World Health Organization

European Region

Care, courage, change: health-sector leadership in tackling violence against women and girls

Abstract

Violence against women and girls remains a pervasive public health emergency in the WHO European Region, affecting nearly one in three women over their lifetime. This report presents updated prevalence estimates and a comprehensive analysis of 241 national policies across 53 countries, revealing critical gaps in health sector responses. While 87% of countries have multisectoral strategies, fewer than half integrate violence against women into health policies or clinical guidelines. Essential survivor-centred services – such as emergency contraception, safe abortion, HIV prophylaxis, mental health care and referrals – are insufficiently included in policies. Mandatory reporting requirements for health professionals against the wishes of adult survivors in 32% of countries risk undermining survivors' autonomy and access to care. Encouragingly, 75% of countries commit to training health workers, and 68% include first-line support for survivors. The report calls for urgent strengthening of health systems to provide compassionate, confidential and comprehensive care aligned with WHO recommendations and human rights standards, emphasizing survivor dignity and empowerment in a multisectoral approach to end violence against women.

Keywords: SEXUAL VIOLENCE, HEALTH POLICY, GENDER, WOMEN'S HEALTH SERVICES, VIOLENCE AGAINST WOMEN PREVALENCE ESTIMATES, VIOLENCE AGAINST WOMEN, VIOLENCE AGAINST WOMEN AND GIRLS, INTIMATE PARTNER VIOLENCE

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Contents

Foreword

Violence against women and girls is not only a grave violation of human rights – it is a public health emergency that touches every corner of society.

Nearly 123 million women and girls in the WHO European Region (the equivalent to the entire populations of Germany, Greece, Hungary, Ireland, Portugal and Sweden combined) will experience physical and/or sexual violence in their lifetime. Among our adolescent girls and young women, the figures are equally alarming – one in four faces violence at the hands of their intimate partners, and many will also face sexual and other forms of violence by non-partners . The responsibility to tackle this crisis is collective, and it is ours.

Ending violence against women and girls is not a duty confined to any one sector: it demands a society and sector-wide response. And here, the health sector is uniquely placed to play a powerful, positive role.

Health workers are often the first – and sometimes the only – professionals to come into contact with survivors. Whether through emergency response, sexual and reproductive care, mental health services or maternal care, health workers are in a position to recognize the signs of violence, offer support and resources, and help survivors begin a journey towards healing.

For that to happen, they must be equipped with the right tools, training and support.

This landmark report explores how countries and health systems across the WHO European Region are responding to the challenge. We now have a comprehensive overview of national health policies, multisectoral strategies and efforts to align with WHO recommendations and international human rights standards. As part of the Second European Programme of Work 2026–2030, we have launched the Special Initiative on Violence against Women and Girls, to catalyse this whole-of-society response and elevate the role of health systems.

While many countries have made important strides, significant gaps remain. Too often, health systems are underprepared to respond effectively. Too often, survivors are met with silence or stigma instead of support. This must change – and this change begins with recognizing the health sector not just as a point of contact but as a pillar of care that plays a leading role in ending violence against women and girls.

We must do better. And we can.

We can make sure that our health systems not only treat the wounds of violence but support survivors with empathy and dignity. We can place accountability where it belongs – not on those who suffer but on those who harm. We can shift the narrative and make sure that survivors are seen, heard and supported, and that violence is met not with silence or indifference but with action.

Dr Hans Henri P. Kluge
WHO Regional Director for Europe

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The analysis for and writing of the policy section of the report were led by Katherine (Kat) Watson (Project Lead), Eva Burke and Gillian Eva, WHO Consultants. Work on the prevalence estimates of violence against women in the WHO European Region was led by Lynnmarie Sardinha, Technical Officer on Violence against Women Data, Estimation and Measurement, WHO.

This report was coordinated under the strategic direction of Natasha Azzopardi-Muscat, Director of the Division of Country Policies and Systems, WHO Regional Office for Europe; and Chris Brown, Head of the WHO European Office for Investment for Health and Development.

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This report draws on information obtained from the WHO violence against women national policies database, which was created under the technical oversight of Avni Amin and Claudia García Moreno of the Rights and Equality across the Life-course Division, Department of Sexual, Reproductive, Maternal, Child and Adolescent Health and Ageing, WHO. The Department also executes the United Nations Development Programme, United Nations Population Fund, United Nations Children's Fund, WHO and World Bank Special Programme of Research, Development and Research Training in Human Reproduction, which provided funding for the database.

Executive summary

New WHO data confirm that 123 million women and girls continue to face violence in their lifetime. The persistence of this staggering figure – virtually unchanged for decades – underscores an urgent public health crisis that shows no sign of abating, and that requires robust solutions. Spikes in rates of femicide in several countries across the Region highlight the urgent need to transform harmful social norms about gender.

Fewer than half of the countries in the WHO European Region include WHO-recommended minimum services in their health-sector policies. This means that many women and girls who face violence are left without the care and support they urgently need as survivors.

This report analyses 241 policies across the 53 Member States in the Region, providing a roadmap for the health sector to strengthen its role within the multisectoral system of prevention and response to violence against women and girls.

Countries are increasingly recognizing the central role of the health sector in both prevention of and response to violence and its consequences. However, translating multisectoral commitments into health-sector-specific policies and ensuring access to life-saving, rights-based services for survivors remains a challenge.

Key findings

The state of affairs

- Violence against women and girls remains widespread and underreported.
- Violence is not a marginal issue: it is pervasive across the WHO European Region. Violence against women and girls remains a serious public health concern, with high prevalence rates indicating that many women have experienced or will experience violence at some point in their lives (Tables ES1–3).
- Health systems are central to preventing and responding to violence. They must integrate prevention and response into policies and services, supported by continuous monitoring and evaluation to track progress and improve actions and responses. Health systems are uniquely positioned to establish and sustain safe, effective, survivor-centred services.
- Data gaps obscure the full picture. Prevalence varies widely across countries, influenced by cultural norms, stigma and underreporting amongst other things. Survivors often avoid the police due to fear, shame, or risks to custody of children or legal status – especially in systems that fail to protect them. Women with disabilities, older women and migrant women face added barriers like discrimination and accessibility challenges. As a result, official data capture only a fraction of the violence, masking its true scale and hindering effective policy and service responses.

Table ES1. Prevalence estimates of intimate partner violence against ever-partnered women in the WHO European Region across the lifetime and in the past 12 months, by age group, 2023

Age group	Prevalence of intimate partner violence across the lifetime (%) (95% uncertainty interval)	Prevalence of intimate partner violence in the past 12 months (%) (95% uncertainty interval)
15–49 years	21.7 (19.1–28.4)	6.5 (5.0–10.2)
15 years and older	21.2 (18.6–28.0)	5.4 (4.2–8.9)

Table ES2. Prevalence estimates of non-partner sexual violence against women in the WHO European Region across the lifetime (since age 15) and in the past 12 months, by age group, 2023

Age group	Prevalence of non-partner sexual violence across the lifetime (since age 15) (%) (95% uncertainty interval)	Prevalence of non-partner sexual violence in the past 12 months (%) (95% uncertainty interval)
15–49 years	9.1 (7.5–14.1)	1.5 (0.7–5.5)
15 years and older	9.1 (7.7–14.3)	1.4 (0.7–4.6)

Table ES3. Prevalence estimates of combined lifetime physical and/or sexual intimate partner violence or non-partner sexual violence among women in the WHO European Region aged 15–49 years and aged 15 years and older, by age group, 2023

Age group	Prevalence (%) (95% uncertainty interval)
1 5–49 years	28.9 (25.6–35.3)
15 years and older	28.4 (25.1–35.0)

The challenge

Survivors are still missing out on life-saving critical health care.

- Plans exist, but practice lags. Despite widespread multisectoral planning, only 45% of countries have clinical guidelines for health-care providers, and just 43% include violence against women in their national health strategies, plans or policies (see Fig. ES1).
- Critical services are incomplete. Fewer than 40% of the 53 countries in the WHO European Region include key services such as emergency contraception (17 countries), safe abortion (7 countries), prophylaxis for sexually transmitted infections (20 countries), HIV post-exposure prophylaxis (17 countries), mental health assessment (20 countries), mental health referrals (23 countries) or referrals to other sectors (25 countries) in their policies. These are core components of WHO's recommendations for the health sector's response.

Seize the opportunity

Momentum for health-sector action is growing.

- Commitment to training the workforce is high. Around 75% of countries in the Region have policies supporting training of health professionals on violence against women. This reflects growing recognition of the health sector's role in identification, response and referral. Sustained investment in both preservice/undergraduate and in-service training is essential to ensure high-quality, survivor-centred care.
- First-line support to respond to intimate partner violence and sexual violence is becoming standard practice. A majority of countries (68%) include first-line support in their health policies, ensuring that survivors receive immediate, empathetic and appropriate support at the first point of contact. This is a critical step towards aligning with WHO guidelines on the health response to intimate partner violence and sexual violence against women.
- Multisectoral plans are in place. Around 87% of countries have adopted multisectoral strategies to address violence against women that include the health sector. These frameworks demonstrate strong political will and intersectoral collaboration. However, their effectiveness depends on translation into concrete, funded actions within the health sector.

Conclusion

The health sector stands on the front line in addressing violence against women and girls, with a vital role to play as part of what needs to be a multisectoral, whole-of-society approach. This has been affirmed in multiple WHO resolutions, including the 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, which provides Member States with a roadmap to strengthen responses through leadership, service delivery, evidence-based prevention and improved data collection. In the WHO European Region, these efforts are reinforced by regional strategies, such as the strategies on health and well-being of women and men and the recently endorsed Second Europea Programme of Work 2026–2030 – "United Action for Better Health". Together, they place gender equality and the prevention of violence against women and girls at the heart of WHO's vision. This report takes stock of progress across the Region – highlighting achievements, exposing persistent gaps, and setting out what must be done to ensure that health systems are equipped to prevent and respond to violence with urgency, compassion and accountability.

