victims of maltreatment across the Region is good (Fig. 18). Child protection services are present in 90% (n = 44) of countries (80% (n = 39) have implemented systematically on a large scale, and 10% (n = 5) once or a few isolated times). There is inequality between countries based on income, indicating that LMICs have scope to upscale child protection services and converge with HICs (Fig. 20).

Poor mental health and psychiatric disorders present long-term devastating consequence for victims of child maltreatment *(73,135)*. Mental health services for child victims of violence exist in 94% (n = 46) of countries in the Region (65% (n = 32) have implemented them systematically on a large scale and 29% (n = 14) once or a few isolated times) (Fig. 18). Mental health services for victims of child maltreatment have been upscaled: 42% of countries in 2013 reported the extent of implementation of such services once or a few isolated times, while the 2017 results show that this proportion has reduced to 26%, with a corresponding increase in large-scale implementation (53% in 2013 to 68% in 2017). By income grouping, 94% (n = 29) of HICs and 94% (n = 17) of LMICs have mental health services for victims, but 68% of HICs have large-scale implementation, compared to 61% in LMICs (Fig. 20).

Scope exists for expanding the provision of mental health services for victims of child maltreatment across the whole Region. WHO guidelines have been developed to provide the evidence base for comprehensive responses, including guidelines on responding to children and adolescents who have been sexually abused *(136)*; guidelines on the health-sector response to child maltreatment will be published later in 2018 by WHO headquarters *(137)*.

Medicolegal services are important for child victims of sexual violence to ensure protection. Health-care providers should be trained to ensure they have a good understanding of their country's jurisdictions in reporting cases of suspected child sexual abuse. Eighty-three per cent (n = 41) of countries in the Region have medicolegal services for victims of rape and sexual assault (67% (n = 33) of countries have it systematically on a large scale and 16% (n = 8) countries once or a few isolated times). Income-level inequalities between countries in the Region exist for implementing medicolegal services for victims, with 84% (n = 26) of HICs and 83% (n = 15) of LMICs reporting provision of this support.

Capacity-building

Training and building capacity within health, social care, welfare and justice sectors is crucial to the provision of appropriate support to children experiencing maltreatment or those at increased risk. Increasing the skills and confidence of health-care staff and other professionals is essential and involves:

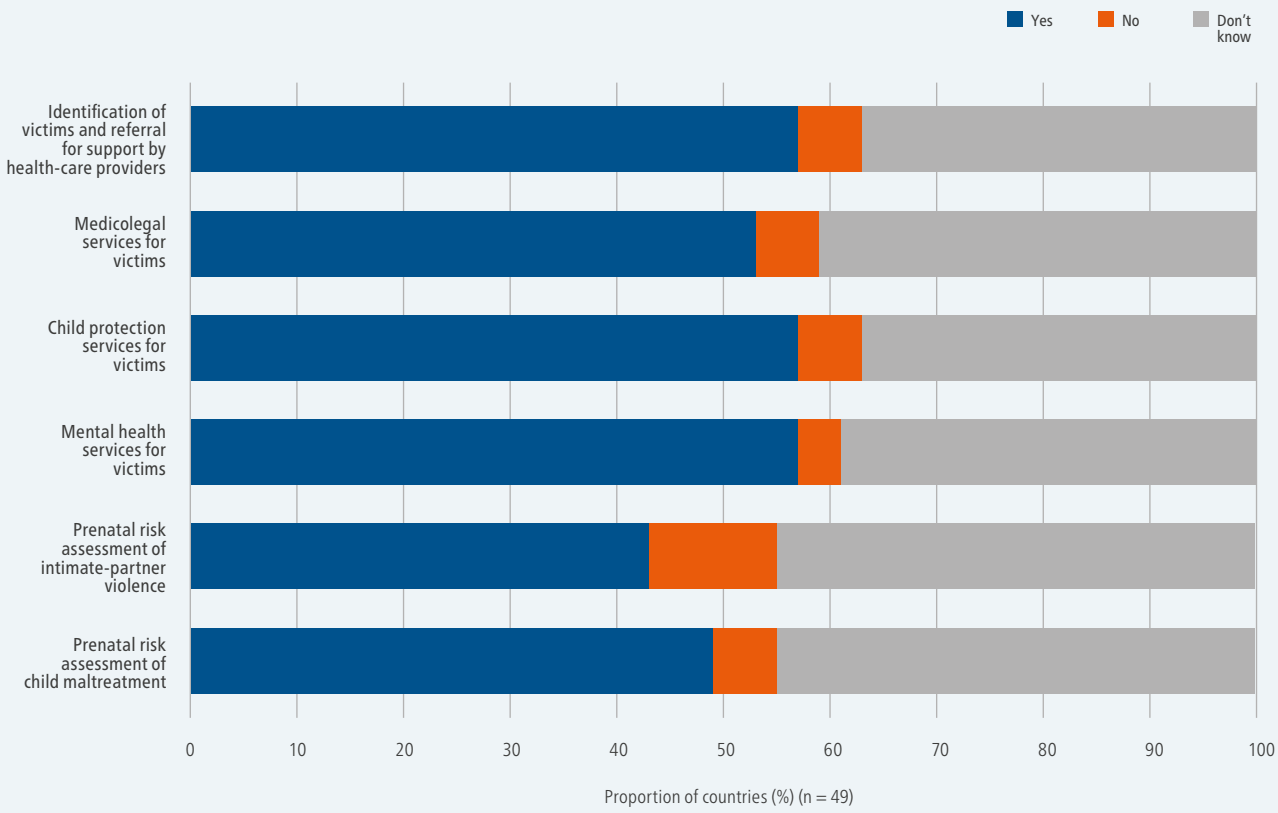
- raising awareness of child maltreatment and its prevalence and impacts;
- educating about how to recognize the signs and symptoms of abuse and neglect;
- developing skills in identifying parental risk factors for maltreatment and harmful parent–child interactions;
- providing or facilitating early intervention or support for parents and carers; and
- highlighting the procedure for reporting and referring cases to welfare and specialist services.

Multi-agency training can be a cost-efficient approach to building a common understanding of prevention and safeguarding across partners, and improving partnership-working. Good examples that involve multi-agency training using participative educational approaches exist across the Region, including one from the United Kingdom *(138)* and the development of a hotline to support health professionals in their child protection work in Germany (Box 12).

Fig. 21 shows capacity-development activities in the Region by type of service, demonstrating that investment in staff development needs to be improved. The most active areas of capacity development are in child protection services (n = 29, 59%), mental health services (n = 29, 59%), identification and referral services for health providers (n = 29, 59%), and medicolegal services for victims (n = 27, 53%). There is a need to improve on this.

Fig. 21.

Proportion of countries reporting capacity-development activities through staff training (%) (n = 49)



Box 12. Child protection hotline for health professionals in Germany [Medizinische Kinderschutzhotline]

A national child protection telephone hotline for health professionals, "Medizinische Kinderschutzhotline" *(139)*, was established in Germany in 2017 to improve communication and data-sharing between health professionals and children's services. It is funded by the Federal Ministry for Families, the Elderly, Women and Youth and is staffed by trained physicians and other professionals all day, every day.

Staff provide advice on interpretation of injuries or behavioural problems, documentation of injuries, the legal framework regarding breach of patient confidentiality and information on how to discuss concerns with parents, and link health professionals to local support services. Cases are discussed anonymously and responsibility for the suspected case remains with the health professional making the call. Evaluation of the intervention found that the support offered by the hotline and its interdisciplinary professional composition is valued by service users. Demand for the hotline is particularly high for professionals working in emergency medicine.

The hotline team has developed an e-learning course, funded by the Federal Ministry of Health, to increase training of health professionals in child protection. A feedback loop ensures difficult cases are discussed regularly by the hotline team and incorporated into the course, in addition to articles targeting health professionals.

Key elements of the hotline's success include high accessibility, wide publicity about availability and details of the service, and its targeting of the broad range of health professionals who have regular contact with children to raise awareness of child protection issues.

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6. Way forward

Way forward

Child maltreatment exists in every country and across all strata of society, driving adverse health and social outcomes throughout the life-course. This situation is not inevitable. The European child maltreatment prevention action plan sets a target of reducing the prevalence of child maltreatment by 20% by 2020. This European status report on the prevention of child maltreatment highlights the progress that has been made at the midpoint of the adoption by the WHO Regional Committee for Europe of resolutions EUR/RC64/12, *Investing in children: the European child and adolescent health strategy 2015–2020*, and EUR/RC64/13, *Investing in children: the European child maltreatment prevention action plan 2015–2020.*

Strong evidence for the relationship between ACEs and poor mental, physical and reproductive health outcomes throughout the life-course has been gathered over the last two decades *(4,15,140).* This makes a compelling case to governments of the urgent need for strong, coordinated and evidence-informed responses to prevent child maltreatment.

The WHO Regional Office for Europe has been advocating for a shift of focus from a protection-centred approach to child maltreatment to one of prevention *(1).* If the risks of child maltreatment can be ameliorated, susceptibility matters less *(141).* Preventing child maltreatment, and thereby stopping the health-harming effects *(20,21)*, is achievable with an approach driven by public health principles, as outlined in the plan. This entails strategies that are population-based, multidisciplinary, evidence-informed and evaluated to enable improvements *(142).* Information-gathering through surveillance systems, the development of comprehensive national action plans, and implementation and monitoring of prevention programmes are key objectives that can enable successful policy and service delivery to reduce the prevalence of child maltreatment.

Objective 1. Information systems

The Region has seen progress in data collection on child maltreatment, but substantial inconsistencies in the completeness and accuracy of data-recording among Member States exists. Vital registration, accurate coding of hospital admissions to identify maltreatment, recording of data by child protection agencies and regular community surveys are crucial information systems to enable a comprehensive national picture of the epidemiology of child maltreatment to emerge. Less than half of responding countries were able to provide data from child protection agencies. Member States are urged to optimize existing information systems across all sectors, share data between sectors, and develop data where lacking.

The current situation is such that 45% of countries in the Region have never conducted a national child maltreatment survey using a standardized instrument, and 65% do not conduct regular surveys, making it challenging to monitor trends in child maltreatment and make comparisons between countries. Without surveillance to provide prevalence data, the real impact of national action plans cannot be evaluated. Guidance on how to improve data collection and surveillance is available in the WHO handbook *Measuring and monitoring national prevalence of child maltreatment: a practical handbook (48).*

Objective 2. National action plans

Substantial gains in preventing child maltreatment can be made by coordinating actors in multiple sectors. Leadership to harness these strengths should be provided by national and local government. The Region has seen close to a 30% increase in the proportion of countries with a national action plan for the prevention of child maltreatment since 2013. This is undoubtedly an achievement of Member States, indicating increased recognition of the need for child maltreatment prevention and protection plans at the highest levels of national policy-making. National action plans nevertheless need to be underpinned by reliable data *(9,49).* It is of concern that more than one in five action plans (22%) have not been informed by a national survey. The strength of a national action plan to comprehensively address child maltreatment depends on nationally representative data to inform relevant objectives, quantified targets, realistic budgets and targeted interventions *(9).*

There is scope for improving the content of national plans to increase their effectiveness, particularly with respect to setting measurable targets and ensuring plans are fully

funded. Action plans are more effective if they are properly funded, if implementation is monitored, and if feedback on their impact on maltreatment is provided. Local authorities are critical players in implementation at municipal level and their engagement in developing and implementing plans and programmes is essential.

In developing action plans and policies for the prevention of child maltreatment, links should also be made with related policies. These include policies for the prevention of intimate-partner violence, youth violence and prevention of NCDs, and with strategies for reducing risk factors for child maltreatment, such as alcohol-related harm and poverty.

Despite two decades of research highlighting ACEs as a major risk factor for the development of NCDs in adulthood *(4,15)*, recognition of this fact in regional action plans for the prevention of NCDs remains inadequate. This is an area that warrants review by countries during any updates of existing NCD prevention action plans, and would serve to increase the visibility and momentum around the prevention of child maltreatment.

Existing legislation to protect the rights of children to live without fear of violence should be strengthened. Corporal punishment has still not been banned in all settings in one third of countries in the Region, despite clear evidence for improved parental and societal attitudes towards physical discipline and reduced use of physical punishment *(75,78,79)*. Inevitably, the impact of any legislation will be limited by the extent of its enforcement, which is highlighted in this report as an area that requires improvement across the Region, especially in LMICs and the CIS subregion. Further changing norms through national debate and social marketing is an essential accompaniment when laws are used in an attempt to change such behaviour by carers.

Objective 3. Prevention programmes

Preventing child maltreatment is achievable and necessitates cross-sectoral approaches that tackle the downstream risk, such as parental attitudes to physical discipline, and the upstream structural factors and societal processes that drive family stressors and adversely affect social cohesion. There is a substantial evidence base to support both universal and targeted programmes that can reduce risk factors for child maltreatment, with certain home-visiting and parenting programmes clearly demonstrating reductions in new cases of child maltreatment *(41,44,82,89,99)*. These may provide support to parents universally or to families in need.

While the costs of implementing evidence-based programmes may be high, there is evidence of a favourable return on investment *(88)*. This is particularly the case for interventions that have multiple components and are multidisciplinary, such as home visiting supplemented with social work interventions and parenting group sessions *(88)*. There is a need for more widespread implementation of approaches such as home-visiting and parenting programmes to support parents in delivering nurturing care. A range of programmes, both universal that can be adapted to the developmental stage of the child and those targeted to the special needs of children and parents, is available. Further research and evaluation is also needed in European settings to clearly establish the cost–effectiveness of many well-recognized prevention programmes.

The package presented in *INSPIRE: seven strategies to end violence against children (8)* can be used to galvanize support for a comprehensive approach that tackles risk factors for child maltreatment across all levels of the ecological model (that is, risk at individual, relationship, community and societal levels). Synergistic strategies and successful programmes to reduce violence against children are presented in INSPIRE and the *INSPIRE handbook: action for implementing the seven strategies for ending violence against children*, and the INSPIRE indicator guidance and results framework provide the support needed for implementation of prevention programmes.

Numerous prevention programmes can be adapted to national contexts; this should reflect fidelity to the particular programme's essential components and a flexible approach to adapting to local needs and resources. Most European settings have universal health-care systems and many are already implementing prevention programmes, but their impact needs to be evaluated.

Children with disabilities, particularly those with intellectual difficulties, mental/behavioural problems and conduct disorder, are at heightened risk of experiencing maltreatment and may experience greater challenges with communicating harm *(143)*. Countries are urged to ensure that prevention programmes are tailored to meet the needs of children with disabilities and their families. Programmes also need to be adapted to access so-called hard-to-reach groups such as migrant and refugee children. The impact on safeguarding these high-risk groups should be closely monitored.

Strengthening capacity for identifying and referring high-risk cases for child maltreatment by health and other professionals is an area that can be improved in the Region. Response services, however, must be resourced adequately to provide holistic, family-centred support, given the potential for increased detection. This is particularly the case as countries introduce mandatory reporting laws. The merits of such legislation are unclear and require further investigation to ensure that the benefits outweigh potential harms *(130)*. Guidelines to support health ministries in achieving the full potential of their workforces are available from WHO. In addition, forthcoming WHO guidelines for the health-sector response to child maltreatment will provide recommendations for health workers, primarily from LMICs, who are involved in identifying, assessing, referring and providing care to victims of child maltreatment.

Conclusions

Good progress has been made in the Region since the adoption of the European child maltreatment prevention action plan, suggesting that the action plan has catalysed action in this neglected area of public health. Data from the past five years show that rates of child homicides have declined by 11%, implying that the Region would be on track to achieve a 20% reduction in child homicides by 2020. There has been a notable increase in countries that have conducted surveys, adopted national prevention action plans, enacted and enforced laws to protect children, and implemented prevention programmes and response services for child maltreatment. It nevertheless is crucial that surveys are held on a regular basis by countries to monitor trends in child maltreatment and determine the success of any prevention initiatives.

Large inequalities persist in the Region, and child homicide rates are higher in LMICs and the CIS compared to HICs and EU countries. This is also the case in terms of policy action: while improvement is needed regionwide, gaps in surveillance, policy development, and prevention and response programming are bigger in LMICs.

In that respect, the country profiles presented in this report document important milestones against which to measure future progress in the countdown to 2020, and in achieving SDG target 16.2 to end all violence against children by 2030. The Region is very diverse and there is an opportunity to share learning among settings. The network of health ministry focal points for violence prevention and national data coordinators presents a medium for exchange of expertise.

The report highlights specific achievements in delivering the European action plan, and where future gains could be made. Future research agendas also need to focus on implementation research to identify how to effectively implement existing programmes in different settings in this Region of enormous diversity. The importance of evaluating innovative new programmes or adaptations of existing programmes is critical to the generation and sharing of knowledge. Improvements in the condition of the Region's children can also be achieved if implementation of evidence-informed programmes takes place at both national and local levels. The role of social media and the Internet needs to be studied not only as a potential medium through which to perpetrate violence against children, but also for its possibilities in harnessing prevention interventions to support parents in preventing maltreatment and develop children's resilience during their development.

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Country profiles

The following 49 country profiles provide a national summary of key indicators of progress in the prevention of child maltreatment. Most have been approved by the Ministry of Health. Where a clear number of incident/prevalent cases of child maltreatment and sample population data were not provided in the returned country questionnaires, it was not possible to report a prevalence and/or incidence rate in the respective country profile.

The country profiles present a selection of core information about child maltreatment prevention, as reported by each of the 49 participating countries. Data reported for population were extracted from the United Nations Population Division database *(1)*, while gross national income (GNI) per capita for 2017 came from World Bank estimates *(2)*. The World Bank Atlas method was used to categorize GNI into bands:

- low income = US$ 995 or less
- middle income = US$ 996 to US$ 12 055
- high income = US$ 12 056 or more.

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[1] All weblinks accessed 15 August 2018

Population 2 930 187 | Gross national income per capita US$ 4 320 | Income group Middle

ALBANIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	State Agency for the Protection of Child Rights
Systematic information exchange between stakeholders	NO

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[a]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	722	0–18 (V)	2016
Prevalence of child maltreatment (%)	Physical: 41.5%	18–24 (R)	Lifetime
Incidence of child maltreatment (per 1 000)	1.5	11–16 (R)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① **❷** ③ ④
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① **❷** ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

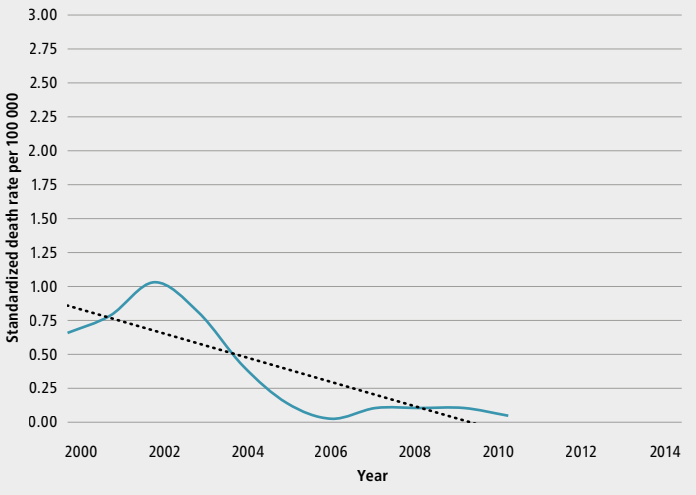
		Enforcement
Ban on corporal punishment in all settings	YES	① **❷** ③ ④
Against statutory rape	YES	① ② **❸** ④
Against child marriage	YES	① **❷** ③ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	**❶** ② ③ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① **❷** ③
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① **❷** ③
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① **❷** ③
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Standardized instruments:* ISPCAN Child Abuse Screening Tool (ICAST); Adverse Childhood Experiences Study Questionnaire (ACE).

