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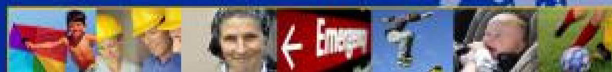
EuroSafe Alert

European Association for Injury Prevention and Safety Promotion



Quarterly publication published by EuroSafe and supported by the European Commission

"Working together to make Europe a safer Place"

►EuroSafe news

Injury monitoring - plan for action

Effective injury prevention needs information on external causes and circumstances as well as comparable indicators for the burden of injuries and their development. In the past decades, 13 Member States have developed a harmonized monitoring system in hospitals, which provides the needed information, complementary to existing health and accident statistics. This system is known as the European Injury Database (IDB).

However, the administrative burden of data collection in nationally representative samples of hospitals has turned out as too high for some countries. Therefore the IDB-network of data suppliers in collaboration with DG Sanco has developed a new strategy which is aiming at an EU level IDB sample in stead of a compilation of national samples. This allows some countries to provide data from a very limited number of hospitals. Supplementary actions are being recommended as to the existing hospital discharge registers. This will facilitate the expansion of country coverage, enhance data quality, and will reduce the annual operating costs.

Joint action

In order to help the new strategy being implemented in countries, EuroSafe has submitted a funding proposal to the Commission, called Joint Action on Monitoring Injuries in Europe (JAMIE). In the framework of the EU-Health programme Joint action are defined as actions initiated and conducted by a public body or a non-profit-making body, designated by the Member State or the competent authority concerned. In principle a joint actions should include the active participation of a majority of Member States.

The proposed project, involving 22 Member States is submitted under the leadership of EuroSafe (Netherlands) and Austrian Road Safety Board-KfV (Austria). The National Centre for Healthcare Audit and Inspection (Hungary), the National Health Information Centre (Slovakia) and School of Medicine at the Swansea University (Wales) have accepted to take responsibility for work packages on evaluation, capacity building and data quality in the proposed project.

In addition, another 19 associated partners on board all confirming to become actively engaged in carrying out the project as soon as the commission services agrees with the proposal and contractual arrangements have been concluded.

The overall aim of the Joint action is to expand and improve injury surveillance based on the current IDB, with a view on an EU-wide injury surveillance system suitable for an eventual integration into the European Statistical System (EES) by 2015. Therefore the project works towards the following objectives:

- A sustainable network of 30 active and capable national data administrators (at least one per country) shall be established by 2013. National data administrators shall be well aware of the methodological requirements, capable to ensure the delivery of data in the needed quality, and endorsed by the responsible national or regional authority.
- Criteria for IDB data quality like representativeness and comparability shall be clearly laid down, in line with the respective requirements of the European Statistical System (ESS), by the end of 2011.

IDB reference hospitals (at least one per country) applying the full IDB coding of external causes shall be established in 25 of the countries of the IDB Network by the end of 2013, and the remaining countries have an implementation plan. IDB data 16) by the beginning of 2013.

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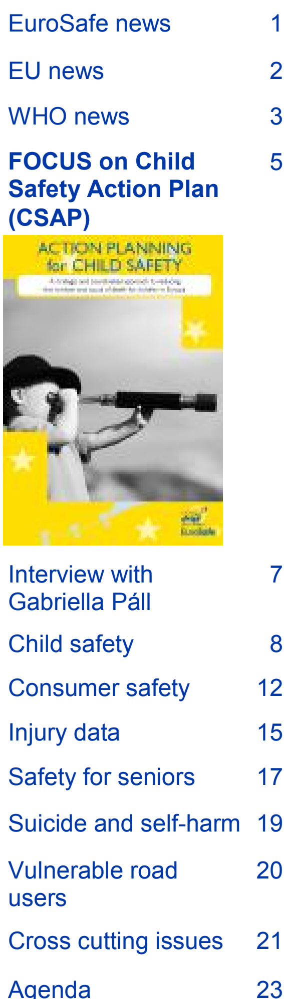

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- Current and new IDB data shall be analysed and reported upon, including yearly uploads of the 2009 to 2012 IDB data sets and making them publically available at the SANCO based IDB website, as well as regular reporting of population based indicators for the EU and represented geographical areas.

A final decision by the Health Programme Committee on funding requests submitted in the framework of the Health Work plan 2010, is expected by June this year.

More information: secrerariat@eurosafe.eu.com

► EU news

New DG for health and consumers

On 31 March 2010 the College of Commissioners confirmed the appointment of Robert Madelin, the Director-General for health and consumers, as Director-General for information society and media. Robert Madelin's successor was also confirmed by the College of Commissioners, at their weekly meeting in Brussels. Paola Testori Coggi, who joined DG Sanco in 2007 as deputy director-general in the health and consumers, will now take on the position of director-general. On 1 April 2010 will be the official starting date of Ms. Testori-Coggi.

Mr. Madelin started working at the Commission in 1993 as a member of the cabinet of former European commissioner Leon Brittan. In 2004 he became director-general for DG Sanco. Under Commission rules, directors-general must change jobs every five to seven years. In his position, Mr. Madelin has had a high profile and was the creator of several initiatives that EPHA and EPHA members participated in, such as the EU Platform for Action on Nutrition, Physical activity and Health and the Alcohol and Health Forum.

Ms. Testori-Coggi has an educational background in biological sciences and started working at the Commission in 1982 on pollution policy. She has worked under former Commissioner Filippo Pandolfi from DG Research, dealing with R&D programmes in the life sciences and the environment. Before joining Health and Consumer Protection DG in 1999, she worked in the office of former commissioner Emma Bonino, where she helped manage the BSE and dioxin crises, and contributed to a new policy on consumer health and food safety following the European Parliament's recommendations on BSE. Ms. Testori-Coggi was previously the Director in charge of the safety of the food chain (SANCO.E), and worked on food safety legislation. This included issues, such as BSE, GMOs, hormones, additives and labelling, as well as managing food and feed safety crises.

Cross border barriers

The spring 2010-Consumer Markets Scoreboard published by the European Commission reveals that EU consumers are still not reaping the full benefits of the internal market due to barriers to cross-border commerce. There is a growing gap between cross-border and domestic e-commerce. The national conditions for consumers – measured e.g. by consumer trust in consumer authorities and NGOs, and the effectiveness of handling disputes – have declined in many countries. Some Member States have improved their scores notwithstanding the difficult economic period. The ability of consumers to afford goods and services varies greatly from one country to another: in six countries, affordability is less than half the EU average. Life in the richer EU countries is more affordable for consumers, despite higher price levels.

The Scoreboard is a two-part tool put in place to make sure that the EU internal market is working for European consumers by offering them a greater choice of products and services, competitive prices, effective complaints handling and ensuring that they are supported by effective national consumer institutions. Consumers' welfare is after all the 'acid test' for the internal market and for the national markets. If it works for them, it is competitive and innovative.

Why should cross-border commerce matter for EU consumers?
Considering the rapid growth of online shopping and border-free travel within the EU, the large EU-wide market – much larger than any domestic market – could be within the consumers' easy reach, resulting in a much wider choice of products and lower prices.

A mystery-shopping study requested by the Commission and published in October 2009 offered concrete evidence that shopping cross-border within the EU could offer genuine savings and a greater choice to consumers.

For example, in 13 countries out of 27 and for at least half of all product searches, consumers were able to find an offer in another EU country which was at least 10% cheaper than the best domestic offer (all costs, such as delivery to the consumer's country, included).

Barriers to cross-border trade
The number and value of cross-border transactions is a measure of how integrated the EU retail market is. Cross-border commerce shows limited growth: in 2009, only 29% consumers made any purchase in another EU country (25% in 2008) and only 25% of retailers sold to any other EU country (20% in 2008). The gap between domestic and cross-border online purchases is growing: in 2009, 34% of EU consumers bought goods or services online from national sellers (28% in 2008), but only 8% ordered from elsewhere in the EU (6% in 2008). Earlier Commission studies showed that shopping cross-border can offer genuine savings and a greater choice to consumers.

But barriers remain, resulting in many traders refusing to deliver abroad. Earlier reports show that over 60% of cross-border orders fail. The Commission is determined to pursue a strategy of dismantling these barriers. They include ending fragmentation of rules, boosting cross-border dispute resolution and simplifying regulations for retailers.

Consumer trust.
The Scoreboard keeps track of the Consumer Environment Index for all EU countries, which is a measure of the quality of national conditions for consumers. The objective is to create a data set which can be used by EU countries to estimate the impact of policies on the welfare of their citizens.

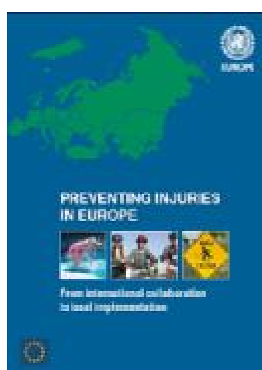
The economic crisis has had an adverse impact on these conditions for consumers, with most countries experiencing a decline. But eight Member States (Portugal, Luxembourg, Ireland, Italy, Austria, France, Slovakia and the United Kingdom) have improved their scores compared with 2008.

