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a safer Place”**

► EuroSafe news

Injury data: Call for sustained EU-coordination

Injury data are essential for making informed decisions about accident prevention priorities and developing effective national and local policies and actions. They are also critical in harnessing political will, public support and funding needed to undertake actions.

In a joint EUPHA/ EuroSafe-conference, held in Brussels November last year, speakers demonstrated the importance of injury data for a wide range of policies and actions. They presented local and national level initiatives that were geared by data from accident and emergency departments at hospitals.

Injury in the European Region is a leading cause of death, and a major source of morbidity and long term disability. We cannot hope to reduce the enormous toll of human suffering from injuries in Europe unless we understand the causes of those injuries, why some people are at greater risk than others, and what can be done to prevent injuries and treat their consequences. This information is essential to develop effective policy responses but, as important, to raise awareness of what is often an inadequately recognised problem.

If there would be only one thing the health sector can do for injury prevention, it is the collection and provision of data on causes, circumstances and consequences of injuries as needed by stakeholders, policy makers and target groups. The health sector is in the unique position to collect and disseminate meaningful data at low costs in order to trigger prevention actions and programmes in policy domains within and beyond the health sector.

Both the WHO European Region (Resolution EUR/RC55/R9) and the European Council (Recommendation 2007/C164/01) have urged member states to develop injury surveillance systems, so that programmes for prevention, care and rehabilitation can be better targeted, monitored and evaluated. The WHO European Region evaluation of these actions shows that there has been made some progress but calls for ‘improved access to reliable and comparable injury surveillance information to make the extent, causes and circumstances of the problem more visible across the Region’.



Good progress made

The Joint Action on Monitoring Injuries in the EU (JAMIE) has led to an updated methodology and format for collecting basic information in a large number of emergency departments at hospitals at almost no additional costs. At present a selection of hospitals in 26 countries are collecting data in their Emergency Departments in line with these harmonised methodology and classification and will soon report to the European Commission and the Member States.

These data are currently being used for a wide range of safety promotion purposes including in helping to design better and safer consumer products. That is one of the reasons why a broad coalition of European organisations called earlier this year on the European Commission to set up a Pan-European Accident and Injury Data System. They are convinced that such a system would

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contribute to fewer accidents and Injuries. The Joint Action has also led to innovations in data collection for instance by automatic free text analysis and coding, and by data linking. Hospitals are also using the resulting information for continuous improvement of quality of care and health services and for initiating community outreach and safety promotion.

Bleak future

These efforts and results will unfortunately come to an end by mid 2014. If no immediate actions are taken by the European Commission and the EU-Member States it will soon be too late to preserve the benefits of the existing system and the capacities and infrastructures that have been built up in countries over the past few years.

Therefore, the conference participants call on the European Commission, WHO-Europe and the Member States that:

- Current initiatives shall be taken forward at national and European level and lead to binding arrangements and sustainable mechanisms for exchange of harmonised injury data;

- Basic data - in line with the Minimum Data Set as developed by JAMIE - shall continued to be recorded and collected in all emergency departments of hospitals across Europe as a matter of routine for all injuries due to accidents or acts of violence;
- In addition to these basic data, in each member state at least one big trauma centre should collect detailed data (Full Data Set) on circumstances and product/substance involved, allowing in-depth investigations into specific categories of risk groups or risk settings;
- The European Commission should continue to facilitate the exchange of injury data, comparable between years, countries, population groups, and policy domains.

Summary report can be found at:

[http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwAssets/7A0E220588591323C1257857003DBDA9/\\$file/Summary%20report%20on%20conference%2013%20Nov.%202013%20-%20total.pdf](http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwAssets/7A0E220588591323C1257857003DBDA9/$file/Summary%20report%20on%20conference%2013%20Nov.%202013%20-%20total.pdf)

EuroSafe report: huge gains possible on investments in injury data collection



In a report recently published by EuroSafe the added value of hospital-based injury data collection is being demonstrated on the basis of information from three countries that are collecting injury data in a consistent manner for more than ten years now. Cost-benefit studies carried out in Austria (region of Vorarlberg), Switzerland and the Netherlands provide substantial evidence as to high return on investments in programmes for injury surveillance in combination with home and leisure accident prevention actions.

The benefit of those prevention actions, if clearly targeted at relevant risk groups and accident risks, outsize the investments by a multiple, ranging from 4-6 times the original investment if only medical and social costs are taken into account. If other costs such as lost productivity are included, the benefits will further increase many more times the investment made.

At present, ample information is available on

accidents that occur in the workplace and on the road owing to specialised reporting system through the inspectorates for safety at work and the police for road traffic accidents. However, none of these dedicated reporting systems collects information on HLAs, while three-quarters of all injuries are due to home and leisure accidents affecting in particular vulnerable groups such as children, older people and people with disabilities.

However, reliable and up-to-date data on home and leisure accidents are of great importance to a wide range of stakeholders at national, regional and European level. Examples are governments, designers, manufacturers, retailers, service providers, standards developers, enforcement authorities, prevention agencies and civil society organisations.

In the three countries that could provide the required cost benefit information, the mere availability of data led to injury-reduction initiatives and benefits exceeding the additional cost of data collection by a multiple, owing to:

- Lowered health care costs
- Lesser social expenditures due to dis-

- abilities caused by injury
- Increased productivity due to fewer medium and long-term absences from work
- Lower compensation costs

As the majority of injuries occur due to inexperienced and/ or thoughtless behaviour of people, awareness raising and promoting safer behaviour remain key to injury prevention. Injury data provide the leverage for such processes taking place and for making society at large more risk aware and safety-minded.

All the same, injury data also provide essential information for analysing the risks of consumer products and environmental features that are involved in injuries and generate actions with a view to improve product design and design of built environments. For that reason, a coalition of twenty-eight European umbrella organisations,

representing a broad social and economic spectrum in Europe, issued in April 2013 a Joint Call urging European Institutions and the Member States to create an EU-funded accident & injury data system under the co-ordination of the European Commission.

Taking into account the potential return on investments, there is no excuse for national and regional authorities to neglect opportunities for using existing injury data and invest into efforts to enhance the specificity of such data for injury prevention policies in countries.

