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TRANSLATING KNOWLEDGE INTO VIOLENCE PREVENTION POLICY TOWARDS THE SUSTAINABLE DEVELOPMENT GOALS IN THE REPUBLIC OF MACEDONIA

Definition and Concepts of Violence

The World Health Organization (WHO) defines violence as intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. (Krug et al. 2002) Thus, ''the use of physical force or power'' should be understood to include neglect and all types of physical, sexual and psychological abuse, as well as suicide and other self-abusive acts. This definition associates intentionality with the committing of the act itself, irrespective of the outcome it produces. (Tozija F. 2016)

The WHO typology (Krug et al. 2002) divides violence into three broad categories according to characteristics of those committing the violent act: self-directed violence, interpersonal violence and collective violence as broad categories which are each divided further to reflect more specific types of violence. The nature of

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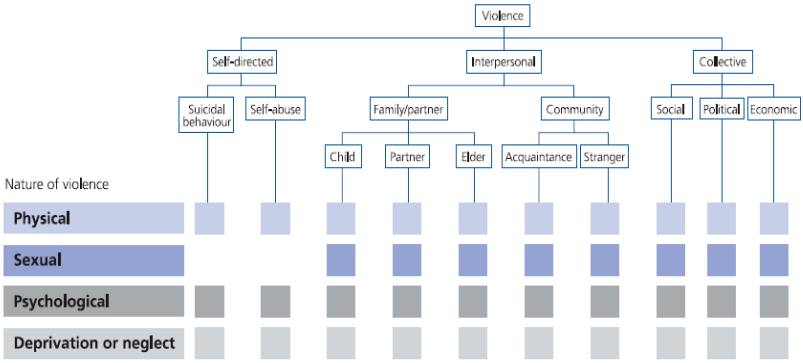
violent acts can be physical, sexual, psychological, involving deprivation or neglect. The horizontal array in Figure 1 shows who is affected, and the vertical array describes how victims are affected.

Figure 1: Typology of violence



Source: World Report on Violence and Health, WHO, 2002 (Krug et al. 2002)

This typology provide a useful framework for understanding the complex patterns of violence taking place around the world, as well as violence in the everyday lives of individuals, families, and communities. It also overcomes many of the limitations of other typologies by capturing the nature of violent acts, the relevance of the setting, the relationship between the perpetrator and the victim, and - in the case of collective violence - possible motivations for the violence. However, in both research and practice, the dividing lines between the different types of violence are not always so clear. (Tozija F.&Butchart. A 2013)

Violence of all types is strongly associated with social determinants such as weak governance; poor rule of law; cultural, social and gender norms; unemployment; income and gender inequality; rapid social change; and limited educational opportunities. Cross-cutting risk factors such as ease of access to firearms and other weapons and excessive alcohol use are also strongly associated with multiple types of violence. Together these factors create a social climate conducive to violence, and in the absence of efforts to address them, sustained violence prevention gains are difficult to achieve. (WHO 2014)

Global Burden of Violence

Violence affects the lives of millions, with long-lasting consequences. More than 1.3 million people worldwide die each year as a result of violence in all its forms (self-directed, interpersonal and collective), accounting for 2.5% of global mortality. WHO has estimated 475 000 deaths in 2012 as a result of homicide. Sixty percent of these were males aged 15–44 years, making homicide the third leading cause of death for males in this age group. There are major variations in violence mortality rates between different regions in the world and between different gender and age groups. The highest estimated rates of homicide occur in low-and middleincome countries, such as the Region of the Americas, with 28.5 homicides per 100 000 population, followed by the African Region with a rate of 10.9 homicides per 100 000 population. The lowest estimated rate of homicide is in the low-and middleincome countries of the Western Pacific Region, with 2.1 per 100 000 population. Over the period 2000–2012, homicide rates are estimated to have declined by just over 16% globally (from 8.0 to 6.7 per 100 000 population), and, in high-income countries, by 39% (from 6.2 to 3.8 per 100 000 population). By contrast, homicide rates in low-and middleincome countries have shown less decline over the same period. For both upper and lower middle-income countries the decline was 13%, and for low-income countries it was 10%. (WHO 2014)