The Scoreboard found large differences between EU countries in the consumers' ability to afford goods and services, taking into account both the average incomes and the price levels. Strikingly, life for consumers is more affordable in the richer EU countries, despite higher price levels: Luxembourg is by far the most affordable country, followed by the United Kingdom, Cyprus, the Netherlands and Austria.

More information:
http://ec.europa.eu/consumers/strategy/docs/3rd_edition_scoreboard_en.pdf

► WHO news

Progress in preventing injuries: from international collaboration to local implementation



The report *Preventing injuries in Europe: from international collaboration to local implementation* is the result of a three-year collaboration between the World Health Organization (WHO) Regional Office for Europe and the European Commission (EC) on a project funded by the Directorate-General for Health and Consumers (DG SANCO) in the framework of the Public Health Programme. This report describes the progress made in implementing WHO Regional Committee for Europe resolution EUR/RC55/R9 and the European Council Recommendation of 31 May 2007 on the prevention of injury and promotion of safety. The report is based on a questionnaire survey of national health ministry focal persons from 47 responding countries of the 53 in the WHO European Region. In addition to questions on the implementation of the main items of the resolution and Council Recommendation, the questionnaire includes questions on whether evidence-based programmes for the primary prevention are being implemented and on programmes targeting the prevention of alcohol-related harm and the reduction of socioeconomic disparities in injuries and violence.

Progress made

Good progress is taking place, and resolution EUR/RC55/R9 and the European Council Recommendation have catalysed change:

75% of the responding countries stated that the resolution had placed violence and injury prevention higher on the national policy agenda and had helped to stimulate action. During the past year, progress has been reported in the following areas: developing national policy in 67% of countries, surveillance in 74%, multisectoral collaboration in 78%, evidence-based emergency care in 61% and capacity-building in 63%. In terms of national policy development, 60% of countries have overall national policies for preventing injuries and 46% for preventing violence. Whereas most countries had a national policy on road safety (95%), half or less had national policies for preventing other unintentional injuries. For preventing violence, 71% of responding countries had national policies on child maltreatment, 76% on preventing intimate partner violence, 64% on preventing sexual violence, 62% on youth violence and less than half on preventing elder abuse and self-inflicted violence.

Of the 99 programmes assessed for preventing injuries and violence, the median implementation score was 73%. The median values for individual types of unintentional injury ranged from 81% for preventing road traffic injuries to 60% for preventing fires, and for preventing violence this ranged from 100% for preventing child maltreatment to 67% for elder abuse and neglect. In many countries, programmes were implemented in selected geographical areas rather than nationally. Progress has also been made between 2008 and 2009 in preventive programming for most types of injuries and violence, although progress has been minimal for some types such as drowning, fires, elder abuse and youth violence. This mapping exercise has shown that the health sector needs to commit to more widespread implementation of effective programmes both in number and coverage and to engage with other stakeholders in a multisectoral response to prevent injuries and violence.

As a result of the survey a database with 47 country profiles, supplemented by WHO information sources, has been developed and is available on the Regional Office web site. Further national policies for violence and injury prevention have also been identified and to date more than 150 policies from 32 countries have been uploaded and are available on the Regional Office web site.

Way forward

Encouraging progress has been made in implementing resolution EUR/RC55/R9 and the European Council Recommendation on the prevention of injury and promotion of safety. The health sector and nongovernmental organization (NGO) partners need sustained action to decrease the inequality in violence and injury between and within countries in the WHO European Region. The progress mapped in the report is encouraging and underlines the fact that future success can only be sustained through political and resource commitment by countries and international organizations. The collaboration between the European Union, NGOs and WHO has benefited all Member States in the WHO European Region.

More information:
http://data.euro.who.int/injuryprevention/.

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Dinesh Sethi (DIN@ecr.euro.who.int)

Full report available at:
http://www.euro.who.int/Document/E93567.pdf

Parma Declaration

On the 15th March, the national governments from Europe adopted a declaration pledging to reduce the adverse health impact of environmental threats in the next decade. The text was endorsed by 53 Member States attending the Fifth Ministerial Conference on Environment and Health in Parma, Italy on 10-12 March 2010. The Conference was the fifth such event held in the WHO European Region as part of the European environment and health process, which began over 20 years ago. The first four conferences were hosted by the governments of Germany (in 1989), Finland (in 1994), the United Kingdom (in 1999) and Hungary (in 2004).

Through the Declaration and Commitment to Act, participating governments agreed to implement national programmes to provide equal opportunities to each child by 2020 by ensuring access to safe water and sanitation, opportunities for physical activity and a healthy diet, improved air quality and an environment free of toxic chemicals.

Governments vowed to tackle the adverse health impact of climate change and to reduce social and gender inequalities in exposure to

risk. They also pledged to place health at the centre of socioeconomic development through increased investment in new technologies and green jobs.

'We need a radically new vision for European health policy to address the biggest health challenges of our Region. This Conference has opened an exciting new chapter in the way European governments work on environment and health - helping to push these closely inter-related issues higher up the political agenda,' says Ms Zsuzsanna Jakab, WHO Regional Director for Europe.

'A significant proportion of Europeans suffers from health problems linked to environmental conditions. Vulnerable groups, such as children, pregnant women and socially disadvantaged people are particularly affected. Policymakers have the responsibility to address this problem. The European Commission will play its part by continuing to focus attention across European Union policies on environmental impacts on health,' says John Dalli, European Commissioner for Health and Consumer Policy.

The future of the European environment and health process

In September 2010, Member States will gather in Moscow for the sixtieth session of the WHO Regional Committee for Europe, WHO's highest decision-making body at the regional level, to endorse the outcomes of this Conference through a resolution. During 2010 and beyond, the European environment and health process will be revitalized through a series of new arrangements.

The governments gathered in Parma agreed to strengthen political coordination between regular ministerial conferences, and will now involve ministers directly in steering the Process - to ensure that cross-sectoral issues are given the highest possible political profile. Ministers from the 53 European Member States will meet again at the Sixth Ministerial Conference on Environment and Health in 2016.

More information:
http://www.euro.who.int/eprise/main/WHO/Progs/ceh/home?language=

► FOCUS on Child Safety Action Plan (CSAP)
Update project impact 2004-2010

After 6 years of multi-sectoral co-operation within 26 EU member states, the CSAP project is increasingly showing its impact through the development of stronger child safety frameworks within the participating countries.

The *Child Safety Action Plan (CSAP)* project is a large-scale initiative that aims to develop child safety action plans in European countries and to raise awareness and commitment to child injury prevention through evidence based good practices. The desired outcomes of the project include (a) government endorsed national child safety action plans and (b) increased capacity at the national level to undertake action to address child injuries. In order to achieve these outcomes, the following areas of action have been supported:

- Encouraging adoption, implementation and monitoring of evidence-based good practices.
- Developing indicator-based country child safety report cards and profiles.
- Developing national child safety action plans through a flexible yet structured mentoring process.

Measurable progress

As of February 2010, three countries have government endorsed plans they are now implementing (Cyprus, Czech Republic and Sweden), six countries have plans and are working on government endorsement and/or implementation (Austria, Belgium, Finland, Germany, Hungary and Northern Ireland) and two countries have a strategic document and are working toward action plans (Scotland and Wales). The other participating countries are at various stages in plan development. A mentoring process for country partners involving both capacity building activities and day-to-day support is ongoing and supports advancement through the Child Safety Action Plan development process.

Two sets of Child Safety Report Cards and Profiles have been released in 2007 and 2009, respectively. They summarise a country's performance with respect to the level of safety provided to children through national level policy, and inform planning by identifying countries' strengths and weaknesses. They also assist countries in the identification of

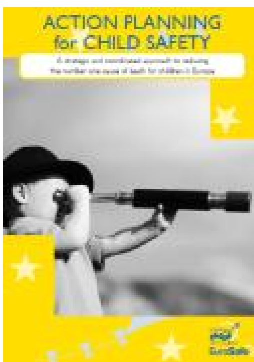
critical gaps and furthermore serve as a baseline for benchmarking and evaluation. These tools have been instrumental in increasing awareness of the child injury issue at the national and European level. An analysis of performance scores for the 14 countries that had a report card in both 2007 and 2009 showed progress for all with the greatest improvements measured in Austria and the Czech Republic. The greatest improvements were found in the areas of leadership, infrastructure and capacity to support child safety actions.

The most current evidence on good practices has been synthesised within the *Child Safety Good Practice Guide: Good investments in unintentional child injury prevention and safety promotion*. Highlighting over 50 proven prevention measures the resource, first published in 2006, assists countries in building their Child Safety Action Plans (CSAP) around evidence-based good practices. An addendum to the Guide will be added in 2010.