Report can be found at:

[http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwAssets/7A0E220588591323C1257857003DBDA9/\\$file/IDB%20as%20effective%20tool%20for%20cost%20saving%20measures.pdf](http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwAssets/7A0E220588591323C1257857003DBDA9/$file/IDB%20as%20effective%20tool%20for%20cost%20saving%20measures.pdf)

The Role of insurers in injury prevention

The relationship between insurers and injury prevention practitioners has always been a complex one. Like in disease prevention, insurers are for many reasons interested in contributing to actions that help to reduce accidental injuries and to lower the resulting costs related to treatment and rehabilitation, lost productivity and absenteeism, long term disability, loss of income and property damage. The benefits are for instance:

- Enhanced customer value;
- Better customer relations and increased loyalty of customers to the company involved;
- Articulation of insurer's commitment to corporate social responsibility;
- Increase in profits and/or opportunities to reduce insurance premiums.

In areas of high risk and/or high cost impacts, such as in the case of chemical industry, commercial centres or heavy freight transport, schemes have been developed to maximise risk reduction efforts by corporate customers and to provide incentives for applying good practices. In most countries insurance business is to some extent also involved in road safety research and prevention. Unfortunately, home and leisure accident prevention is in most countries not yet on the radar screen of insurers.

As long as increase in expenditures for healthcare, social benefits and property loss can be balanced by adjustments of premium levels, the business lacks proper incentives to

invest in prevention. Another important disincentive for increased investments in prevention is the volatility of the insurance market where corporate and private customers easily can change their insurance policies and insurance providers. As preventive services only pay off at the long term, the profit may fall to a competitor as customers swap easily from one to another provider.



In a debate with a representative of the insurance sector, EuroSafe-members recently exchanged examples of good practices in home and leisure accident prevention actions based on public-private partnership with insurance business. Questions addressed include the following:

- To what extent can investments in prevention enhance customers value and enhance a longer term relationship between insurer and insured?
- Could home and leisure injury prevention also contribute to short term profitability of the business?
- Are there examples of good practices that deserve a wider uptake?

It was concluded that a joint approach by the public and private sector will help to

strengthen the impact of isolated efforts. In particular in the German speaking countries insurers managed to join forces among themselves by creating a pool of resources that supports national level know-how on injury prevention, brings together stakeholders in private and public sector in view of addressing key priority issues and ensures sustainable communications towards the general population with an aim to increase risk awareness and motivate groups at risk to take safety precautions.

As to the inadequacies of the insurance market, solutions may be found by connecting

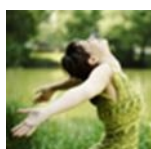
the insurance sectors, such as those for healthcare, social security, workers compensation, casualty, life, property and liability, and to seek opportunities for increasing the effectiveness of investments in prevention and to better share the profitability of these investments. Increased collaboration between insurers and local authorities (in health, education and welfare) will also contribute to enhanced impact and effectiveness of healthy and safe interventions.

More information:

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► EU news

Third EU-Health programme adopted



On 9 November 2011, the Commission adopted a legislative proposal for the 3rd multi-annual programme (2014-2020). The new programme aims to help EU countries respond to economic and demographic challenges facing their health systems and enable citizens to stay healthy for longer.

The proposed third programme of EU action in the field of health (2014-2020), 'Health for Growth', strengthens and emphasises the links between economic growth and a healthy population to a greater extent than the previous programmes. The Programme is geared towards actions with clear EU added value, in line with the Europe 2020 objectives and current policy priorities.

The financial crisis has further highlighted the need to improve the cost-effectiveness of health systems. Member States are under pressure to strike the right balance between providing universal access to high-quality health services and respecting budgetary constraints. In this context, supporting Member States' efforts to improve the sustainability of their health systems is deemed crucial to ensure their ability to provide high quality healthcare to all their citizens now and in the future. The Health for Growth Programme wants to contribute to finding and applying innovative solutions for improving the quality, efficiency and sustainability of health systems, putting the emphasis on human capital and the exchange of good practices.

As such, innovation in health has the potential

to help reduce healthcare costs and improve the quality of care. Many areas of the proposed Health for Growth Programme, such as health technology assessment (HTA), medical devices, clinical trials and medicinal products, as well as the European Innovation Partnership on Active and Healthy Ageing, aim to strengthen the link between technological innovation and its uptake and commercialisation; while fostering security, quality and efficiency of healthcare. Other initiatives focus on promoting the uptake and interoperability of e-Health solutions, to improve for example cross-border use of patient registers.

The Programme will further support better forecasting, planning of needs and training of health professionals, which will contribute to both organisational innovation and inclusive growth. As the population ages and demand for healthcare grows, the health sector has great potential to create new jobs.

Health problems are one of the major causes of absenteeism from work and early retirement. Keeping people healthy and active for longer has a positive impact on productivity and competitiveness. Increasing the number of healthy life years is a prerequisite if Europe is to succeed in employing 75 % of 20-64 year-olds and avoiding early retirement due to illness. In addition, keeping people over 65 years of age healthy and active can impact on labour market participation and lead to potential important savings in healthcare budgets.

The general objectives of the Health for Growth Programme are to work with Member States to encourage innovation in healthcare and increase the sustainability of health

systems, to improve the health of the EU citizens and protect them from cross-border health threats.

It focuses on four specific objectives with a potential for economic growth through better health:

- to develop common tools and mechanisms at EU level to address shortages of resources, both human and financial and to facilitate up-take of innovation in healthcare in order to contribute to innovative and sustainable health systems;
- to increase access to medical expertise and information for specific conditions also beyond national borders and to develop shared solutions and guidelines to improve healthcare quality and patient safety in order to increase access to better and safer healthcare for EU citizens;
- to identify, disseminate and promote the up-take of validated best practices for cost-effective prevention measures by addressing the key risk factors, namely

smoking, abuse of alcohol and obesity, as well as HIV/AIDS, with a focus on the cross border dimension, in order to prevent diseases and promote good health; and

- to develop common approaches and demonstrate their value for better preparedness and coordination in health emergencies in order to protect citizens from cross border health threats.

By funding a € 446 million EU programme for a 7-year period, the Programme would fund grants and public procurement contracts for public or private bodies, national authorities, European NGOs and international organisations. It would help EU countries to find cost-effective solutions to the challenges they face and to make their health systems more responsive and sustainable.

More information:

http://ec.europa.eu/health/programme/policy/2014-2020/state_of_play_en.htm

Health inequalities



Reducing inequalities in health between different socio-economic groups and between different parts of the EU is one of the burning issues facing the European Union today. For the last 4 years, the public health directorate in SANCO has been coordinating the implementation of the EU strategy to address health inequalities 'Solidarity in Health'. On 11th December 2013, the Commission published the EU-funded report "Health Inequalities in the EU", produced by a consortium led by Sir Michael Marmot of University College, London. The Health Inequalities (HI) - report summarises new evidence on health inequalities in the EU and assesses the effectiveness of policy responses. The report provides an outline of new evidence on health inequalities in the European Union and the policy response at EU and national level to

health inequalities since 2009.