[b] *Sources:* 2013, Community survey on prevalence of adverse childhood experiences in Albania; 2013, Balkan Epidemiological Study on Child Abuse and Neglect; 2016, RAPORTI study [in Albanian].

Population 76 965 | Gross national income per capita No data | Income group High

ANDORRA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	NO
Child maltreatment protection	NO
Noncommunicable disease prevention	NO

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	NO

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	1	0–17 (V)	2016
Violent assaults hospital admissions	2	0–17 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

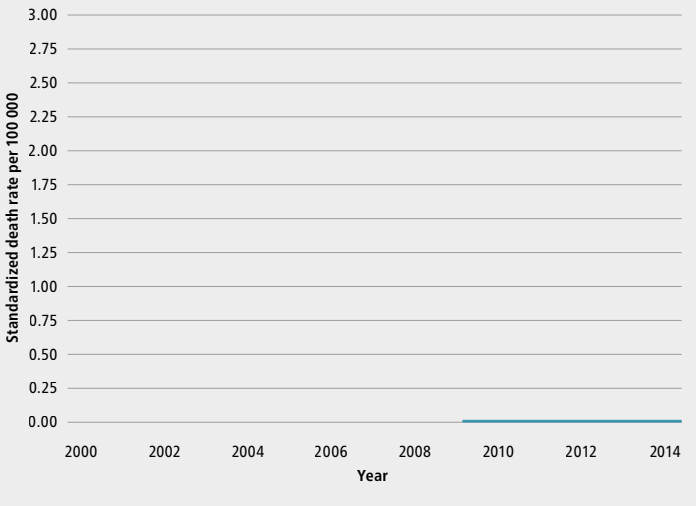
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ❸ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	NO	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* Ministry of Social Affairs, Justice and Interior; Ministry of Education and High Education; Ministry of Health; Ombudsman.
[b] *Sources:* health facility records; vital registration data.

Data cleared by Ministry of Social Affairs, Justice and Interior

Population 2 930 450 | Gross national income per capita US$ 4 000 | Income group Middle

ARMENIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	NO
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	NO
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	YES	① ② **❸** ④
Primary school-based empowering children	NO	**❶** ② ③ ④
School-based antibullying	NO	**❶** ② ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

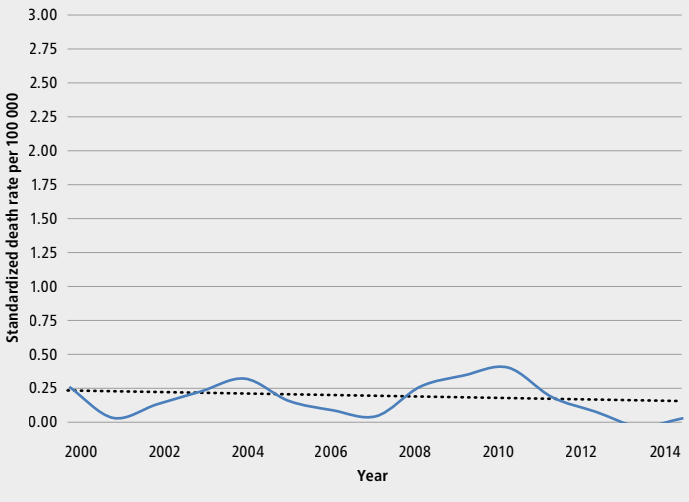
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① **❷** ③
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Labour and Social Security; Police of the Republic of Armenia; National Commission for the Protection of the Rights of the Child.

[b] *Programmes:* Triple P (parenting education).

Population 8 735 453 | Gross national income per capita US$ 45 440 | Income group High

AUSTRIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[c]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES[b]
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES[a]
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	3	0–15 (V)	2016
Hospital admissions	55	0–14 (V)	2016
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	400	1–18 (V)	2015
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[e]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

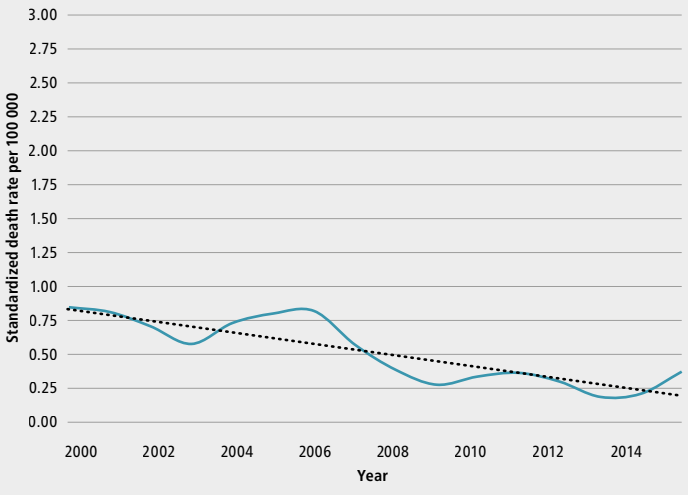
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	—	—
Identification of victims and referral for support by health-care providers	—	—
Response to child maltreatment		
Mental health services for victims	—	—
Child protection services for victims	—	—
Medicolegal services for victims	—	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] Subnational. [b] *Target:* elimination of child maltreatment by 2032. [c] *Government agencies:* Federal Ministry of Labour, Social Affairs, Health and Consumer Protection; Children's Rights (Monitoring Board); youth welfare liasion officers' conference, children's ombuds-officers of each of the nine Lander. [d] *Sources:* police records; 2016, annual report of the Children's Protection Centre, Vienna. [e] *Programmes:* Early Head Start (home visiting); Triple P (parenting education).

Population 9 468 338 | Gross national income per capita US$ 5 280 | Income group Middle

BELARUS

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	NO
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	—
Survey on child mental well-being	NO

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Psychological: 10–12, 9.2%; 13–17, 16.5%, Physical: ages 10–12, 15.8%; ages 13–17, 19.5%, Sexual: 10–12, 5.8%; 13–17, 1.4%	a) 10–12 b) 13–17 (V)	1 year
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	NO	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

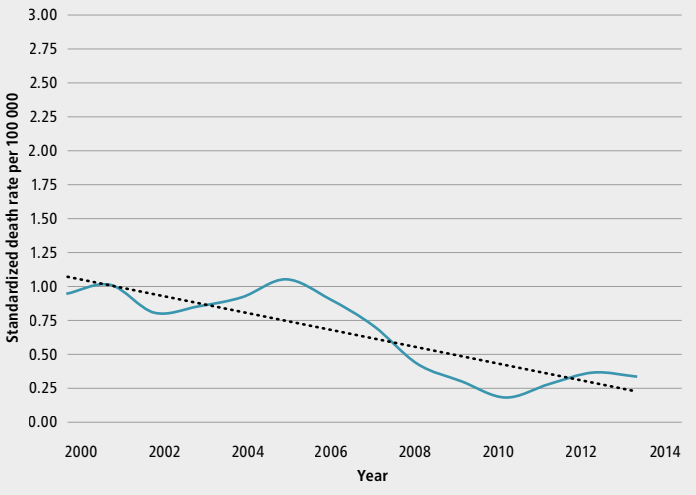
		Enforcement
Ban on corporal punishment in all settings	YES	—
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Internal Affairs; Ministry of Education; Ministry of Health. [b] *Standardized instrument:* ISPCAN Child Abuse Screening Tool (ICAST).
[c] *Source:* 2018, Violence against children in the Republic of Belarus, United Nations Children's Fund.

Population 11 429 336 | Gross national income per capita US$ 41 790 | Income group High

BELGIUM

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES[b]

Representative survey	
Survey on child maltreatment	YES[b]
Standardized instruments/methods	YES
Prevalence	YES
Incidence	NO
Survey on child mental well-being	—

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	162	0–10 (V)	2016
Violent assaults hospital admissions	196	0–10 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Sexual: girls 20.4%; boys 10.1%	0–14 (V)	2015
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ❷ ③ ④
Primary school-based empowering children	NO	—
School-based antibullying	—	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

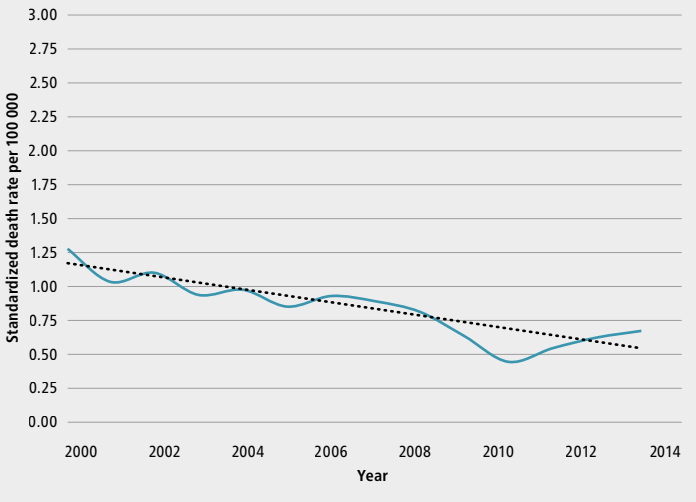
		Enforcement
Ban on corporal punishment in all settings	NO[d]	—
Against statutory rape	YES	① ② ❸ ④
Against child marriage	YES	—
Against female genital mutilation	YES	① ❷ ③ ④
Reporting of suspected child maltreatment	NO	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	—	—
Identification of victims and referral for support by health-care providers	—	—
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	—	—
Medicolegal services for victims	YES	① ❷ ③
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	YES	
Child protection services for victims	—	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* Minister of Youth Aid and Minister for Children (Federation Wallonie-Bruxelles); Office of Birth and Childhood, General Administration of Youth Aid, Ministry of the Federation Wallonie-Bruxelles [translation from French]. [b] Subnational. [c] *Sources:* hospital data; 2015, Krahé B et al. Prevalence and correlates of young people's sexual aggression perpetration and victimisation in 10 European countries: a multi-level analysis. Cult Health Sex. 17(6):682–99. [d] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Data cleared by Federal Public Service (Health), Food Chain Safety and Environment

Population 3 507 017

Gross national income per capita US$ 4 940

Income group Middle

BOSNIA AND HERZEGOVINA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES[a]

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	NO
Hospital admissions	NO
Contact with child protection agency	YES[a]

Representative survey

Survey on child maltreatment	YES[a]
Standardized instruments/methods	YES[c]
Prevalence	NO
Incidence	NO
Survey on child mental well-being	—

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES[d]	① ❷ ③ ④
Parenting education	NO	—
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

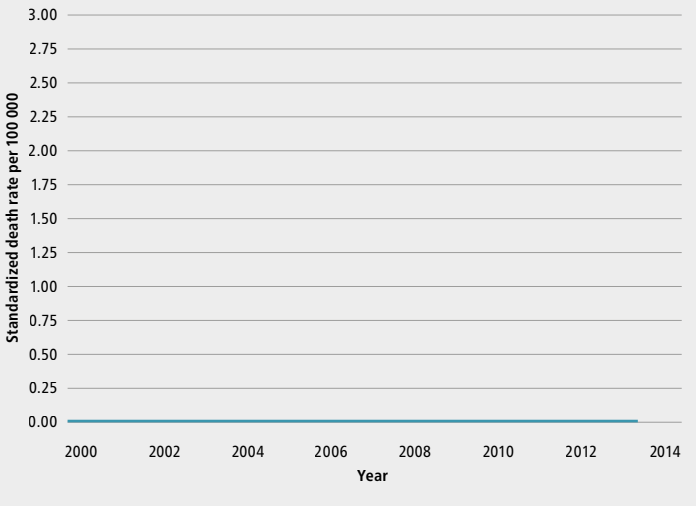
		Enforcement
Ban on corporal punishment in all settings	NO[e]	① ② ③ ❹
Against statutory rape	YES[a]	① ② ③ ❹
Against child marriage	YES[a]	① ❷ ③ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES[a]	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	—	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] Subnational. [b] *Government agencies:* Ministry of Human Rights and Refugees; Council for Children; Ministry of Interior of Republic of Srpska; Ministry of Family, Youth and Sports of Republic of Srpska; Ministry of Education and Culture of Republic of Srpska; Ministry of Health and Social Welfare of Republic of Srpska; Ministry of Justice of Republic of Srpska; Public Institution Centre for Social Welfare of Republic of Srpska; Ombudsman for Children; Gender Centre of the Government of the Republic of Srpska; Children Council of the Government of the Republic of Srpska. [c] *Standardized instrument:* ISPCAN Child Abuse Screening Tool (ICAST). [d] *Programmes:* nurse–family partnerships (home visiting). [e] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 7 084 571 | Gross national income per capita US$ 7 760 | Income group Middle

BULGARIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	—

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	NO

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	NO
Hospital admissions	—
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	3 741	0–18 (V)	2015
Prevalence of child maltreatment (%)	Sexual: 9%	0–14 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ❷ ③ ④
School-based antibullying	YES	① ❷ ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

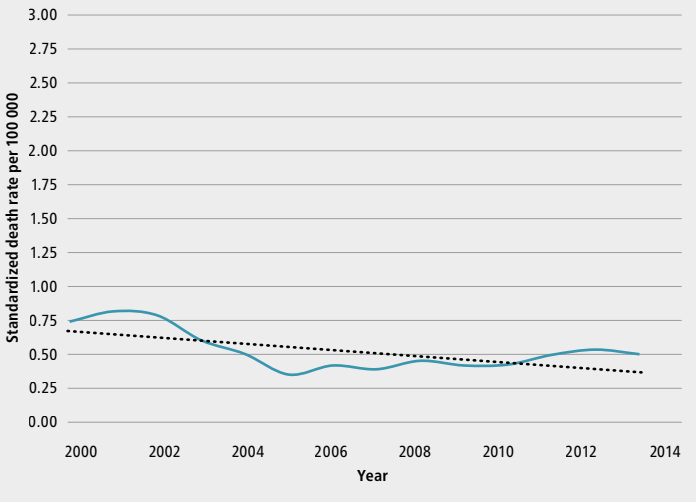
		Enforcement
Ban on corporal punishment in all settings	YES	—
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ❷ ③ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ❷ ③ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	—	—
Identification of victims and referral for support by health-care providers	—	—
Response to child maltreatment		
Mental health services for victims	—	—
Child protection services for victims	—	—
Medicolegal services for victims	—	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* State Agency for Child Protection; Agency for Social Assistance; local commissions for combatting antisocial behaviour of juveniles.

[b] *Source:* 2011, Sexual violence among women in Bulgaria, Alpha Research.

Population 4 189 353

Gross national income per capita US$ 12 430

Income group High

CROATIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	—

Representative survey	
Survey on child maltreatment	YES[b]
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	0–9 (V)	2016
Hospital admissions	1	0–9 (V)	2016
Violent assaults hospital admissions	0	0–9 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Psychological: 73.0%, Physical: 66.7%, Sexual: 10.2%, Neglect: 35.3%	11–16 (R)	Lifetime
Incidence of child maltreatment (per 1 000)	Psychological: 660, Physical: 458, Sexual: 72, Neglect: 288	11–16 (R)	2011

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[e]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

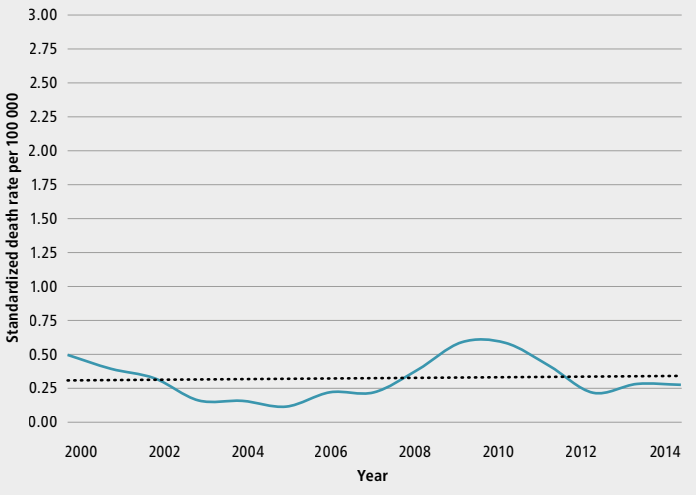
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	—	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Croatian National Institute of Public Health

[a] *Government agencies:* Ministry for Demography, Family, Youth and Social Policy; Ministry of Interior; Ministry of Health; Ministry of Science and Education; Ministry of Justice; State Attorney's Office; The Office of the Ombudsman for Children; The Office for Human Rights and the Rights of National Minorities; family centres; centres for social welfare; Child and Youth Protection Centre of Zagreb; City's Government; County's Government; Council for Children. [b] Subnational. [c] *Standardized instrument:* ISPCAN Child Abuse Screening Tool (ICAST). [d] *Sources:* Bureau of Statistics; National Institute of Public Health; health facility records; vital registration data; 2011, Balkan Epidemiological Study on Child Abuse and Neglect. [e] *Programmes:* nurse–family partnerships (home visiting); Triple P, Incredible Years (parenting education); Stay Safe (primary school-based empowering children); Olweus (school-based antibullying).

Population 1 179 551 | Gross national income per capita US$ 23 720 | Income group High

CYPRUS

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	The Voice: interministerial structure coordinating application of action plan
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	—
Hospital admissions	—
Contact with child protection agency	—

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	NO
Prevalence	YES
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[a]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Emotional: 33.1%, Physical: 9.6%, Neglect: 52.9%	9–12 (R)	2012
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

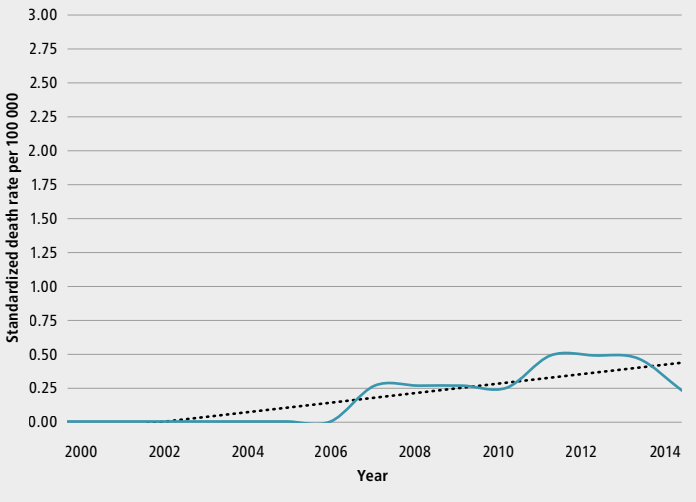
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Source:* 2012, Theoklitou D et al. Physical and emotional abuse of primary school children by teachers. Child Abuse Negl. 36(1):64–70.