Martina Abel, the Director of SafeKids Germany who led the CSAP development process for Germany and is now working with national partners on implementation agrees that the CSAP project has led to measurable results. 'The project has given quantitative results related to planned actions - increased data, new activities, increased quality management, a transparent structure and action plan and potential new partners, plus some funds to develop the plan.'

Value of the Initiative and lessons learned

Partners have found that the process of developing a child safety action plan is in many ways as important as the final plan itself. By engaging government and non-government stakeholders from multiple sectors in the planning process they are increasing awareness of the child safety issue and building capacity by creating a common understanding of the injury issue.



Giuseppina Lecce from the Ministry of Health in Italy said 'The CSAP process has opened new doors for partnership to advance child safety', and the other partners agree that people and relationship building have been the drivers of the process. Further having national partners going through the process together is ensuring common goals and alignment of priorities so that all stakeholders work together toward a shared vision.

Challenges across Member States have been fairly consistent and include:

- change in elected government;
- challenges in getting the right people involved in the planning process and attaining government commitment;
- obtaining infrastructure and resources to support planning ; and
- obtaining data to support planning and eventual implementation and monitoring.

The value of the project has been greater than anticipated. The development of national plans is providing clearer direction for national and European level supports and actions. Dr. Jorge Parise of The Spanish Pediatric Association agrees, stating 'CSAP brought a new level of attention to child safety and we have a new identity as a result of being part of the larger process.'

Specific lessons learned have included the importance of:

- Leadership and commitment;
- Early and continued involvement of the right people;
- Having good tools and resources to work with;
- Public benchmarking of progress and current performance to motivate action; and
- Linking into existing political commitments.

The European Child Safety Alliance is proud to serve as lead on this project, and to play a vital role in advocating for equity in safety for the children of Europe with the aim of making Europe a safer place for them all.

Selected outcomes achieved

- Nine countries with national child safety action plans where none existed previously and others in development.
- Published Child Safety Good Practice Guide as reference for more effective planning.
- 24 countries with child safety report cards and profiles and a European summary report card.
- Demonstrated value of report card indicators used in benchmarking progress.
- Demonstrated value of standardised yet flexible plan development process.
- New and/or stronger links with government and between national partners.
- Increased awareness of child injury issue and increased capacity to take action.

- Increased multi-sectoral cooperation and collaboration.
- Enhanced political commitment to the injury issue.
- New collaborative and guidance structures at the national level (e.g., Child Safety Councils, multi-sectoral government committees).
- Strengthening of the Alliance network and provision of an umbrella activity under which all other activities are now being placed.

More information: *secretariat@childsafetyeurope.org* or at *http//:www.childsafetyeurope.org*

u INTERVIEW with Gabriella Páll, National Institute of Child Health, Hungary

Hungary's participation began in 2004 with the General Inspectorate for Consumer Protection acting as Country Coordinator to the Child Safety Action Plan (CSAP) initiative. The General Inspectorate invited the National Institute of Child Health to co-lead the initiative and that was when Dr. Gabriella Páll, first became involved. During the first phase, the two organisations completed the child safety report card assessments, wrote a widely distributed situational analysis on the issue of children's injuries in Hungary for stakeholders and worked to engage government and national stakeholders in the CSAP development process. Beginning in 2008, the National Institute of Child Health received an official mandate from Government to lead the CSAP development process. The process, which was initiated that year with multi-sectoral participation, resulted in the completion of a 10-year plan for children and youth 0-24 years in 2009. An English version of the plan is available at: *http://www.ogyei.hu/anyagok/ogyei_a.pdf*

Gabriella Páll is a Hungarian paediatrician and epidemiologist, who has also had the role of CSAP Coordinator for Hungary since 2008. She took on the challenge of working as an epidemiologist for the National Institute of Child Health, Hungary in 2003, after spending 14 years working as a clinical paediatrician. More recently she has been working as a part time senior councillor with the Institute in addition to running a primary care paediatric practice and coordinating the next steps for the Hungarian CSAP. Child safety is the focus of her interest.

Gabriella was recently interviewed regarding Hungary's participation in the CSAP initiative.

What have been the positive outcomes of Hungary's participation in the CSAP initiative?

We are among the countries with a national action plan on Child and Youth Safety. I think that is the most important outcome of our participation, and I really do believe that without the CSAP initiative this 10-year plan, tailored to the national situation, would not be ready yet. While working on the development of our plan we learned a lot, found new partners and friends, and I hope that this knowledge will help us in the implementation of the programme as well. Producing strategic plans like this is not the overall goal. The final goal is to make the world safer for children, to let them grow in safety and health. Such a plan is an indispensible necessity to reach that goal.

What have been the greatest challenges for the process?

The greatest challenge, which is as of today is just partially solved, was to get child safety onto the agenda of decision makers. This is a task that needs continuous effort. At the beginning of the programme the issue of injury prevention received much less attention and support than it should based on its contribution to child mortality and morbidity, tremendous health and social costs. We've begun to change that, but there is much work still to be done to ensure the support matches the cost.

What have you personally gotten out of participating in CSAP?

Being a part of a well coordinated international network, having the opportunity to share the experience, to get continuous information on other countries efforts, ideas, solutions and challenges has been unquestionably inspiring. Armed with this knowledge I could more easily find the way forward in managing the development of our national

document. I better understood the importance of strategic planning, the careful situational analysis, the use and adaptation of good practices, and the purpose of inter-sectoral approach.

What are the next steps for the Hungarian CSAP process? How do you think the upcoming EU Presidency will impact your efforts?

We have a 10-year target for the 0-24 year-old population of 30% reduction of mortality due to unintentional injuries. We have developed the actions for the first three years (2010-2012) and this year started to implement the action plan, though with limited resources. We have initiated a number of actions, but there is still a lot of work needed to raise the awareness of decision makers and stakeholders and to maintain and increase governmental support in favour of the effective implementation. That work will continue and take on greater significance this spring when there will be elections in Hungary as pollster agencies are forecasting a change in the governance of the country. With regards to the Hungarian EU Presidency in 2011, child health in general, including child safety, will be one of the priority areas addressed. We are hoping that the focus will have a bi-directional effect. On one hand Hungary will gain from the interest of the broader European community, which should be helpful to us in ensuring support to implement the CSAP and make progress in reaching the goals. On the other hand Europe will also gain from the fact that child safety will receive increased attention during the Hungarian Presidency.

What advice do you have for other countries looking to undertake a similar planning process?

I advise them to be prepared for a long, but promising work experience. Committed persons at each level are a prerequisite. An appropriate situational analysis, realistic planning, unbroken implementation, ability to work with a number of sectors and partners, using the evidence based solutions, and overcoming ongoing challenges and failures may lead to success. I hope that Hungary is one of the examples for this.

More information: gabipall@ogyei.hu

► Child safety

Safe At Home passes milestone of 100 local schemes

More than 100 local schemes have been approved to join Safe At Home, England's national home safety equipment scheme run by the Royal Society for the Prevention of Accidents (RoSPA).

The milestone was reached a year after the scheme was officially launched.

It means that free access to home safety equipment is a reality for thousands of families in areas with the highest accident rates in England. Many more families are benefiting from safety information and advice which is helping them take steps to prevent home accidents.

Safe At Home, which was launched in February 2009, aims to reduce accidents among the most vulnerable under-fives.

Partnership working is the foundation on which the scheme is based. It involves RoSPA, a safety charity, working with local authorities, children's centres, fire and rescue services and other charities to provide and fit home safety kits to disadvantaged families. The kits include: safety gates (up to 2); window restrictors (up to 6); non-slip bath or shower mat; fire guard; locks for kitchen cupboard containing cleaning chemicals and medications (x2); corner cushions (up to two packs of 4); and cord shorteners for families with looped-cord blinds and curtains.

A scheme in Durham, in north east England, became the 100th to be approved and it began installing equipment in February 2010. The scheme, which also covers Chester-le-Street and Easington, is being run by the Whoops! Child Safety Project. Whoops has been running Safe At Home schemes in Gateshead, North Tyneside and South Tyneside since last year.

Complementing the provision of safety equipment, safety education and information is a crucial tenet of Safe At Home.

Last year, the scheme released an eight-minute film highlighting the dangers facing under-fives in the home.

The free film comes with discussion notes and is designed to be used as a starting point for practitioners to talk to families about home safety. It follows the story of two-year-old Sam as he tries desperately to make his parents aware of the hazards facing him in the family home. Embarking on a series of challenges, called Operation Unlocked Window, Operation Unsecured Medicine Cupboard and Operation Unsecured Matches, Sam uses his toys in an attempt to alert his parents to the dangers. You can watch the film online at www.safeathome.rospa.com

A height chart backs up the information in the film and is a resource which families can take home. It highlights the most common home accidents involving under-fives, including falls, burns and scalds and poisoning, and gives prevention tips.