Violence is a major contributor to death, disease and disability, and other health and social consequences worldwide. The magnitude of violence as public health problem is best represented by a clinical pyramid where violent deaths recorded in official statistics are represent only the apex of the pyramid. Deaths are only a fraction of the health and social burden arising from violence and are only the most visible part of the violence iceberg, the visible outcome of recorded violent behaviour and for every death there are many more non-fatal cases. (Tozija F. 2016). Hundreds of thousands of victims of violence receive emergency medical care each year For every violence-related death there are many more individuals who seek emergency treatment for an injury sustained from an act of interpersonal violence. Tens of thousands of people around the world are victims of non-fatal violence every day.(WHO 2014)

Women, children and elderly people are the most vulnerable groups bearing the burden of the non-fatal consequences of physical, sexual and psychological abuse. (Tozija F. at al 2012) Globally, an estimated 42% of women who have been physically and/or sexually abused by a partner have

experienced injuries as a result of that violence. About 30% of ever-partnered women throughout the world have experienced physical and/or sexual violence by an intimate partner at some point in their lives. One in five girls has been sexually abused during childhood, with estimates from some countries placing that proportion closer to one in three. Globally, 6% of older adults report significant abuse in the past month. Violence contributes to lifelong ill health, particularly for women and children. (WHO 2014)

Violence has high economic costs – preventing violence can promote economic growth The health and social consequences of violence take an economic toll on countries too, although the precise burden is unknown, particularly in developing countries where economic losses and impact tend to be underestimated. The provision of treatment, mental health services, emergency care and criminal justice responses are some of the direct costs associated with violence. There are also a wide range of indirect violence related costs to the individual, family, community and society as a whole (Tozija F.&Butchart A. 2013). The majority of victims of violence are in the most economically productive age range of 15-44 years, and for every one of the thousands of millions of dollars spent on direct medical care for victims, many more financial resources are lost due to indirect factors such as time away from work and disruption of family routines. The direct costs and indirect costs of lost productivity due to interpersonal violence represent an enormous economic burden to victims, families and society. The economic burden of interpersonal violence in the USA has been estimated to be 3.3% of GDP, while in England and Wales the annual total costs from violence are estimated at US$ 40.2 billion (WHO 2007). In the United States, the total lifetime economic burden resulting from new cases of fatal and non-fatal child maltreatment is approximately US$ 124 billion annually (in 2010 dollars). (WHO 2014)

Macedonian Health Profile and Burden of Disease

The last official population estimate by State Statistical Office (SSO 2016) is 2 071 278 inhabitants in 2015, which is 1.6% more compared with 2005. The estimation from the Institute for Health Metrics and Evaluation (IHME 2015) is even higher 2.1 milion**.** In the period 2005-2015, there has been a continuous increase in the number of immigrated foreigners in the Republic of Macedonia. The Macedonian population is increasingly ageing, with increasing participation of the old population over 65 years grew

from 11.1% in 2005 to 13.0% in 2015. Sex structure shows that males are slightly dominant with 50,1%. In the same period (2005-2015), the number of marriages decreased by 2.2%, while the number of divorces rose by 41.8%. (SSO 2016) In 2015, life expectancy at birth in Macedonia was 73.9 years for males (compared to 69.4 in 1990) and 79.1 years for females (compared to 74.1 in 1990) or decrease of 4.5 years for males and 5 years for females. (IHME 2015) The changes in the age structure are reflected in the constant increase of the number of deaths and mortality rate of 9.9 deaths per 1000 population in 2015 (compared to 9.0 in 2005). (SSO 2016)