The report confirms significant health inequalities between and within EU Member States. The size of the health inequalities is for the most part similar to that identified in 'Health inequalities: Europe in profile', published in 2006. Within this broad picture some indicators of inequality have decreased, some have remained constant and others have increased.

It is evident that social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. The report demonstrates also marked differences in the social determinants of health across EU Member States and inequalities in health between social groups based on these determinants.

Policy response

The HI-report includes a review of actions on health inequalities at EU and national levels in the last few years. At the EU level, the publication in 2009 of the European Commission's communication 'Solidarity in health: reducing health inequalities in the EU' was an important step, and the HI-report provides information on how this initiative is being taken forward — including through a joint action by Member States and the EU.

The EU research programme has supported a number of studies on health inequalities,

several of which are ongoing. There has also been support for the development and exchange of information on addressing health inequalities through the EU programme for employment and social solidarity. There have been a number of improvements in data availability in the EU enabling the assessment of health inequalities.

The EU health programme has also supported work on measuring differences in health between vulnerable groups of the EU population, such as migrants or ethnic minorities, and the population as a whole. And there has been some use of EU Structural Funds for addressing health inequalities.

Despite these developments, the analysis of the EU policy response in the HI-report suggests some concerns around dedicated funding for health inequalities in future research and other programmes, and the need for more policy coherence in relation to the goals of Europe 2020.

At national level, the extent of the policy response across European countries was found to be highly variable. The majority of countries do not have national-level strategies in place for tackling health inequalities. Only 12 % of policies reviewed as part of this study were national- or regional-level policies with an explicit focus on health inequalities.

There is a clear gap between policymaking and the actual implementation of policies. Since 2006, there has been a positive development demonstrating that knowledge about 'health-in-all-policy' approaches (links between the social determinants and health outcomes) is becoming widespread, and should be cultivated further.

Most strategies and policies are still not sufficiently monitored or evaluated. There appears to be a generalised trend towards decentralisation in health system governance and the delivery of health services, including strategies to tackle health inequalities. The Commission is advised to consider means of including regional-level policymakers in EU discussions and providing support to the regional and local level, including more effective use of EU spending instruments.

Conclusions

The HI-report concludes that action on health inequalities, should remain a public health

priority at EU and national levels. However, the current financial, economic and social crisis is threatening to undermine existing policies, and may negatively affect health inequalities.

The role of the health sector in tackling health inequalities is vital, though it has failed to incorporate the issue into its core policies. Wider engagement outside the health sector remains essential.

Most policies with explicit aims to reduce health inequalities focus on 'vulnerable groups' such as immigrants, ethnic minorities, early school leavers, people from lower socio-economic groups or unemployed or homeless people. Equally, universal policies almost never have a proportionate 'levelling-up' component. The policy implications of the social gradient in health, and effective methods of addressing these gradients, appear to be poorly understood and acted upon. Greater emphasis should be placed on introducing, monitoring and evaluating policies which have this component.

The HI-consortium states that current resources to support actions within the EU to incorporate health inequalities across the broad range of relevant policies are inadequate to enable the comprehensive consideration of health inequalities that is required if action is to be stepped up.

It is finally recommended that Member States should:

- lead on clear and comprehensive strategies to redress the current patterns and magnitude of health inequalities;
- ensure the coherence and effectiveness of action to reduce health inequalities at all levels of government and across all sectors and stakeholders;
- ensure that the capacities exist for coherent and effective implementation of action on health inequalities;
- ensure progressive improvement in the availability and use of data needed to identify priorities, plan action, monitor trends and evaluate what actions are most effective.

Report can be found at:

http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf

► WHO news

UN report on the global road safety crisis

The UN Secretary-General, Ban Ki-Moon, has issued a report Improving global road safety, in advance of the 68th session of the UN General Assembly. The report draws attention to key developments in global road safety over the last two years, including the launch of the Global status report on road safety 2013; the Second UN Global Road Safety Week; the creation of the Global Alliance for Care of the Injured; and the annual World Day of Remembrance for Road Traffic Victims.

In the report the UN Secretary-General highlights the global and national achievements towards improving the safety of roads and vehicles; legislation on key risk factors such as speeding, drink-driving, and the non-use of motorcycle helmets, seat-belts and child restraints; and trauma care systems.

Despite progress, the UN Secretary-General notes that much more needs to be done to meet the goal of the Decade of Action for Road Safety 2011-2020 to save 5 million lives, particularly with regard to protecting vulnerable road users and adopting and enforcing comprehensive road safety laws. The report also underlines that financial support for road safety continues to be a challenge to the attainment of the goal of the Decade of Action.

The report calls on Member States to, among others:

- Implement a good road safety management system, including a lead agency, a national plan in line with the Global Plan for the Decade of Action, and quality data and statistics;
- Develop strategies, policies and programmes that pay particular attention to the needs of vulnerable road users;



- Develop comprehensive road safety legislation and improve implementation through sustained enforcement and social marketing campaigns;
- Participate in new car assessment programmes in order to foster availability of consumer information about the safety performance of motor vehicles; and
- Acknowledge the importance of the current funding mechanisms for road safety, and the need to develop new innovative mechanisms.

In the context of the discussions on the post-2015 agenda, the lack of road safety is an important obstacle to sustainable development. The UN Road Safety Collaboration will discuss a number of these key action items, including the need for internationally agreed upon targets and indicators for road safety, incorporation of safe and sustainable transport into the post-2015 development agenda, and the mid-term review conference for the Decade of Action.

More information: http://www.un.org/ga/search/view_doc.asp?symbol=A/68/368

Spinal cord injuries

As many as 500 000 people suffer a spinal cord injury each year. People with spinal cord injuries are two to five times more likely to die prematurely, with worse survival rates in low- and middle-income countries. A new WHO report, International perspectives on spinal cord injury, summarizes the best available evidence on the causes, prevention, care and lived experience of people with spinal cord

injury.

Up to 90% of spinal cord injury cases are due to traumatic causes such as road traffic crashes, falls and violence. Variations exist across regions. For example, road traffic crashes are the main contributor to spinal cord injury in the African Region (nearly 70% of cases) and the Western Pacific Region

(55% of cases) and falls the leading cause in the South-East Asia and Eastern Mediterranean Regions (40% of cases).