Population 10 618 303 | Gross national income per capita US$ 18 160 | Income group High

CZECHIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	—

Government coordination of child maltreatment prevention	
Lead agency	Office of the Government of Czechia
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	YES
Incidence	—
Survey on child mental well-being	—

Summary of child maltreatment data[a]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	155	0–17 (V)	2015
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Girls: 20.4%, Boys: 36.7%	12–18 (R)	2017
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	YES	① ② ③ ❹
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

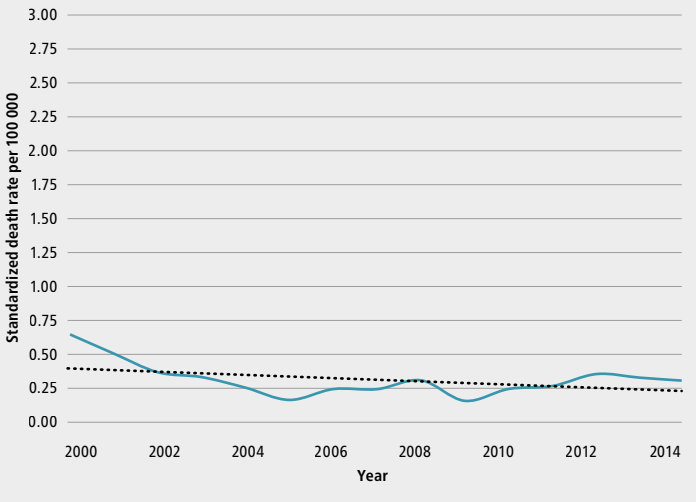
		Enforcement
Ban on corporal punishment in all settings	NO[c]	① ② ❸ ④
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	YES	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)

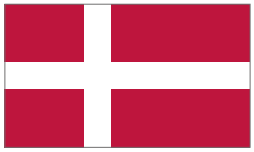


Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Sources:* police records; 2018, Löfving-Gupta et al. Community violence exposure and substance use: cross cultural and gender perspectives. Eur Child Adolesc Psychiatry 27(4):493–500.

[b] *Programmes:* nurse–family partnerships (home visiting); Triple P, Parenting for Lifelong Health (parenting education). [c] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.



Population 5 733 551

Gross national income per capita US$ 55 220

Income group High

DENMARK

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	NO[a]
Child maltreatment protection	NO
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2015
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	0.12%	0–7 (V)	1 year
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

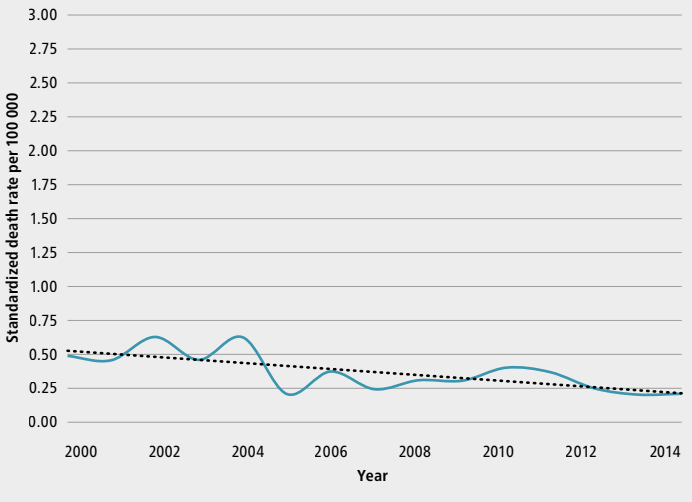
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry for Child and Social Affairs

[a] There are cross-sectional action plans in accordance with a sector accountability principle which ensures the rights of children, including freedom from any type of violence and maltreatment.

[b] *Government agencies:* Ministry for Children and Social Affairs; National Board of Social Services; National Social Appeals Board; Children's Office at the Parliamentary Ombudsman; the Auditor General; Danish Health Authority.

[c] *Sources:* children's houses; national health registers.

Population 1 309 632 | Gross national income per capita US$ 18 190 | Income group High

ESTONIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES[a]
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	—
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–9 (V)	2016
Hospital admissions	12	0–18 (V)	2016
Violent assaults hospital admissions	38	0–18 (V)	2016
Contacts with child protection agency	7 924	0–18 (V)	2015
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ❷ ③ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

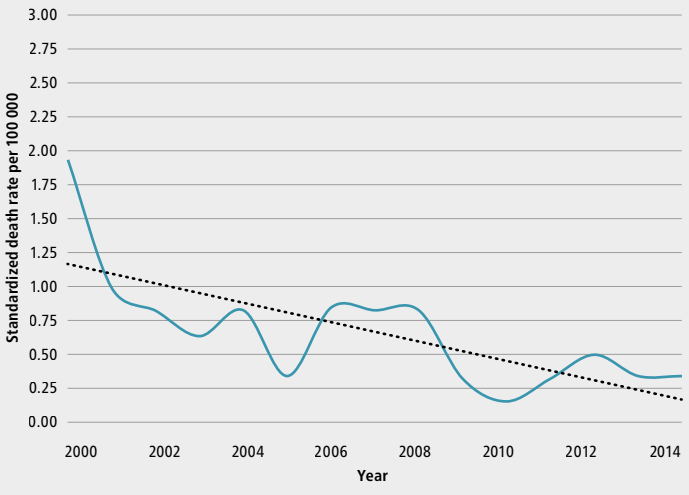
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	—
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Justice

[a] *Target:* zero cases of child maltreatment in timeframe 2012–2020.
[b] *Government agencies:* Ministry of Justice; Ministry of Social Affairs; National Institute for Health Development; Social Insurance Board; roundtable of the strategy for preventing violence for years 2015–2020; Child Protection Council.
[c] *Programmes:* The Incredible Years (parenting education).

Population 5 523 231 | Gross national income per capita US$ 44 580 | Income group High

FINLAND

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	YES
Incidence	—
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–17 (V)	2016
Hospital admissions	Inpatient hospital care: 57, Doctor visits in special care: 375	0–17 (V)	2015
Violent assaults hospital admissions	17	0–17 (V)	2015
Contacts with child protection agency	57 784	0–17 (V)	2016
Prevalence of child maltreatment (%)	23.4%	0–18 (V)	2015
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

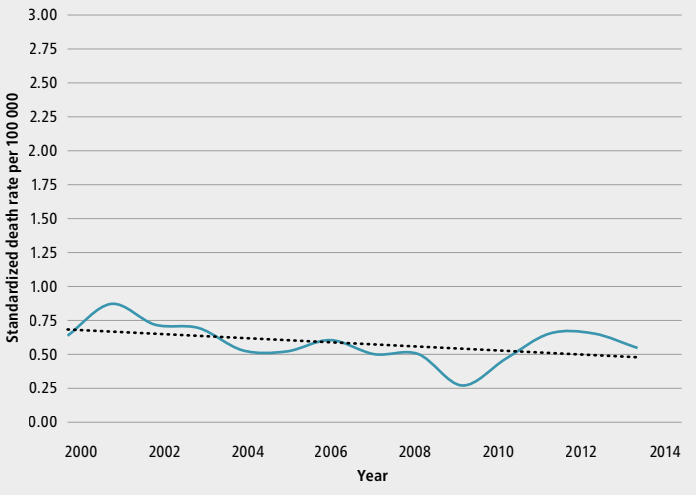
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	—
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ❷ ③
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

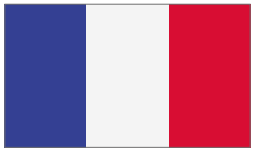
Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Social Affairs and Health

[a] Subnational. [b] *Government agencies:* Ministry of Social Affairs and Health/National Institute for Health and Welfare; regional level.
[c] *Sources:* police data; care notification system; child protection handbook; 2015, Forsman et al. Sexually coercive behavior following childhood maltreatment. Arch Sex Behav. 44(1):149–56.
[d] *Programmes:* Incredible Years (parenting education); KiVa (school-based antibullying).



Population 64 979 548 | Gross national income per capita US$ 37 970 | Income group High

FRANCE

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	—
Contact with child protection agency	—

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	131	0–17 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	20.4	0–18 (V)	2016

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	YES	① ② ③ ❹
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

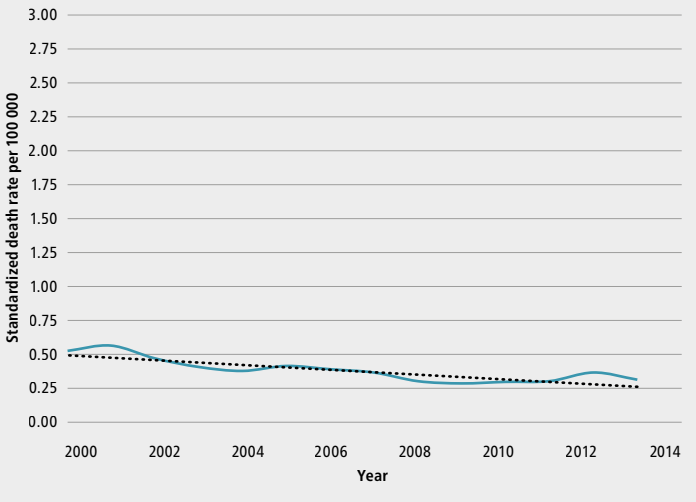
		Enforcement
Ban on corporal punishment in all settings	NO[d]	—
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

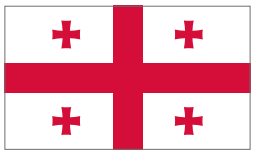
Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* National Observatory for the Protection of Children; High Council for Families, Children and Age; Ministry of Social Affairs and Health; Ministry of National Education; National Observatory for Social Action [translated from French]. [b] *Sources:* police records; health facility data; vital registration records; National Observatory for the Protection of Children. [c] *Programmes:* Steps Towards Effective Enjoyable Parenting (home visiting); Triple P (parenting education). [d] Does not cover: home. Covers: alternative care settings, day care, schools, penal institutions.



Population 3 912 061 | Gross national income per capita US$ 3 790 | Income group Middle

GEORGIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES[a]

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	YES
Incidence	YES
Survey on child mental well-being	NO

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	0	0–10 (V)	2016
Violent assaults hospital admissions	2	0–18 (V)	2016
Contacts with child protection agency	8	0–18 (V)	2016
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	0.001	0–18 (V)	2016

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	NO	—
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ❷ ③ ④
School-based antibullying	NO	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

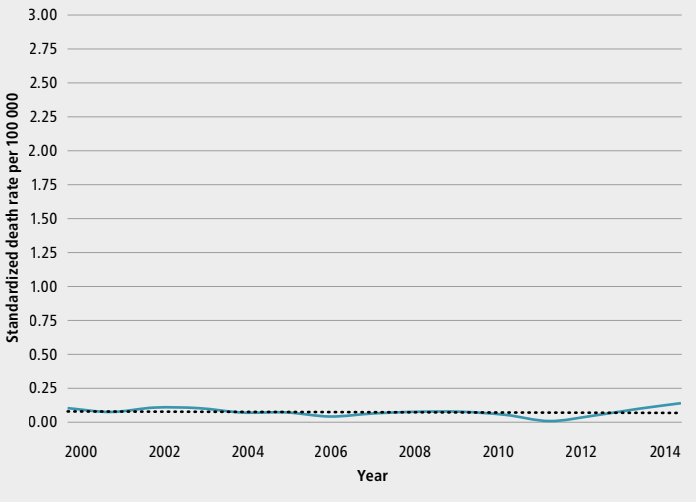
		Enforcement
Ban on corporal punishment in all settings	NO[e]	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ❷ ③ ④
Reporting of suspected child maltreatment	YES	① ❷ ③ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ❷ ③
Medicolegal services for victims	YES	① ❷ ③
Capacity development		
Prenatal risk assessment of child maltreatment	NO	
Prenatal risk assessment of intimate-partner violence	NO	
Identification of victims and referral for support by health-care providers	NO	
Mental health services for victims	NO	
Child protection services for victims	NO	
Medicolegal services for victims	NO	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] Subnational. [b] *Government agencies:* State Fund for Protection and Assistance; Victims of Human Trafficking; Office of Public Defender of Georgia.
[c] *Sources:* police records; health facility data; vital registration; National Centre for Disease Control. [d] *Programmes:* nurse–family partnerships (home visiting); Stay Safe (primary school-based empowering children).
[e] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 82 114 224

Gross national income per capita US$ 43 490

Income group High

GERMANY

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	138	0–13 (V)	2014
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	136 925	0–18 (V)	2016
Prevalence of child maltreatment (%)	10.4%	11–17 (R)	1 year
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② ③ **❹**
Hospital-based parental training (abusive head trauma)	YES	① ② **❸** ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	—	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

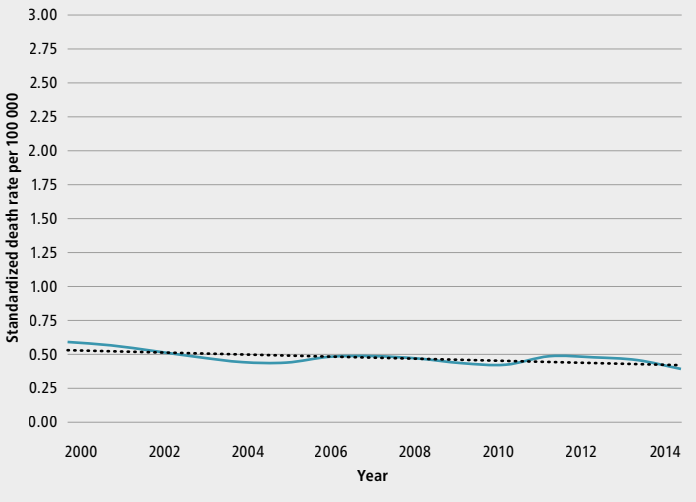
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	NO	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① **❷** ③
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* Independent Commissioner for child sexual abuse issues; youth welfare authorities/committees at federal-state and municipal levels; National Centre on Early Prevention.

[b] *Sources:* police records; statistics on child and youth welfare; 2017, Witt et al. Child maltreatment in Germany: prevalence rates in the general population. Child Adolesc Psychiatry Ment Health 11:47.

[c] *Programmes:* nurse–family partnerships, Steps Towards Effective Enjoyable Parenting (home visiting); Triple P (parenting education).

Population 11 159 773 | Gross national income per capita US$ 18 090 | Income group High

GREECE

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	NO
Child maltreatment protection	NO
Noncommunicable disease prevention	NO

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey

Survey on child maltreatment	YES[b]
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	4	0–10 (V)	2015
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Psychological: 83.2%, Physical: 76.4%, Sexual: 15.9%, Neglect: 37.2%	11–16 (R)	Lifetime
Incidence of child maltreatment (per 1 000)	6.05	11–16 (R)	2010

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	NO	—
Parenting education	YES	① ❷ ③ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

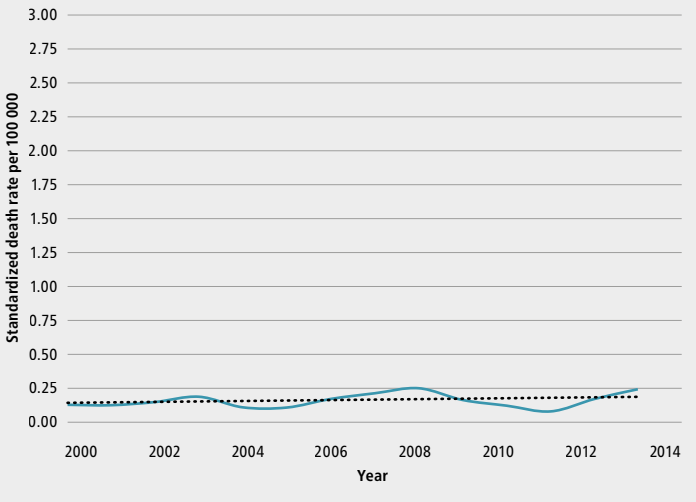
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ❸ ④
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ❷ ③ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	—	—
Identification of victims and referral for support by health-care providers	—	—
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ❷ ③
Medicolegal services for victims	YES	① ❷ ③
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health and Social Welfare

[a] *Government agencies:* Ministry of Labour; Social Insurance and Social Solidarity; National Centre for Social Solidarity; Ombudsman for the Rights of the Citizen; Department for the Rights of the Child; Ministry of Health; Institute of Child Health; Department of Mental Health and Social Welfare; Centre for the Study and Prevention of Child Abuse and Neglect. [b] Subnational. [c] *Standardized instrument:* ISPCAN Child Abuse Screening Tool (ICAST).
[d] *Sources:* vital registration data; National Statistical Authority; 2010, Balkan Epidemiological Study on Child Abuse and Neglect.

Population 9 721 559 | Gross national income per capita US$ 12 870 | Income group High

HUNGARY

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	NO
Child maltreatment protection	NO
Noncommunicable disease prevention	NO

Government coordination of child maltreatment prevention	
Lead agency	NO
Systematic information exchange between stakeholders	NO

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	—

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[a]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	3	0–9 (V)	2014
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① **❷** ③ ④
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① **❷** ③ ④
School-based antibullying	YES	① **❷** ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

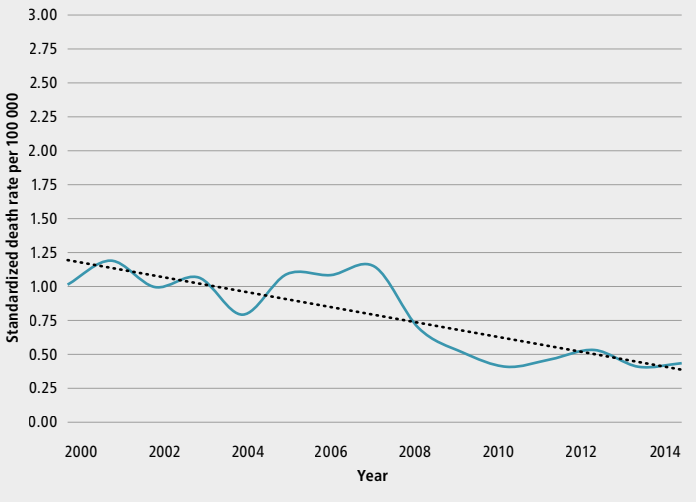
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② **❸**
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① **❷** ③
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① **❷** ③
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)

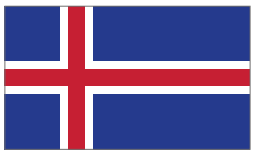


Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Human Capacities

[a] *Source:* vital registration data.

[b] *Programmes:* KiVa (school-based antibullying).