The political and economic processes have brought new lifestyles to the society influencing the health of the population as well; new disease patterns emerged, with the non-communicable diseases and violence and injuries taking over the lead in morbidity and mortality trends. (IHME 2015) The most common causes of death in Macedonia in 2015 were circulatory system diseases with 58.4% of the total number of deaths, followed by neoplasms with 18.3%, endocrine, nutritional and metabolic diseases with 4.3%, respiratory diseases and injuries and external causes etc. (SSO 2016) The leading causes of death in Macedonia in 2010 were diseases of circulatory system with SDR of 553 per 100 000, followed by malignant neoplasms with SDR 172 and external causes of injury and poisoning with SDR of 28 per 100 000 (European Health for All data base). (WHO 2016)

Years lived with disability (YLDs) are estimated by weighting the prevalence of different conditions based on severity. The top five leading causes of YLDs in Macedonia in 2010 were low back pain, major depressive disorders, falls, neck pain, and diabetes (IHME 2010), while in 2015 low back&neck pain, sense organ disorders, depressive disorders, diabetes and skin diseases. (IHME 2015) Disability-adjusted life years (DALYs) quantify both premature mortality (YLLs) and disability (YLDs) within a population. In Macedonia non-communicable diseases and injuries are generally on the rise, while communicable, maternal, neonatal, and nutritional causes of DALYs are generally on the decline. Overall, the three risk factors that account for the most disease burden in Macedonia are dietary risks, high blood pressure, and tobacco smoking. Intimate partner violence is ranked as 14th among top 15 risk factors in 2010. (IHME 2010) The leading risk factors for children under 5 and adults aged 15-49 years were household air pollution from solid fuels and dietary risks, respectively, in 2010. In 2015 in terms of DALYs in Macedonia, high systolic blood pressure is the leading risk factor followed by dietary risks, tobacco smoke, high body mass index and high fasting plasma glucose. (IHME 2015)

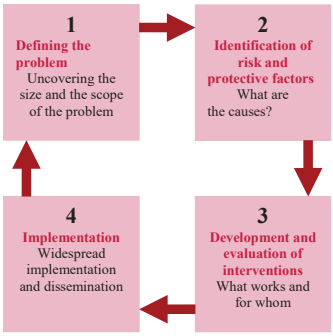
Understanding the relative performance of Macedonia against other

comparator countries provides key insight into public health successes and areas where Macedonia might be falling behind. In 2010. Macedonia was ranked 4th for age standardized YLL rate and 10th for age-standardized death rate. across 14 other comparator countries, selected and ordered by income per capita, for five metrics of interest, with 1 indicating the best rank and 15 indicating the worst rank. (IHME 2010)

Estimating Magnitude of Violence in Macedonia

Violence is serious public health problem in Republic of Macedonia that has negative impact on health, causing fatal injuries and death as well as injuries and psychological trauma that require outpatient treatment or hospitalization. (Tozija F. 2009) Public health approach, human rights approach and ecological model have been used as a leading framework for situation analysis of the problem of violence in Macedonia, it's magnitude, burden, causes and risk factors at variuous levels, and to provide reccomendations for evidence based policy interventions. (Tozija F. et al. 2006) The public health approach is a science-based, multi-disciplinary approach for understanding and preventing violence. (Tozija F.&Butchart A. 2005) The approach is intended to help coordinate actions by representatives of the many different sectors relevant to violence prevention, including welfare, social work, education, employment, health, police and justice. The public health approach consists of four steps: describing and monitoring the problem; identifying the risk and protective factors; the development and evaluation of prevention programmes; and the implementation and dissemination of these programmes. (Krug at al 2002) (Figure 2)

Figure 2: The public health approach



Source: WHO (Krug at al 2002)

Ecological model: Violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors. Understanding how these factors are related to violence is one of the important steps in the public health approach to prevent violence. Because violence is a multifaceted problem with biological, psychological, social and environmental roots, it needs to be confronted on several different levels at once (Tozija et al. 2007). The ecological model serves a dual purpose in this regard, it explores the relationship between individual and contextual factors and considers violence as the product of multiple levels of influence on behaviour: each level in the model represents a level of risk and each level in the model can also be thought of as a key point for intervention (Krug et al. 2002). (Figure 3)