Non-traumatic spinal cord injury results from conditions such as tumours, spina-bifida, and tuberculosis. A third of non-traumatic spinal cord injury is linked to tuberculosis in sub-Saharan Africa.

Most people with spinal cord injury experience chronic pain, and an estimated 20-30% show clinically significant signs of depression. People with spinal cord injury also risk developing secondary conditions that can be debilitating and even life-threatening, such as deep vein thrombosis, urinary tract infections, pressure ulcers and respiratory complications.

Spinal cord injury is associated with lower rates of school enrolment and economic participation. Children with spinal cord injury are less likely than their peers to start school, and once enrolled, less likely to advance. Adults with spinal cord injury face similar barriers to socio-economic participation, with a global unemployment rate of more than 60%. Spinal cord injury carries substantial individual and societal costs.

Many of the consequences associated with spinal cord injury do not result from the condition itself, but from inadequate medical care and rehabilitation services, and from barriers in the physical, social and policy environments that exclude people with spinal cord injury from participation in their communities. Full implementation of the Convention on the Rights of Persons with Disabilities is urgently required to address these gaps and barriers.

Essential measures for improving the survival, health and participation of people with spinal cord injury include:

- Timely, appropriate pre-hospital management: quick recognition of suspected spinal cord injury, rapid evaluation and initiation of injury management, including immobilization

of the spine.

- Access to ongoing health care, health education and products such as catheters to reduce risk of secondary conditions and improve quality of life.
- Access to skilled rehabilitation and mental health services to maximize functioning, independence, overall well-being and community integration.
- Access to appropriate assistive devices that can enable people to perform everyday activities, reducing functional limitations and dependency.

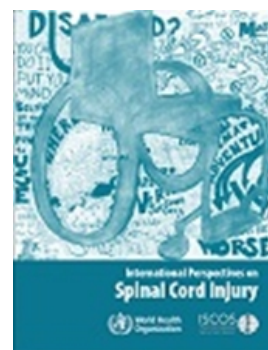
Essential measures to secure the right to education and economic participation include legislation, policy and programmes that promote:

- Physically accessible homes, schools, work places, hospitals and transportation.
- Inclusive education and elimination of discrimination in employment and educational settings.
- Vocational rehabilitation to optimize the chance of employment.
- Micro-finance and other forms of self-employment benefits to support alternative forms of economic self-sufficiency.

The report was launched on the occasion of the International Day of Persons with Disabilities on 3 December 2013.

More information:

http://www.who.int/disabilities/policies/spinal_cord_injury/en/



► Injury Data

Injury surveillance in Balkan region

In October last year, the WHO Regional Office for Europe organised in collaboration with the Norwegian Directorate of Health a sub-regional workshop on “Improving capacity for injury prevention through improved injury surveillance” in South-eastern Europe, in Belgrade (Serbia). The workshop was attended by 37 participants, including nine Member States belonging to the South-east European Health Network, i.e. Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, Republic of Moldova, Romania, Serbia and the former Yugoslav Republic of Macedonia. The format of the meeting was a series of key note lectures followed by group work.

In break out sessions many constraints were identified such as the lack of legislation and the lack of motivation and knowledge on the part of health professionals. In addition to that, a common concern is that hospitals are overloaded. Proper legislation at national level and awareness raising of staff of the importance of surveillance through better education and engagement through shared feedback is needed.

The importance of legal requirements was debated. Better use had to be made of existing data with better standardization. Financial incentives for data collection were not sustainable in all countries, and support was needed in terms of health information systems. Some countries needed better governance mechanisms to allow data sharing.

Availability and accessibility of data and bureaucratic impediments were discussed. Data sharing and analysis can be conditioned by political priorities, and governance frameworks were needed, including those that allowed data sharing whilst protecting confidentiality. There is also a certain amount of duplication which could be circumvented by better data sharing. Ownership of data was felt to be important to improve motivation.

In roundtable discussions the following priorities needs were identified by the participants:

- implement uniform but inexpensive surveillance systems;
- improve coding, particularly for injuries due to violence;
- better recording and wider dissemination of information on non-fatal injuries greater emphasis on improving injury surveillance systems in the eastern part of the Region;
- continuing the international exchange of data, experiences and solutions;
- find common approaches to motivate health personnel to collect data in hospitals; and
- achieve better coverage of external causes in order to guide targeted prevention actions and to monitor the eventual impact of such targeted actions.

The exchange of common problems and solutions in the similarity of the South-eastern European context is found invaluable. For the next sub-regional meeting the following focus is suggested:

- the proposal of an injury minimum dataset for registration in hospitals in line with the JAMIE-methodology and agreement on classifications and definitions to be used in the Region;
- how to increase the awareness of importance of injury surveillance for prevention in the political and administrative areas and attract greater resources; and
- how to improve the organization of data collection in hospitals and emergency units.

More information: <http://www.euro.who.int/en/health-topics/disease-prevention/violence-and-injuries/news/news/2013/12/south-eastern-european-health-network-injury-focal-points->



► Country update on Injury Surveillance



In the framework of the Joint Action on Injury Monitoring in Europe (JAMIE) we are regularly informing the Alert-readers on current activities of our JAMIE-partners in injury surveillance.

The objective of JAMIE, co-funded by the EU and its Executive Agency for Health and Consumers (EAHC) is to work towards one common hospital-based surveillance system for injury prevention in operation in all Member States (MSs) by 2015, that is integrated within the Community Statistics on Public Health (see also <http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/I2injurydata.htm>).

In this issue of the Alert our colleagues from the UK share with us their latest experiences in injury surveillance and reporting.

Injury data collection in the UK/ Wales



Background

The UK has a long history in injury surveillance, having developed the Home Accident Surveillance System (HASS) and the Leisure Accident Surveillance System (LASS) that also contributed to the development of the European Home and Leisure Accident Surveillance System (EHLASS), the precursor to the Injury Data Base (IDB). HASS/LASS was based around surveillance in 20 emergency departments and operated to support product safety research and implementation by the Department of Trade and Industry until its demise in 2002.

A number of other emergency department based surveillance systems have been in operation across parts of the UK over the past 15 years, including child health injury surveillance in Glasgow and the All Wales Injury Surveillance System (AWISS).

The UK signed up to implementing JAMIE when first discussed. It is important to note that health is a devolved issue in the UK and hence each of the UK countries (England, Scotland, Wales and Northern Ireland) develops its own health policy. In general there has been support from health ministries for the JAMIE concept. However, given current financial pressures it has been hard to find funding for data collection.