Fig. ES1. Key numbers on the state of policies responding to violence against women in the WHO European Region

Creating an enabling environment for health-sector action on violence against women

87% of countries have **multisectoral policies addressing violence against women and girls**

43% of countries have **national health policies that include violence against women and girls**

45% of countries have **health-sector policies on violence against women and girls**

23% of countries have **all three types of policies on violence against women and girls**

75% of countries have commitments to **train health workers in addressing violence against women**

32% of countries have policies that do not align with **WHO guidance on mandatory reporting**

11% of countries have policies that **fully align with WHO guidance on mandatory reporting**

Survivor-centred care: promoting the right to the highest attainable standard of health and freedom from discrimination

53% of countries **include at least one component of confidentiality**

49% of countries **include at least one component of privacy**

Essential health-care services for survivors of violence included in policies

68% of countries include **first-line support**

47% of countries include **referrals to services in other sectors**

38% of countries include **prophylaxis for sexually transmitted infections**

32% of countries include **clinical enquiry**

32% of countries include **emergency contraception**

32% of countries include **HIV post-exposure prophylaxis**

13% of countries include **abortion**

43% of countries include **referral to specialist care in policies on violence against women and girls**

38% of countries include **mental health assessment in policies on violence against women and girls**

28% of countries include **both elements in policies on violence against women and girls**

Proportions of countries in the WHO European Region that mandate the provision of differentiated services for specific groups

17% of countries for **women with disabilities**

8% of countries for **pregnant women**

6% of countries for **adolescent girls and young women**

Background

Violence against women and girls – a health emergency: time for a system shift

Violence against women and girls is one of the most widespread yet underrecognized threats to the health of women and girls in the WHO European Region. Nearly a third (28.9%) of ever-partnered women aged 15–49 years in the Region have experienced physical and/or sexual intimate partner violence over their lifetime, and 6.5% have experienced this in the past 12 months. For non-partner sexual violence, prevalence is 9.1% of women since age 15 and 1.4% in the past 12 months *(1)*. The persistent underreporting of both intimate partner violence and even more so, non-partner sexual violence means that the actual prevalence is likely to be higher.

These are only two of the many forms of violence that women experience. Given current measurement challenges, the figures for intimate partner violence do not yet include psychological abuse, which is widespread and has serious impacts on women's health. Survivors face increased risks – including injuries, depression, anxiety, post-traumatic stress disorder (PTSD), unsafe abortion, sexually transmitted infections, substance abuse and self-harm *(2)*. When it happens during pregnancy, violence is associated with miscarriage, low birth weight and pre-term birth. Women and girls often seek help from health professionals for conditions related to violence, although they usually do not disclose the violence; this provides opportunities to intervene early and prevent re-victimization *(3,4)*.

Prevalence between and within countries varies widely, reflecting a complex interplay of social, cultural, economic, legal and methodological factors *(5)*. Intimate partner violence and sexual violence occur among women of all ages, classes, cultures and ethnicities; however, certain women are more exposed than others – particularly those subjected to intersecting forms of discrimination.

Women may also experience trafficking, forced labour, sexual exploitation and abuse, forced marriage, and denial of sexual and reproductive health rights. The most extreme form of violence against women and girls – femicide – is most often perpetrated by intimate partners or other family members at home. In Europe, up to 64% of murders of women are committed by their intimate partners *(2,3,6)*.

The WHO mandate to address violence against women and girls

Thirty years since the Beijing Platform for Action in 1995, global and regional attempts to end violence against women have seen limited progress *(7)*. This is a critical part of the 2030 Agenda for Sustainable Development *(8)*, and is explicitly reflected in several Sustainable Development Goals (SDGs), including SDG 5 (gender equality) and SDG 16 (peace, justice and strong institutions). Owing to the interconnected nature of the SDGs, achieving SDG 5 and SDG 16 also affects progress on SDG 3 (good health and well-being), SDG 10 (reduced inequalities) and SDG 8 (decent work and economic growth), all of which are off-track to meet the 2030 targets. To support action to achieve these Goals, in 2016, through the "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 *(9)*, and the "Strategy on women's health" and well-being in the WHO European Region *(10)*, the 53 Member States in the WHO European Region committed to strengthening health systems to prevent and respond to violence against women and girls. As part of multisectoral action, the health sector also plays a crucial role in implementing the "Services ensured" pillar of the interagency "RESPECT women framework for prevention on violence against women" *(11)* (Fig. 1).

Listening to survivors' voices

The 2024 United Nations Economic Commission for Europe regional review of progress on implementation of the Beijing Platform for Action *(12)* found that while some countries had introduced or strengthened services for survivors of violence (including specialized health services), rates of violence had not declined. The high number of reported cases in some countries may also indicate improved awareness and shifting social norms around the acceptability of violence. However, many countries still have inadequate legal frameworks, including definitions of rape that are not based on consent, and a lack of legal norms for technology facilitated violence. Stigma, shame, victim-blaming attitudes, fear of reprisals from perpetrators, and discriminatory laws and policies continue to prevent many survivors from accessing critical health care and other multisectoral services *(13)*. Women's voices have usually not sufficiently been heard in the design of health services. Evidence shows that women value emotional connection and empathy, practical support through action and advocacy and an approach that is respectful and recognizes their autonomy and is tailored to their individual needs *(4)*. When they disclose abuse they want health professionals to recognize and validate their abuse, document and treat their injuries and other health problems, and to offer care and support-not just referrals to shelters or legal advice. For many, the health system is the first-and sometimes only-point of contact *(3)*. Further research is needed to ensure that health service responses are accessible to and address the needs of women and girls who may be at heightened risk or who may experience multiple forms of discrimination, including adolescent girls, women with disabilities, women from ethnic or racial minority groups, migrant workers and older women.

Fig. 1. The WHO mandate to address violence against women and girls

In 2016, the 53 Member States in the WHO European Region committed to strengthening health systems to prevent and respond to violence against women and girls.

As part of multisectoral action, the health sector plays a crucial role in implementing the "Services ensured" pillar.

Thirty years since the Beijing Platform for Action in 1995, global and regional attempts to end violence against women have seen limited progress.

The health sector: from bystander to first responder

In the new Second European Programme of Work 2026–2030 – "United Action for Better Health", the WHO Regional Office for Europe is calling for accelerated progress on addressing violence against women *(14)*. Although the findings listed in this report indicate that good efforts have been directed to improving training of clinicians on violence against women, more attention is required to address systemic issues at the health management and policy level. Beyond policy, data from 2021 show that only 20 of the 53 countries in the WHO European Region have post-rape care available in accordance with WHO recommendations. This indicator is limited in terms of assessing availability beyond one location countrywide, however, and it does not provide information on coverage and accessibility of services *(15)*. Beyond availability, greater attention must be given to the accessibility and quality of survivor-centred care (Box 1).

Box 1. Survivor-centred care and first-line support

Survivor-centred care is care that places a person's rights, needs, safety and dignity at the core of all processes, ensuring that they are fully involved in decisions about their care, respected and empowered throughout their journey of recovery. Key principles include safety, confidentiality, respect and non-discrimination *(3)*.

First-line support in responding to intimate partner and sexual violence is immediate support that should be provided to women and girls who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator. This includes ensuring that the consultation is conducted in private and confidentially; being non-judgemental, supportive and validating what the woman is saying; providing practical care and support; asking about any history of violence, but not pressuring her to talk; helping her access information about resources; and assisting her to increase safety for herself and her children *(3)*.

Recent studies show that poor responses from health professionals can worsen mental health, delay recovery and deter future help-seeking *(4,16)*. However, health professionals face many barriers when trying to provide high-quality care: lack of private spaces, unclear protocols and referrals that are fragmented or have limited availability. Health workers' attitudes and beliefs about violence may also create barriers, including the belief that intimate partner violence is a private matter, fear of causing harm, or the view that it is not the role of health services to ask about violence. On the other hand, a safe, effective, caring response can support women's path to healing. Research shows that the personal commitment of health professionals can be strengthened with skills-based training *(17)*. Training on the WHO LIVES model (Listen, Inquire, Validate, Enhance safety and Support; Fig. 2) has helped health workers respond with empathy to disclosures, including across the WHO European Region *(18,19)*. This training needs to be supported by a strong system of mentoring, support and supervision.

The Framework for action on the health and care workforce in the WHO European Region 2023–2030 *(20)* can support implementation of gender-responsive policies and zero tolerance of abuse and violence against health workers. This would support health workers providing care to survivors of violence, and would also address sexual harassment and discrimination experienced by health-care providers *(21)*. The European Union (EU) Directive on combating violence against women and domestic violence *(22)* and the new EU Roadmap for Women's Rights *(23)* provide a further opportunity for the health sector to play a stronger role in addressing violence against women in both prevention and care and support for survivors.

Fig. 2. The WHO LIVES model

Source: WHO *(18)*.

Objectives and audience

This report provides a clear and accessible overview of the state of violence against women and girls in the WHO European Region, combining WHO prevalence estimates with a review of national health-sector policies and good practice policy examples. Its target audience is health policy-makers, managers, clinicians and researchers. It aims to make the scale of the problem visible, the gaps in response undeniable, and the path forward actionable.

Methodology

This report combines prevalence estimates and policy analysis for the 53 Members States in the WHO European Region. The global, regional and national prevalence estimates represent a systematic review of scientific data (2000 to 2023) on the prevalence of two forms of violence against women: sexual violence by non-partners and intimate partner violence (physical or sexual, or both) and a country consultation process. Developed by WHO and partners as part of an interagency working group, the methodology adopts a rigorous and internationally recognized Bayesian modelling approach to estimate the prevalence of intimate partner violence and non-partner sexual violence in a comparable way *(1)*. These estimates draw from hundreds of surveys conducted across the world, including in the WHO European Region, collected by WHO in a systematic way and reviewed against eligibility criteria to ensure quality and rigour. The data are extracted, and minimal adjustments are made where there are variations in the sample and measures used. Nevertheless, it is vital to recognize that no survey can fully capture the true scale of this violence. Many women do not disclose their experiences – especially when it comes to sexual violence by non-partners, which is still deeply stigmatized and often silenced by fear, shame and social repercussions. The new estimates presented in this report, based on data for the period 2000–2023, supersede all previously published WHO or United Nations estimates for years that fall within the same period. Owing to modifications in methodology and data availability, changes in prevalence between the 2018 estimates and these new 2023 estimates are not strictly comparable and should not be interpreted as representing time trends.