Population 335 025 | Gross national income per capita US$ 60 830 | Income group High

ICELAND

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	YES
Incidence	YES
Survey on child mental well-being	—

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–17 (V)	2017
Hospital admissions	0	0–17 (V)	2016
Violent assaults hospital admissions	0	0–10 (V)	2016
Contacts with child protection agency	9 345	0–17 (V)	2016
Prevalence of child maltreatment (%)	6.8%	0–17 (V)	1 year
Incidence of child maltreatment (per 1 000)	66.6	0–17 (V)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

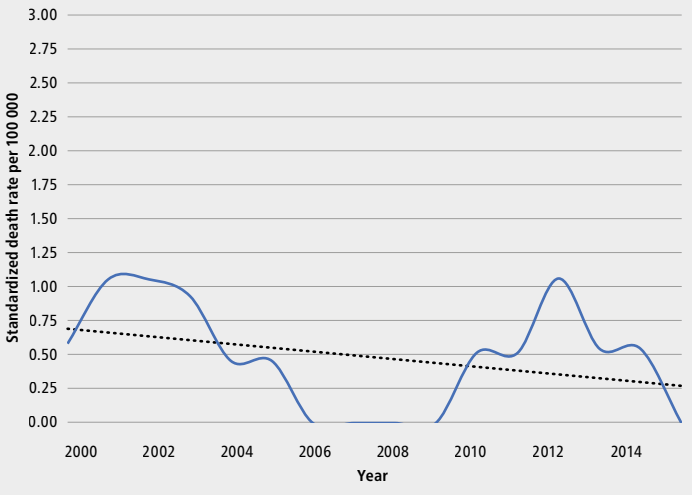
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* primary health care; Directorate of Health; Ministry of Welfare.
[b] *Sources:* police records; vital registration data; Government Agency for Child Protection.
[c] *Programmes:* Oleweus (school-based antibullying).

Population 8 321 570

Gross national income per capita US$ 37 270

Income group High

ISRAEL

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	NO

Characteristics of national plan for child maltreatment prevention

Measurable targets	—
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	NO
Hospital admissions	YES[b]
Contact with child protection agency	YES[b]

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	1 898	0–12 (V)	2016
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	52.9%	12–17 (R)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

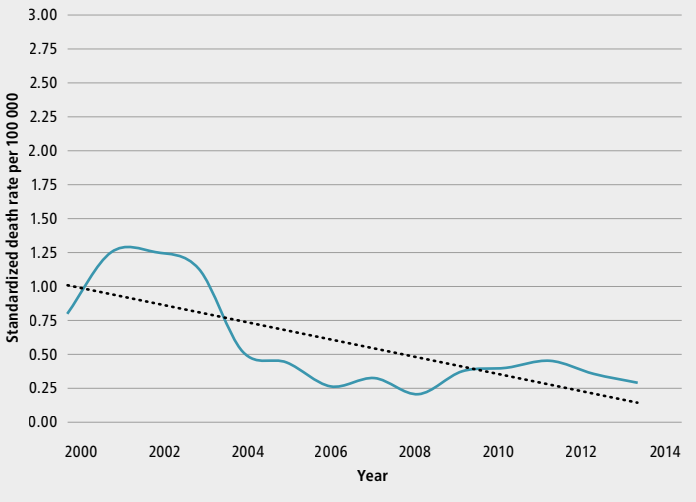
		Enforcement
Ban on corporal punishment in all settings	YES	—
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ❷ ③ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ❸ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ❷ ③
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Welfare; Ministry of Health; Ministry of Internal Security; National Programme for Children at Risk; Israel National Council for the Child; Haruv Institute.
[b] Subnational. [c] *Standardized instrument:* Juvenile Victimization Questionnaire (JVQ).
[d] *Source:* 2016, Lev-Wiesel et al. Prevalence of child maltreatment in Israel: a national epidemiological study. Journ Child Adol Trauma 2:141–50.

Population 59 359 900 | Gross national income per capita US$ 31 020 | Income group High

ITALY

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	YES
Contact with child protection agency	NO

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	0–17 (V)	2015
Hospital admissions	58	0–17 (V)	2016
Violent assaults hospital admissions	74	0–10 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	3.8%	0–17 (V)	2013
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ❷ ③ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

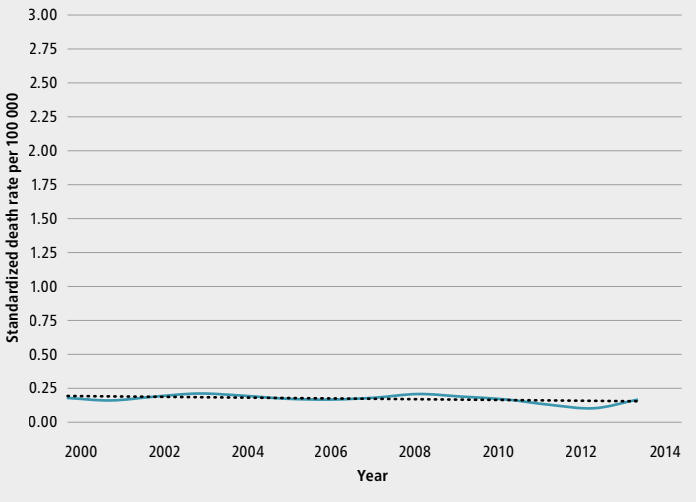
		Enforcement
Ban on corporal punishment in all settings	NO[d]	—
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ❷ ③
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Department of Equal Opportunities; Department of Family; Ministry of Justice; Ministry of Home Affairs. [b] *Standardized instrument:* ISPCAN Child Abuse Screening Tool (ICAST).
[c] *Sources:* Guarantor Authority for Children and Adolescents; Coordination of Services against Child Maltreatment and Abuse; Terre des Hommes (Italy); National Institute of Statistics; vital registration data.
[d] Does not cover: home.

Population 18 204 499

Gross national income per capita US$ 7 890

Income group Middle

KAZAKHSTAN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	NO
Hospital admissions	—
Contact with child protection agency	YES[a]

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	YES	① ② ③ ❹
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	NO	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

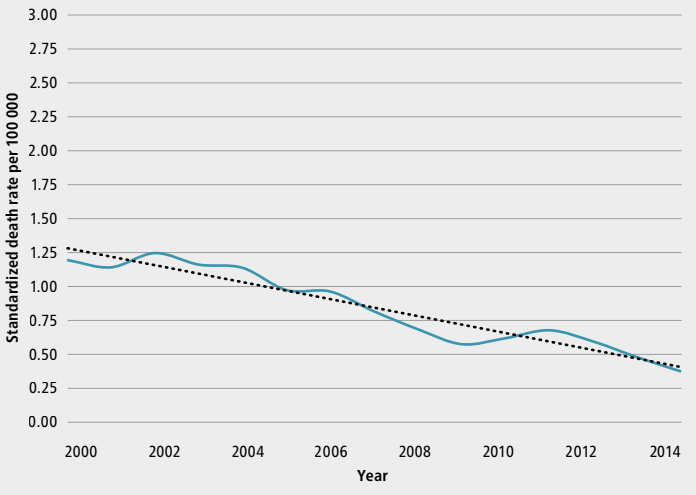
		Enforcement
Ban on corporal punishment in all settings	NO[d]	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Subnational. [b] *Government agencies:* Ministry of Justice; Ministry of Internal Affairs; General Prosecutor's Office; Committee for the Protection of Children's Rights of the Ministry of Education and Science; Ministry of Labour and Social Protection; Interdepartmental Commission for Minors Affairs under the Government of the Republic of Kazakhstan. [c] *Programmes:* nurse–family partnerships (home visiting). [d] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 6 045 117 | Gross national income per capita US$ 1 130 | Income group Middle

KYRGYZSTAN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES[b]
Hospital admissions	YES
Contact with child protection agency	YES[b]

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	NO

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	1 041	2–16 (V)	2015–2017
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	10.4%	2–16 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[e]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

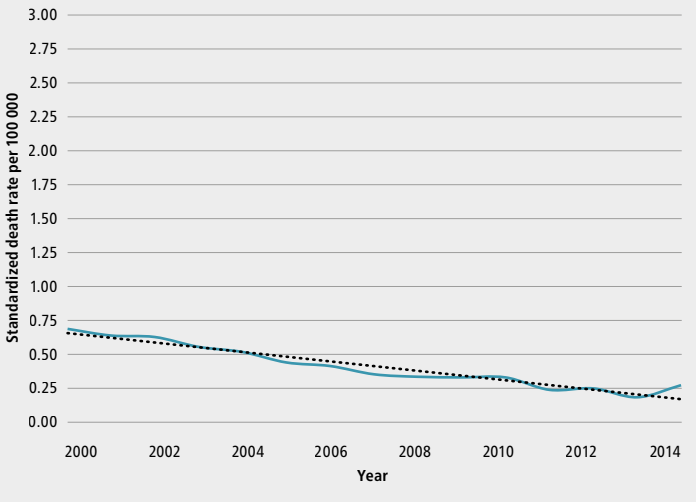
		Enforcement
Ban on corporal punishment in all settings	NO[f]	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministries of: Internal Affairs; Education; Labour and Social Development; Health; and Education; Office of the Government; Jogorku Kenesh; Ombudsman; General Prosecutor's Office; State Penitentiary Service; state-municipal service; General Prosecutor's Office – Juvenile Justice; United Nations Children's Fund. [b] Subnational. [c] *Standardized instruments:* ISPCAN Child Abuse Screening Tool (ICAST); Juvenile Victimization Questionnaire (JVQ); Adverse Childhood Experiences Study Questionnaire (ACE). [d] *Sources:* police records; health facility records; vital registration data. [e] Programmes: nurse–family partnerships, Step Towards Effective Enjoyable Parenting (home visiting); Triple P, Adults and Children Against Violence (ACT), Safe Environment for Every Kid (parenting education); Kidpower (primary school-based empowering children); Olweus (school-based antibullying). [f] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 1 949 670

Gross national income per capita US$ 14 740

Income group High

LATVIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES[a]
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	7	0–17 (V)	2016
Hospital admissions	106	0–17 (V)	2016
Violent assaults hospital admissions	11	0–10 (V)	2016
Contacts with child protection agency	1 102	0–18 (V)	2016
Prevalence of child maltreatment (%)	Emotional: 31.5%, Physical: 16.4%, Sexual: 10.3%	0–18 (V)	2011
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	NO	—
Parenting education	NO	—
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	NO	—
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

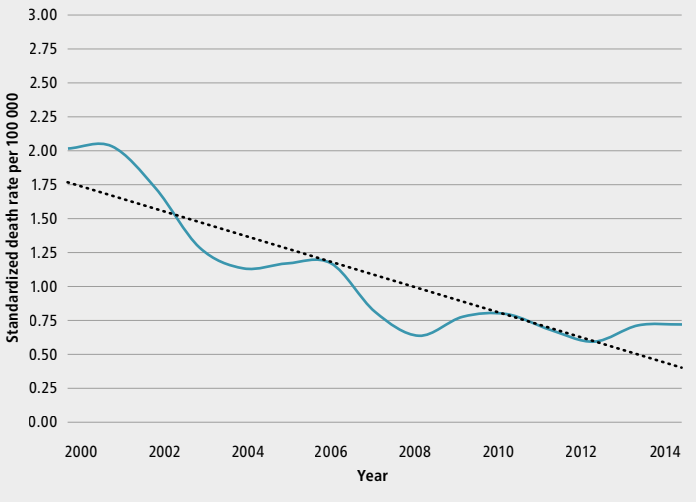
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	NO	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	NO	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Target:* 282 to 250 injuries from domestic violence in time span 2009–2014. [b] *Government agencies:* State Inspectorate for Protection of Childrens Rights under the Ministry of Welfare; Child Affairs Cooperation Council, the Ministry of Interior; State Police. [c] *Standardized instrument:* Adverse Childhood Experiences Study Questionnaire (ACE). [d] *Sources:* police data; Management Information System; 2011, Adverse childhood experiences of young adults in Latvia (five Latvian cities) – study report from the 2011 survey.

Population 2 890 297 | Gross national income per capita US$ 15 200 | Income group High

LITHUANIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES[b]

Representative survey	
Survey on child maltreatment	YES[b]
Standardized instruments/methods	YES[c]
Prevalence	—
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–9 (V)	2016
Hospital admissions	6	0–9 (V)	2016
Violent assaults hospital admissions	24	0–9 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[e]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① ② ③ **❹**
School-based antibullying	YES	① ② ③ **❹**

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

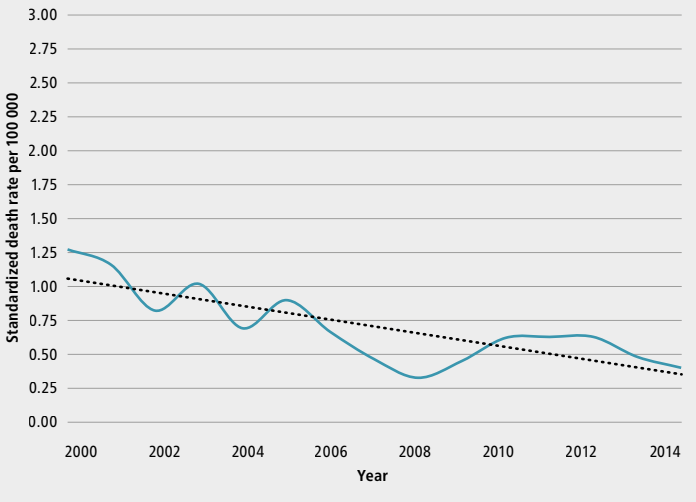
		Enforcement
Ban on corporal punishment in all settings	YES	① ② **❸** ④
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② **❸**
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Institution of the Ombudsman for Children Rights; Ministry of Social Security and Labour; Committee of Social Affairs and Labour of the Seimas (Parliament); State Child Rights Protection and Adoption Services under the Ministry of Social Security and Labour; child rights services of relevant municipality administrations; Intersectoral Council of Child Well-being. [b] Subnational. [c] *Standardized instrument:* Adverse Childhood Experiences Study Questionnaire (ACE). [d] *Sources:* vital registration data; compulsory health insurance information system; hospital discharge data. [e] *Programmes:* Olweus (school-based antibullying).

Population 583 455 | Gross national income per capita US$ 70 260 | Income group High

LUXEMBOURG

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	NO
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES[a]

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2015
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ❷ ③ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

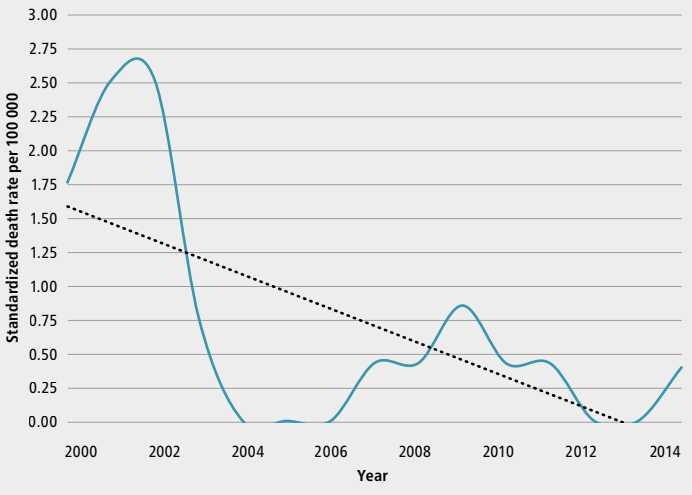
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Subnational. [b] *Government agencies:* Ministry of Health; School of Medicine, Ministry of Education; Ministry of Justice; interministerial collaboration and working groups; National Office for Children & Social Association for Paediatrics in Luxembourg. [c] *Sources:* statsitics on causes of death since 1995; Trauma in Luxembourg (RETRACE): analysis of hospital data for 2013 and the register of causes of death; extract from the statistics on causes of death for 2015; Mortality in Luxembourg: historical evolution, current situation and future prospects of the national mortality surveillance system [translated from French]. [d] *Programmes:* Kidpower (primary school-based empowering children); KiVa (school-based antibullying).

Population 430 835 | Gross national income per capita US$ 23 810 | Income group High

MALTA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	NO

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2012–2016
Hospital admissions	2	0–10 (V)	2015
Violent assaults hospital admissions	2	0–10 (V)	2015
Contacts with child protection agency	403	0–18 (V)	2016
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

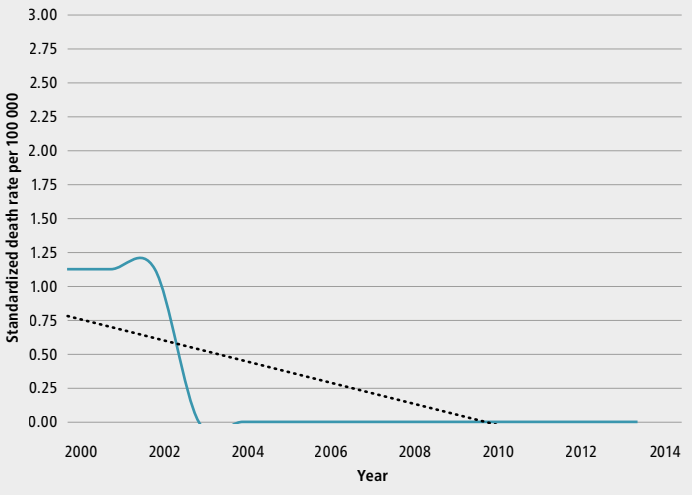
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	NO	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* Ministry of Health; Ministry of Education and Employment; Ministry for the Family, Children's Rights and Social Solidarity.
[b] *Source:* vital registration data. [c] *Programmes:* Triple P, Incredible Years (parenting education).

Population 628 960

Gross national income per capita US$ 7 350

Income group Middle

MONTENEGRO

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	YES[a]
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–18 (V)	2016
Hospital admissions	0	0–18 (V)	2016
Violent assaults hospital admissions	0	0–10 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[e]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① ② ③ **❹**
School-based antibullying	YES	① **❷** ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

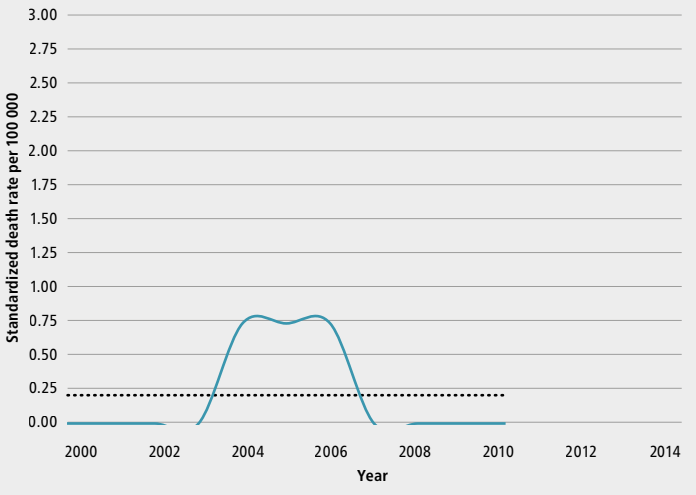
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① **❷** ③
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Target:* 20% reduction of children exposed to domestic violence by 2021. [b] *Government agencies:* Ministries of: Labour and Social Welfare; Health; Education; Human and Minority Rights; Culture; Sports; Internal Affairs; and Justice. Ministry of Health Focal Point for Prevention of Injuries and Violence. Directorates for: Social Welfare and Child Protection; Health Care; Quality Control and Strengthening of Human Resources in Health Care; Preschool and Primary Education and the Education and Training of People with Special Educational Needs; General Secondary and Adult Education; and Youth. Councils for: Child Rights Advice; Social Advice; and Gender Equality. National Office for Combating Trafficking in Human Beings; Police Administration; centres for social work; Public Health Institute. [c] *Standardized instruments:* Juvenile Victimization Questionnaire (JVQ); Adverse Childhood Experiences Study Questionnaire (ACE); Short Child Maltreatment Questionnaire. [d] *Sources:* vital registration data; Institute for Public Health. [e] *Programmes:* nurse–family partnerships, Step Towards Effective Enjoyable Parenting (home visiting); Triple P, Adults and Children Together Against Violence (parenting education); Kidpower (primary school-based empowering children); Olweus (school-based antibullying).