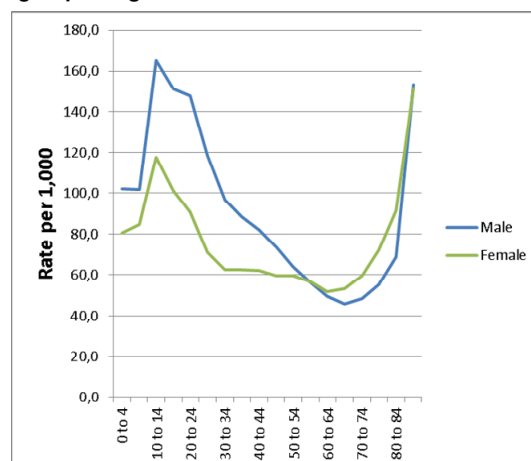
Current data

The UK responded to the JAMIE challenge by first exploring to what extent current data collection systems met the needs of the JAMIE Minimum and Full Data Sets (MDS, FDS). There was considerable variation in

coding completeness and variable extent across many UK EDs but after detailed examination there were 29 EDs in England with >80% of data completeness. Data from these centres have been used to develop the UK MDS in the first instance.

In 2011 there was 565,751 injury cases treated at these 29 hospitals creating the first derived UK MDS. Using the JAMIE methodology to derive a population denominator allows rates to be calculated. The UK MDS injury rate was 84 per 1,000 of the reference population overall with a rate of 94 for males and 74 for females. Figure 1 shows the variation in injury rates by 5 year age group and gender. It is evident that males have a higher rate up to the 55 to 59 year age range, beyond which rates are higher among females.

Figure 1: Rate of 2011 UK MDS injury cases per 1,000 of the reference population, stratified by age group and gender



A breakdown of the 'Nature of Injury' field reveals that, discounting the category of 'Other' (27%), the highest frequency of cases are due to 'Open wound and abrasion' (17%), 'Sprain and strain' (15%) and 'Fracture' (12%).

One of the key problems with the existing data is that not all the necessary fields are collected. In particular there is not yet a standardised way to record fall related injuries across the UK. The consequence of this is that a breakdown of the 'Mechanism of Injury' field results in 75% of cases falling in the category of 'Unknown'. This is likely to be due to the large number of fall related cases having to be coded to this category. However, despite this limitation the UK MDS data records can still be used to calculate European Community Health Indicator 29b, the incidence of home and leisure injuries. In 2011, ECHI29b for the UK was 43 per 1,000 reference population.

Implementing the Minimum Data Set (MDS)

The next step is to improve the data collection systems to ensure that the JAMIE MDS can be collected. In Wales, this has taken the form of commissioning a new software system that has the JAMIE MDS (Figure 2) and extended UK MDS.

Whilst the JAMIE MDS fulfils European requirements for calculating ECHI 29b it does not fulfil all existing UK policy requirements to support multi-sectoral prevention and reduce pressure on EDs.

Therefore a slightly "extended version" of the JAMIE MDS was designed to aid injury prevention practitioners and clinicians in supporting the targeting and evaluation of local injury and violence prevention initiatives as well as contributing to national and international efforts to reduce the burden of injury.

The extended version includes one additional question for road traffic injuries identifying "type of road user", nine brief additional questions for victims of assaults identifying "perpetrator details", and one additional question for sport injuries identifying "type of sport involved".

These questions are designed to support a number of initiatives, including the All Wales Injury Surveillance System (AWISS) and Home Office guidance on collaborative working between the police and health sectors, agreed with the College of Medicine. The new software will start to be installed in hospitals from 2014 onwards.

A new health and social care system also

Figure 2- JAMIE MDS - Screen Shots

Initially an emergency department clerk will be presented with just two questions; the first is a text field asking for a description of the presenting complaint (this already exists in most systems but may not be in the best place in relation to workflow), and the second asking whether given the information provided in the presenting complaint the reason for attendance is due to an injury (including poisoning and assault).

1. PRESENTING COMPLAINT:	<input type="text" value="Text Field"/>
2. INJURY (INCLUDING POISONING AND ASSAULT)?:	<input type="radio"/> Yes <input type="radio"/> No

If the clerk selects 'yes', identifying the presenting complaint as an injury, four further injury related questions will appear (Q3 – Q6). The Second Screen, together with the injury yes/no question on the first screen constitutes the UK JAMIE MDS.

3. HOW DID THE INJURY OCCUR:	<input type="radio"/> Road Traffic Injury* <input type="radio"/> Fall <input type="radio"/> Cut/Pierce <input type="radio"/> Poisoning <input type="radio"/> Burn/Scald <input type="radio"/> Other <input type="radio"/> Unknown
4. INTENT:	<input type="radio"/> Accidental <input type="radio"/> Deliberate/Self-harm <input type="radio"/> Assault* <input type="radio"/> Unknown
5. WHERE DID THE INCIDENT TAKE PLACE:	<input type="radio"/> Road/Pavement <input type="radio"/> Educational establishment/ Grounds <input type="radio"/> Home/Garden <input type="radio"/> Pub/Club <input type="radio"/> Other Incident location (only for assault/RTI e.g. pub/street): <input type="text" value="E.g. Where Joe Bloggs Street crosses Smith Street"/>
6. WHAT WAS THE PATIENT DOING AT THE TIME OF THE INJURY:	<input type="radio"/> Paid Work <input type="radio"/> Sports* <input type="radio"/> Other <input type="radio"/> Unknown

came into effect in England from 1 April 2013. Significant changes from the former system include the creation of Public Health England and NHS England and changes to other relevant organisations. It will take some time for roles, responsibilities and processes in the new system and their relationship to each other and the Department of Health to become clear and embedded. This includes policies and actions related to data collection and analysis.

The Department of Health (DH) has recently also introduced a set of Accident & Emergency Clinical Quality Indicators for England, which is based on data from the existing ED dataset in England. This development will inevitably improve data quality and completeness.

Information on overall data coverage and completeness for the ED dataset is regularly published for individual NHS organisations,

and an NHS Information Standard was recently issued setting out the requirement on all NHS organisations providing ED services to collect the mandated ED dataset.

There are also a number of other opportunities, including building on the current collection of an extended MDS dataset in two pilot sites in England and expanding the data collected for syndromic surveillance used by Public Health England. The latter is derived from a number of EDs in near real-time, the majority of which use the Ascribe system.