Figure 3: Ecological Model

Source: WHO (Krug et al 2002)

The *human rights approach* is based on the obligations of states to respect, protect and fulfill human rights and therefore to prevent, eradicate and punish violence. It recognizes violence as a violation of many human rights: the rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; the rights to be free from torture and cruel, inhuman and degrading treatment or punishment; the right to privacy; and the right to the highest attainable standard of health. These human rights are enshrined in international and regional treaties and national constitutions and laws, which stipulate the obligations of the state, and include mechanisms to hold states accountable. The Convention on the Elimination of All Forms of Discrimination Against Women, for example, requires that countries party to the Convention take all appropriate steps to end violence against women. The Convention on the Rights of the Child in its Article 19 states that States shall take all appropriate legislative, administrative, social and educational measures to protect the child from all

forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. (Tozija F. 2016)

Burden of Violence in Macedonia

Violence, i.e. suicides and homicides in the Republic of Macedonia as in most of the countries of South-East Europe show ascending trend in the 90s, reaching the highest rates in 2001 – 13.9 per 100 000 population. In 2004, mortality was 11.6 per 100 000. In the total structure of injuries that were the third leading cause of death with mortality rate of 35 per 100 000 and total of 708 deaths in 2004, intentional injuries were increased to 33% (8% are homicides and 25% suicides); particular increase was registered in suicides, by 30% compared to year 2003, i.e. suicide rate per 100000 has increased from 6.8 to 8.8 in 2004. (Tozija F. et al. 2006)

Most of the victims of violence remained unregistered because in addition of the existing legislation for monitoring violence as external cause of injury, there was no systematic recording and monitoring of the victims of violence in the health sector, institutions for social protection, educational and other institutions in the Republic of Macedonia. Ascending trend of mortality due to violence was not followed by ascending trend of registered morbidity, on contrary, there was descending trend and decrease in outpatient morbidity of 25/100,000 in 1990 to 3/100,000 in 2004, i.e., decrease in number of victims of violence from 532 to 62. Official health statistics showed that only 449 individuals injured in violent acts were hospitalized in year 2003. Clinical pyramid for injuries due to violence was reverse to the typical one, where the tip represents deaths and the base represents cases treated in outpatient clinics in primary health care. The proportion of 235 deaths, 62 treated in PHC and 449 hospitalized is due to inappropriate coding of the external cause of death, and insufficient recording and reporting of such cases. The inappropriate recording of violence increases further with introduction of private health sector in which most of the morbidity was not registered, thus leading to artificial and unreal decrease in morbidity. (Tozija F. et al. 2006)

In Macedonia due to inappropriate evidence of violence, it was not possible to give objective assessment of the burden with injuries due to violence. That was the reason to undertake additional survey in collaboration

with WHO, Community injury survey on 1000 households. Findings from this survey showed that violence-related injuries were reported for 2 209 respondents in the weighted sample or 4% of the reported injuries in the survey, affecting mostly men in more than half of the cases. Intimate partner was identified by women as the most frequent perpetrator in 43.9%. Men were victims of their friend or official autthority. More than half of the respondents were not always able to control their temper and majority had never carried a weapon. Half of those victims had experienced physical abuse in childhood. (Tozija F. et al. 2008)

Global School Based Student Health Survey has shown that overall 10.0% of students aged 13-15 years had been bullied on one and more days during the past 30 days, while 8.6% of students seriously considered attempting suicide during the past 12 months; male students (6.8%) were less likely than female students (10.5%) to seriously consider attempting suicide. (Tozija F. et al. 2008)