At the start of 2010, the availability of height charts and DVD copies of the film was extended nationally. The resources are now available free-of-charge to all home safety practitioners across England, whether they work in a Safe At Home area or not.

A particular highlight of Safe At Home's first year is that more than 4,200 copies of the DVD and more than 208,600 height charts have been requested so far.

RoSPA has also been delighted with the response from families who have received equipment during Safe At Home's first year.

One mum, Julie Davies, of Sunderland in north east England, found out about Safe At Home through her health visitor. She was so impressed with the pair of kitchen cupboard locks she received that she has decided to get some more to prevent 10 month-old Ben opening other cupboard doors.

She said: "These are an excellent product but we need more because of our son being a very lively and mobile little baby who loves to open cupboard doors constantly!

"I would encourage all parents with babies and small children to take advantage of Safe At Home and to get their safety equipment fitted free of charge. You have nothing to lose and a lot to gain from going ahead with the scheme."

Laura Duckhouse, of Dudley in central England, had a Safe At Home assessment and received equipment when her daughter Lauren was 11-months-old. She said: "This scheme is brilliant. It has saved Lauren from hurting herself, and I've got a little nephew too, so it's not just about Lauren."

Sheila Merrill, RoSPA's home safety manager for England, said: "Safe At Home aims to prevent the suffering caused when young children are injured in home accidents. To have reached the milestone of 100 approved schemes is exciting. Figures can be bland, but let's not forget that for each scheme, there are many families receiving equipment and advice which is making a real difference in their everyday lives."

Safe At Home is funded by the Department for Children, Schools and Families.

You can read more news from local schemes and participating families at www.safeathome.rospa.com/news/

Child Safety Education Coalition projects to help children and young people learn about risk

More children and young people in England will have practical opportunities to learn about danger and how to cope with it thanks to a range of projects launched by the Child Safety Education Coalition (CSEC).

CSEC is a group of member organisations which are working together to promote practical education to help children and young people protect themselves and others from five main types of unintended injury: road traffic injuries, drowning, poisoning, burns and scalds and trips and falls.

During the coalition's first year, CSEC co-ordinators have been working with members to develop and pilot practical safety education projects.

Among the highlights have been:

- around 70 play workers taking part in new training to give them the confidence to lead activities sometimes deemed "too risky" ;
- outdoor activity instructors piloting training which focuses on how children can learn safety skills through adventure pursuits like canoeing, mountain biking and sailing;
- a partnership with university students who

are developing computer games which will help children learn about fire safety;
- the review and development of injury prevention and immediate first aid training for children;
- the parents of six- and seven-year-olds developing skills to help their children learn how to stay safe on the road; and
- secondary school students developing a practical safety education programme for their peers.

Other projects to be launched in the coming months include:
- a national wildlife-focused initiative to encourage children and young people to explore and enjoy the outdoors while also breaking down the perceived “health and safety barriers” to this;
- a project to get children thinking about safety during farm visits;
- a programme linking nature and safety learning at a waste and recycling education centre; and
- the development of a resource profiler which will be used to identify the strengths and weaknesses of existing and future safety education resources.

John Vallender, CSEC manager, said: “CSEC’s projects are founded on the belief that giving children and young people the opportunity to think about and experience risks helps them develop safety skills which will last a lifetime. The aim is to help them reach a point at which they are able to protect themselves and others from unintended injury.

“We’re delighted to be working with a wide range of organisations on projects which see children learning these skills in the course of everyday activities. The projects are being made as flexible as possible so they can be easily adapted to different settings and rolled out to benefit children and young people across the country.”

CSEC was launched publicly in February 2009 and, since then, 80 organisations have joined.

In addition to working on practical projects, members are developing core competence sets for the five unintended injury areas, answering the following question:
- What can we reasonably expect children and young people to do to reduce unintended injuries to themselves, their family and friends?

A draft set of competencies related to emergency first aid has already been developed.

The full collection of competence sets will come together in the CSEC Risk Competence Framework. This will be England’s first national reference document for developing resources and services which focus on how to recognise, remove, reduce and recover from harms and injuries.

As a final note, those who attended the CSEC/AdRisk international seminar in November will recall taking part in discussions that sought to define “high quality practical safety education”.

The CSEC team has considered the findings and taken them forward to arrive at the following definition, which will be used in the development of CSEC policy, strategy, resources and services.

High quality practical safety education can be recognised because it has clear aims and objectives which:
- help children and young people develop risk competence appropriate for their age and developmental stage;
- use active, interactive and experiential learning in a variety of challenging but controlled environments;
- develop injury prevention knowledge, skills, perceptions and attitudes
- encourages and supports reflection on the attitudes;
- is quality assured against evidence based standards;
- encourages personal responsibility for keeping themselves (and others) safe;and
- is part of a wider strategy to prevent unintentional injury.

Summing up the benefits of working as a coalition, John Vallender said: “There is considerable strength in community and joining together brings opportunities to take expertise and services to a wider audience.”

You can find out more about the practical projects, including quotes from participants, and details about CSEC’s other work at www.csec.org.uk

Testing Survey: Child-Resistant Re-closable Packages

In 2009 the Federal Ministry of Agriculture, Forestry, Environment and Water Management ("Lebensministerium") ordered a testing survey concerning child-resistant re closable packages for toxic or corrosive substances or mixtures which had been conducted by the Austria Road Safety Board (KfV).

The main aspect of this survey was to find out whether packages, fulfilling standard EN ISO 8317, can be opened by children more frequently than allowed.

The issue

In 1970 the "Poison Prevention Packaging Act" was enacted in the USA as a result of the efforts of numerous paediatricians. This was considered necessary, as children suffered severe intoxications and chemical burns. In the following years child-resistant packages were provided for a limited number of medications such as aspirin.

More than ten years later an evaluation took place and a multicenter study in the USA showed a decline from 5.7/1,000 to 3.4/1,000 children which suffered from intoxications due to ingestion. The death rate even declined from 2.0/1,000 to 0.5/1,000 during the same time.

Various countries adopted the idea of child-resistant packages and 2004 the standard ISO 8317:2003 was provided in German language. This standard describes a procedure for testing child resistant fastening with the assistance of children as well as of individuals at the age of 50+. In 2004 this standard became European standard (EN) and the last revision took place in 2005.

In 2008 an EC regulation concerning "classification, labelling and packaging of substances and mixtures" was published. One of the topics of this regulation is dealing with child-resistant re closable packages and therefore referring to EN ISO 8317.

Survey

The survey was conducted with the help of 43 up to 101 children per package in 76 different kindergartens throughout the City of Vienna. The maximum number of children was restricted to 101 children. Less children were required, when the result laid within a 95% confidence interval for a conclusive result. The age group – according to EN ISO 8317 – for the children assisting in these tests was 42 to 51 months.

Twelve packages were subject to this testing survey, each of which contained corrosive substances or mixtures (pellets or liquids) when bought and therefore required child-resistant fastenings. These packages were cleaned thoroughly as it was foreseeable that the children would also use their teeth if nothing else worked out. After each test the used package was cleaned and checked for damage.

Before each test the packages were closed using the middle finger and the thumb of the right hand, in order to provide an equal closure torque for all bottles.

Testing

This survey was restricted to the upper limiting line provided by ISO EN 8317. This line – provided for sequential testing – also permits for sequential testing. In this case 25 of 100 children could be able to open each container.

The tests were run in kindergartens in order to make sure that the children felt comfortable in the chosen testing beds. Generally these testing beds were separate rooms such as sports halls, or the director's office or – if nothing else was available – separate parts of the playing rooms (such as doll's kitchens etc.).

Most of the children were very ambitious and tried various techniques in order to open the packages. Within the first test period of five minutes the children tried to open the packages, generally trying to turn the fastenings and / or pull them off. After demonstrating the opening of the packages – without explanation as demanded by EN ISO 8317 – those children, who had not been able to open their packages before, had another five minutes to open them. During this time the approach towards the given task was mostly the same as before. The longer it took the children to open the fastening, the more difficult it became to motivate them to continue their task.

The actual time for opening the packages did range between a couple of seconds up to almost ten minutes, depending very much on the fastening.

No child which had taken part in the testing was able to “read” the diagrams embossed on each fastening showing the required method for opening it but they were all familiar with the opening mechanism of “normal” bottles.

Results

Each of the twelve packages had been opened by at least one child.

Three packages had been opened by over 25% of the children and therefore had to be classified as “not child-resistant”.

Five products had been opened by less than 10% (lower limit) of the children and therefore can be considered as child-resistant as far as children are concerned.

The types of fastenings which were opened by over 25% of the children did display two main deficiencies:

The material of the fastening and / or the container was too soft. Therefore the fastenings could be detached easily as it was either deformed by the hands of the children directly or the force they applied on both parts of the package.