The policy analysis included in this report is based on the WHO violence against women national policies database as of October 2025 *(24)*, which was launched in 2021 to strengthen accountability and support evidence-based action. Grounded in WHO's global plan of action on violence *(9)* and international human rights norms, the database captures over 70 data points on national health and multisectoral policies addressing violence against women. During the initial phase, researchers reviewed the available policies from 194 WHO Member States – including those submitted through a 2018 baseline assessment in the WHO European Region – and conducted content analysis to inform a global status report *(25)*. In 2024, the database was updated using countries' responses to the five-yearly WHO sexual, reproductive, maternal, newborn, child and adolescent health policy survey *(15)*. In 2025, the WHO Regional Office for Europe commissioned a comprehensive updated survey of policies across all 53 Member States. This report contains a summary of the results.

The researchers sourced government-endorsed national policies through repositories, country outreach and surveys. Subnational and third-party documents (such as United Nations reports) were excluded.

Three main types of policy documents were reviewed (see Annex 1):

- national health policies on violence against women;
- national multisectoral policies on violence against women – including gender policies with a strong component on violence against women; and
- health-sector implementation tools to respond to violence against women, such as clinical guidelines.

Each type of policy acts on different levels of the system and delivery of services. Health-sector policies and standards such as clinical guidelines have the most direct impact on survivor care owing to their proximity to service delivery.

A structured document review was conducted using 15 priority indicators focused on enabling environments, survivor-centred care and health services (see Table A2.1 in Annex 2). Indicators were prioritized to include the minimal essential services required for a health-sector response, in addition to specific policy areas already identified as a barrier to accessing services across the WHO European Region (such as mandatory reporting). The denominator used for all indicators was 53 – the total number of countries in the Region. Translation tools and artificial intelligence platforms supported analysis across languages, ensuring inclusivity and regional relevance.

Following the review and extraction of information from the documents, a descriptive analysis was conducted to identify key trends and gaps. Eligible policy documents were unavailable for four countries, and some data reflect older policies due to limited public access to updated versions *(26)*.

Violence against women prevalence estimates in the WHO European Region, 2025

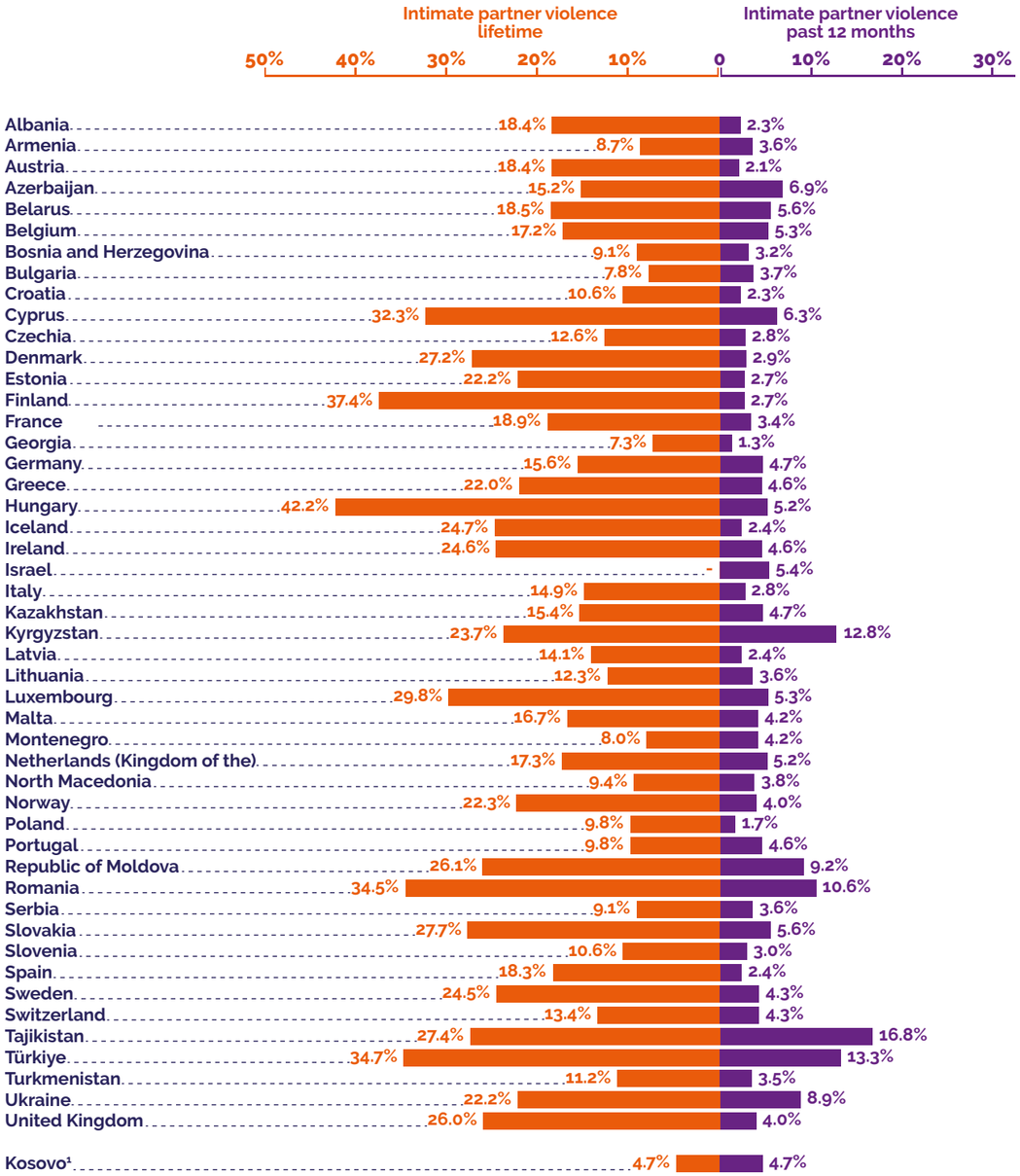
The estimates in this report were based on a thorough and systematic review of available prevalence data spanning the period 2000–2023 *(1)*. The findings clearly demonstrate that violence against women is widespread. It is not an issue confined to certain groups; instead, it represents a global public health crisis of epidemic proportions, impacting millions of women and demanding immediate intervention.

Intimate partner violence is violence by a husband or male intimate partner (physical, sexual or psychological) and is one of the most widespread forms of violence against women. Table 1 and Fig. 3 show prevalence estimates of physical and/or sexual intimate partner violence against ever-partnered women across the lifetime and in the past 12 months in the WHO European Region by age group and by country and area.

Table 1. Prevalence estimates of physical and/or sexual intimate partner violence among ever-married/partnered women across the lifetime and in the past 12 months in the WHO European Region, by age group, 2023

Age group	Prevalence of intimate partner violence across the lifetime (%) (95% uncertainty interval)	Prevalence of intimate partner violence in the past 12 months (%) (95% uncertainty interval)
15–19 years	17.6 (15.5–20.6)	6.6 (5.1–9.2)
20–24 years	20.0 (17.7–24.7)	7.5 (5.7–10.8)
25–29 years	21.6 (19.0–26.9)	7.4 (5.7–10.9)
30–34 years	22.7 (19.7–29.7)	6.8 (5.2–11.1)
35–39 years	23.5 (20.3–31.8)	6.2 (4.7–11.1)
40–44 years	24.1 (21.0–31.7)	5.4 (4.1–9.6)
45–49 years	23.8 (20.9–30.8)	4.5 (3.5–8.0)
50–54 years	22.5 (19.7–29.2)	3.7 (2.8–6.7)
55–59 years	21.6 (18.9–28.4)	3.1 (2.3–5.7)
60–64 years	20.5 (17.2–28.9)	2.6 (1.9–5.4)
65 years and older	19.1 (16.2–26.7)	2.1 (1.5–4.5)
15–49 years	21.7 (19.1–28.4)	6.5 (5.0–10.2)
15 years and older	21.2 (18.6–28.0)	5.4 (4.2–8.9)

Fig. 3. Prevalence estimates in the 53 Member States and Kosovo[1] in the WHO European Region, 2025



[1]All references to Kosovo should be understood to be in the context of United Nations Security Council resolution 1244 (1999). It is included in this table because data on Kosovo were available that met the inclusion criteria.

Source: WHO *(1)*.

Non-partner sexual violence refers to acts of sexual violence against women, experienced since the age of 15 years, perpetrated by someone other than a current or former husband or male intimate partner (for example a male relative, friend, acquaintance or stranger) (Table 2).

Table 2. Prevalence estimates of non-partner sexual violence among women across the lifetime (since age 15) and in the past 12 months in the WHO European Region, by age group, 2023

Age group	Prevalence of non-partner sexual violence across the lifetime (since age 15) (%) (95% uncertainty interval)	Prevalence of non-partner sexual violence in the past 12 months (%) (95% uncertainty interval)
15–49 years	9.1 (7.5–14.1)	1.5 (0.7–5.5)
15 years and older	9.1 (7.7–14.3)	1.4 (0.7–4.6)

Although women face various types of violence, physical and/or sexual intimate partner violence and sexual violence by non-partners constitute a significant share of the violence experienced by women worldwide. Combining prevalence estimates for these two types of violence offers a more comprehensive understanding of the proportion and number of women affected over their lifetimes, even though it does not capture the entire scope of violence women endure (Table 3).