Policy Informed Interventions

The Report on violence and health and gudie for prevention (Tozija F. et al. 2006) provided evidence for policy interventions and response from the Government of Republic of Macedonia in order to fulfil the obligations defined in Resolution No. 56.24 of the World Health Assembly (WHA) 2003, for implementation of recommendations of the World Report on Violence and Health and the European Council Recommendation of 31 May 2007. The Governemnt policy response was in line with resolution WHA67.15 from May 2014 on Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children. (WHO 2014), the Global plan of action to strengthen the role of the health system in addressing interpersonal violence, in particular against women and girls, and against children (WHO 2016) and the United Nations' Sustainable Development Goals (SDGs) and related targets as per Agenda 2030. (UN 2015) (see Box 1)

Violence control and prevention was set high as priority public health problem by the Government of Macedonia in many strategic documents such as Health Strategy of the Republic of Macedonia 2020–Safe, efficient and just health care system (MOH 2007) (target 9), National Strategy for control and prevention of non communicable diseases (strategic priority area 4 - control and prevention of injuries, violence including domestic violence) (MOH 2009). National Strategy for protection of domest Na-

tional Strategy for protection of domestic violence 2008-2011 and 2012-2015 (MLSP 2008 and 2012) and many other as described below have been developed to address violence in Macedonia following the WHO reccomendations to achieve the SDG targets directly or indirectly related with violence. (Box 1)

Box 1. United Nations' Sustainable Development Goal targets in/ directly aimed at violence prevention (UN 2015)

Targets directly aimed at violence prevention	***Targets indirectly aimed at violence prevention***
Target 16.1: Significantly reduce all forms of violence and related deaths everywhere Target 16.2: End abuse, exploitation, trafficking and all forms of violence and torture against children Target 5.2: Eliminate all forms of violence against women and girls Target 5.3: Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation.	Targets 1.3 and 10.2: Social protection and poverty reduction Target 3.5: Prevention and treatment of drug use and harmful use of alcohol Target 4.3: Early childhood development, care and pre-primary education Target 11.1: Adequate, safe and affordable, housing and basic services, and slum upgrading Target 16.3: Rule of law at national and international levels and equal access to justice for all.

Violence prevention is set as priority in the collaboration of the Ministry of Health with World Health Organization since 2004 in the Biennial collaborative agreements including the current BCA 2016-2017. The WHO country Office implements the agreement in close collaboration with Ministry of health and other national institutions and international partner agencies.

Republic of Macedonia has been undertaking evidence based policy interventions that are in line with WHO key reccomendations at a national level (WHO 2014) to achieve the SDG targets related wth violence:

- strengthen data collection to reveal the true extent of the problem;
- develop comprehensive and data-driven national action plans;
- integrate violence prevention into other health platforms;
- trengthen mechanisms for leadership and coordination;
- ensure prevention programmes are comprehensive, integrated and informed by evidence; • ensure that services for victims are comprehensive and informed by evidence;
- strengthen support for outcome evaluation studies;

- enforce existing laws and review their quality;
- implement and enact policies and laws relevant to multiple types of violence;
- build capacity for violence prevention.

The Whole of the Government approach applied

Health in all policies, the whole of the Government and the whole of the society approach have been applied and contributed to the success of violence prevention policies in Macedonia in line with the European policy framework on health and well-being, Health 2020 and SDGs. (WHO 2012)

Violence prevention has been set as priority in the BCA WHO/MOH. since 2004. National task force for Violence and health was established in 2005 with representatives from Ministry of health, interior, education, justice, labor and social policy, NGOs and WHO within the BCA WHO/MKD 2005/2006.

Governmental National Coordination Body for domestic violence prevention was established with Government decision in 2009 with representatives of Ministry of Health, Labor and social policy, Interior, Education, Justice, Institute of Public Health, NGOs, WHO and other stakeholders responsible for implementation of the new National Strategy for protection of domestic violence prevention.

Specific national policies for domestic violence prevention have been developed and annual action plans for implementation: National Strategy for protection of domestic violence 2008-2011 was implemented and coordinated by the National Coordination Body (MLSP 2008) and second National Strategy for protection of domestic violence 2012-2015 (MLSP 2012) has been developed and implemented. Joint Protocol for treatment in case of domestic violence (MLSP 2010) was prepared in collaboration with Ministry of Health, Labor and social welfare, Interior, Education, Justice, NGOs, UNDP, UNFPA, WHO, UNIFEM and other UN agencies in 2010.