The inner part of the fastening interlocked with its outer part as the children were able to apply a sufficient pulling force on the fastening.

Recommendations

No “single-shell” fastenings should be used for corrosive, toxic or very toxic substances or mixtures – such fastenings are too soft to resist even the forces of small children.

Wide diameters for small packages – children find it more difficult to grip wide objects firmly.

For customers: Keep dangerous good out of reach for children!
None of the tested packages was 100% “childproof”.

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► Consumer safety

Cords in children's clothing

When EU consumers buy clothes for their children they should not have to worry about safety risks. A recent EU market surveillance exercise, checked in particular, the safety of children's clothes with cords and drawstrings, with which there can be a risk of strangulation, especially for children up to 7 years. Market surveillance authorities in 11 Member States inspected more than 16.000 such garments between 2008 and 2010, and the results show that 1 in 10 items were in breach of safety requirements under the relevant European standard.

The main aim of the project was to reduce the amount of unsafe children's clothing on the EU market, whether produced in Europe or imported. It resulted in many RAPEX notifications and corrective measures have been taken. The European Commission has received more than 250 RAPEX notifications on dangerous children’s clothes from January to August 2009. This compares with approximately 60 notifications in the same period of last year. Presumably, the increase is due to the focus on cords and drawstrings created by the joint action.

It also enabled Member States to gain experience in working together. National authorities will intensify their work to ensure compliance with the relevant safety requirements and to inform and educate economic operators and consumers.

More information: *http://www.prosafe.org/read_write/file/Newsletters/Newsletter-Issue%2011-March%202010.pdf*

Safety of sunbeds

Last year the Product Safety Enforcement Forum Europe (PROSAFE) carried a EU-wide market surveillance out, with financial support from the European Commission. The results and the main conclusions from the survey have been recently reported by PROSAFE. More than 350 locations were inspected and more than 550 sunbeds were investigated. The great majority of these inspections were at service providers (tanning salons, wellness centres, etc) and concentrated on the safety information and advice provided to consumers, including the 18 years age threshold, on the labelling of the sunbeds, the availability of eye protection and the UV–radiation emitted by the sunbeds.

The percentage of artificial tanning service operators that claimed to provide sufficient information on safe use of the sunbeds to their customers varied considerably between the participating Member States and was between 13% and 94%. Similar percentages of the providers of tanning services indicate that they have intake interviews with new customers. People under the age of 18 years were often not refused when entering a studio to use a sunbed. Where proprietors did claim to provide guidance this could generally not be demonstrated.

Deficiencies in labelling of sunbeds
Checks of 207 sunbeds at service providers on the compliance with the labelling requirements revealed that a substantial percentage failed to comply. For the common labelling requirements for electrical equipment (e.g. CE-marking, brand name, name and address of manufacturer) more than 20% of the sunbeds did not comply. Sunbed type was not listed on 32% of the inspected sunbeds and the warning that UV radiation may cause injury was not present on 52% of the sun-beds.

UV radiation limits exceeded
The risks of artificial tanning are not only determined by the way consumers use the sun beds, but also by the amount of UV radiation emitted from the UV-tubes. This radiation, measured as erythemally weighted irradiation (EWI), should not exceed 0,3 W/m2. In the sun bed joint action the EWI values of 84 sunbeds were determined with equipment partly financed by the joint action program. Of the 84 sun beds that were tested 70 gave EWI values exceeding the limit of 0,3 W/m2 (83,3 %). The highest value measured was 1,43 W/m2. Because the measured sunbeds were drawn from a population of 472 inspected sunbeds an estimate for the percentage of sunbeds that do not comply with the limit can be calculated to be at least 14,4%. It is highly likely, however, that the actual percentage is higher.

The overall conclusions from the results of the inspections in this first action on sun beds are that:

1. Consumer guidance in tanning studios is regularly not given and often not verifiable;
2. The labelling of the sun beds fails to comply in at least 20% of the cases; and
3. That the maximum EWI values for sunbeds are violated at least in one of every 7 sunbeds made available at tanning services.

The European Sunlight Association ESA has been informed about the results and is currently developing a European Code of Conduct for tanning ser-vices, training materials for tanning studios. It also organizes information seminars for stakeholders in cooperation with national associations in the Member States.

More information: http://www.prosafe.org/read_write/file/Newsletters/Newsletter-Issue%2011-March%202010.pdf

Best practice in market surveillance

Market surveillance is an important tool to quickly remove dangerous products from markets and thus to ensure consumers being protected from injury risks. Market surveillance is the responsibility of the Member States, who conduct their activities in a professional way. However, experience has shown the need to enhance market surveillance and to encourage a more uniform approach. In fact, this is the aim of several of the European Commission's initiatives, such as the General Product Safety Directive 2001/95/EC which defines the Member States' obligations with respect to market surveillance of consumer product safety.

Cross-border surveillance
The need for cross-border cooperation has become increasingly evident. The EU Consumer Policy Strategy aims at increasing cross-border trade in Europe. As a result, the

fragmented national market will gradually be replaced by an EU-wide market, the biggest retail market in the world. This process necessitates a reinforced EU-wide cooperation between market surveillance authorities.

Thus, it is necessary to promote common procedures for the practical part of market surveillance actions, including cross-border cooperation and cooperation with stakeholders, and to develop a set of recommendations to assist and enhance market surveillance in Europe. In 2006, the Product Safety Enforcement Forum of Europe (PROSAFE) started a three-year project aimed at ensuring a basic level of expertise and practical experience within the market surveillance organisations of the Member States of the European Economic Area (EEA).

Guide on best practice

One result of the project is the publication of guide presenting best practices in market surveillance that has been collected from Member States as well as from other regions in the world. The main target audience is the enforcement authorities in Europe and other interested parties including policymakers, regulators, businesses and consumer representatives.

The Guide introduces readers into the legislative background for market surveillance and the framework for non-food consumer product safety in the EU, i.e. the provisions as laid down in the General Product Safety Directive.

It presents organisational issues that must be addressed when setting up a market surveillance organisation, such as infrastructure, approaches to market surveillance, competences, external relations (to stakeholders, media and others) and operational risks. It also highlights a number of essential standard operating procedures, e.g. quality assurance, intervention policies, handling of notifications and consumer complaints, and procedures for inspections, sampling and testing.

The Guide looks into issues such as the prioritising of market surveillance activities, presents tools that can be used for priority setting and discusses how to focus activities in order to ensure the largest effect. Key performance indicators for monitoring the progress surveillance activities are being identified.

The Guide provides also a lot of practical tools and formats for example for procedures and checklists for the inspectors and identifies basic equipment to be used by market surveillance inspectors. It gives examples of how to make screening tests for consumer products, electrical products, toys and personal protective equipment for consumers. It describes practical ways to handle samples, including procedures for sampling, registration, packaging and labelling of collected samples. It discusses cooperation with test laboratories and addresses the necessary involvement of the economic operators in the investigations and the follow-up.

The Guide includes an introduction to risk assessment and how risk assessment is being applied in the context of market surveillance (e.g. as opposed to production control). It describes the data that are necessary and how they can be obtained. Cases of a risk assessment exercises are being presented. And finally it presents an overview of cross-border market surveillance activities, in particular the role of customs in market surveillance. It introduces the legal basis and presents several examples of best practices in cooperation between customs and market surveillance authorities, e.g. exchange of information about dangerous products, setting up risk profiles, customs' inspection of products and notification of arriving consignments.

More information: *http://www.prosafe.org/default.asp?itemID=16&itemTitle=undefined*

► Injury Data

Measuring consequences of accidents

The consequences of accidents and injuries can be very severe, for both victim and society. Available data about consequences of accidents and injuries mainly relate to mortality, hospital admissions and direct costs. However, figures about the long-term disability consequences on human functioning (impact on activities and participation of the persons involved) as result of accidents and injuries are sparse.

The ICF, the International Classification of Functioning, Disability and Health provides the most recent and comprehensive model of functioning and disability and is especially relevant in the field of rehabilitation medicine. In the logic framework of ICF, a person's functioning and disability is conceived as a dynamic interaction between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors. "Functioning" encompasses body functions and structures and activities and participation. "Activity" is the execution of a task or action by an individual and represents the individual perspective of functioning. "Participation" refers to the involvement of an individual in a life situation and represents the social perspective of functioning. Disability is complementary to functioning and encompasses impairments in function or structure, activity limitations and participation restrictions. The Activity and Participation parts of the ICF cover all areas of daily life and have a hierarchical structure of 9 chapters, 21 subchapters, further called "domains", 118 2-digit categories and approximately 400 3- and 4-digit categories.

IMPACT

Because of a lack of a measure that accurately reflects the ICF, IMPACT (ICF Measure of Participation and ACTivities) has been developed. IMPACT is a generic self-report measure to describe functioning and disability independent of health condition, usable in large-scale epidemiological and outcome studies.