Table 3. Prevalence estimates of combined lifetime physical and/or sexual intimate partner violence or non-partner sexual violence among women aged 15–49 years and aged 15 years and older in the WHO European Region, by age group, 2023

Age group	Prevalence of violence (%) (95% uncertainty interval)
15–49 years	28.9 (25.6–35.3)
15 years and older	28.4 (25.1–35.0)

What countries are doing to address violence against women and girls

Violence against women and girls is a public health challenge and a violation of human rights. Addressing it requires more than clinical care – it demands a system-wide approach, grounded in survivor-centred principles. Drawing on findings from the document analysis, this chapter presents a regional overview of how countries are responding. The researchers examined the policies through a lens of three pillars essential to a resilient health-system response *(3)*:

- enabling environments – national health and multisectoral policies that enable action;
- survivor-centred care – policies that uphold dignity, safety and rights; and
- commitment to provision of health services – availability and quality of essential services for survivors.

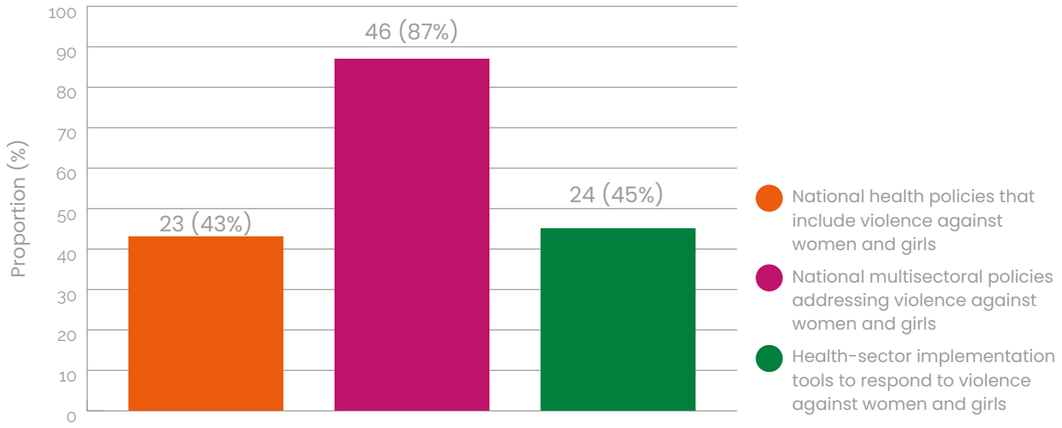
To highlight good practices, excerpts from key policy documents are included in this report, illustrating how different countries are addressing a range of issues. Fig. 4 includes some key findings at a glance.

Creating an enabling environment for health-sector action on violence against women

An enabling environment begins with strong policy foundations. The findings of this analysis show that 87% of countries have multisectoral policies addressing violence against women, but fewer than half have national health policies that include violence against women (43%) or health-sector policy implementation tools that address violence against women (45%). Only 23% of countries had all three types of policy on violence against women (Fig. 5). Encouragingly, 75% of countries have commitments to train health workers in addressing violence against women. However, 32% require health-care providers to report adult women experiencing intimate partner violence to the police, independently of their wishes. This practice is not recommended by WHO; it risks undermining trust in health services and deterring survivors from seeking care *(3)*.

Fig. 4. Key findings at a glance

Fig. 5. Numbers and proportions of countries in the Region with a multisectoral policy, a health-sector policy and a national health policy on violence against women



Note: numbers on the bars indicate number of Member States.

Existence of policy

Policies may reflect governments' commitments and intentions, as well as alignment with international health standards and principles of gender equality and human rights *(27,28)*. Clear policies set an agenda that can be resourced and implemented. Without this agenda, health systems are not empowered or equipped to deliver consistent, high-quality and survivor-centred care. Box 2 sets out an example of good policy practice from Spain.

Mandatory reporting to police by health-care providers: a barrier to survivor-centred care

WHO does not recommend blanket mandatory reporting of intimate partner violence against women to the police by health-care workers *(3,32,33)*. Mandatory reporting policies risk violating women's autonomy and confidentiality, and can deter survivors from disclosing abuse to health-care providers, ultimately preventing access to timely care. Women may also fear harms to their children, including losing custody of them. Where there is a legal requirement to report, WHO recommends that health-care providers inform women about this requirement before disclosure, so that they can make an informed decision about whether to disclose. If they wish to pursue reporting to the police or criminal justice system, the health provider may offer to report violence on their behalf or to assist those women who wish to report for themselves *(3)*.

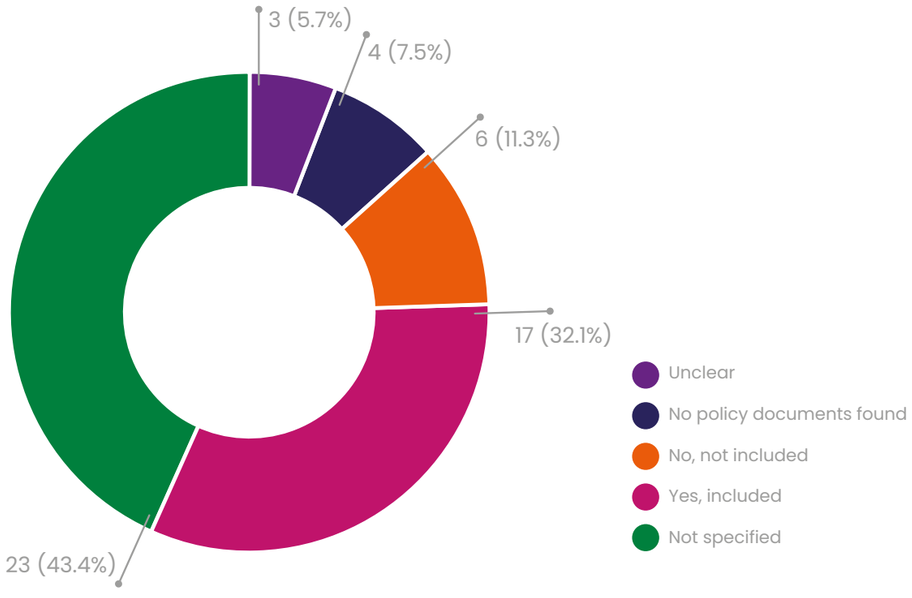
This analysis shows that over a third of countries in the WHO European Region (32%) still include mandatory reporting in policy (Fig. 6). Only 11% of countries have policies that fully align with WHO guidance (see Table A3.5 in Annex 3).

Box 2. Good policy practice example from Spain

Spain stands out as one of only 12 countries in the WHO European Region with a comprehensive policy framework that facilitates health-sector action on violence against women. This includes:

- a multisectoral policy addressing violence against women – *A guide to rights for victims of gender-based violence and sexual violence* – setting the foundation for cross-sector collaboration and shared responsibility *(29)*;
- a national health policy – *National strategy for sexual and reproductive health* – integrating violence prevention and response into core health priorities *(30)*; and
- a health-sector implementation tool on violence against women – *National Health System common protocol for health-care action in the face of sexual violence* – translating policy into practice, equipping health professionals with clear guidance for clinical care *(31)*.

Fig. 6. Numbers and proportions of countries with a mandatory reporting requirement in policy



Box 3 sets out an example of good policy practice from North Macedonia.

Box 3. Good policy practice example from North Macedonia

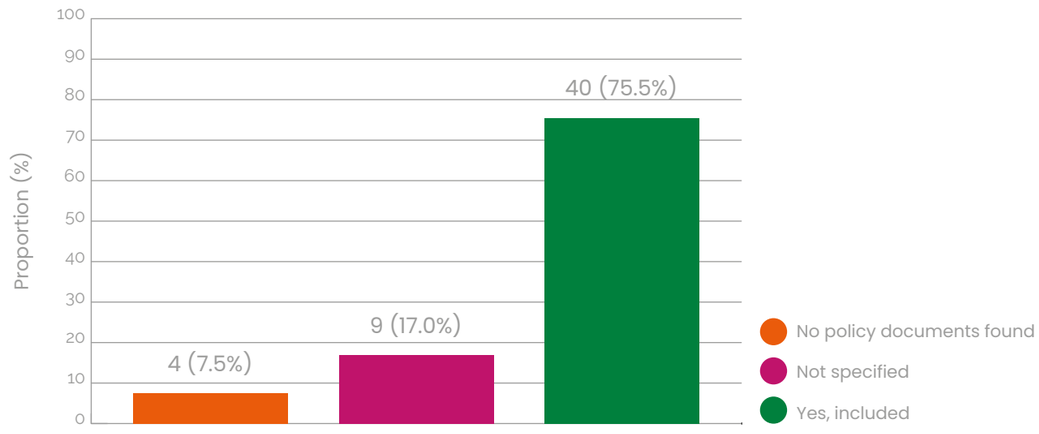
North Macedonia's *Handbook for health-care workers in cases of gender-based violence, including people with disabilities* provides clear guidance for health workers to respect the wishes of the survivor on whether to report an incident to the authorities. It states: "Mandatory reporting of intimate partner violence to the police is not recommended, but health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wishes to do so and is aware of her rights" *(34)*.

Training health workers: building system readiness with compassion and competence

Health workers are often the first – and sometimes the only – point of contact for survivors of violence. Their ability to respond with empathy and respect can mean the difference between silence and healing. Training must go beyond technical skills. It must challenge harmful gender norms and equip providers to respond empathetically, and without judgement, bias or stigma. Training alone is also insufficient, without a supportive environment to enable provision of care aligned with survivor-centred principles. Low-intensity, high-frequency training appears to show the best results in building health providers' competencies, rather than one-off training. Supportive supervision, regular interdisciplinary case reviews and ongoing training are also critical *(18,19)*.

Encouragingly, 75% of countries in the WHO European Region have made a policy-level commitment to train health workers in responding to violence against women (Fig. 7; see Table A3.6 in Annex 3).

Fig. 7. Numbers and proportions of countries with a commitment in policy to train health-care providers on responding to violence against women



Note: numbers on the bars indicate number of Member States.

Box 4 sets out an example of good policy practice from Poland.

Box 4. Good policy practice example from Poland

Poland's *Government Programme for Counteracting Domestic Violence 2024–2030* demonstrates strong leadership by embedding violence prevention and response into both preservice and in-service training for health professionals *(35)*.