Joint UN Program "Strengthening National Capacities to Prevent Domestic Violence" – started in December 2008 and finished in August 2012 providing technical and financial assistance to the National Coordination Body in the implementation of the National Strategy for protection from domestic violence. UN agencies UNDP, UNFPA, WHO, UNICEF and UNIFEM have worked together with the national partners: ministries of labor and social policy, interior, justice, health, and education and sci-

ence, providing funding of 2,458,000US$ from Government of Netherlands, 958,000US$ from UN Trust Fund, 43,000US$ from UN agencies. 70000US$ in kind have been provided by Government of Republic of Macedonia.

New Law for prevention and protection from domestic violence was adopted in 2014 (OG 2015) and by laws for the implementation of this Law has been developed for relevant sectors: health, social protection and interior have been adopted in 2015. Protocol for intersectoral collaboration of responsible institutions and associations for protection of domestic violence (MLSP 2015) was prepared in 2015 for implementation of the new legislation.

The prevention and protection of child maltreatment has envisaged in several strategic documents such is the National Action Plan for Prevention and Combating Child Abuse and Neglect (2013-2015) (MLSP 2013) as well as National Strategy for the Fight against Poverty and Social Exclusion 2010–2020 which addresses children's rights, including social protection, social inclusion, health, education, and employment. (MLSP 2010) National Plan of Action on the Rights of the Child (2012–2015) aims to promote equity, inclusion, and efficiency in the provision of services for children such as health care and education. (MLSP 2012) Action Plan for Children on the Streets 2013–2015 addresses combating harmful effects of street work by providing such children services including education. (MLSP 2013) Protocols for child abuse and neglect, sexual abuse and pedophilia have been prepared (MLSP 2009). Multidisciplinary protocol for treatment (identification and referral) of Street Children in Republic of Macedonia (MLSP 2010) was developed in 2010. The Law on Child Protection which regulates the system, the organization and the manner of providing protection to the children was ammended. (OG 2009) The Family Law provides preventive and repressive protection of the rights and the interests of the child through the Centers for Social Work. (OG 2009)

Training and capacity building for violence prevention

WHO Training Education Advancing Collaboration in Health Violence and Injury Prevention (TEACH VIP) modular training curriculum on violence prevention and control has been applied to address capacity building needs in violence control and prevention in Republic of Macedonia, as one of the WHO tools to support national implementation of Resolution EUR/RC55/R9 on Prevention of Injuries in Europe. These trainings were within the activities of the health sector in the implementation of the National

Strategy for prevention of domestic violence and NPAA, financially supported by the Joint UN Program and WHO, organized in collaboration with Ministry of Health (MOH) and Institute of Public Health (IPH).

Trainings of one day TEACH VIP workshops were organized at different cities in Macedonia by the Associations of general practitioners, emergency medicine, pediatritions, gynaecologists, psychiatrists and nurses in collaboration with WHO country office and IPH VIP Department, and were accredited by the Doctors Chamber. 2390 health proffesionals have completed these trainings within the period 2010-2012. Trainings were financially suported by WHO within the UN Joint program mentioned above while the teaching was provided by university professors from Faculty of Medicine in Skopje and WHO.

Sixty university professors have been trained in 3 three day Training the trainers on TEACH VIP workshops from: Faculty of Medicine, Psychology, Social Work, Gender Studies, Pedagogy and Pedagogical Faculty, Law, Police Academy in 2009-2010. These workshops were specially designed by WHO for trainers in violence prevention and were organized by the WHO Country Office in Skopje/WHO EURO VIP/ WHO HQ VP in collaboration with the Ministry of Health, IPH, University St Cyril and Methodius to further strengthen national capacity for violence prevention and to use it in the curriculum in the future educational interventions.