A disability measure must succinct enough to be included in a battery of questionnaires, but also allow a detailed assessment of disability in one or more domains. For this reason, IMPACT has been designed as a 2-level instrument.

Level 1, the screener part, covers all ICF activity and participation chapters with 32 items and can also be used as an independent measure (IMPACT-S) of activity limitations and participation restrictions in one or more domains. IMPACT-S results in one scale score for each ICF chapter, summary scores for Activities, Participation and a total IMPACT-S score. The reliability and validity of IMPACT-S has been tested and found satisfactory. IMPACT-S has been translated into English and is available as a question-naire. The responsiveness of IMPACT-S for outcomes of rehabilitation is currently being tested in four rehabilitation centers in the Netherlands.

Level 2 consists of a series of more specific items in 21 modules. These modules are linked to items in IMPACT-S. The sensitivity and specificity of IMPACT-S as a screener for Level 2 have been tested in 24 persons with a variety of disability and were found to be sufficient. IMPACT (level 1 and 2, Dutch version) is made available on the internet, hosted by TNO. Respondents are provided a login code to tno.nl/Impactvragenlijst.

As part of a government funded project, IMPACT is currently expanded with items related to body functions and structures.

Current and future applications of IMPACT

The internet version of IMPACT is currently applied as part of a diagnostic tool in a Dutch regional indication agency for persons with traumatic brain injury. About 250 clients will be asked to report on the items of IMPACT before they visit the agency for further diagnostics.

In 2009, the Dutch Council of the Chronically ill and the Disabled (DCCD) funded a project for identifying characteristics of chronically ill persons who reported that they would not benefit from current regulations as to compensation for extra costs of daily living due to their chronic illness. Chronically ill persons were invited to fill in a questionnaire including IMPACT-S. Results were presented by the DCCD to the Dutch parliament with a request to upgrade the inclusion criteria for getting a lump sum on the basis of IMPACT-S. The Dutch Ministry of Health initiated a project to study the possible inclusion of these criteria for current legislation.

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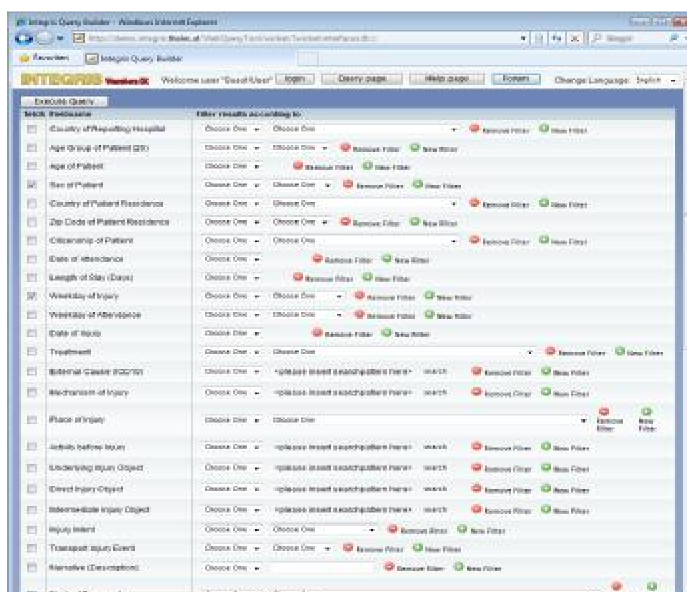
INTEGRIS: Up-to-date injury surveillance and disability indicators

The INTEGRIS-project (Improved Methodology for data collection on accidents and disabilities– Integration of European Injury Statistics) aims to validate the potential of the IDB to fulfill the requirements of the European statistical system by integrating these data with the existing hospital discharge registers (HDR). The overall goal is to develop and evaluate a data model for the integration of routine and more detailed hospital data on injuries, namely through linking the official HDR with the EU-IDB. This integrated data model would enable hospitals to generate a standard injury data set from the routinely collected information with minimal additional efforts. Moreover, a methodology for gaining representativity of the integrated data model is being developed and applied. The development of state-of-the-art electronic interfaces to streamline the data collection is an important part of the project.

The INTEGRIS project aims to provide the necessary research and technology input for the IDB-HDR integration through an evaluated demonstration project in six Member States. Up to now the following results have been achieved in the project:

- Unique INTEGRIS disability indicator: indicators for injury related disability have been developed based on a DALY model.
- INTEGRIS data set: integration of local HDR and IDB data for local and central IT implementation.
- ß-Version of the INTEGRIS database online: access to the query levels 1 and 2 of the web application
- Pilot in 7 countries: a total of 17 hospitals could be recruited for the INTEGRIS pilot data collection.
- Dissemination: 2 INTEGRIS newsletters have been disseminated, presentations at DG Sanco and Eurostat were given, and several INTEGRIS articles were published or submitted (see website for these publications).

Today the project team is working on creating web-based access to the INTEGRIS data for all injury surveillance and injury prevention stakeholders. The screen shot provides a preview of how easy it will be to access injury data online from a variety of European countries.



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► Safety for seniors

Fall prevention clinics

The Finish research institute UKK, the Tampere University Medical School and University Hospital, and the Tampere Research Centre of Sports Medicine are collaborating in establishing fall prevention-clinics at hospitals. One of the first steps is to pilot test the development of such a clinic at the university hospital in Tempered and to evaluate the effectiveness of the programme in preventing injuries.

All home-dwelling persons aged 70 years or more with high-risk for falling and fall-induced injuries and fractures are eligible and belong to the target group. Primarily, these individuals are referred to the Fall prevention clinic by the regional health care professionals (physicians, nurses, physical therapists), but relatives and older adults by themselves can also contact the clinic.

Inclusion criteria are:

- problems in mobility and everyday function;
- 3 or more falls in the last 12 months;
- previous fracture after the age 50;
- osteoporotic fracture (hip fracture) in a close relative (mother or dad);
- osteoporosis; measured or strong suspicion
- low body weight (BMI <19); and
- suffering a disease that is increasing the risk for osteoporosis, falls or fractures.

The included older persons are first interviewed and examined at the clinic by a nurse (entry interview), physical therapist (mobility, balance and strength tests), and physician (medical examination) to assess all individual intrinsic and extrinsic risk factors for falls and fall-induced injuries such as fractures.

After the comprehensive and individual assessment of the risk factors for falling, the participants are randomised to the intervention group and control group. Thereafter, the clinical staff decides on individual basis, the proper mixture of fall prevention measures that suits the needs and demands of the individual as well as the environment he/she is living in, and supervises their implementation. The control group receives general injury prevention guidelines in the form of a brochure made by a Finnish Campaign called 'Prevention of Home Accidents' (Kotitapaturmien ehkäisykampanja)

The falls prevention measures in the intervention group include:

- general guidance for physical activity (physical activity prescription);
- guidance for adequate nutrition (calcium and vitamin D supplementation);
- individually tailored or group training of strength and balance (led by a professional exercise leader);
- treatment of illnesses increasing the risk of falling;
- review of medications (withdrawal of redundant psychotropic medication);
- advice for alcohol use reduction, if necessary;
- for all smokers request to stop smoking;
- recommendation to use hip protectors for high-risk groups;
- specific treatment of osteoporosis, if necessary; and
- home hazard assessment and modification.

In both groups, the number of falls and fall-related injuries will be recorded over a period of 12 months by phone interview at 3rd and 9th month, and by follow-up visits at 6th and 12th month. It is envisaged to have persons in the intervention group to sustain 30% lesser falls and related injuries than their counterparts in the control group.

The pilot study is still in process. So far, 910 participants have been followed for 12 months. At the one-year follow-up, 464/910 (51%) of the participants had fallen at least once having and altogether 1066 falls have been recorded up to now. These falls caused 565 injuries, 45 of them (8%) being fractures. The mean age of the participants is currently 77 years at baseline and 87% of them were women.

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Declining fall-injury trends in the US

Falls occur frequently among persons aged 65 years and older—30% fall annually- and approximately 1% of all falls result in hip fracture. In 2006 in the United States, there were 293,000 hospital admissions for hip fracture. A leading risk factor for hip fracture is osteoporosis, a metabolic disease that affects postmenopausal women and elderly men, which makes bones porous and susceptible to fracture. The National Osteoporosis foundation estimates that more than 10 million people over age 50 in the United States have osteoporosis and another 34 million have low bone density and are at risk for osteoporosis.

A recent analysis of hospital admissions for hip fracture in people aged 65 and older showed that age-adjusted hip fracture rates declined significantly from 1990 to 2006 for both men and women. Men's rates declined 10.6%, from 54.6 per 10,000 to 48.8 per 10,000, while women's rates declined 15.4%, from 108.4 per 10,000 to 91.7 per 10,000. When examined by age group, this trend was only significant among men aged 85 and older (p=.002.) and among women aged 75-84 (p<.001) and 85 and older (p=.040). Similar trends have been observed in a number of other countries like Canada, Finland, Sweden, Norway and Denmark.