Ensuring access to high-quality survivor-centred care

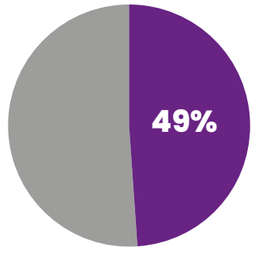
WHO clinical and policy guidelines are clear: health services for survivors must be consistent with internationally recognized human rights principles and standards – including the rights to autonomy, privacy, confidentiality, and informed consent *(26)*. This includes promoting the right to the highest attainable standard of health and freedom from discrimination. These translate in practice into principles of autonomy, privacy, confidentiality, informed consent and choice *(3)*. At the regional level, the Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) *(36)* and the EU Directive on combating violence against women and domestic violence *(22)* require support to be provided with the highest standards of privacy and confidentiality. These principles are not optional; they are the foundation of survivor-centred care. However, in the WHO European Region just under half (49%) of countries include at least one component of privacy, and only 53% include at least one component of confidentiality (Fig. 8).

Fig. 8. Ensuring access to high-quality survivor-centred care

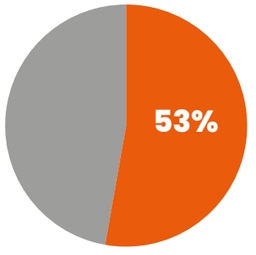
Health services for survivors must be consistent with internationally recognized human rights principles and standards – including the rights to autonomy, privacy, confidentiality, informed consent and choice.

These principles are not optional; they are the foundation of survivor-centred care.

However, the evidence is stark.



Countries in the Region that include at least one component of **privacy**

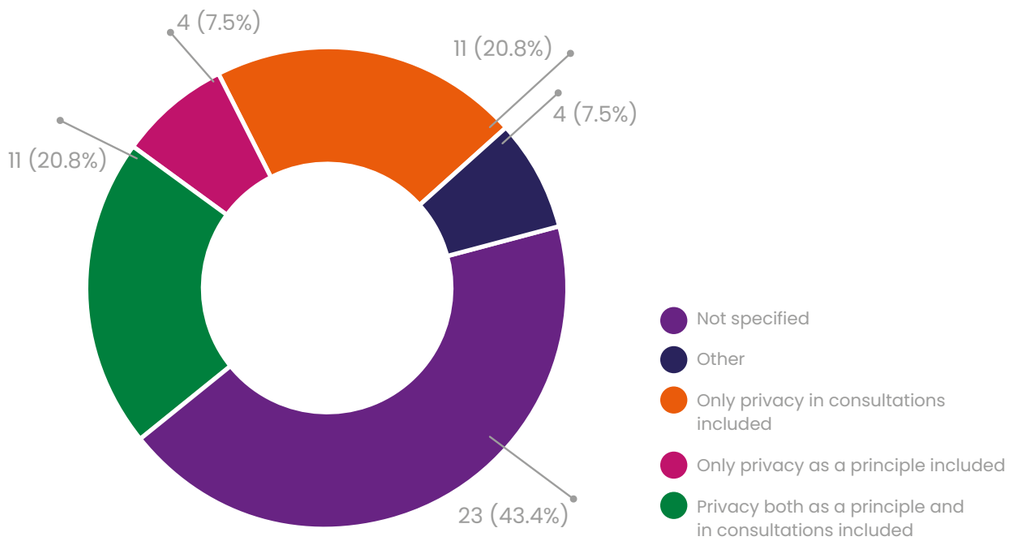


Countries in the Region that include at least one component of **confidentiality**

Privacy as a component of survivor-centred care

This review assessed whether privacy is reflected in policy in two ways: as a guiding principle of survivor-centred care and as a requirement during service provision or consultations with survivors. Only 28% of countries include privacy as a principle, and 42% mandate privacy during consultations (Fig. 9). Just 21% include both components. Overall, 49% of countries include one or both components (see Tables A3.7–A3.9 in Annex 3).

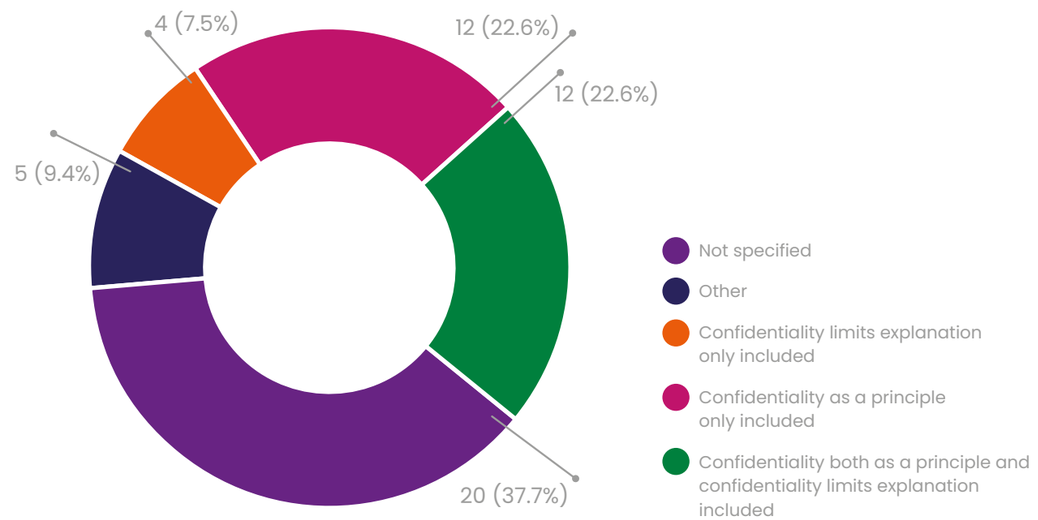
Fig. 9. Numbers and proportions of countries that include that include privacy as a component of survivor-centred health care in policy



Confidentiality as a component of survivor-centred care

WHO recommends that providers ensure confidentiality and inform survivors of its limits – particularly in contexts where mandatory reporting may apply *(3,37)*. The analysis found that 45% of countries include confidentiality as a principle, 30% require survivors to be informed about its limits, and only 23% include both (Fig. 10). Overall, 53% of countries include one or both components (see Tables A3.10–A3.12 in Annex 3).

Fig. 10. Numbers and proportions of countries that include confidentiality as a component of survivor-centred health care in policy



Box 5 sets out an example of good policy practice from Austria.

Box 5. Good policy practice example from Austria

Austria's *Health care for women affected by violence: a guide for hospitals and medical practices (38)* highlights the importance of confidentiality and consent. It states:

> *The knowledge of the medical confidentiality obligation towards the patient and her social environment provides security. Finally, information may only be passed on to third parties with the patient's consent. This also applies to information to family members. The patient should always be informed of this confidentiality obligation at the beginning of the conversation.*

Closing the gaps: essential health-care services for survivors of violence

The review looked at whether policies include clinical enquiry and the following WHO-recommended health services for survivors:

- clinical enquiry for intimate partner/domestic violence
- first-line support
- emergency contraception
- safe abortion
- HIV post-exposure prophylaxis
- prophylaxis of sexually transmitted infections
- mental health care
- referrals to services in other sectors.

It found that 68% of countries in the WHO European Region include first-line support in their policies. However, fewer than 40% of countries include clinical enquiry for identification of intimate partner violence, emergency contraception, prophylaxis for sexually transmitted infections, HIV post-exposure prophylaxis, abortion for sexual assault (to the maximum extent of the law), or mental health assessment and referrals. Among countries that mandate these services in policy, the majority do so through health-sector policies on violence against women – in other words at a level that has a direct impact on service delivery (Fig. 11; see Tables A3.8–A3.11 in Annex 3).

Clinical enquiry: asking the right questions at the right time

WHO recommends that health-care providers ask about experiences of intimate partner violence when assessing conditions that may be caused or complicated by such violence – that is, clinical enquiry *(3)*. Examples of conditions that may prompt questions about intimate partner violence include symptoms of depression, adverse reproductive outcomes, alcohol or other substance use, and unexplained injuries or chronic unexplained gastrointestinal symptoms *(3,37)*. Specific requirements to be met before asking, highlighted by WHO, include existence of a clear standard operating procedure or protocol, providers that have been trained how to ask and or asking and on first-line support as a minimum, ability to ensure privacy and confidentiality, and established referral networks. In the WHO European Region, 17 out of 53 countries (32%) include clinical enquiry in policy (Fig. 12; see Table A3.13 in Annex 3).