Implementing the Full Data Set (FDS)

Since 2002 and the demise of HASS no hospital within the UK seems to have collected FDS level data. It has not been possible to find funds to implement the standard method of collecting the FDS through more in-depth patient interviews and completing pre-coded categories. However some countries, such as the US code FDS type data from expanded narrative fields.

A pilot project is being run at Morriston Hospital, Swansea from Mid December 2013 to February 2014 in collecting additional text on the aetiology of injuries. The intention is that the narrative will be manually coded to FDS in the short term. In the longer term the intention is to develop automated computer systems using natural language processing being developed by the Centre for Improvement in Population Health through E-records Research (CIPHER), one of the four coordinating centres of the UK's new Farr Institute of Health Informatics Research.

The expectation is that this information with the additional information from the extended

version of the MDS will meet to a large extent the requirements for FDS-level of data as defined by the JAMIE-project.

Evaluation of interventions and measurement of population burden

The recent growth in UK capacity and capability in health informatics research, primarily utilising anonymised linked datasets supported by a consortium of health research funders, means that the data once collected can now be re-used for a wide variety of purposes, including supporting and evaluating local and national efforts to reduce injuries through interventions from within or out with the health service, as we reported in a recent [paper](#)

In addition, linked data can be used to improve measurement of the burden of injuries in the overall population and in sub-groups using the Disability Adjusted Life Year (DALY) approach used in the [Global Burden of Diseases study](#).

Multi-sectoral data linkage is also key to quantification of many of the social impacts of injury outlined in the [Injury List of All Deficits Framework](#) and in persuading policy makers of the importance of injury prevention. These developments should have a considerable impact on the ability to support local and national interventions and policies to reduce the burden of injuries across the UK.

More information: Ronan Lyons (R.A.Lyons@Swansea.ac.uk) and Steven Macey at the Farr Institute of Health Informatics Research, Swansea University and Public Health Wales NHS Trust, UK.



► Consumer safety

Setting safety requirements

ANEC, the European consumer voice in standardisation, published a position paper on 'Working methods for setting safety requirements in the context of the General Product Safety Regulation' with a view to help streamlining the working methods for drafting safety requirements across the EU.

Under Directive 2001/95/EC on general product safety (GPSD), Article 4 for the drawing up of European standards states that requirements shall be determined to ensure that products which conform to these standards satisfy the general safety requirements of the GPSD.

The Regulation on European Standardisation (1025/2012), which became effective on 1 January 2013, lays down the general framework for the development of European standards, and is also applicable to standards to be developed in the context of the GPSD.

However, there is a lack of a standard operating procedure or working method to draft and develop safety requirements under the GPSD. The way in which the safety requirements are currently drafted and developed differs from case to case and is not always consistent. In some cases, this has led to lengthy discussions in the GPSD Committee meetings. The crucial point is how detailed the safety requirements should be and which details

As a result, the European Commission introduced the document 'Working methods for setting safety requirements in the context of the General Product Safety Directive' at the October 2013 meeting of the GPSD Committee. Members and observers of the Committee have been invited to submit comments on this document until the end of November 2013.

Overall, the ANEC position paper states that it is satisfied with the level of technical detail of the already adopted safety requirements under the GPSD. However, a more systematic approach may be useful to ensure a consistent level of detail. To this end, ANEC makes the following recommendations:

- The process of drafting safety requirements should involve the identification of the hazards that need to be addressed by the standard. In this respect, we propose a hazard matrix to be used as a basis when developing safety requirements.
- The safety requirements should be drafted outside the GPSD Committee by small groups of experts according the related product(s).
- Safety requirements should be 'upgraded' to directly applicable legal requirements under the upcoming Consumer Product Safety Regulation (CPSR), in order to ensure legal certainty for economic operators and market surveillance authorities.

Last but not least, the safety requirements should be drafted in an open and transparent process. Transparency is important to ensure that the interests of all stakeholders are met. ANEC welcomes the proposal to ensure participation of experts from Member States and stakeholders in the development of the safety requirements.

If the process of drafting the safety requirements is transparent and inclusive, this will also ensure that all relevant safety requirements are included.

More information:
<http://www.anec.eu/>



► Child safety

Children product safety guide

The European Child Safety Alliance along with its country partners and 3 key sponsors, Underwriters Laboratories (UL), Kid Rapt Ltd. in the United Kingdom and the Consumer Safety Commission (CSC) in France, released in December last year the Child Product Safety Guide: Potentially dangerous products. The Guide was written to increase knowledge as a step toward reducing child injuries related to products that are in regular use by children and their caregivers.

Each day children are injured when interacting with products in their everyday environment; even with products made especially for children. Estimates from the EU Injury Data Base identify that each year approximately 19,000 children under 14 years of age in the 28 countries of the European Union will have injuries involving bunk beds, 51,000 will have injuries involving trampolines and a further 52,000 will have toy related injuries that are serious enough to require a visit to the emergency department.

The rapid alert system of the European Commission, RAPEX, reported that the second most frequently identified category of serious risk notifications in 2011 was toys and the sixth was childcare articles and children's equipment – all products specifically designed for children! In the past 5 years there have been 43 RAPEX alerts related to high chairs alone from 13 different Member States. Risks identified in these alerts include choking risks due to detachable or breakable parts of the high chair accessible to the child, fall risks due to a lack of stability in high chair design, non-compliant folding or locking mechanisms or lack of an effective restraint system.

Children are at risk of injury when a product has a design defect, when parts become broken or are missing or when the design creates an unforeseen hazard during its use. Injuries can also occur when a product is not used as intended, when use is age inappropriate or when use is not appropriately supervised. Increased risk of injury can also occur with second hand products if the history of the product is not well known and the product has been damaged, or the complete instructions for safe use are no longer available. Children are needlessly suffering preventable injuries and accidents, including many that result from interaction with everyday products. Children across the European Union should

be provided with the same level of safety, and that means ensuring safe and affordable child care articles are available for children and their families and that their safe use is understood.

The Guide provides comprehensive information on 26 products that child safety experts in Europe and evidence-based research have identified as posing injury risks to children using the following criteria:

- products that are used by a large proportion of parents and caregivers,
- products that cause either frequent or severe injuries, and
- products that are considered 'safety' products for children, but are widely mis-used by consumers.

The Guide is meant to raise awareness and educate consumers and professionals to recognise the hidden hazards that a child encounters with products in their daily life and ways to prevent injuries resulting from these products. For each product the reader is provided with information on:

- why the product may pose a safety problem;
- why it can be dangerous for children;
- what to look for when buying or prior to using the product and lastly;
- advice on how to use the product safely.