105 professionals were trained in three day introductory workshop for psychosocial treatment of perpetrators, while 14 professionals were trained by MODUS Center Zagreb in four-month training program in 2011. 220 doctors were trained in one day workshops for evidence of violence and web register in Skopje in 2012 by VIP IPH.

Guidelines for referral mechanisms for professionals have been prepared for police, heath, social protection, education, justice in 2010 and capacity building 2 day workshops for implementation of Joint protocol for domestic violence prevention were organized in 8 municipalities in 2011-2012, supported by the UN Joint Program. 200 professionals from different sectors have been trained: health workers, social workers, policemen, teachers, municipal staff etc.

3 one day capacity building workshops for protocol for intersectoral collaboration for domestic violence prevention were organized in 2015 and 90 doctors, nurses, social workers and other workers were trained.

Training for violence and injury control and prevention and safety promotion are being held for undergraduate and postgraduate students at Medical School in Skopje.

Institutional Changes

National violence and injury control and prevention focal points were appointed in 2003 and 2005. Department for violence and injury control and prevention (VIP) was established in the Institute of Public Health of Republic of Macedonia in 2004 as a lead agency for violence prevention in the health sector. The structure and organization in the Institute of Public Health was changed, new positions and job descriptions were prepared for the staff recruited from the current employees from the Sector for social medicine at that time and financing secured from the IPH budget.

The VIP Department has been working on projects in collaboration with WHO, UNFPA, UNICEF, OSI, World Bank and other international organizations that have provided technical and financial assistance as well as national governmental and civil society organizations on many research projects: in collaboration with WHO: Report on violence and health in Macedonia and guide for prevention – 2006, Evaluation Report of the emergency medical services in Macedonia – 2007, Community injury survey Report – 2008, Global School-Based Student Health Results - Republic of Macedonia – in collaboration with UNICEF – 2008 and participated in preparation of the WHO Global Status Report on Violence Prevention-2014. In 2012 VIP Department was inaugurated as Safe Community Affiliate Support Center.

Specialists of social medicine and organization of health care from IPH and CPHs have been involved in the surveys organized by VIP Department and have been appropriately trained on workshops during the projects and have completed TEACH VIP capacity building training program.

Extensive capacity building program for violence prevention was conducted for different professions as presented above: 2 390 health professionals and 60 university professors have completed TEACH VIP course, 220 doctors were trained for evidence of violence and web register, 200 professionals from different sectors at local level have been trained: health workers, social workers, policemen, teachers, municipal staff etc. for implementation of the first Joint protocol for treatment of the victims of domestic violence, while 90 doctors, nurses, social workers and other workers were trained for implementation of the second protocol for intersectoral collaboration for domestic violence prevention.

Counseling Center for perpetrators was established in Clinic for psychiatry in 2012 (Official Gazette of RM n. 69/2012) and first group of perpetrators with court decision completed the first cycle of the treatment.

Funding has been provided by the Join UN Program as previously described with total budget higher than 3 million euro.

New program for the specialisation in social medicine and public health was introduced and new curriculum developed in 2015. (OG 2015)

Module for violence and injury control and prevention and safety promotion has been developed and is part of the accredited curriculum for master and doctoral studies in public health and for specialization for family medicine at the Faculty of medicine in Skopje.