Fig. 11. Essential health-care services for survivors of violence

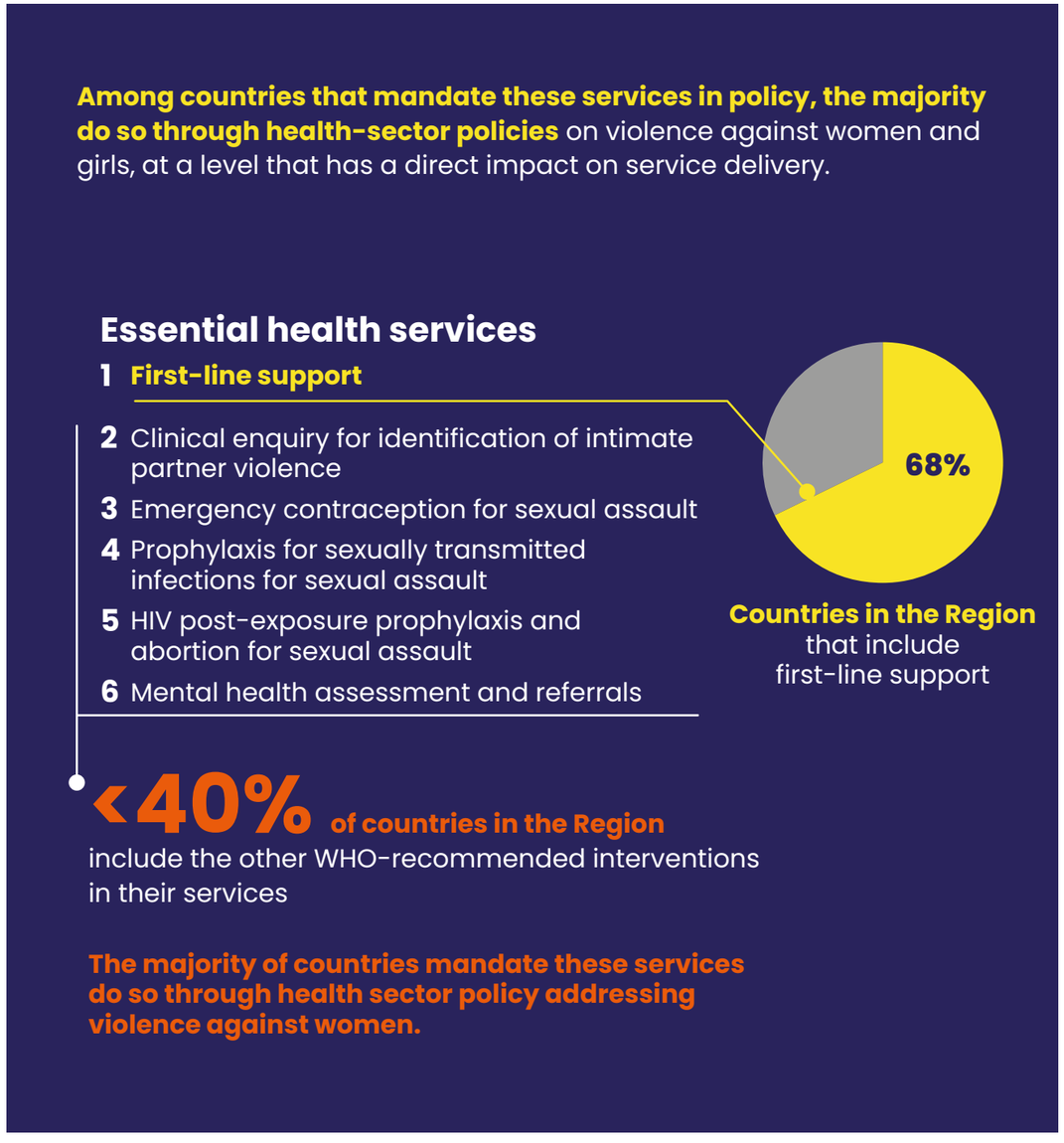
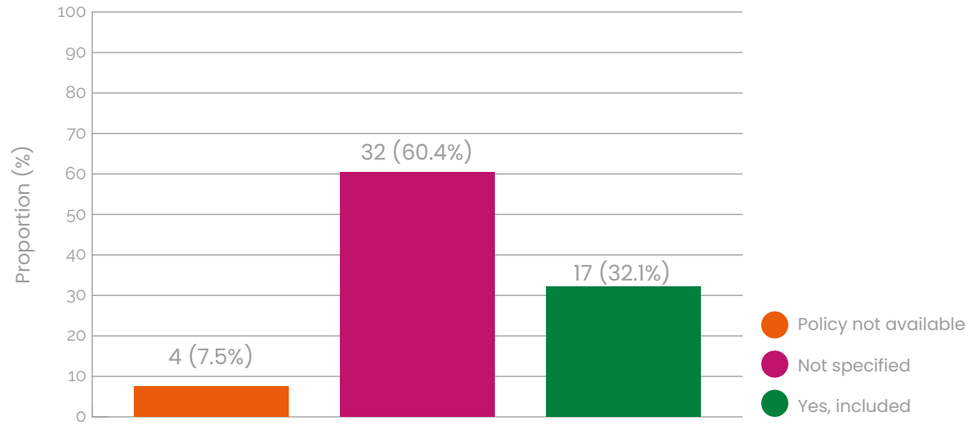


Fig. 12. Numbers and proportions of countries that include clinical enquiry in policy



Note: numbers on the bars indicate number of Member States.

Box 6 sets out an example of good policy practice from Andorra

Box 6. Good policy practice example from Andorra

Andorra's *Guide to collaboration and action protocols in cases of gender violence and domestic violence (39)* emphasizes the importance of health-care professionals being aware of violence and being able to detect warning signs. It states:

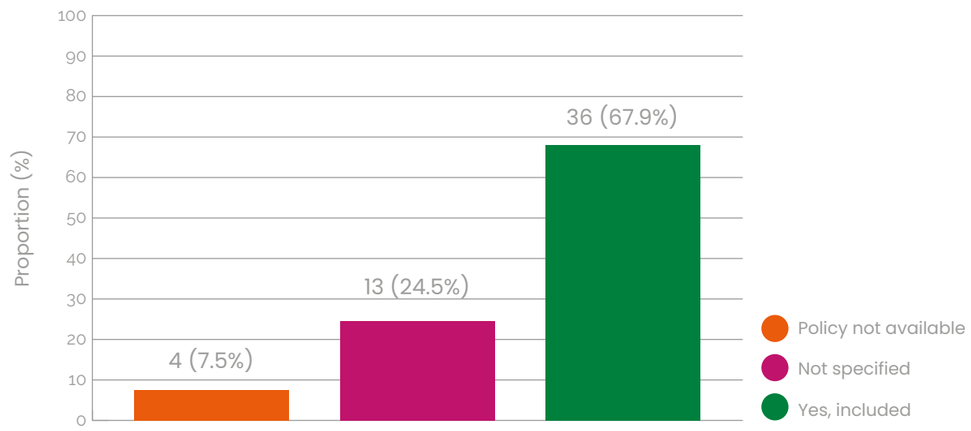
> *When it comes to detection, it is important that all health-care professionals are aware of this issue and incorporate strategies for detecting warning signs into their daily practice, adapted to their activity. For those who work with records such as medical histories, a protocol should be established that systematically includes the monitoring of indicators that may reveal situations of this type.*

First-line support: the minimum standard of care

First-line support is the foundation of survivor-centred care. WHO recommends offering first-line support (via the LIVES model; see Fig. 2) to all survivors who disclose violence, at all levels of health service delivery. LIVES is an adaptation of psychological first aid, and aims to provide practical care and support, which responds to the survivor's concerns but does not intrude on her autonomy *(3)*.

Encouragingly, 68% of countries include first-line support in policy (Fig. 13; see Table A3.14 in Annex 3).

Fig. 13. Numbers and proportions of countries that include first-line support in health policy



Note: numbers on the bars indicate number of Member States.

Box 7 sets out an example of good policy practice from France.

Box 7. Good policy practice example from France

France's *Combating intimate partner violence: professionals' role (40)* specifies the step-by-step first-line care for survivors of violence as follows.

- Listen.
- Gather factual information.
- Assess the severity of the violence, advise and take action.
- Provide treatment.
- Refer.

Care following rape and sexual assault: time-sensitive, life-saving interventions

Survivors of sexual assault must be offered a package of care within critical time windows: emergency contraception (within 120 hours), HIV post-exposure prophylaxis (within 72 hours) and prophylaxis for sexually transmitted infections *(3,37)*. If pregnancy occurs, safe abortion should be offered to the full extent of the law (see Tables A3.15 – A3.18 in Annex 3). Table 4 sets out the numbers and proportions of countries that include post-rape care in policies.

Table 4. Numbers and proportions of countries that include post-rape care

Component of post-rape care	Number (proportion) of countries that include it in policy
Emergency contraception	17 (32%)
Abortion	7 (13%)
HIV post-exposure prophylaxis	17 (32%)
Sexually transmitted infection prophylaxis	20 (38%)

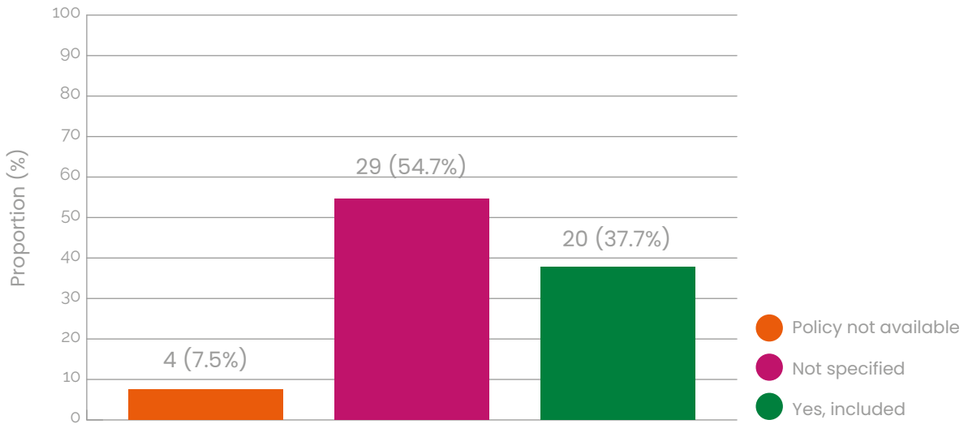
Box 8 sets out an example of good policy practice from Albania.

Box 8. Good policy practice example from Albania

In Albania, the *Standard operating procedures for handling domestic violence and gender-based violence cases (41)* clarify that survivors should be offered abortion services in accordance with national law. They state: "If a woman shows up after the time required for emergency contraception (five days), then this contraceptive is not worth using, and if the woman is pregnant as well as a result of the rape, she must be offered a safe abortion, in accordance with national law."

In relation to HIV post-exposure prophylaxis, 32% of countries include it in policy. Further, 38% of countries include prophylaxis for sexually transmitted infections (Fig. 14).