The Child Product Safety Guide provides essential safety information for parents, caregivers and professionals; to not only help them make smart, safe choices, but also how to put safety into daily practice. One example is the proper use of a child restraint system, which greatly reduces the chance of ejection from a car:

- An unrestrained child has a 49% chance of ejection in the event of a motor vehicle crash.
- A child incorrectly fastened into an age appropriate child restraint system has a 35% chance of ejection.
- A child correctly fastened in the wrong size child restraint system has a 10% chance of ejection,
- However, a child correctly fastened in an age appropriate child restraint system has only a 3% chance of ejection.

Product safety is enhanced through effective



work by manufacturers and standards organisations including regular monitoring and continued improvements in design. But safety is a shared responsibility, and by also enhancing the awareness and knowledge of consumers and professionals on safe inter-

action with products, children in Europe will lead safer lives.

The complete Child Product Safety Guide is available at www.childsafetyeurope.org

EU-wide poison prevention campaign



The Bundesarbeitsgemeinschaft (BAG) Mehr Sicherheit für Kinder e.V. (Safe Kids Germany) is currently working with the support of the

German Federal Ministry for the Environment, Nature Conservation and Nuclear Safety, in cooperation with the European Child Safety Alliance (ECSA) and Große Schützen Kleine in Austria, on a new project, which seeks to prevent household poisoning cases involving children.

Poisoning is the third leading cause of unintentional injury death in the WHO European Region. Each year 3,000 young children aged 0 to 14 die of acute poisoning. Children 5 years and under account for the majority of all poison exposures with children up to two years old especially vulnerable. More than 90% of all poisonings occur within the home environment and many common household products can poison children, including cleaning supplies, alcohol, plants, pesticides, medicines, and cosmetics. Cigarettes and tobacco can also cause sickness if eaten and should be kept well out of the reach of young children.

A picture book on the topic of poisoning has been designed for preschool Children. The new picture book is based on a story of "Tomi and Mila Tracking the Poisons", which was developed by the BAG in 2012 with and for the target group of migrant families in Germany. It has been conceived for parents to read together with their children and solve the riddles in a playful manner. Children by the same token learn about hazard symbols and find out about how to distinguish poisonous products from non-poisonous ones. The picture book is currently available in three language versions: German-Turkish, German-Russian and German-Arabic.

The picture book is currently being modified together with the project partners to align with European cultures and standards and will then be translated into three new languages, always in combination with German: English, French and Spanish. It will then be printed and distributed at international events beginning in 2014.

You can download the picture book in its current versions at

http://www.kindersicherheit.de/html/medien_download.html

► Safety for seniors

The risk of inactivity

Juliet Harvey and others have recently published in the International Journal of Environmental Research and Public Health a systematic review on the self reported and objectively measured prevalence of sedentary behaviour in older people.

Sedentary behavior is a cluster of behaviors adopted in a sitting or lying posture where little energy is being expended. Sedentary behavior is a risk factor for health independent to inactivity. Currently, there are no published systematic reviews on the prevalence of sedentary behavior objectively measured in, or subjectively reported by, older adults. The aim of this systematic review

was to collect and analyze published literature relating to reported prevalence of sedentary behavior, written in English, on human adults, where subjects aged 60 years and over were represented in the study. 23 reports covered data from 18 surveys sourced from seven countries. It was noted that sedentary behavior is defined in different ways by each survey. The majority of surveys included used self-report as a measurement of sedentary behavior. Objective measurements were also captured with the use of body worn accelerometers. Whether measurements are subjective or objective, the majority of older adults are



sedentary.

It is well known that physical activity (PA) is an influencing factor for healthy aging and lack of PA has been associated with chronic disease, frailty and increased fall risks. Recently, an emergence of research in sedentary behaviour (SB) has indicated that SB is an independent health risk factor, separate to lack of PA, associated with successful aging, morbidity and mortality. Therefore, both SB and PA are important factors to consider in the health of older adults.

Generally, the older adult section of society is underserved in physical activity and sedentary behaviour research. Although there is a fair amount of research on the sedentary behaviour of children and young adults, there is little on older people to allow policy recommendations to give detailed information on reducing sedentary behaviour in older adults.

Globally, almost 60% of older adult's report sitting for more than 4 h per day. When objectively measured it is found that 67% of the population are sedentary for more than 8.5 h in their waking day. Both screen time and TV time can be used as proxy measurements of sedentary behaviour. When screen time is reported, 53% of older adults report sitting in front of a screen for over 4 h daily. 15% report watching more than 4 h of TV daily and 54% reported levels of 3h daily. Computers are reportedly used by 65% of older adults with

fewer than 10% of older adults using a computer for over 1.6 h daily. Computer use is likely to increase with time as people become more familiar with computer technology. There is little difference in sedentary behaviour trends between genders and there is a slight increase in sedentary time in the age groups over 75, compared with 65–74, with the exception of computer use.

Those individuals who are less sedentary tend to age more successfully and report better quality of life. There has been shown to be an association between sitting time and negative health outcomes, such as increased risk of cardiovascular disease and all causes of mortality. TV viewing has also been well correlated with negative health outcomes. TV viewing is also associated with other unhealthy habits such as consumption of unhealthy food and drinks or the influence of advertising to encourage these behaviours, therefore may also be a confounding factor with negative health effects of sitting.

There is little difference between genders and there is a slight increase in the prevalence of sedentary activity with age, with the exception of computer use. These findings suggest that sedentary behaviour is very prevalent in older adults.

The article is open access and can be viewed at :

<http://www.mdpi.com/1660-4601/10/12/6645>

► Sport safety

Sports injury prevention strategy in Victoria State (AUS)

The Victorian Government Sports Injury Prevention Taskforce issued last year a comprehensive strategy to improve risk management strategies in sports and sports injury prevention.

Sports-related injury is a major component of accidental injury in Victoria. It is second only to road traffic injuries in terms of years lost to disability and direct hospital costs. For children under 15 years, sports-related injuries now represent four times the public health burden when compared to road trauma related costs.

The Sports Injury Prevention Taskforce has estimated that each year in Victoria approximately 4,500 people drop out from participation in five of the top team based sports due to sports injuries.

In the absence of effective injury prevention strategies and plans, the net rate of reduction in participation in all organised sport, due to injury related drop out, is expected to reach nearly 20,000 per year by 2020.