Osteoporosis screening, when linked to treatment, has been shown to reduce hip fractures. One US-study reported that bone density screening was associated with 36% fewer hip fractures over six years, possibly because those screened increased their calcium and bisphosphonate use. In randomized clinical trials, bisphosphonates reduced hip fracture risk by 40% to 51%. However, the use of osteoporotic medications is problematic. Evidence suggests that patients frequently discontinue treatment because of gastrointestinal side effects or because they do not fully understand their osteoporosis status..

While evidence is mounting that hip fracture rates are declining in a number of countries, there are no definitive explanations. There are multiple osteoporosis treatments including calcium and vitamin D, hormone replacement therapy, and pharmacological therapies, so it is difficult to attribute the decrease in hip fracture rates to a single cause. Possible explanations include the increased use of estrogen; increased bone density screening, diagnosis and use of pharmacological treatments for osteoporosis; decreased use of sedative-hypnotic drugs to decrease fall risk; increased influx of immigrants with a lower genetic risk of osteoporotic fractures; a cohort effect due to a healthier aging population; the protective effect of increased average body weight; and improved functional abilities. There are likely also unknown protective factors.

The world population is aging; people over age 85 are the fastest growing segment and those most susceptible to hip fracture. Research is needed to identify the factors contributing to declining hip fracture rates in order to maintain, and possibly accelerate, the downward trend. It is also important to increase both primary and secondary prevention efforts, including increased osteoporosis screening and treatment; education about osteoporosis risk and protective factors; and dissemination and implementation of effective fall prevention programs.

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► Suicide and self-harm

Preventing depression and suicide

On 10th - 11th December 2009, European Commission and Hungarian Ministry of Health, with the support of the Swedish Presidency of the EU and in collaboration with the WHO Europe, organised a conference on Preventing of Depression and Suicide.

For that purpose, a number of background documents have been prepared, one of them looking into the challenges of building partnerships in suicide prevention.

Prevention requires inter-sectoral work
Prevention of depression and suicide is not only a challenges to the health sector but are highly relevant for other sectors such as child and family policies, education, labour policies, and environmental planning. Evidence indicates that sound public policies, such as those that address social protection, education, labour and urban planning, also improve mental health and reduce the risk of mental disorders. Important life span settings in prevention of depression include early life, child care, schools, and work life.

Child and family policies are decisive, as foundations of adult mental health are laid in early life. Abusive or hostile parenting and neglect leads to adult depression and emotional unavailability of parents predicts adolescent suicide attempts. Support for parenting by family policies, good quality day care for all, and flexible work life arrangements for parents, as well as programmes addressing parenting skills, contribute to prevention of depression and suicide.

Education sector contributes with life skills. Social and emotional learning at schools significantly reduces later depression. Girls who have been victims of bullying in elementary school later do more suicide attempts and suicides. Evidence as students reduces the risk for mental disorders and is an important component in mental health promotion across the lifespan .

Unemployment and work life adversities are risk factors for depression and suicide. Long-term unemployment doubles the risk of increased depressive symptoms. Precarious and insecure work, irregular working times, conflicts at work with other persons, work overload or incapability to manage the work can have a negative impact on mental wellbeing. The combination of a high level of job strain and high job insecurity may increase the risk of depression by fourteen times compared to those who have control over active, secure jobs. Workplace interventions have been shown to promote mental health and wellbeing and to reduce the risk of depression.
Unemployment is linked also to suicides, especially among men and in cases of insufficient social protection. Programmes for unemployed people, including peer support, job search training and preparation for setbacks, protect against depressive symptoms and depression.

Environmental planning can support mental health and prevent depression and suicide. Mental health can be compromised by living in deprived neighbourhoods with high unemployment, poor quality housing, limited access to services, poor quality environment and low social capital. Good urban planning creates a safe and inviting environment, which is especially important for children to enable safe enlargement of the zones for their socio-emotional developmental activities. Improved housing conditions can promote mental health and increase social and community participation. Community mobilisation facilitates better mental health of its members.

What works?
Mental health promotion in early age is effective. Provision of a safe and nurturing environment for every child by addressing physical and sexual abuse of children, access to good quality childcare for all, and by actions against school bullying are effective.

Evaluation research also indicate that social emotional learning (SEL) and Skills for life (SFL) programmes enhance the social and emotional skills of children and youngsters, and significantly reduce or prevent behaviour and mental problems or disorders, such as violent, aggressive and antisocial behaviour, drug problems, anxiety and depressive symptoms and disorders. These programmes are more effective if provided in the context of a comprehensive school strategy rather than stand alone classroom programmes.

Targeted policy measures for specific groups at risk for depression may also contribute to reduce depression. Such measures should include social protection, access to job search and socio-emotional skills training for unemployed people. Debt management and psychosocial support should be available for all persons in high debt.

Labour policies should set “healthy working climate” as the target of every working place by capacity building of managers and staff.

Finally, safe environments will contribute to prevent suicide attempts. Prevention of suicide can be taken into account already in the planning process or after an environment (e.g. bridges, railways) has been identified as a suicide hot-spot.

Conclusion

Action against depression is necessary, possible and pays off. Evidence-based, cost-effective actions are available. Suicides can be prevented by diversified actions within and outside of health care. Evidence of cost-effectiveness is emerging. Suicide prevention is especially needed in the present times of rapid economic change.

A successful fight against depression and suicide requires continued investment in mental health research and monitoring, willingness to work across sectors, and readiness to address determinants, such as child abuse and bullying, gender and health inequalities, high debts, work life problems and poor social protection. Effective instruments in the fight are responsive primary health care services, collaborative media, a health promoting educational system and healthy work places.

Above all the effective prevention of depression and suicide requires political commitment and its implementing sound strategic action frameworks.

More information:
http://ec.europa.eu/health/ph_determinants/life_style/mental/ev_20091210_en.htm

► Vulnerable road users

EU Road Safety Targets for 2020

In an open letter to EC Vice President and Transport Commissioner Sim Kallas, ETSC and 75 other road safety stakeholders, including EuroSafe urge the European Commission to set realistic targets for reducing road deaths and serious injuries by 2020. They stress that, although the last 50% death reduction target adopted back in 2001 has not been fully achieved, it still helped to reduce road deaths by at least 30%.

The European Commission is expected to publish its 4th Road Safety Action Programme (RSAP) before summer this year. Road safety visions need numerical targets to be realised. The target of halving road deaths in 2001-2010 was set in the Transport White Paper in 2001 and implemented with the help of the measures of the 3rd Road Safety Action Programme published in 2003. It is essential that new targets are set for 2020. Having adopted a target for the last decade, and not setting one for the next decade would risk diminishing the EU’s credibility as a global leader in road safety.

Targets motivate stakeholders to act and help stakeholders responsible for the road transport system be accountable for achieving defined results. A shared target at European level helps each Member State to see that its road safety improvements are contributing to addressing a Europe-wide problem, anything less could lead to a fragmented and less satisfactory road safety policy.

It is crucially important for the realisation of the EU’s road safety policy that it is guided by challenging yet achievable numerical targets. These targets should be based on the forecast and estimated potential for further improvement. ETSC proposes reducing road deaths by at least 40% between 2010 and 2020 and serious injuries by at least the same percentage.

Research from across the globe shows that improvements in road safety will only be brought about by adopting a more rational, systematic management approach based on setting target levels, defining priorities for use of limited resources, implementing cost-effective measures and regularly monitoring progress. Setting empirically-derived numerical targets is a vital part of this approach.

More information:
http://www.etsc.eu/home.php

One third of road deaths due to speeding

Excessive or inappropriate speed has a singularly devastating impact on health and safety of road users, increasing both the risk of a crash and the severity of crash outcomes. It is estimated that speeding contributes to as much as one third of all crashes resulting in death, and it is the most important contributory factor to road deaths and injuries. Therefore tackling speed must form a central part of the EU's forthcoming Road Safety Action Programme, according to the European Transport Safety Council (ETSC).

Trends in driving speeds show that overall there is little progress in Europe. Average speeds and speed limit violations remain high with encouraging signs only in a few countries. In most societies speeding is still considered more socially acceptable than drink driving, and the risk posed by so-called 'minor speeding' is also grossly underestimated: in fact it is estimated that at any one moment about

35% of drivers exceed speed limits outside built-up areas and as much as 50% in urban areas. The fact that speeding is so common poses a very significant threat to safety.

Yet there are numerous measures that can help manage speed: action can be taken in all of the road safety pillars. New measures that ETSC hopes will be adopted in the framework of the upcoming 4th Road Safety Action Programme should include for example as a matter of priority guidance to Member States to tackle traffic law enforcement of speed as well as a new Cross Border Enforcement Directive.