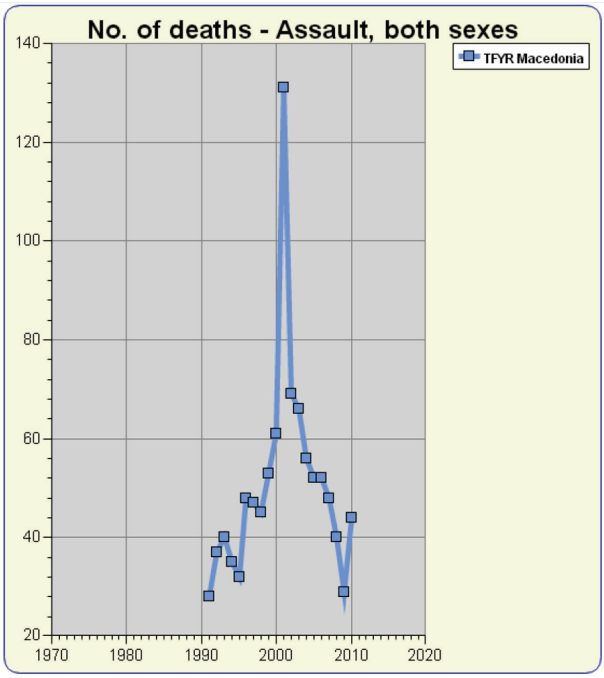
The new Law for evidence of health (OG 2009) has been adopted in 2009 by which reporting of violence has become mandatory in a special register for violence

The commitment of the country for implementing e-Health and the availability of the modern information technology was confirmed in 2011 when Ministry of Health started "My term" that initially served as real-time appointment system for specialist and acute hospital services with the aim to reduce waiting times for certain medical procedures. Later it has been expanded to include e-health records of all visiting patients including national registries of diseases, medicine prescribing levels, etc. The system is envisaged to be expanded into data collection on risk factors of NCDs including violence, especially environmental and behavioural aspects. (MOH 2011)

Health professionals, in addition to, their regular tasks of performing curative and preventive health services should also look for and detect signs of violence, provide suitable health care immediately as well as undertake measures for its prevention. Appropriate recording violence in accordance with ICD 10 is important in determination of cases of violence and risk factors, particularly in vulnerable categories, such as children, youth and elderly, which will have important impact on prevention.

Outcome: Resolution EUR/RC55/R9 was successfully implemented in Macedonia with 82% of 99 effective interventions, compared to European Region median score of 73% and much lower mortality of injuries with SDR 28/100000. (Figure 4)

Figure 4: Number of deaths from violence



Source: WHO HFA Database, 2016

Summary of achievements in violence prevention are presented in the country profile in the WHO Global Status Report on Violence Prevention. (WHO 2014) (see Box 1).

Lessons learnt

Significant achievements in this story are in national policy development, injury surveillance, capacity-building and multisectoral collaboration. Applied the whole-of-the-government and whole-of-society approaches with joint efforts of national governmental and civil society organizations and international organizations with strong vertical and horizontal coordination, with provided resources, legislative and organizational changes establishing a system of health in all policies for violence prevention was main contributing factor for this successful story. It can be replicated on a larger scale if all these preconditions are fulfilled.

Future Challenges

Despite the enormous progress made in violence control and prevention and safety promotion further efforts and a more strategic approach is needed in the years ahead, especially for adrressing violence and achieving the SDG targets related with violence.

Future challenges are evidence–based interventions for safety promotion and reducing socioeconomic inequalities, addressing violence and achieving SGDs.

The SDGs constitute a potentially powerful violence prevention agenda. Successful implementation of the SDG's will not automatically reduce violence everywhere. Much work is needed to achieve focus and make the targets measurable. Overall strengthening the main functions and especially development of violence prevention policies and legislation and establishing strong monitoring will significantly add value to the integrated system for violence prvention with applied health in all policies.

Abstract

Evidence based policy interventions have been implemented in Republic of Macedonia translating knowledge into practice. There are significant achievements in national policy development, capacity-building, multisectoral collaboration and violence surveillance. Applied the whole-of-the-government and whole-of-society approaches with strong vertical and horizontal coordination, with provided resources, legislative and organizational changes establishing a system of health in all policies for violence prevention was main contributing factor for this successful story. It can be replicated on a larger scale if all these preconditions are fulfilled. Resolution EUR/RC55/R9 was successfully implemented in Macedonia with 82% of 99 effective interventions, compared to European Region median score of 73% and much lower mortality of injuries with SDR 28/100000. Future challenges are evidence–based interventions for safety promotion and reducing socioeconomic inequalities, addressing violence and achieving SGDs especially targets aimed at violence prevention.

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