Fig. 14. Numbers and proportions of countries that include prophylaxis of sexually transmitted infections for survivors of violence in health policy



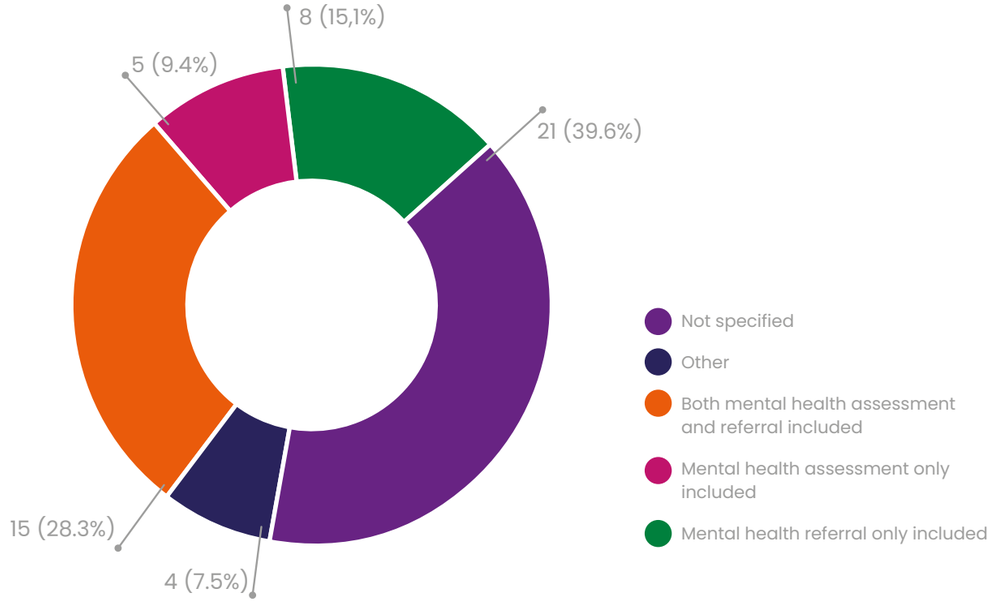
Note: numbers on the bars indicate number of Member States.

Mental health assessment and referral

WHO guidelines recommend a range of mental health-care interventions for survivors of violence, including basic psychosocial support, assessment of moderate to severe depression, referral to specialist care where applicable, and treatment for diagnosed mental health conditions such as depression and PTSD *(3,37)*. While treatment details may be embedded in broader mental health policies not covered in this review, two key indicators were reviewed: mental health assessment and referral for treatment.

Currently, only 38% of countries in the WHO European Region include mental health assessment in violence against women policies, and 43% include referral to specialist care. Just 28% include both (Fig. 15; see Table A3.19 in Annex 3).

Fig. 15. Numbers and proportions of countries that include mental health care in health policy



Box 9 sets out an example of good policy practice from Belgium.

Box 9. Good policy practice example from Belgium

Belgium's *National Action Plan to Combat Gender-Based Violence 2021–2025 (42)* includes a clear mandate to ensure that survivors have access to specialized psychological treatment. It states: "Ensure access to specialized post-traumatic psychological support for victims of domestic and/or intra-family violence."

Referral to other sectors: building a coordinated response

The health sector is often the first point of contact for survivors, and must act as a gateway to broader support. Just under half of countries (47%) include referrals to other sectors, such as social services, legal aid and law enforcement. This is essential for a coordinated, multisectoral response that meets survivors' full range of needs (see Table A3.20 in Annex 3).

Groups with specific needs

Pregnancy and adolescence are important moments in women's and girls' lives for identifying intimate partner violence and providing support and services. Pregnant women experiencing violence have specific needs, and the violence has an impact on the health of both the mother and her infant/child. Furthermore, pregnancy offers an opportunity for women to interact with health workers over a period of time – from antenatal to postnatal care. Adolescent girls are at a particularly formative time in their development, and early intervention to address exposure to violence can have important benefits for the rest of their lives (Fig. 16).

Women living with disadvantage or in vulnerable situations, or who face intersecting and multiple forms of discrimination, are at a higher risk of experiencing violence. This may include, for example, women with disabilities, migrant women, women from ethnic or racial minority groups and trans women *(8,20)*. In keeping with the SDG commitment to "leave no one behind", it is important to reach these groups of women and ensure that they do not face discrimination in accessing health and other services. Health worker training should include consideration of the specific needs of such groups.

Although the document review did not include indicators for the inclusion of specific groups in policy due to scope limitations, this section draws on global data from 2021 to show the extent to which policies recognize the needs of some of these specific groups of women and commit to this in policy. These analyses are based on data from 48 rather than 53 countries, unlike the other indicators in this report.

Limitations and strategic considerations

While this report offers valuable insights into the policy landscape addressing violence against women and girls across the WHO European Region, several limitations exist. Nevertheless, these still offer opportunities for investment in research – particularly initiatives that are cross-sectoral and foster cooperation *(26)*.

Understanding the true scale of violence against women

Despite improvements in measurement, no survey can fully capture the true scale of violence against women. Data gaps persist, and challenges in survey design and interviewer training can further distort the picture. Policy-makers should be aware that even high-quality survey data may not reflect the full burden. Further research is urgently needed to understand the health burden of violence;

how different forms of violence interact and accumulate over time; and how violence experienced in childhood affects subsequent experiences of violence, shaping the health and well-being of women and girls across their lives. A lack of data about the prevalence, magnitude and forms of violence against women living with intersecting forms of discrimination who may be at higher risk (such as women with disabilities, and migrant, Indigenous and transgender women) also remains a data gap that needs to be addressed *(26)*.

Scope and availability of policies

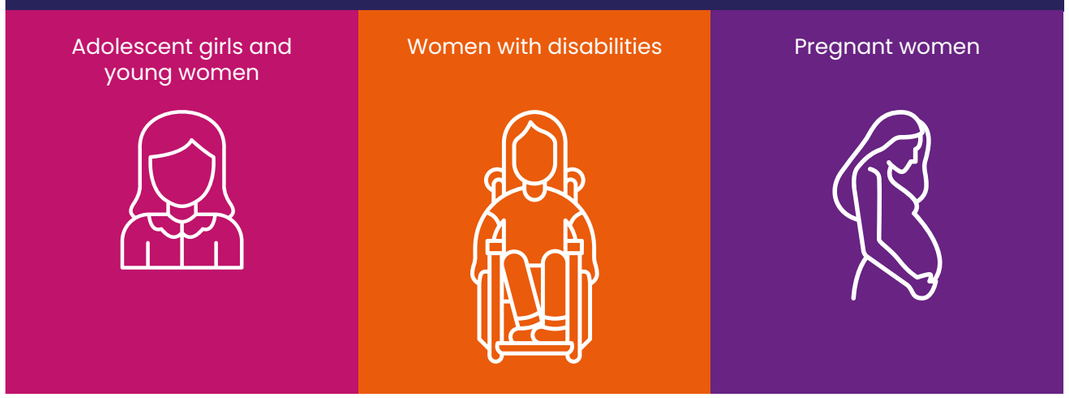
This policy analysis focused on the health sector's role in preventing and responding to violence against women. To stay consistent with that aim, it prioritized policy documents most likely to include health-related measures. Legal and sectoral documents – such as laws, parliamentary resolutions and justice or police policies – were excluded because they do not directly address health-sector responsibilities, resources or service delivery; they were therefore beyond the scope of this exercise, which is focused on the health sector. Document analysis was also limited where policies were not available (in four countries in the Region).

Policy implementation not assessed

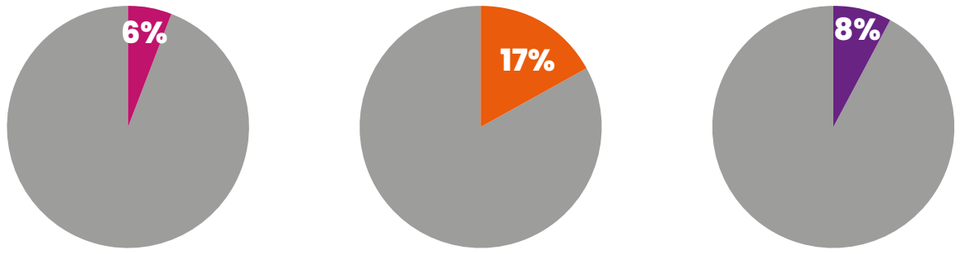
This report focuses on the existence and content of policies – not their implementation. While policy inclusion is a critical first step, it does not guarantee that survivors of violence receive high-quality, survivor-centred and rights-based care. Bridging the gap between policy and practice remains a shared responsibility for governments, health systems and civil society. The Second European Programme of Work 2026–2030 prioritizes key actions to guide Member States across the WHO European Region in ensuring that the health sector is equipped to respond to violence against women – including some activities that are contingent on resources and collaboration across sectors. WHO has developed guidance and tools – including a clinical handbook *(37)*, a manual for health managers *(19)* and a curriculum for health workers *(18)* – that can support countries in their efforts to strengthen the health system response to violence against women *(3,9)*.

Fig. 16. Proportion of countries in the WHO European Region that mandate the provision of services for specific groups

Pregnancy offers an opportunity for women to interact with health workers over a period of time – from antenatal to postnatal care. Adolescent girls are at a particularly formative time in their development, and early intervention to address exposure to violence can have important benefits for the rest of their lives.



Proportion of countries in the WHO European Region that mandate the provision of differentiated services for specific groups:



Women living with disadvantage or in vulnerable situations, or who face intersecting and multiple forms of discrimination, are at a higher risk of experiencing violence. This may include, for example, women with disabilities, migrant women, women from ethnic or racial minority groups and trans women.

Note: These analyses are based on 48 countries, not 53 as the other indicators in this report; the reason for this can be found in the methodology section *(25)*.

Conclusions and a call to action for health leaders

This report reveals both progress and persistent gaps in the health response to violence against women across the WHO European Region. While multisectoral frameworks are in place in most countries, health sector policies remain inconsistent, incomplete and – in many cases – misaligned with WHO guidance.

Survivors are clear about what they need: respect, safety, dignity, care and choice. Health systems must be ready to respond – not just in principle, but in practice. This means bringing the voices of survivors to policy discussions and embedding survivor-centred care into every level of the health system, from primary to tertiary.

Drawing on the recommendations made by existing WHO guidelines, the following actions to address violence against women are recommended for health policy-makers.

Key recommended actions for health policy-makers

Embedding violence against women in national health policies and ensuring supportive environments

As recommended by WHO guidelines *(3)*, health policy-makers should:

- ensure that violence against women is explicitly addressed in national health strategies, plans, and policies;
- ensure that policies include the essential health services for post-rape care, actions to ensure an enabling environment, and provision of survivor-centred care; and
- ensure that policies align with WHO evidence-based guidance and international human rights standards to create a coherent mandate for action.