Population 17 035 938 | Gross national income per capita US$ 46 180 | Income group High

NETHERLANDS

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES[a]

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	—
Hospital admissions	—
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	YES
Incidence	—
Survey on child mental well-being	NO

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	4 255	0–18 (V)	2017
Prevalence of child maltreatment (%)	19%	0–18 (V)	1 year
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② **❸** ④
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① **❷** ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

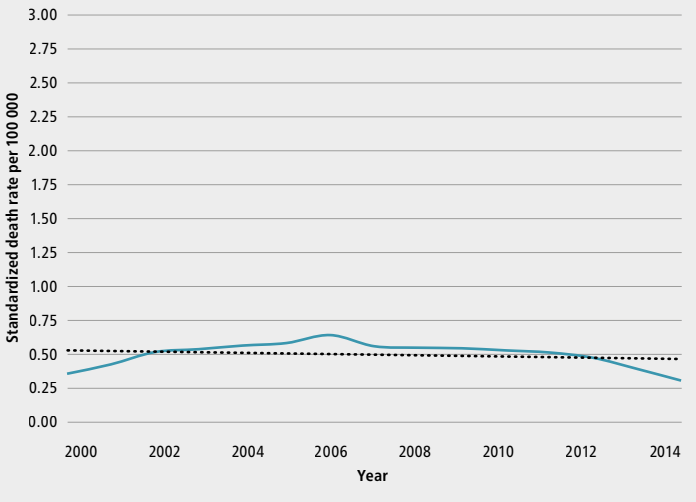
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	NO	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

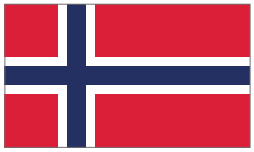
Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data collected from questionnaire

[a] Subnational. [b] *Government agencies:* Ministry of Welfare; Ministry of Health; Ministry of Safety and Justice; Dutch Youth Institute; Augeo Foundation. [c] *Source:* 2010, Child abuse [Kindermishandeling].
[d] *Programmes:* nurse–family partnerships (home visiting); Triple P, Incredible Years (parenting education); Kidpower (primary school-based empowering children); Olweus (school-based antibullying).



Population 5 305 383

Gross national income per capita US$ 75 990

Income group High

NORWAY

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES[a]

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	NO
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–9 (V)	2015
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	58 254	0–22 (V)	2016
Prevalence of child maltreatment (%)	Physical: girls 4.9%; boys 5.1%, Sexual: girls 10.2%; boys 3.5%	0–13 (sexual) (V), 0–18 (physical) (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ❷ ③ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

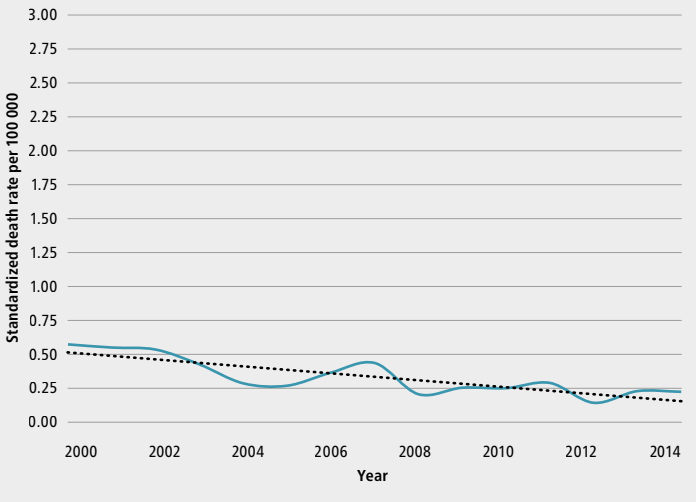
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health and Care Services

[a] Subnational. [b] *Government agencies:* Ministry of Children and Equality; Ministry of Health and Care Services; Ministry of Education; Ministry of Justice and Public Security.
[c] *Sources:* Register of Causes of Death; Statistics Norway – child welfare; 2015, Thoresen et al. Violence against children, later victimisation, and mental health: a cross-sectional study of the general Norwegian population. Euro J Psychotraumatol. 6(1):PMC4296052. [d] *Programmes:* nurse–family partnerships (home visiting); Olweus (school-based antibullying).

Population 38 170 712 | Gross national income per capita US$ 12 710 | Income group High

POLAND

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	YES[a]
Funds to implement	FULLY

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	NO
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	YES
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	20	0–18 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	46 969	0–18 (V)	2015
Prevalence of child maltreatment (%)	19.8%	0–18 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ③ ❹
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

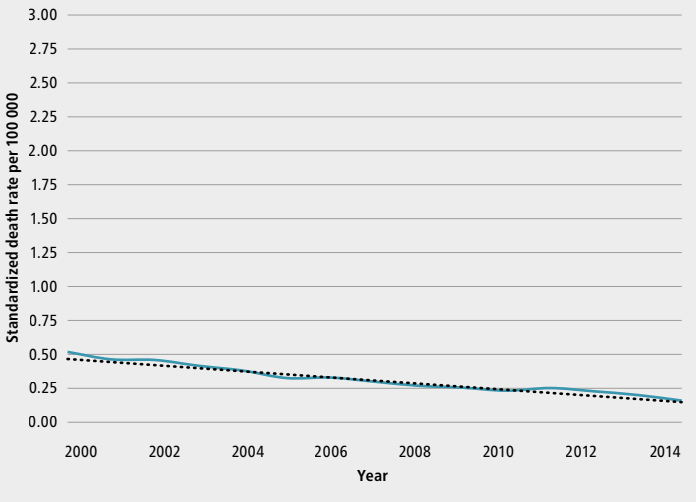
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Target:* reduction in violent experiences for children from 39% in 2011 to 31% in 2020.
[b] *Government agencies:* Ministry of Justice; Ministry of Family, Labour and Social Policy; Ministry of Health; monitoring team for matters connected with violence in the family; Ombudsman for Children.
[c] *Sources:* police records; Ministry of Labour and Social Policy; Statistical Office of Poland. [d] *Programmes:* Triple P (parenting education).

Population 10 329 506 | Gross national income per capita US$ 19 820 | Income group High

PORTUGAL

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULLY

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	NO
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	30 400	0–19 (V)	2015
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	13.3	0–19 (V)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② **❸** ④
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② ③ **❹**

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

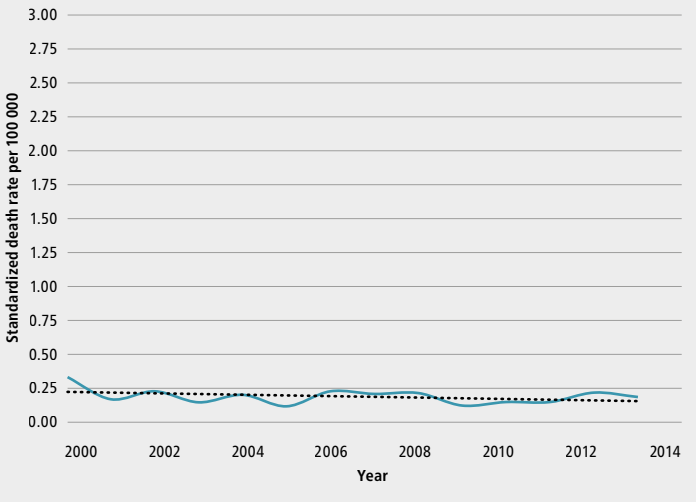
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② **❸**
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Health; General Prosecutor of the Portugese Republic; National Commission for the Protection of Children and Young Persons and the Promotion of their Rights. [b] *Sources:* judicial records; evaluation of the activity of children and youth protection committees; 2015, Dias et al. Child maltreatment and psychological symptoms in a Portuguese adult community sample: the harmful effects of emotional abuse. Eur Child Adolesc Psychiatry 24(7):767–78; 2015, National Commission for the Promotion of Protection of Children and Young People. [c] *Programmes:* nurse–family partnerships, Early Head Start (home visiting).

Population 4 051 212 | Gross national income per capita US$ 2 180 | Income group Middle

REPUBLIC OF MOLDOVA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	—
Incidence	—
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1 313	0–18 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	1 223	0–18 (V)	2016
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① **❷** ③ ④
Hospital-based parental training (abusive head trauma)	YES	① ② **❸** ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② **❸** ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

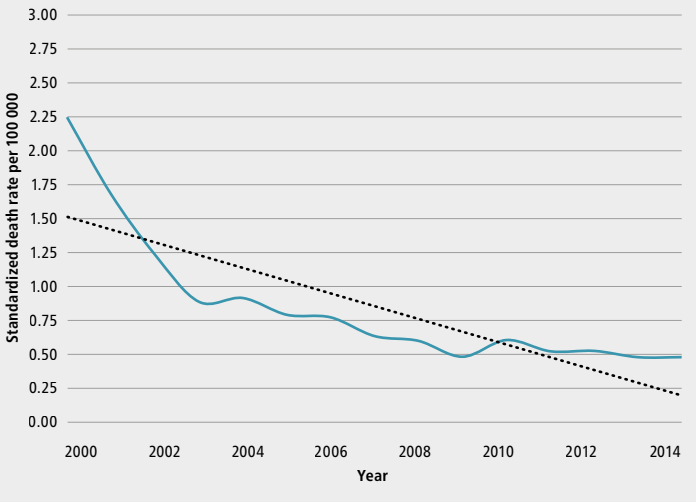
		Enforcement
Ban on corporal punishment in all settings	YES	① ② **❸** ④
Against statutory rape	YES	① ② **❸** ④
Against child marriage	YES	① ② **❸** ④
Against female genital mutilation	YES	① ② **❸** ④
Reporting of suspected child maltreatment	YES	① ② **❸** ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* National Council for the Protection of the Rights of the Child.
[b] *Sources:* police records; health facility records; Ministry of Health, Labour and Social Protection.
[c] *Programmes:* Stay Safe (primary school-based empowering children).

Population 19 679306 | Gross national income per capita US$ 9 970 | Income group Middle

ROMANIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	National Authority for the Protection of the Rights of the Child and Adoption
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	—

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	1–4 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	121	0–18 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Emotional: 3–5%, Verbal: 16%, Physical: 62%, Sexual: 1–3%, Neglect: 8–18%, Exploitation: 2–8%	0–18 (V)	2012
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ❷ ③ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ❷ ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

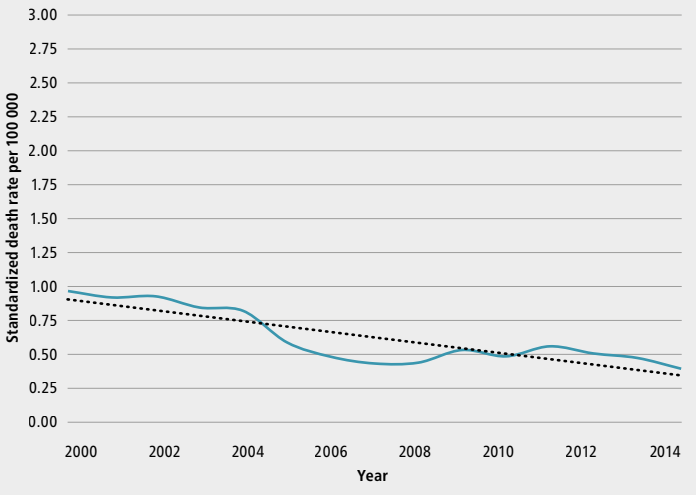
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)

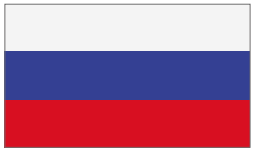


Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Subnational. [b] *Sources:* police records; vital registration.

[c] *Programmes:* nurse–family partnerships (home visiting); Triple P (parenting education); Kidpower (primary school-based empowering children); KiVa, Olweus (school-based antibullying).



Population 143 989 754 | Gross national income per capita US$ 9 230 | Income group Middle

RUSSIAN FEDERATION

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	—
Hospital admissions	—
Contact with child protection agency	—

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	—

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Emotional: 37.9%, Physical: 14%, Sexual: 5.7%, Neglect (physical): 53.3%, Neglect (emotional): 57.9%	0–18 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	—	—
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② **❸** ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

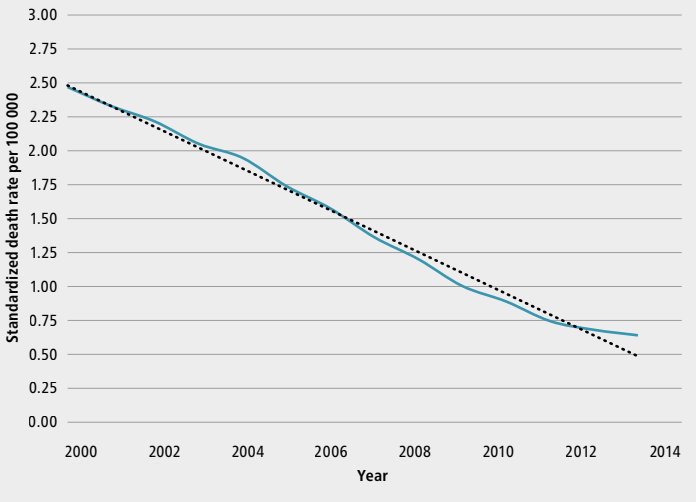
		Enforcement
Ban on corporal punishment in all settings	NO[e]	—
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	NO	**❶** ② ③
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	NO	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Health; Ministry of Education and Science; federal and regional interdepartmental commissions on the prevention of cruel treatment of children; State Duma Expert Council on improving legislation on child safety and creating a friendly environment for their development; Council on Problems of Drug Addiction Prevention; Interdepartmental Commission for Forensic Expert Activities; ombudsmen for children's rights.
[b] *Standardized instrument:* Adverse Childhood Experiences Study Questionnaire (ACE). [c] *Sources:* 2014, Survey on the prevalence of adverse childhood experiences among young people in the Russian Federation.
[d] *Programmes:* Triple P (parenting education). [e] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 33 400

Gross national income per capita —

Income group High

SAN MARINO

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES
Prevalence	NO
Incidence	YES
Survey on child mental well-being	NO

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–18 (V)	2016
Hospital admissions	1	0–18 (V)	2016
Violent assaults hospital admissions	0	0–10 (V)	2016
Contacts with child protection agency	19	0–18 (V)	2016
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	3.8	0–18 (V)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	NO	—
Hospital-based parental training (abusive head trauma)	YES	① **❷** ③ ④
Primary school-based empowering children	YES	① **❷** ③ ④
School-based antibullying	YES	① ② **❸** ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

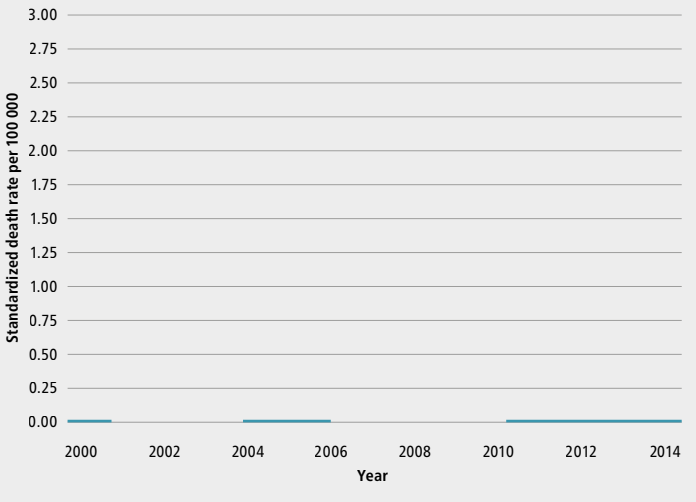
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ **❹**
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② **❸**
Prenatal risk assessment of intimate-partner violence	YES	① ② **❸**
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Health Authority

[a] *Government agencies:* Equal Opportunities Authority; UOS Protection of Minors; UOC Paediatrics; UOS Women's Health; police; Guardia di Rocca; Department of Foreign Affairs, Adoption Service; Health Authority [translated from Italian].

[b] *Sources:* health facility records; Institute for Social Security; UOC Minors Service.

Population 8 790 574 | Gross national income per capita US$ 5 180 | Income group Middle

SERBIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[b]
Systematic information exchange between stakeholders	NO

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[c]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	NO

Summary of child maltreatment data[d]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–9 (V)	2016
Hospital admissions	0	0–9 (V)	2016
Violent assaults hospital admissions	0	0–9 (V)	2016
Contacts with child protection agency	6965	0–18 (V)	2016
Prevalence of child maltreatment (%)	Psychological: 36.7%, Sexual: 4.3%, Neglect (physical): 8.9%	0–18 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	Psychological: 596, Physical: 464, Sexual: 62, Neglect: 228	11–16 (R)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

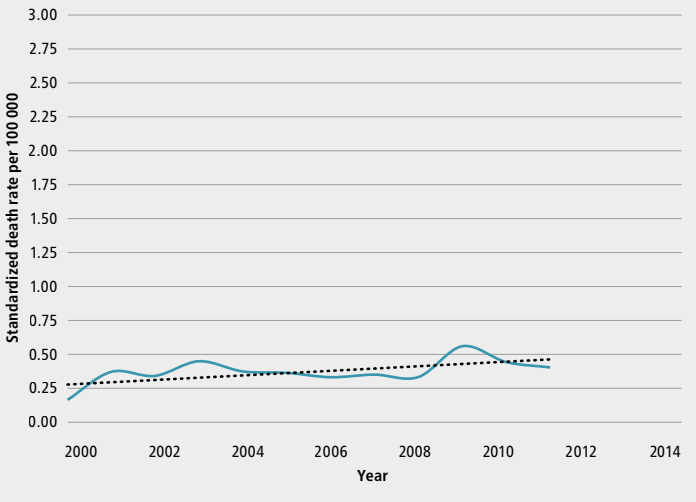
		Enforcement
Ban on corporal punishment in all settings	NO[e]	① ② ❸ ④
Against statutory rape	YES	① ② ❸ ④
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	YES	① ❷ ③
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Subnational. [b] *Government agencies:* Ministry of Health; Ministry of Education; Ministry of Internal Affairs; Ministry of Justice; Ministry of Labour and Social Welfare; Social Welfare System; Ombudsman; Council for Child Rights. [c] *Standardized instruments:* ISPCAN Child Abuse Screening Tool (ICAST); Adverse Childhood Experiences Study Questionnaire (ACE). [d] *Sources:* police records; health facility records; vital registration data; 2011, Balkan Epidemiological Study on Child Abuse and Neglect; 2015, Survey of adverse childhood experiences among Serbian university students; 2016, Report on the work of centres for social work. [e] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 5 447 662 | Gross national income per capita US$ 16 610 | Income group High

SLOVAKIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	National Coordination Centre for Resolving Issues of Violence against Children (Ministry of Labour, Social Affairs and Family)
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	—
Hospital admissions	—
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	NO
Prevalence	—
Incidence	—
Survey on child mental well-being	YES

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	—	—
Parenting education	YES	① **❷** ③ ④
Hospital-based parental training (abusive head trauma)	—	—
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② ③ **❹**

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

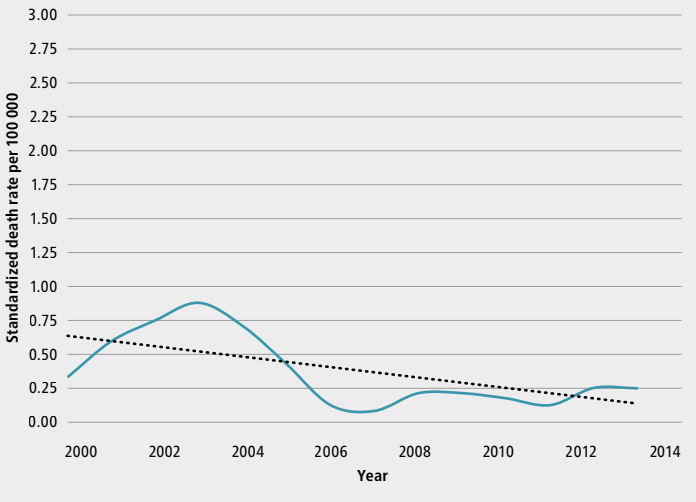
		Enforcement
Ban on corporal punishment in all settings	NO[a]	① ② ③ **❹**
Against statutory rape	YES	① ② **❸** ④
Against child marriage	YES	① ② **❸** ④
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	—	—
Prenatal risk assessment of intimate-partner violence	—	—
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source*: WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Does not cover: home. Covers: alternative care settings, day care, schools, penal institutions.