The in-vehicle Intelligent Speed Assistance (ISA) technology and their supporting digital speed maps should also be developed, as well as EU Guidelines to reduce speed via traffic calming measures. There is ample evidence of successful measures reducing speeding. For example, the UK has successfully introduced a National Driver Offender Retraining Scheme, with clear evidence that after attending the scheme offenders have safer and more responsible attitudes towards road user behaviour than before. The Dutch sustainable safety approach led to significant infrastructure improvements that helped drivers to behave safely.

Speed management is an area of road safety work that has been and continues to be extensively investigated, and many solutions exist. While political commitment is needed, individuals from all sectors and at all levels of society can still play a role in demonstrating and implementing these solutions.

More information:
http://www.etsc.eu/home.php

► Cross cutting issues

Guide for safety investigations

Safety investigation of accidents is a field which is expanding. Operating feedback or learning from experience is one of the pillars of safety management. It helps to reveal failures in the socio-technical system, which can be remedied in order to avoid repeat.

In order to support practitioners in performing safety investigations, the European Safety, Reliability and Data Association (ESReDA) has published Guidelines. ESReDA is a non-profit making association of European industrial and academic organisations concerned with advances in the safety and reliability field.

These guidelines have been prepared for investigators, investigation managers, people who order investigations, responsible persons who will have to learn from the event, victims and researchers. These guidelines provide a minimum, current and recognised cross-sectorial best practices oversight to conduct investigations related to industrial, technological and organisational events.

In-depth analysis of accidents and incidents clearly show that any event is generated by direct or immediate causes (technical failure and/or human error). Nevertheless their occurrence and/or their development is considered to be induced, facilitated or accelerated by underlying organisational conditions (complex factors) found in socio-technical system and organisational networks. This implies that we have to deal with different natures of causalities: mechanistic ones met in technical installations and more complex ones met in human and social systems. Addressing those causalities requires various competencies (tapping off from disciplines from exact sciences, to engineering and social sciences) to investigate and to learn from an accident.

Accident investigation can be performed for various purposes which may be conflicting as well, depending on the stakeholders involved (private companies, authorities, or public parties) and their interests. Quite often, investigations are simultaneously being carried out (e.g. by criminal justice, work place safety inspectorate,..) and it may lead to operational conflicts such as conflicts related to access to the accident scene and witnesses, collection of the facts, preservation of evidence, publication of findings and public communications.

Corporate, political, cultural and societal requirements are shaping the context in which the investigation is conducted. This should be clarified and stated when defining the mandate of the investigation. Despite the diversity of contexts, an investigation shall obey the basic principles of investigative research (protocols, coordination, competence, data and evidence, reporting, follow-up of lessons learned and communication) and principles of research implementation (defining terms of reference, appointing team, collecting data, hypotheses generation, analysis, findings and recommendations). Methodologies are readily available to facilitate some investigation tasks. They use different logical constructions, different underlying models, and address different levels of phenomena with various perspectives (what happened, why it happened and what is recommended to prevent its repetition).

The Guide describes the various approaches to accident investigation, the basis principles as well as the procedures for thoroughly conducting investigations. It provides practical advise as to important issues such as training of investigators as well as communication during and after the investigation process. Aim of investigations, of course, is to provide stakeholders with findings in order to initiate and facilitate learning processes. Most organisations have to face many barriers as to learning lessons.

More information:
http://www.esreda.org/images/stories/FLA_WG/esreda_glsia_final_june_2009_for_download.pdf

WHO-global strategy on alcohol related harm

In May 2010, member states of the WHO-Assembly will consider a draft global strategy to reduce harmful use of alcohol. The global strategy aims to give guidance for action at all levels; to set priority areas for global action; and to recommend a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level, taking into account national circumstances, such as religious and cultural contexts, national public health priorities, as well as resources, capacities and capabilities.

National and local efforts can produce better results when they are supported by regional and global action within agreed policy frames.

Alcohol related harm
The harmful use of alcohol has a serious effect on public health and is considered to be one of the main risk factors for poor health globally. The harmful use of alcohol is a significant contributor to the global burden of disease and is listed as the third leading risk factor for premature deaths and disabilities in the world.3 It is estimated that 2.5 million people worldwide died of alcohol-related causes in 2004, including 320 000 young people between 15 and 29 years of age. Harmful use of alcohol was responsible for 3.8% of all deaths in the world in 2004 and 4.5% of the global burden of disease as measured in disability-adjusted life years lost, even when consideration is given to the modest protective effects, especially on coronary heart disease, of low consumption of alcohol for some people aged 40 years or older.

Harmful drinking is a major avoidable risk factor for neuropsychiatric disorders and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic crashes and violence, and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively young people

Time to act
A substantial scientific knowledge base exists for policy-makers on the effectiveness and cost–effectiveness of strategies and interventions to prevent and reduce alcohol-related harm. Although much of the evidence comes from high-income countries, the results of meta-analyses and reviews of the available evidence2 provide sufficient knowledge to inform policy recommendations in terms of comparative effectiveness and cost–effectiveness of selected policy measures. With better awareness, there are increased responses at national, regional and global levels. However, these policy responses are often fragmented and do not always correspond to

the magnitude of the impact on health and social development.

The harmful use of alcohol can be reduced if effective actions are taken by countries to protect their populations. Member States have a primary responsibility for formulating, implementing, monitoring and evaluating public policies to reduce the harmful use of alcohol. Such policies require a wide range of public health-oriented strategies for prevention and treatment. All countries will benefit from having a national strategy and appropriate legal frameworks to reduce harmful use of alcohol, regardless of the level of resources in the country.

The draft strategy identifies a huge number of policy options and interventions available for national action. These are grouped in ten categories, including drink–driving policies and countermeasures, restrictions on availability of alcohol, pricing policies and reducing the impact of marketing in particular on young people.

WHO-leadership
International coordination and collaboration will help to create synergies and increased leverage for Member States to implement evidence-based measures. WHO, in cooperation with other international partners will provide leadership, promote networking and exchange of experience among countries and strengthen partnerships and resource mobilization; WHO is committed to assist countries in resource mobilization and pooling of available resources to support global and national action to reduce harmful use of alcohol in identified priority areas.

The WHO-secretariat will report regularly on the global burden of alcohol-related harm, make evidence-based recommendations, and advocate action at all levels to prevent and reduce harmful use of alcohol. It will collaborate with other intergovernmental organizations and, as appropriate, other international bodies representing key stakeholders to ensure that action to reduce harmful use of alcohol receives appropriate priority and resources.

In the 63rd annual meeting of the World Health assembly (17-22 May), the member states are being invited to endorse the draft global strategy to reduce harmful use of alcohol and to mobilize political will and financial resources for that purpose.

More information:
http://www.who.int/substance_abuse/activities/globalstrategy/en/index.html

► AGENDA 2010

19-20 May, Reykjavik, Iceland
Second European Regional Safe Community Conference: Incorporating the 7th Nordic Conference on Safe Communities
Website: www.publichealth.is/SC-2010Iceland

27-28 May, Stockholm, Sweden
EAHSA's 3rd Conference: 'Towards Sustainable Elderly Care'
Website: www.micasa.se/Documents/Omv%C3%A4rld/Eahsa/Latest_invitation_Eahsa.pdf

15-17 June, Edinburgh, UK
Consumer Affairs & Trading Standards Conference & Exhibition
Website: www.tradingstandards.gov.uk/events/Conference_2010.cfm

21-22 June, Brussels, Belgium
4th European Alcohol Policy Conference: From Capacity to Action
Website: http://www.eurocare.org

1-4 September, Rome, Italy
Integrating knowledge for an interdisciplinary approach to suicidology and suicide prevention
Website: www.esssb13.org/

20 September, Oxford, United Kingdom
11th International Conference on Falls and Postural Stability
Website: www.nuh.nhs.uk/nch/PGEC/forthcoming.htm

29 September, Honolulu, Hawaii, USA
XVIII ISPCAN International Congress on Child Abuse and Neglect
Website: www.ispcan.org/congress2010/

27-29 October, Florence, Italy
Child in the city 2010 conference
Website: www.childinthecity.com

10-13 November, Amsterdam, Netherlands
3rd European Public Health Conference
Website: www.eupha.org/site/upcoming_conference.php

10th World Conference on

Injury Prevention and Safety Promotion

21 -24 September 2010

Queen Elizabeth II Conference Centre

London, UK

www.safety2010.org.uk

Early bird registration fee available until 31 May 2010, the fee is £550.00.

From 1 June 2010 the full fee is £650.00.

Register for the Conference at: www.safety2010.org.uk/ File/booking.asp

EuroSafe

the European Association for Injury Prevention and Safety Promotion is the network of injury prevention champions dedicated to making Europe a safer place

Together we can make a difference!

CONTACT US

www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l2membership.htm

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