Implementing health sector policies on violence against women

As recommended by WHO guidelines *(3)*, health policy-makers should:

- translate national commitments into operational guidance, including clinical protocols, standard operating procedures, and training for health workers (preservice/undergraduate and in-service, residency and specialty training); and
- ensure that policies are accessible and up-to-date, and that they reflect the realities of service delivery.

Ensuring availability of essential services, including for post-rape care

As recommended by WHO guidelines *(3,18,19)*, health policy-makers should:

- prioritize survivor-centred care that is safe and includes the full package of essential services, especially at the primary health care level: early identification of partner violence through clinical enquiry, first-line support, mental health assessment, and referrals to other services, and in cases of rape also emergency contraception, safe abortion (to the maximum extent of the law), HIV and prophylaxis for sexually transmitted infections;
- ensure that all health-care providers receive competency-based training on how to ask about violence, offer first-line support, and deliver clinical care for survivors of sexual assault and intimate partner violence;
- ensure that health providers are trained to recognize and challenge attitudes that normalize violence, since this can undermine care even when policies exist; and
- make efforts to ensure that services do not discriminate against anyone, but instead enhance access to those most at risk and less likely to use services such as women from racial or ethnic minority groups, migrant women, transgender women and women with disabilities.

Removing barriers for survivors to access high-quality, rights-based health care

As recommended by WHO guidelines *(3,19)*, health policy-makers should:

- review and revise policies that require health professionals to report violence to the police/justice system without the survivor's consent; and
- uphold confidentiality and autonomy, ensuring that survivors are informed of their rights and options and are fully involved in decisions about their care.

Developing quality assurance and accountability mechanisms

As recommended by WHO guidelines *(3,44)*, health policy-makers should:

- implement health readiness assessments to develop a baseline against which to measure impact – this should include data on the coverage, availability and accessibility of services at the national and subnational levels;
- develop and implement mechanisms and conduct research to track policy implementation, service quality and survivor outcomes;
- develop data systems that can report on the coverage and quality of essential services for survivors in accordance with WHO guidance; collecting and analysing aggregated anonymized data to share with other sectors; and
- involve survivors meaningfully in the design, monitoring and evaluation of the policies underlying service delivery and implementation of improvements.

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Annex 1. Types of policy document reviewed

Table A.1.1 details the three types of policy document reviewed.

Table A1.1. Types of policy

Type of policy	Description
National health policy on violence against women	This is a health-sector-specific policy document that includes violence against women, although not as a key issue. It may be a generic health policy, plan or strategy, or one specific to sexual and reproductive health or HIV. To be included in the violence policies database, the national health policy must include violence against women, although this need not be a strategic priority within the document.
Multisectoral policy on violence against women	A multisectoral policy document on violence against women contains the country's overall plan for prevention and/or response to violence against women, and assigns responsibilities to varying ministries and/or other governmental and nongovernmental agencies involved in prevention of and response to violence against women. Gender equality and/or other policies that address the advancement of women and contain a strong component of violence against women may also be included under this document type.
Health-sector policy and implementation tools on violence against women	A health-sector-specific policy or guidance document focusing specifically on violence against women provides guidance for the health sector on the provision of preventive and/or responsive services, care and/or treatment responding to violence against women. Documents that fall into this category may be clinical protocols, standard operating procedures, training manuals or guidance for health professionals, managers and/or administrators involved in prevention of and response to violence against women.

Annex 2. Indicators and answer categories

Table A2.1 sets out the 15 priority indicators focused on enabling environments, survivor-centred care and health services that were used during the structured document review.

Table A2.1. The 15 priority indicators for the WHO European Region

Number	Indicator
Enabling environment indicators	
1–2	Is there a national health policy or a health-sector policy that includes violence against women?
3	Is there a multisectoral violence against women policy for preventing and/or responding to violence against women that includes the health sector?
4	Is there a commitment in policy to train health-care providers on violence against women?
5	Is mandatory reporting of violence against women required by health-care providers in policy?
Survivor-centred care indicators	
6	Does the policy include privacy as a component of survivor-centred care?
7	Does the policy include confidentiality as a component of survivor-centred care?
Commitment to the provision of health service indicators	
8	Does the policy include first-line support for survivors?
9	Does the policy include clinical enquiry for identification of intimate partner violence?
10	Does the policy include emergency contraception provision for survivors of rape or sexual assault?
11	Does the policy include safe abortion for survivors of rape or sexual assault?
12	Does the policy include HIV post-exposure prophylaxis for survivors of rape or sexual assault?
13	Does the policy include sexually transmitted infection prophylaxis for survivors of rape or sexual assault?
14	Does the policy include mental health care for survivors?
15	Does the policy include referral to support services outside the health sector?

Table A2.2 outlines the possible answer categories used by the researchers for each document during the review.

Table A2.2. Answer categories and descriptions used in the review

Category	Description
Yes, included	Used when the indicator or sub-indicator is found within the policy document
Not specified	Used when the indicator or sub-indicator is not found within the policy document
No, not included	Used when the policy document explicitly states that something is not to be done
Unclear	Used when the policy document is unclear about the indicator or provides contradictory information
Other	Only applies for composite indicators, where one of the feeder indicators has an "Unclear" answer option
Policy not available	Used for countries for which no policy documents are available

Annex 3. Data tables

Tables A3.1–A3.20 set out the data identified during the policy analysis, giving the numbers and proportions of the 53 countries in the WHO European Region for each category.

Table A3.1. Countries with a multisectoral policy on violence against women

Multisectoral policy on violence against women	Number	Proportion
Yes	46	87%
Not found	7	13%

Table A3.2. Countries with a health-sector policy on violence against women

Health-sector policy on violence against women	Number	Proportion
Yes	24	45%
Not found	29	55%

Table A3.3. Countries with national health strategy or plan that includes violence against women

National health policy on violence against women	Number	Proportion
Yes	23	43%
Not found	30	57%

Table A3.4. Countries that have three, two, one or no types of policy document addressing violence against women in the health sector

Existence of policy types	Number	Proportion
Three types	12	23%
Two types	20	38%
One type	17	32%
No types	4	8%

Note: the three types of policies referred to are multisectoral policies on violence against women; health-sector policies on violence against women; and national health policies on violence against women. This table shows the number of types of policies, but it does not reflect where countries have more than one of a particular type of policy.

Table A3.5. Countries that include mandatory reporting of violence by health-care professionals in policy

Mandatory reporting	Number	Proportion
No, not included	6	11%
Yes, included	17	32%
Not specified	23	43%
Unclear	3	6%
Policy not available	4	8%

Table A3.6. Countries that include a commitment to train health-care professionals on preventing and responding to violence against women

Training	Number	Proportion
Yes, included	40	75%
Not specified	9	17%
Policy not available	4	8%

Table A3.7. Countries that include privacy as a principle of survivor-centred care in policy

Privacy principle	Number	Proportion
Yes, included	15	28%
Not specified	34	64%
Policy not available	4	8%

Table A3.8. Countries that include respect for privacy during consultation in policy

Privacy during consultation	Number	Proportion
Yes, included	22	42%
Not specified	27	51%
Policy not available	4	8%

Table A3.9. Countries that include each component or both of privacy in policy

Privacy	Number	Proportion
Yes, privacy in principle and in consultations included	11	21%
Yes, privacy as principle included	4	8%
Yes, privacy in consultations included	11	21%
Not specified	23	43%
Other	4	8%

Note: these categories are mutually exclusive, such that a country can only be included in one row of the table.

Table A3.10. Countries that include confidentiality as a principle of survivor-centred care in policy

Confidentiality as a principle	Number	Proportion
Yes, included	24	45%
Not specified	25	47%
Policy not available	4	8%

Table A3.11. Countries that include a requirement to explain the limits of confidentiality in policy

Confidentiality limits explained	Number	Proportion
Yes, included	16	30%
Not specified	32	60%
Unclear	1	2%
Policy not available	4	8%

Table A3.12. Countries that include each component or both of confidentiality in policy

Confidentiality	Number	Proportion
Confidentiality in principle and limits explanation included	12	23%
Confidentiality as a principle only included	12	23%
Confidentiality limits explanation only included	4	8%
Not specified	20	38%
Other	5	9%

Note: these categories are mutually exclusive, such that a country can only be included in one row of the table.

Table A3.13. Countries that include clinical enquiry in policy

Clinical enquiry	Number	Proportion
Yes, included	17	32%
Not specified	32	60%
Policy not available	4	8%

Table A3.14. Countries that include first-line support for survivors in policy

First-line support	Number	Proportion
Yes, included	36	68%
Not specified	13	25%
Policy not available	4	8%

Table A3.15. Countries that include emergency contraception in policy

Emergency contraception	Number	Proportion
Yes, included	17	32%
Not specified	31	58%
Unclear	1	2%
Policy not available	4	8%

Table A3.16. Countries that include abortion in policy

Abortion	Number	Proportion
Yes, included	7	13%
Not specified	42	79%
Policy not available	4	8%

Table A3.17. Countries that include HIV post-exposure prophylaxis in policy

HIV post-exposure prophylaxis	Number	Proportion
Yes, included	17	32%
Not specified	32	60%
Policy not available	4	8%

Table A3.18. Countries that include sexually transmitted infection prophylaxis in policy

Sexually transmitted infection prophylaxis	Number	Proportion
Yes, included	20	38%
Not specified	29	55%
Policy not available	4	8%

Table A3.19. Countries that include mental health assessment, referral for treatment or both

Mental health assessment and/or refer	Number	Proportion
Both mental health assessment and referral included	15	28%
Mental health assessment only included	5	9%
Mental health referral only included	8	15%
Not specified	21	40%
Other	4	8%

Note: these categories are mutually exclusive, such that a country can only be included in one row of the table.

Table A3.20. Countries that include referrals to other sectors

Referrals	Number	Proportion
Yes, included	25	47%
Not specified	24	45%
Policy not available	4	8%

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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Kyrgyzstan
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Malta
Monaco
Montenegro
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North Macedonia
Norway
Poland
Portugal
Republic of Moldova
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