Population 2 079 976 | Gross national income per capita US$ 22 000 | Income group High

SLOVENIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES[b]

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	0–10 (V)	2016
Hospital admissions	1	0–10 (V)	2016
Violent assaults hospital admissions	1	0–10 (V)	2016
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② ③ **❹**
Hospital-based parental training (abusive head trauma)	YES	① ② **❸** ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② **❸** ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

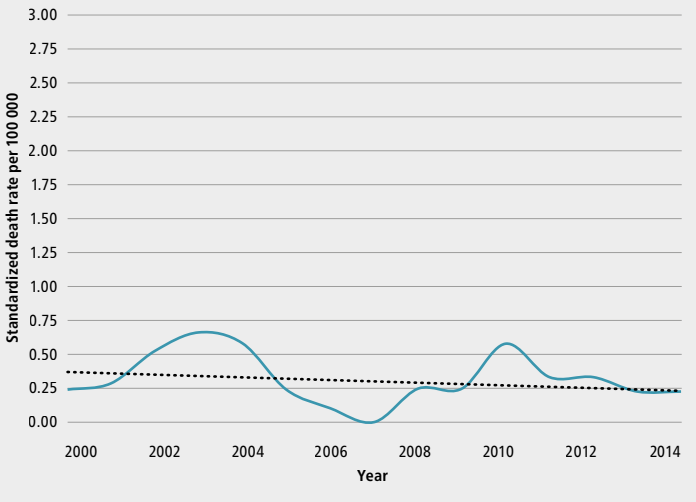
		Enforcement
Ban on corporal punishment in all settings	YES	① **❷** ③ ④
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② **❸** ④
Against female genital mutilation	YES	① ② ③ **❹**
Reporting of suspected child maltreatment	YES	① ② **❸** ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	YES	① **❷** ③
Identification of victims and referral for support by health-care providers	YES	① ② **❸**
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	NO	
Prenatal risk assessment of intimate-partner violence	NO	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	NO	
Child protection services for victims	NO	
Medicolegal services for victims	NO	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by National Institute of Public Health

[a] *Government agencies:* Ministry for Labour, Family, Social Affairs and Equal Opportunities; Family Directorate; Social Protection Institute; police.
[b] Subnational. [c] *Sources:* vital registration data. [d] *Programmes:* Incredible Years (parenting education).

Population 46 354 321

Gross national income per capita US$ 27 180

Income group High

SPAIN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	12	0–13 (V)	2016
Hospital admissions	99	0–9 (V)	2015
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	42 628	0–17 (V)	2015
Prevalence of child maltreatment (%)	4.3%	8–17 (V)	2006
Incidence of child maltreatment (per 1 000)	2.16	0–17 (V)	1 year

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ❸ ④
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

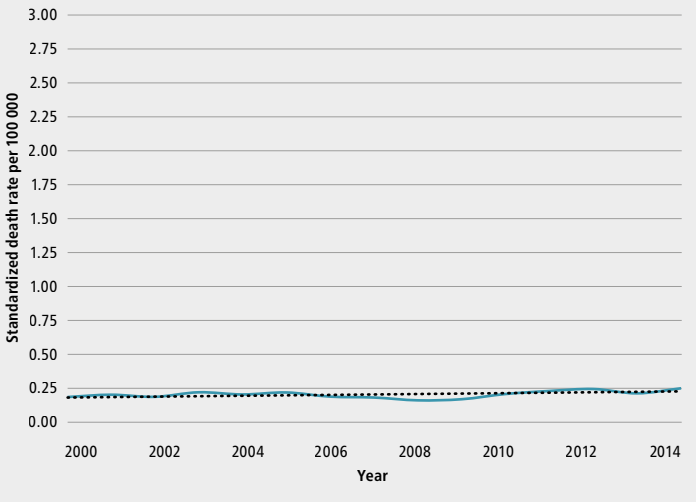
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* The Childhood Observatory, under the General Directorate for Services to Families and Childhood, Ministry of Health, Social Services and Equality; all ministries with competence in the field of childhood; regional and local childhood authorities [translated from Spanish]. [b] *Sources:* police records; Data and Statistics Security System of the Ministry of the Interior [translated from Spanish].
[c] *Programmes:* nurse–family partnerships (home visiting); Triple P (parenting education); KiVa (school-based antibullying).

Population 9 910 701 | Gross national income per capita US$ 52 590 | Income group High

SWEDEN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	PARTIAL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES[b]

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	YES
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	0–9 (V)	2016
Hospital admissions	20	0–9 (V)	2015
Violent assaults hospital admissions	23	0–9 (V)	2015
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	23.7%	0–17 (V)	2016
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

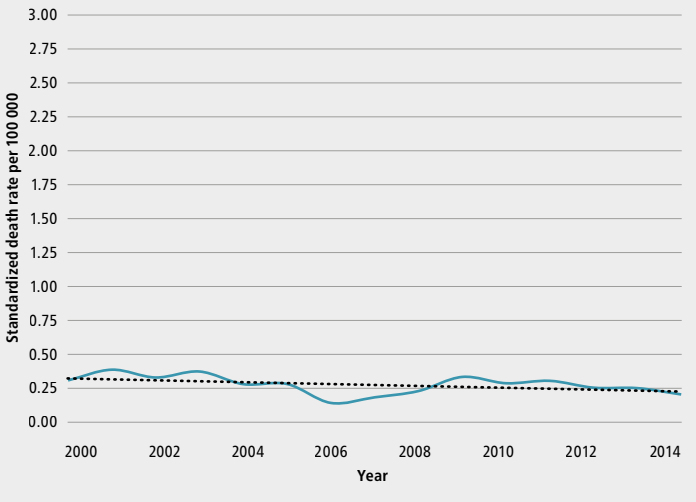
		Enforcement
Ban on corporal punishment in all settings	YES	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	—	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	—	
Child protection services for victims	YES	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health and Social Affairs

[a] *Government agencies:* Ministry of Health and Welfare; Ministry of Education; Ministry of Justice; Barnafrid (National Knowledge Centre on Violence against Children). [b] Subnational.
[c] *Sources:* Register of Deaths; National Council for Crime Prevention. [d] *Programmes:* nurse–family partnerships (home visiting); Triple P, Incredible Years, Adults and Children Against Violence (parenting education).

Population 8 476 005 | Gross national income per capita US$ 80 560 | Income group High

SWITZERLAND

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	Federal Social Insurance Office
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	YES
Hospital admissions	YES
Contact with child protection agency	NO

Representative survey	
Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	51	0–18 (V)	2015
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Sexual: girls 22%; boys 8%	13–19 (R)	Lifetime
Incidence of child maltreatment (per 1 000)	Psychological: 0.79; Physical: 0.83; Sexual: 0.62; Neglect: 0.92; Witnessing intimate-partner violence: 0.77	0–18 (V)	Three months

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[d]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

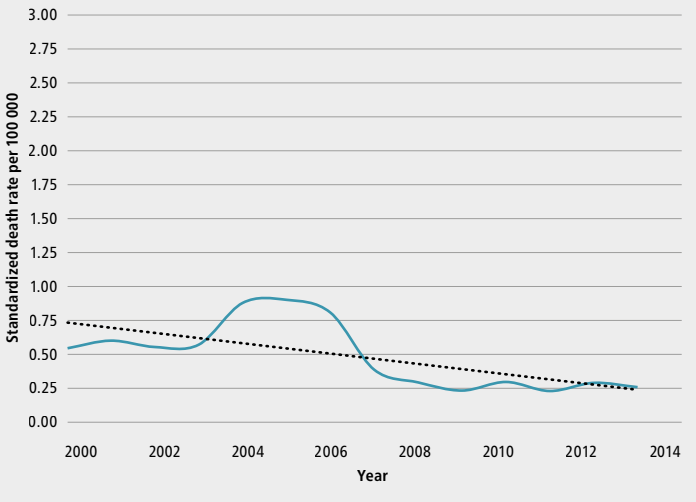
		Enforcement
Ban on corporal punishment in all settings	NO[e]	① ② ❸ ④
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ② ③ ❹
Reporting of suspected child maltreatment	—	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	NO	—
Response to child maltreatment		
Mental health services for victims	NO	—
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	—	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] Subnational. [b] *Standardized instrument:* Juvenile Victimization Questionnaire (JVQ). [c] *Sources:* vital registration data; 2011, Sexual victimization of children and adolescents in Switzerland: final report for the UBS Optimus Foundation. 2018, Child endangerment in Switzerland. [d] Programmes: Triple P (parenting education); Olweus (school-based antibullying). [e] Does not cover: home and alternative care settings. Covers: day care, schools, penal institutions.

Population 8 921 343 | Gross national income per capita US$ 990 | Income group Low

TAJIKISTAN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES[a]
Child maltreatment protection	YES[a]
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	Ombudsman for the Rights of the Child under the Government of the Republic of Tajikistan
Systematic information exchange between stakeholders	NO

Characteristics of national plan for child maltreatment prevention

Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	—
Hospital admissions	NO
Contact with child protection agency	—

Representative survey

Survey on child maltreatment	YES[a]
Standardized instruments/methods	—
Prevalence	NO
Incidence	—
Survey on child mental well-being	NO

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	—	—
Parenting education	YES	① ❷ ③ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	—	—
School-based antibullying	—	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

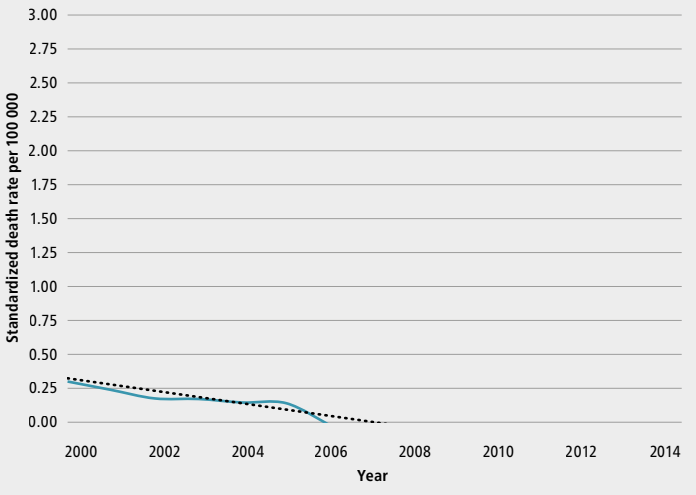
		Enforcement
Ban on corporal punishment in all settings	NO[c]	① ❷ ③ ④
Against statutory rape	—	—
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	YES	① ② ❸ ④
Reporting of suspected child maltreatment	—	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		Implementation
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	YES	① ❷ ③
Response to child maltreatment		
Mental health services for victims	YES	① ❷ ③
Child protection services for victims	YES	① ❷ ③
Medicolegal services for victims	YES	① ❷ ③
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	—	
Mental health services for victims	—	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] Subnational.
[b] *Programmes:* Adults and Children Against Violence (parenting education).
[c] Does not cover: home, alternative care settings, day care, penal institutions. Covers: schools.

Population 2 083 160

Gross national income per capita US$ 4 880

Income group Middle

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	FULL

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	YES

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	—
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	YES
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	0	0–10 (V)	2016
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	27	5–18 (V)	2016
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ **❹**
Parenting education	YES	① ② ③ **❹**
Hospital-based parental training (abusive head trauma)	YES	① ② **❸** ④
Primary school-based empowering children	YES	① ② **❸** ④
School-based antibullying	YES	① ② **❸** ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

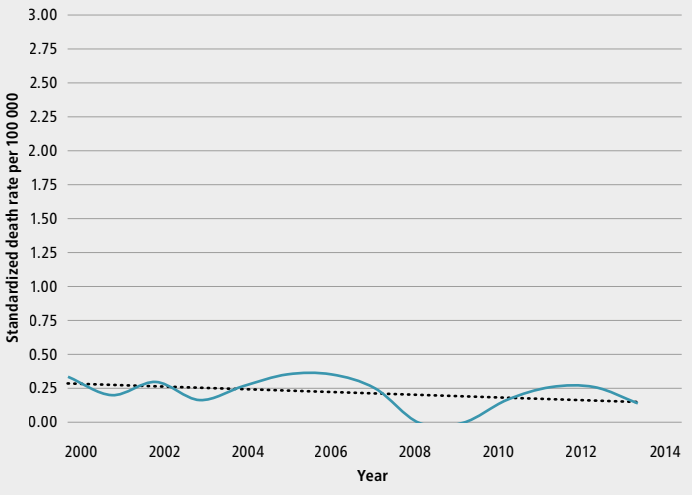
		Enforcement
Ban on corporal punishment in all settings	YES	① **❷** ③ ④
Against statutory rape	YES	① ② **❸** ④
Against child marriage	YES	① ② ③ **❹**
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ③ **❹**

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① **❷** ③
Prenatal risk assessment of intimate-partner violence	YES	① **❷** ③
Identification of victims and referral for support by health-care providers	YES	① **❷** ③
Response to child maltreatment		
Mental health services for victims	YES	① ② **❸**
Child protection services for victims	YES	① ② **❸**
Medicolegal services for victims	YES	① ② **❸**
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Social Policy; Ministry of Health; Ministry of Justice; Ministry of Interior; Ministry of Education; Ombudsman; nongovernmental organizations; WHO; United Nations Children's Fund; United Nations Population Fund; National Coordinating Body on Protection of Child Abuse and Neglect; National Coordinating Body for Prevention and Protection of Domestic Violence; National Coordinating Body of the Government of the Republic of Macedonia. [b] *Standardized instruments:* ISPCAN Child Abuse Screening Tool (ICAST); Adverse Childhood Experiences Study Questionnaire (ACE). [c] *Sources:* police records; health facility records; vital registration data; 2013, Balkan Epidemiological Study on Child Abuse and Neglect.

Population 80 745 020 | Gross national income per capita US$ 10 930 | Income group Middle

TURKEY

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans	
Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention	
Lead agency	Ministry of Family and Social Affairs, Child Services General Directorate
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention	
Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment	
Deaths	—
Hospital admissions	—
Contact with child protection agency	YES[a]

Representative survey	
Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[b]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	Emotional: 1%, Sexual: 14.7%, Neglect (Emotional): 4.7%	0–18 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[c]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ③ ❹
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ② ③ ❹
School-based antibullying	YES	① ② ③ ❹

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

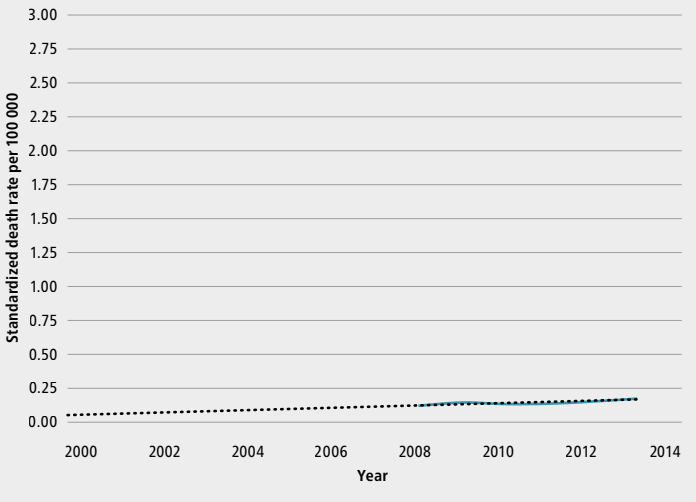
		Enforcement
Ban on corporal punishment in all settings	NO[d]	① ② ③ ❹
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ③ ❹

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] Subnational. [b] *Source:* 2014, Bellis et al. Adverse childhood experiences and associations with health-harming behaviours in young adults: surveys in eight eastern European countries. Bull World Health Organ. 92(9):641–55.
[c] *Programmes:* nurse–family partnerships (home visiting). [d] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 44 222 947 | Gross national income per capita US$ 2 390 | Income group Middle

UKRAINE

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	NO

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	NO

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	NO
is a risk for developing health-risk behaviours	NO
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	NO
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	YES	① ❷ ③ ④
School-based antibullying	NO	—

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

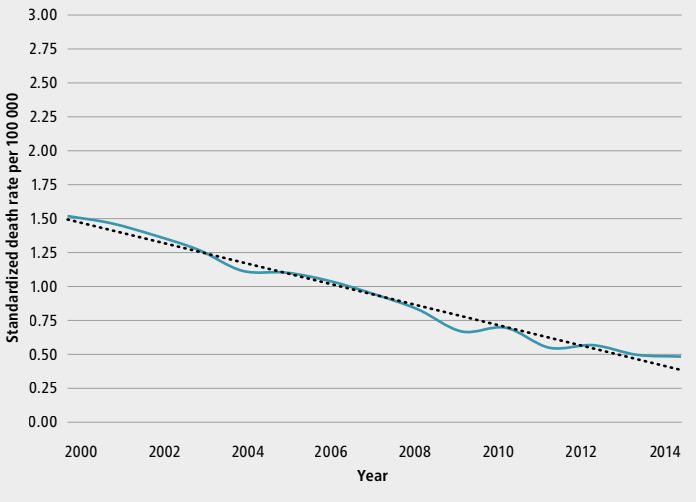
		Enforcement
Ban on corporal punishment in all settings	YES	❶ ② ③ ④
Against statutory rape	YES	① ❷ ③ ④
Against child marriage	YES	① ② ❸ ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	YES	① ② ❸ ④

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

		Implementation
Detection of child maltreatment		
Prenatal risk assessment of child maltreatment	YES	① ❷ ③
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	NO	—
Medicolegal services for victims	NO	—
Capacity development		
Prenatal risk assessment of child maltreatment	—	
Prenatal risk assessment of intimate-partner violence	—	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	—	
Medicolegal services for victims	—	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Department of Adoption and Child Protection, Ministry of Social Policy; Ministry of Interior; National Police of Ukraine; Ministry of Education and Science; Ministry of Health; Regional Commission for Child Protection; Interministerial Commission for Child Protection. [b] *Programmes:* Triple P (parenting education).