Focus areas

Many sport injuries are predictable events that can be prevented. Investment in the use of prevention strategies on many levels, which is the approach taken with other public health concerns, could deliver benefits to both participation and performance outcomes in sport as well reduce the personal and health costs attributable to sports injuries.

The taskforce identified the following four focus areas through which the linked themes of



participation, performance and sports injury prevention and management could be driven over the years:

- Increase the awareness of the benefits of sports injury prevention and management.
- Enhance the safe participation of children and adolescents.
- Address injury in the high participation (team) sports.
- Improve the sport medical emergency response and injury prevention practice.

Key enablers

There are three suggested approaches across the four areas to be considered. These are:

- Use existing government supported sports development and management initiatives to incorporate sports injury prevention actions and related accountabilities.
- Commence work with the high participation sports such as basketball, cricket, football (soccer) and netball. They provide the best opportunity to trial the initial actions and demonstrate and promote the benefits of injury prevention strategies.
- Increase efforts to ensure coaches are skilled, which must include all coaches being well trained in injury prevention.

Recommendations

In the context of the suggested approaches across the focus areas, the strategies and actions recommended by the taskforce are:

- Build public and sector awareness and develop common messaging for government and non-government agencies involved in the sector.
- Support coaches by implementing a more systemic approach to injury prevention and management. In conjunction with priority sports, develop systems to ensure the latest

injury prevention information is effectively transferred to community clubs, coaches and parents. Create an injury prevention module that can be included in tertiary sport and recreation curricula and an injury prevention module that can be delivered to administrators, volunteers and trainers.

- Utilise the role and influence of coaches to build a positive culture around sports injury prevention and the management of injuries to increase participation and improve performance.
- Ensure sports injury prevention is actively supported by policies, practices and reward and recognition systems. Use grant and funding processes to encourage national sporting associations/governing bodies to demonstrate a commitment to continuous improvement in reducing sports injuries.
- Use facility lease agreements and grant funding guidelines to influence improvements in medical emergency preparedness and sports injury prevention planning and practice.

Additional suggestions made by the task force include the need to improve sports injury data and enhance sports injury prevention research to build a stronger evidence base to make more informed decisions and the need to assess club excellence programs and develop a model program that includes excellence in sports injury prevention and extend the program across all major organised team sports.

More information:

http://www.dpcd.vic.gov.au/_data/assets/pdf_file/0004/156937/SIPT_110613_Final_v2_Medium_Standard.pdf

► Vulnerable road users

Greek Presidency and EU-Road safety priorities

In 2012, some 28,000 people died on EU roads. As well as the unbearable human tragedy, road casualties cost the equivalent of 2% of European GDP. In a recently issued briefing the European Transport Safety Council (ETSC) outlines its recommendations on the key EU road safety policy dossiers to be steered by the Greek presidency of the European Union in the first half of 2014. One of the recommendations is to secure agreements on EU legislation on automated in-vehicle emergency calling (eCall) and safer lorry design.

The dossier also examines the main recent and forthcoming policy initiatives from the

European Commission including progress on in-vehicle safety technologies such as Intelligent Speed Assistance (ISA) for professional vehicles and alcohol interlocks for certain vehicle and driver categories, with recommendations for maximising the results for road safety. ETSC is calling on the Greek presidency to promote the uptake of these technologies in the EU.

In order for the EU to reach its 2020 target to cut road deaths by half, compared to the 2010 level, it must embark immediately on a systematic programme of actions and activities and it is now up to the Greek EU Presidency



to work together with the Member States, the European Commission and the European Parliament to initiate such a programme by implementing the key aspects of the policy framework known as the EU's "Policy Orientations on Road Safety 2011-2020".

Members of the European Parliament have an important voice when it comes to improving road safety in the EU. ETSC hopes the new MEPs –to be elected from the 22nd to the 25th of May next year – will show the leadership needed to sustainably curb the loss of life and limb on our roads. ETSC has prepared a Manifesto addressed to candidates for the next Parliamentary mandate. Current MEP candidates must make road safety a priority for the 2014-2019 mandate. Reaching the EU 2020 road safety target will depend in part on the activities of newly elected MEPs, who must support and fuel the stepping up of Efforts to improve road safety, both at the national and EU level.

Transport safety should be considered as an essential component of sustainable mobility and mobility planning with concrete provisions, tackling effectively joint objectives of mobility and safety. In attempting to secure change in urban mobility patterns, road safety can be regarded as a critical challenge, largely because of the social and economic cost of road collisions. As such, safety should be

addressed at all levels of mobility planning. Real and perceived safety can have a profound effect on modal choice especially in terms of the most sustainable transport modes. Transport safety should be integrated not only into the development of Urban Mobility Plans but also into proposed Urban Mobility Audits and Guidelines and be reflected in common targets.

Plans should adopt a clear hierarchy of transport users, with pedestrians, cyclists and public transport users at its top, meaning placing them at the heart of the planning process. A higher share of travel by collective transport, combined with minimum service obligations, will allow for increasing the density and frequency of services, thereby generating a virtuous circle for public transport modes. The Commission should also add another benefit: the core public transport modes (bus and rail) are the safest modes of transport. This is another reason why the EU should promote the extension, quality and use of public transport.

In the final part of the briefing, ETSC examines Greece's own track record on road safety with recommendations for improvement.

More information: http://www.etsc.eu/documents/2013_12_greek_memo.pdf

► AGENDA

2014

25-28 February in Orlando - Florida, USA
ICPHSO's 2014 Annual Meeting and Training Symposium
Website: <http://www.icphso.org/>

14 March, City Hall of Thessaloniki, Greece
European Consumer Day: "Consumer protection and social inclusion in the times of crisis"
Website: <http://www.eesc.europa.eu/?i=portal.en.events-and-activities-consumer-day-2014>

10-12 April in Monaco
IOC World Conference on Prevention of Injury & Illness in Sport
Website: <http://www.ioc-preventionconference.org/>

3-5 June in Harstad, Norway
4th European Regional Safe Community Conference
Website: http://www.safecomeurope.com/uploads/Safe_Community_Conference_flyer.pdf

10-13 June in Hyderabad, India
12th International Federation of Ageing Global Conference
Website: <http://ifa2014.in/index.php>

16-20 June in Brussels, Belgium
International Product Safety Week 2014
E-mail: sanco-ipsw-replies@ec.europa.eu

27-28 November in Brussels, Belgium
6th European Alcohol Policy Conference
Website: http://www.eurocare.org/media_centre/upcoming_events

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