Population 66 181 585 | Gross national income per capita US$ 40 530 | Income group High

UNITED KINGDOM

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	YES
Child maltreatment protection	YES
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	NO
Funds to implement	FULLY

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	YES
is a risk for developing health-risk behaviours	YES
is a risk factor for noncommunicable diseases	NO

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	YES
Hospital admissions	YES
Contact with child protection agency	YES

Representative survey

Survey on child maltreatment	YES
Standardized instruments/methods	YES[b]
Prevalence	YES
Incidence	NO
Survey on child mental well-being	YES

Summary of child maltreatment data[c]

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	1	0–9 (V)	2015
Hospital admissions[d]	658	0–9 (V)	2015/2016
Violent assaults hospital admissions[e]	874	0–9 (V)	2015/2016
Contacts with child protection agency[f]	621 470	0–18 (V)	2015/2016
Prevalence of child maltreatment (%)	a) 8.9% b) 21.9%	a) 0–10 b) 11–17 (V)	Lifetime
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[g]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② ③ ❹
Parenting education	YES	① ② ❸ ④
Hospital-based parental training (abusive head trauma)	YES	① ② ❸ ④
Primary school-based empowering children	YES	① ② ❸ ④
School-based antibullying	YES	① ② ❸ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

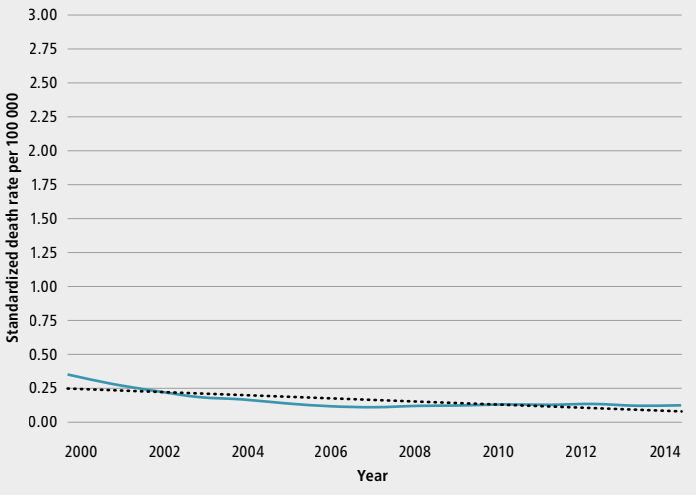
		Enforcement
Ban on corporal punishment in all settings	NO[h]	① ② ❸ ④
Against statutory rape	YES	① ② ③ ❹
Against child marriage	YES	① ② ③ ❹
Against female genital mutilation	YES	① ❷ ③ ④
Reporting of suspected child maltreatment	NO	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	YES	① ② ❸
Prenatal risk assessment of intimate-partner violence	YES	① ② ❸
Identification of victims and referral for support by health-care providers	YES	① ② ❸
Response to child maltreatment		
Mental health services for victims	YES	① ② ❸
Child protection services for victims	YES	① ② ❸
Medicolegal services for victims	YES	① ② ❸
Capacity development		
Prenatal risk assessment of child maltreatment	YES	
Prenatal risk assessment of intimate-partner violence	YES	
Identification of victims and referral for support by health-care providers	YES	
Mental health services for victims	YES	
Child protection services for victims	YES	
Medicolegal services for victims	YES	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

[a] *Government agencies:* ENGLAND: Department for Education, Department of Health, Home Office, Ministry of Justice, Department of Communities and Local Government; NORTHERN IRELAND: Department of Health (Health and Social Care Board, Department of Education, Department of Justice). SCOTLAND: Directorate for Children and Families; WALES: Welsh Government, Social Services, Public Health Wales, National Safeguarding Team. [b] *Standardized instruments:* Juvenile Victimization Questionnaire (JVQ); Adverse Childhood Experiences Study Questionnaire (ACE). [c] *Sources:* National Statistics, Hospital Inpatient System; ISD SMR01 General/acute inpatient and daycase; Patient Episode Database for Wales; NHS Wales Informatics Service; vital statistics; death registers; 2015/2016, Children's social work statistics for Scotland; 2015/2016, Children's social care statistics for Northern Ireland; 2016, characteristics of children in need; 2016, local authority child protection registers in Wales. [d] *Hospital admissions:* England: 582; Northern Ireland: < 5; Scotland: 40; Wales: 31. [e] *Violent assaults hospital admissions:* England: 771; Northern Ireland: 5; Scotland: 51; Wales: 47. [f] *Contacts with child protection agencies:* referrals (England: 33 536; Northern Ireland: 34 124; Scotland: not available; Wales: 33 536). New registrations (England 6 310; Northern Ireland: 2 040; Scotland 4 265; Wales: 4 400). [g] *Programmes:* nurse–family partnerships (home visiting); Triple P, Incredible Years (parenting education); KiVa (school-based antibullying). [h] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

Population 31 910 641 | Gross national income per capita US$ 1 980 | Income group Middle

UZBEKISTAN

Key: No response/not applicable —; YES; NO

POLICY LANDSCAPE

National action plans

Child maltreatment prevention	NO
Child maltreatment protection	NO
Noncommunicable disease prevention	YES

Government coordination of child maltreatment prevention

Lead agency	MULTIPLE[a]
Systematic information exchange between stakeholders	YES

Characteristics of national plan for child maltreatment prevention

Measurable targets	—
Funds to implement	—

Recognizes that child maltreatment:	
co-exists with other adverse childhood experiences	—
is a risk for developing health-risk behaviours	—
is a risk factor for noncommunicable diseases	—

SURVEILLANCE AND MONITORING

Available data on child maltreatment

Deaths	NO
Hospital admissions	NO
Contact with child protection agency	NO

Representative survey

Survey on child maltreatment	NO
Standardized instruments/methods	—
Prevalence	NO
Incidence	NO
Survey on child mental well-being	NO

Summary of child maltreatment data

	Frequency	Age of victims (V) and respondents (R)	Observation time/year
Deaths	—	—	—
Hospital admissions	—	—	—
Violent assaults hospital admissions	—	—	—
Contacts with child protection agency	—	—	—
Prevalence of child maltreatment (%)	—	—	—
Incidence of child maltreatment (per 1 000)	—	—	—

IMPLEMENTATION OF PREVENTION PROGRAMMES AND RESPONSE SERVICES

Primary prevention programmes for child maltreatment[b]

Key: No/don't know ❶ One/few times ❷ Several times multiple areas ❸ Larger scale ❹

		Implementation
Home visiting	YES	① ② **❸** ④
Parenting education	YES	① ② **❸** ④
Hospital-based parental training (abusive head trauma)	NO	—
Primary school-based empowering children	NO	—
School-based antibullying	YES	① **❷** ③ ④

Child maltreatment laws

Key: Not enforced/don't know ❶ Limited ❷ Largely ❸ Full ❹

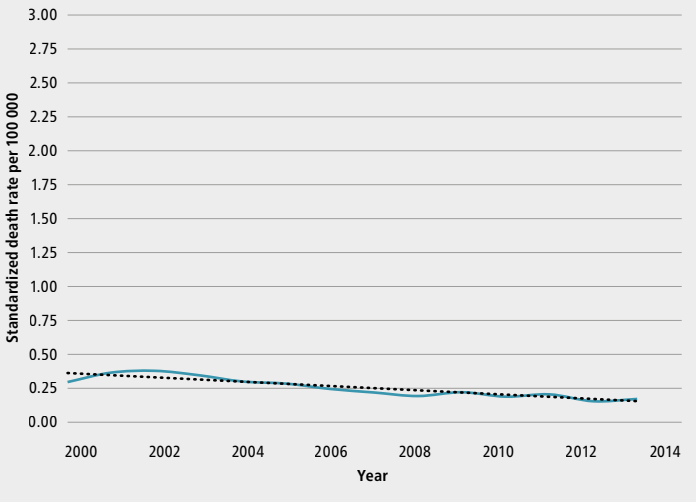
		Enforcement
Ban on corporal punishment in all settings	NO[c]	—
Against statutory rape	YES	① ② ③ **❹**
Against child marriage	YES	① ② **❸** ④
Against female genital mutilation	NO	—
Reporting of suspected child maltreatment	NO	—

Health and social services

Key: No/don't know ❶ Once/few times ❷ Larger scale ❸

Detection of child maltreatment		**Implementation**
Prenatal risk assessment of child maltreatment	NO	—
Prenatal risk assessment of intimate-partner violence	NO	—
Identification of victims and referral for support by health-care providers	NO	—
Response to child maltreatment		
Mental health services for victims	YES	① **❷** ③
Child protection services for victims	NO	—
Medicolegal services for victims	YES	① **❷** ③
Capacity development		
Prenatal risk assessment of child maltreatment	NO	
Prenatal risk assessment of intimate-partner violence	NO	
Identification of victims and referral for support by health-care providers	NO	
Mental health services for victims	YES	
Child protection services for victims	NO	
Medicolegal services for victims	NO	

Trends in child homicide (0–14 years)



Three-year moving averages. *Source:* WHO European Detailed Mortality Database.

Data cleared by Ministry of Health

[a] *Government agencies:* Ministry of Interior; Ministry of Health.
[b] *Programmes:* nurse–family partnerships (home visiting); Triple P (parenting education).
[c] Does not cover: home, alternative care settings, day care. Covers: schools, penal institutions.

EUROPEAN STATUS REPORT
ON PREVENTING
CHILD MALTREATMENT

Annexes

Annex 1. Definitions

The 2002 World report on violence and health *(1)* defines child abuse and neglect as:

> all forms of physical and/or emotional or sexual abuse, deprivation and neglect of children or commercial or other exploitation resulting in harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

The report and the WHO consultation on child abuse prevention of 1999 *(2)* identify four types of child maltreatment:

- physical abuse
- sexual abuse
- emotional and psychological abuse
- neglect.

Physical abuse

Physical abuse is defined as the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning and suffocating. There is evidence that a great proportion of physical violence against children in the home is inflicted with the object of punishing. The most common reason for physical abuse is corporal punishment as a disciplinary measure in the so-called education of the child.

Physical abuse also includes the act of deliberately causing symptoms of disease in the child by parents, guardians or other adults responsible for the child (the so-called Munchausen syndrome by proxy) *(1,2)*.

Sexual abuse

Sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else violates the laws or norms of society. Children can be sexually abused by adults and other children who are – by virtue of their age (five or more years older) or stage of development – in a position of responsibility, trust or power over the victim. This may include, but is not limited to: pimping or forcing the child to indulge in unlawful sexual activity; using the child for exploitation in prostitution or other unlawful sexual practices; and exploiting the child for pornographic performances and materials.

Sexual abuse includes: exposing private parts to a child (so-called flashing) and showing the child pornographic pictures; taking pictures of the body of the child; touching the body in a sexual way; inciting the child to touch the body of an adult in a sexual way; and attempting to have or performing sexual intercourse (anal, vaginal). Accordingly, sexual abuse can happen with or without body contact (non-penetrating and penetrating) *(1,2)*.

Emotional (psychological) abuse

Emotional or psychological abuse involves isolated incidents and a pattern of failure over time on the part of a parent or guardian to provide a developmentally appropriate and supportive environment. Acts in this category may have a high probability of damaging the child's physical or mental health, or his or her physical, mental, spiritual, moral or social development. Abuse of this type includes rejecting, degrading, blaming, threatening, frightening, terrorizing, isolating, corrupting, discriminating against or ridiculing; exploiting and other non-physical forms of rejection or hostile treatment; and denying emotional responsiveness *(1,2)*.

Neglect

Neglect includes isolated incidents and a pattern of failure over time on the part of a parent or caregiver to provide for the development and well-being of the child – where the parent is in a position to do so – in one or more of the following areas: health; education; emotional development; nutrition; and shelter and safe living conditions.

Neglect is not necessarily connected with poverty. In the case of poor parents or guardians, it may be that despite their best wishes, they are not in a position to provide the child with what his or her development requires *(1,2)*.

Prevention of child maltreatment versus protection

It is important to understand the difference between prevention of, and protection from, child maltreatment.

WHO describes this basic difference as follows *(3,4)*:

- child protection services investigate and try to substantiate reports of suspected child abuse and either directly provide or refer victims and their families to appropriate support, care, and treatment; child protection intervenes after the child maltreatment has taken place; and
- child maltreatment prevention refers to measures taken to prevent child maltreatment before it occurs by addressing the underlying causes and risk and protective factors – such as teaching positive parenting skills to pregnant first-time mothers.

References[1]

1. World report on violence and health. Geneva: World Health Organization; 2002 (http://www.who.int/violence_injury_prevention/violence/world_report/en).
2. Report of the consultation on child abuse prevention, 29–31 March 1999. Geneva: World Health Organization; 1999 (http://apps.who.int/iris/handle/10665/65900).
3. World report on violence and health. Geneva: World Health Organization; 2002 (http://www.who.int/violence_injury_prevention/violence/world_report/en).
4. Gilbert R, Kemp A, Thoburn J, Sidebotham P, Radford L, Glaser D et al. Recognising and responding to child maltreatment. Lancet 2009;373:167–80.

1 All weblinks accessed 15 August 2018.

Annex 2. National data coordinators

National data coordinators by country/area shown in Table A2.1.

Table A2.1. National data coordinators by country/area

Country/area	National data coordinator(s)	Country/area	National data coordinator(s)
Albania	Gentiana Qirjako	**Lithuania**	Audronė Astrauskienė
Andorra	Jordi Olivé Cadena	**Luxembourg**	Bechara Georges Ziade
Armenia	Nune Pashayan	**Malta**	Claudia Mifsud Neville Calleja Marika Borg Karen Vincenti
Austria	Ewald Filler	**Montenegro**	Svetlana Stojanović
Belarus	Valentina Volchok	**Netherlands**[a]	
Belgium	Jelle Osselaer	**Norway**	Freja Ulvestad Kärki
Bosnia and Herzegovina	Dalibor Pejović Sanja Skenderija Alen Seranic	**Poland**	Anna Trzewik
Bulgaria	Rumyana Dinolova	**Portugal**	Andreia Silva da Costa
Croatia	Ivana Brkić Biloš	**Republic of Moldova**	Revenco Nelly
Cyprus	Myrto Azina-Chronides	**Romania**	Daniel Verman
Czechia	Alena Švancarová	**Russian Federation**	Margarita Kachaeva Svetlana Shport
Denmark	Maria Schultz Anne Martha Malmgen-Hansen	**San Marino**	Gabriele Rinaldi
Estonia	Brit Tammiste	**Serbia**	Marija Markovic
Finland	Pirjo Lillsunde	**Slovakia**	Hana Rajkovičová Martina Matejkova Katarina Slotova
France	Alexis Rinckenbach Alexia Lozano	**Slovenia**	Barnara Miheva Ponikvar
Georgia	Ketevan Goginashvili	**Spain**	Pilar Campos
Germany	Almut Hornschild Anna Maria Lemcke	**Sweden**	Kerstin Carlsson Cecilia Sköld Kordelius
Greece	Georgios Nikolaidis	**Switzerland**	Céline Fürst Isabel Streit
Hungary	Dóra Várnai Zsófai Mészner	**Tajikistan**	Aziza Rahmatova
Iceland	Jenny Ingudottir	**The former Yugoslav Republic of Macedonia**	Fimka Tozija
Israel	Zohar Sahar Lavi	**Turkey**	Aylin Yuksel Sureyya Sak
Italy	Serena Battilomo	**Ukraine**	Chornyi Iurii
Kazakhstan	Maira Beisen	**United Kingdom**	Mark Bellis
Kyrgyzstan	Samatbek Toimatov	**Uzbekistan**	Alisher Iskandarov
Latvia	Jane Feldmane		

[a] Questionnaire completed by Hans Grietens.

Annex 3. Country and income listings

Country and income listings are shown in Table A3.1.

Table A3.1. Country and income listings

Country group/income listing	Countries
Commonwealth of Independent States	Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan
European Union Members	Austria, Belgium, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom
WHO European Region	Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan
High-income countries	Andorra, Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom
Low- and middle-income countries	Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Romania, Russian Federation, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan

Annex 4. Corporal punishment of children across the Region

A summary of the legislative situation on corporal punishment in the Region is reported in Table A4.1. These data have been provided by the Global Initiative to End All Corporal Punishment of Children and approved by national data coordinators where possible.

Table A4.1. Legislation on corporal punishment in different settings in the European Region

State	Prohibited in the home	Prohibited in alternative care settings	Prohibited in day care	Prohibited in schools	Prohibited in penal institutions
Albania	YES[1]	YES	YES	YES	YES
Andorra	YES[2]	YES	YES	YES	YES
Armenia[3]	YES	YES	YES	YES	YES
Austria	YES[4]	YES	YES	YES	YES
Azerbaijan[5]	NO	NO	NO	YES	YES
Belarus[6]	YES	YES	YES	YES	YES
Belgium	NO[7]	SOME[8]	NO	YES	YES
Bosnia and Herzegovina[9]	SOME[10]	SOME[10]	SOME[10]	YES	YES
Bulgaria	YES[11]	YES	YES	YES	YES
Croatia	YES[12]	YES	YES	YES	YES
Cyprus	YES[13]	YES	YES	YES	YES
Czechia	NO	SOME[14]	SOME[15]	YES	YES
Denmark	YES[16]	YES	YES	YES	YES
Estonia	YES[17]	YES	YES	YES	YES
Finland	YES[18]	YES	YES	YES	YES
France[19]	NO	YES	YES	YES	YES
Georgia[20]	NO	SOME[21]	NO	YES	YES
Germany	YES[22]	YES	YES	YES	YES
Greece	YES[23]	YES	YES	YES	YES
Hungary	YES[24]	YES	YES	YES	YES
Iceland	YES[25]	YES	YES	YES	YES
Ireland	YES[26]	YES	YES	YES	YES
Israel	YES[27]	YES	YES	YES	YES
Italy	NO[28]	YES	YES	YES	YES
Kazakhstan	NO	SOME[29]	SOME[30]	YES	YES
Kyrgyzstan[31]	NO	SOME[32]	NO	YES	YES
Latvia	YES[33]	YES	YES	YES	YES
Lithuania	YES[34]	YES	YES	YES	YES
Luxembourg	YES[35]	YES	YES	YES	YES
Malta	YES[36]	YES	YES	YES	YES
Monaco	NO	NO	NO	YES	YES

Table A4.1. contd

State	Prohibited in the home	Prohibited in alternative care settings	Prohibited in day care	Prohibited in schools	Prohibited in penal institutions
Montenegro	YES[37]	YES	YES	YES	YES
Netherlands	YES[38]	YES	YES	YES	YES
Norway	YES[39]	YES	YES	YES	YES
Poland	YES[40]	YES	YES	YES	YES
Portugal	YES[41]	YES	YES	YES	YES
Republic of Moldova	YES[42]	YES	YES	YES	YES
Romania	YES[43]	YES	YES	YES	YES
Russian Federation	NO	NO	SOME[44]	YES	YES
San Marino	YES[45]	YES	YES	YES	YES
Serbia[46]	NO	NO	SOME[47]	YES	YES
Slovakia[48]	NO	YES	YES	YES	YES
Slovenia	YES[49]	YES	YES	YES	YES
Spain	YES[50]	YES	YES	YES	YES
Sweden	YES[51]	YES	YES	YES	YES
Switzerland	NO[52]	SOME[53]	YES	YES	YES
Tajikistan[54]	NO	NO	SOME[55]	YES	NO
The former Yugoslav Republic of Macedonia	YES[56]	YES	YES	YES	YES
Turkey[57]	NO	NO	NO	YES	YES
Turkmenistan	YES[58]	YES	YES	YES	YES
United Kingdom[59]	NO	SOME[60]	SOME[61]	YES[62]	YES
Ukraine	YES[63]	YES	YES	YES	YES
Uzbekistan	NO	NO	NO	YES	YES

Notes

[1] Prohibited in Law on the Protection of the Rights of the Child 2010. [2] Prohibited in 2014 amendments to Criminal Code 2005. [3] Data provided through consultation with the national data coordinator (2018) and approved by Ministry of Health. [4] Prohibited in 1989 amendment to General Civil Code, reiterated in Federal Constitutional Act on the Rights of Children 2011. [5] Government accepted United Nations Human Rights Council Universal Periodic Review (UPR) recommendations to prohibit (2009, 2013). [6] Data provided through consultation with the national data coordinator (2018) and approved by Ministry of Health. [7] Draft legislation which would prohibit under discussion (2016); Government gave a mixed response to UPR recommendations to prohibit (2016). [8] Prohibited in institutions in Flemish community. [9] Government accepted UPR recommendations to prohibit (2015). [10] Prohibited in Republic of Srpska. [11] Prohibited in Child Protection Act 2000 (amended 2003) and Regulations on the Implementation of the Child Protection Act 2003. [12] Prohibited in Family Act 1998, superseded by Family Act 2003. [13] Prohibited in Violence in the Family (Prevention and Protection of Victims) Law 1994, reiterated in Act on Violence in the Family 2000; right "to administer punishment" formally repealed from Children's Law 1956 in 2013. [14] Unlawful in institutions. [15] Prohibited in preschool provision. [16] Prohibited in 1997 amendment to Parental Custody and Care Act 1995, reiterated in Danish Act on Parental Responsibility 2007. [17] Prohibited in Child Protection Act 2014, in force January 2016. [18] Prohibited in Child Custody and Rights of Access Act 1983. [19] Data provided through consultation with the national data coordinator (2018) and approved by Ministry of Solidarity and Health. [20] Government accepted UPR recommendation to prohibit in all settings (2015). [21] Possibly prohibited in care institutions. [22] Prohibited in 2000 amendment to Civil Code. [23] Prohibited in Law 3500/2006 on the Combating of Intra-family Violence 2006. [24] Prohibited in 2004 amendment to Child Protection Act 1997. [25] Prohibited in Children's Act 2003. [26] Prohibited in 2015 amendment to Offences Against the Person (Non Fatal) Act 1997. [27] 2000 Supreme Court judgement ruled against all violence in child rearing; "reasonable chastisement" defence repealed same year. [28] 1996 Supreme Court judgment ruled against all violence in child-rearing but this not yet confirmed in legislation. [29] Possibly prohibited in children's villages. [30] Prohibited in preschool education and training. [31] Government accepted UPR recommendation to prohibit in all settings (2015). [32] Prohibited in residential institutions. [33] Prohibited in Children's Rights Protection Law 1998. [34] Prohibited in 2017 amendments to Law on the Fundamentals of Protection of the Rights of the Child 1996. [35] Prohibited in Law on Children and the Family 2008. [36] Prohibited in 2014 amendment to Criminal Code but some legislation still to be formally repealed. [37] Prohibited in 2016 amendments to Family Law 2007. [38] Prohibited in 2007 amendment to Civil Code. [39] Prohibited in 1987 amendment to Parent and Child Act 1981, confirmed in further amendments 2010 following 2005 Supreme Court decision supportive of "lighter smacks". [40] Prohibited in 2010 amendment to Family and Guardianship Code 1964. [41] Prohibited in 2007 amendment to Penal Code. [42] Prohibited in 2008 amendment to Family Code. [43] Prohibited in Law on Protection and Promotion of the Rights of the Child 2004. [44] Unlawful in preschool provision. [45] Prohibited in 2014 amendments to Penal Code and Law of 26 April 1986 No. 49 on Family Law Reform. [46] Government accepted UPR recommendations to prohibit (2008, 2013). [47] Prohibited in day care which forms part of education system. [48] Government accepted UPR recommendation to prohibit (2009); prohibiting legislation being drafted (2015). [49] Prohibited in Law Amending and Supplementing the Law on Prevention of Family Violence 2016. [50] Prohibited in 2007 amendment to Civil Code. [51] Prohibited in 1979 amendment to Parenthood and Guardianship Code. [52] 2003 Federal Court ruling stated repeated and habitual corporal punishment unacceptable but did not rule out all corporal punishment in child-rearing. [53] Possibly lawful in family placements. [54] Government accepted UPR recommendation to prohibit in all settings (2011). [55] Prohibited in preschool education settings. [56] Prohibited in Law on Child Protection 2013. [57] Government accepted UPR recommendations to prohibit (2010, 2015). [58] Prohibited in Law on Guarantees of the Rights of the Child 2002, reiterated in Family Code 2012. [59] Draft legislation under discussion in Scotland and Wales. [60] Prohibited in residential institutions and foster care arranged by local authorities and voluntary organizations. [61] Prohibited in day care and childminding in England, Wales and Scotland; in Northern Ireland, guidance states physical punishment should not be used but no prohibition in law. [62] In 2014, Government confirmed no prohibition in "unregistered independent settings providing part-time education". [63] Prohibited in Family Code 2003.

Annex 5. Supplementary figures

Supplementary data are presented in Fig. A5.1–A5.4.

Fig. A5.1.

Reported availability of child protection agency data by level of country income in the WHO European Region (%) (high-income countries (HICs) = 31; low- and middle-income countries (LMICs) = 18) (%)

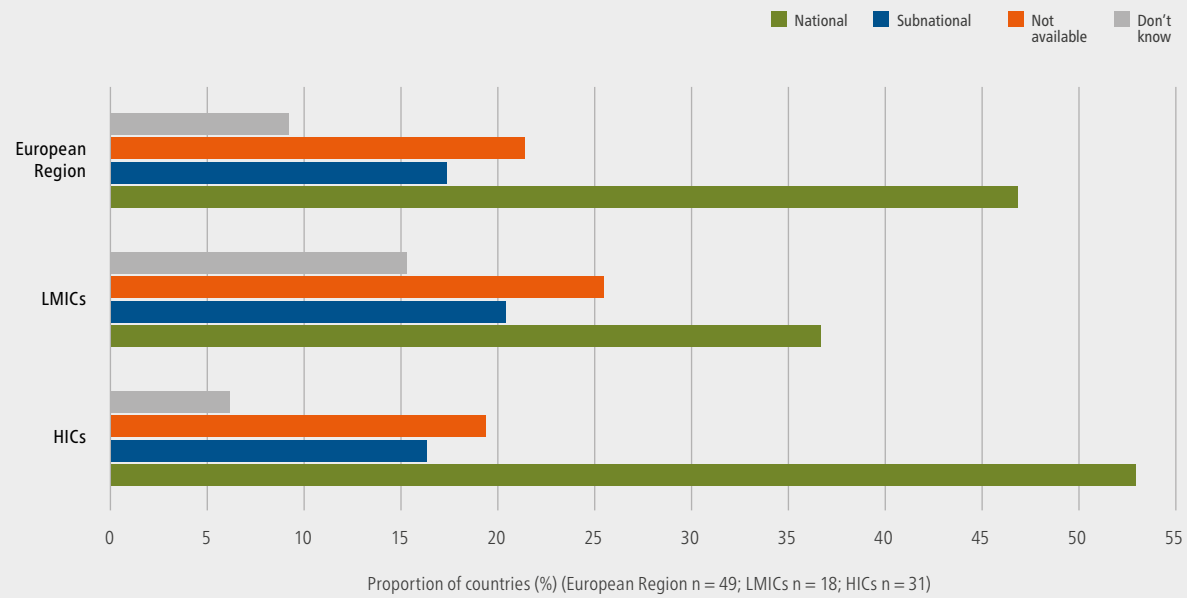


Fig. A5.2

Countries with a national child maltreatment protection plan

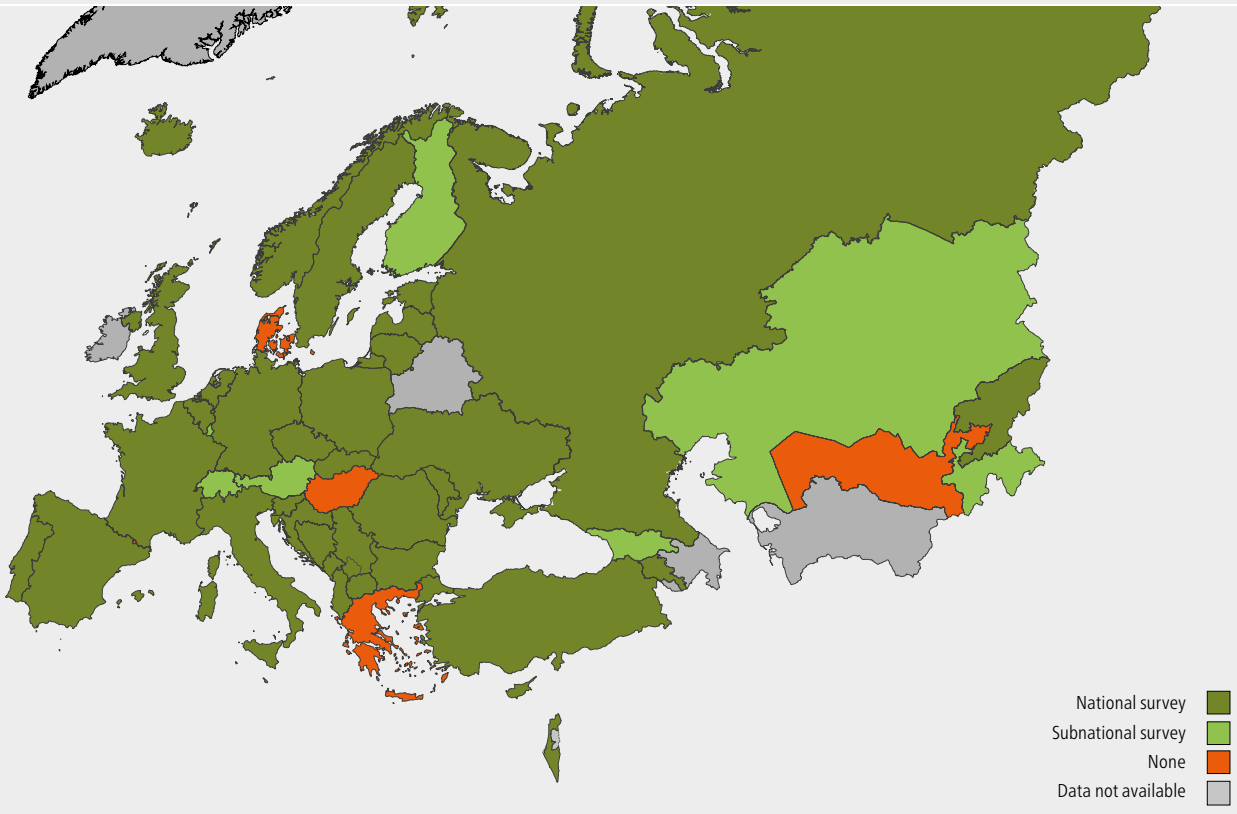


Fig. A5.3.

Proportion of countries with laws relating to the prevention of child maltreatment (%) (n = 49)

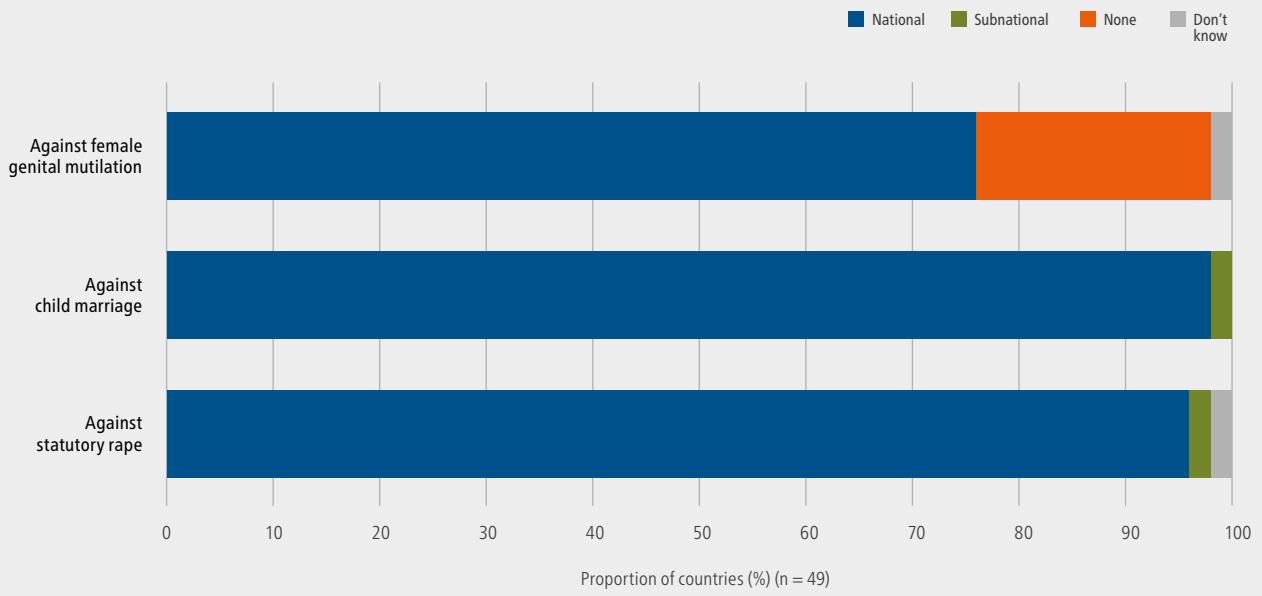
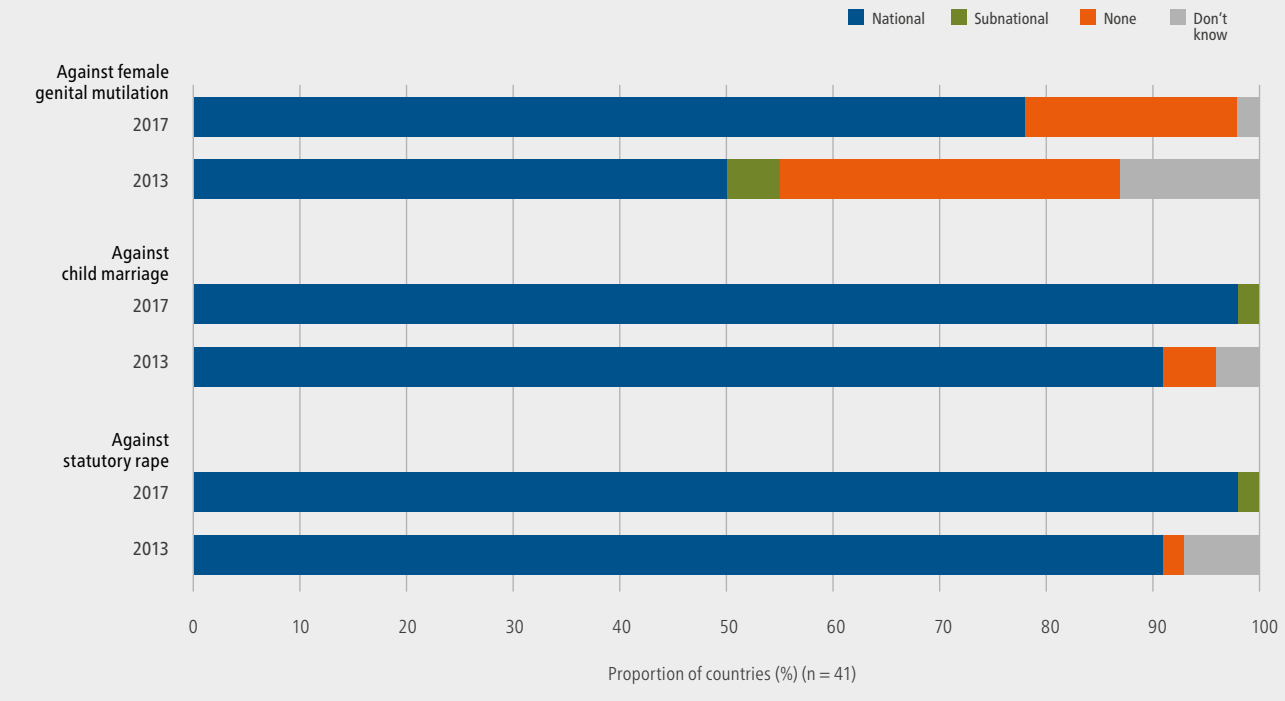


Fig. A5.4.

Proportion of countries with laws concerning child maltreatment in 2013 and 2017 surveys (%) (n = 41)



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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European status report on preventing child maltreatment

Child maltreatment is a major public health problem, affecting at least 55 million children in the WHO European Region. The impact of abuse and/or neglect in childhood is detrimental to physical, psychological and reproductive health throughout the life-course, yet the high costs to society are avoidable. There are clear risk factors for maltreatment at the level of the individual, family, community and society. This status report documents the progress that has been made by Member States in implementing the WHO *European child maltreatment prevention action plan 2015–2020* at its midpoint. The plan has a target of a 20% reduction in child maltreatment and homicides by 2020. Data were collected through a survey of government-appointed national data coordinators of 49 participating countries in the Region. Results show that good progress is being made overall towards achieving the objectives. Development of national policy for the prevention of child maltreatment has increased across the Region, with three quarters of countries reporting an action plan, but these must be informed by robust national data. Surveillance of child maltreatment remains inadequate in many countries, with information systems in low- and middle-income countries most in need of strengthening. Legislation to prevent maltreatment is widespread, but better enforcement is warranted. The implementation of child maltreatment prevention programmes, including home-visiting, parenting education, school and hospital-based initiatives, has accelerated, but evaluation of impact is needed. Child maltreatment is a societal issue that crosses sectoral boundaries, meaning a sustained, systematic, multidisciplinary and evidence-informed approach to prevention must remain a priority for governments.

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int