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EuroSafe Alert

European Association for Injury Prevention and Safety Promotion

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► EuroSafe news

"Working together to make Europe a safer Place"

3rd European conference on Injury Prevention and Safety Promotion, June 16th and 17th 2011, Budapest

Call for Registration and Poster abstracts

Contents

The 3rd European injury prevention conference is a major international event bringing stakeholders in the prevention of accidents and injuries from Europe and other continents to exchange, debate and discuss the latest results in injury research, policies and practices.

The *key theme* of the conference is how best to transfer and apply good practice in new settings and environments. The conference will highlight successful safety promotion initiatives and actions and encourages uptake of good practices in countries.

The conference is being organised by EuroSafe and the government of the Republic of Hungary, President of the European Council in first half 2011, and co-sponsored by the European Commission and the WHO Regional Office for Europe.

Bringing knowledge into action

Over the last few decades the issue of safety has gained significant importance for both European citizens and for Europe's politicians. However the burden of injury is still high and unequally distributed across the European region. Also within countries there are marked differences between age groups and with economically and socially vulnerable groups being at greater risk.

The WHO-Europe Resolution on the prevention of injuries (EUR/RC55/R9) and the European Council Recommendation on the prevention of injuries and the promotion of safety (2007/C164/01) have undoubtedly generated new initiatives in Member States to address the injury issue more comprehensively. In response to a survey carried out by the WHO-European office, the majority of Member States report that it has now placed injury prevention higher on the national policy agenda and has increased efforts in injury surveillance and in capacity building.

However, the same survey reports that on average only three quarter of the available set of evidence based interventions is being implemented in countries, which leaves a window of opportunities for all Member States to maximise the outcome of their policies. There is ample evidence of proven effectiveness in prevention measures that are still not yet widely applied throughout the European region.

The 3rd European Conference on Injury Prevention and Safety Promotion will report on successful injury prevention policies and assist participants in benchmarking progress as regards the implementation of these action plans. The conference will highlight available evidence based interventions and address the challenges of implementation and

the transfer of good practices in less resources environments and in particular in new Member States.

Conference objectives

- To offer a forum for the exchange of experiences in implementing and monitoring national action plans for injury prevention in MS's, with a view to benchmark policies and their outcomes;
- To highlight successful safety promotion initiatives and actions as evidenced through the various European collaborative projects, to encourage the uptake of good practices and to facilitate their implementation in particular in New Member States;
- To highlight opportunities and challenges to mainstream injury prevention and safety promotion into relevant policy domains; and to
- To enhance the involvement of relevant stakeholders within countries (i.e. government, civil society, private sector and academia) and to foster sustainable and collaborative commitments as to actions for injury prevention and safety promotion in MS's.

Programme highlights

In plenary sessions cross cutting issues will be discussed such as how best to share the knowledge base for good practices in injury prevention, how to establish national plans and infrastructures for coordinated implementation of these plans, and what methodologies are available for effective risk communication and capacity building.

Concurrent sessions and poster sessions will present that latest state of art in Child safety, Adolescents and risks taking, Sport safety, Safety of older people, Safety of consumer products, Vulnerable road users, Work safety, Family violence, Prevention of youth violence, Suicide and self harm, National plan development and Injury surveillance

Call for Poster abstracts

Take the opportunity of sharing your experience in safety promotion with leading stakeholders in Europe. Make a poster presentation about how you applied general safety principles and evidence based good practices to help to make your community or country a safer place. It is envisaged to have abstracts to be published in a scientific journal.

Abstracts can only be submitted in accordance with the instructions on our website http://www.eurosafe.eu.com/ and by using the online abstract form. Abstracts should be sent to the conference secretariat before January 15, 2011. Confirmation of acceptance for poster presentations will be sent out by February 15, 2011.

Registration

Registration is open now. Registration form can be found on website:
http://www.eurosafe.eu.com/

The registration fee is € 375 before March 15, 2011, € 450 after March 15, 2011

More information:
secretariat@eurosafe.eu.com

3rd European conference on Injury Prevention and Safety Promotion, June 16th and 17th 2011, Budapest

Call for Registration and Poster abstracts

http://www.eurosafe.eu.com

► EU news

New EU health information system under construction

European Community Health Indicators Monitoring ECHIM

Comparable health information is essential to improving citizen's health across Europe. Such information is expected to incite initiatives reduce health differences as well as provide a basis for well-focused health promotion programmes, and thus, ultimately, increase healthy life-years.

This is what the experts of the EU-funded project ECHIM (European Community Health Indicators and Monitoring) envisage of the new European health information system, which has been under development for ten years. The Core Group of ECHIM met recently to consolidate previous achievements and make further plans for introducing a range of comparable population health indicators in all EU countries. These proposed indicators will cover for example health determinants, major chronic diseases and accidents, infectious diseases, functional limitations and mortality.

Although considerable steps have been taken, still a few more years of work is needed to make all indicators accessible within each member state and at the EU level. The benefits are obvious. Today, many countries lack access to much-needed information on health, thereby limiting the implementation of evidence-based policy and the planning of health systems and health care. With relevant and comparable information, resources can be directed at preventive and curative health actions that provide the best health returns, bringing significant improvements in health.

Closing the gap

The mortality rate is one of the few comparable indicators available on a European level, and it shows that over the last decade the average life expectancy of Europeans has increased by more than two years. This increase is not, however, evenly distributed: the average life expectancy for men in Europe today according to the latest available data is 76.3 years, while for women it is 82.4 years. Moreover, average life expectancy differs between the 27 EU Member States by up to 10.6 years.

Many of the differences in life expectancy are due to diseases that can be prevented by intervention programmes. Many countries have successfully implemented vaccination programmes. Measures to control high cholesterol and high blood pressure, reduce smoking, and improve dietary habits have been accompanied by an 80 per cent reduction in mortality from cardiovascular diseases in Finland since 1970. In England and Wales, CVD mortality rates fell by 54 per cent between 1981 and 2000. In Eastern Europe the tide began to turn in the early 1990s.

Similarly, accidental injury deaths have been reduced in many countries by introducing structural and legislative measures such as road improvements, bicycle lanes, enforced speed limits, mandatory use of safety belts and child safety seats. There is still, however, considerable variation in the number of traffic accidents and related mortality, from less than 4 deaths per 100 000 persons in The Netherlands to 15 in Lithuania in 2008.

An effective health promotion programme cannot be implemented unless reliable data is available on risk factors and health trends, including trends in health behaviour. We still lack a complete picture of the status of public health in Europe. We are short on information, for instance, on the true extent of diabetes and on the prevalence of mental health problems like depression. Other deficiencies in current health information include the risk factors of major diseases and physical and mental disability. The various deficiencies mean that we still cannot accurately predict the need for future prevention and care of the ageing populations in Europe.

The ECHIM project is expected to close the health information gap, which should in due course result in improved health in all of Europe.

More information: *http://www.echim.org/*

► WHO news

World Conference Safety 2010

More than a thousand experts on injuries and violence from 130 countries met in London for the *Safety 2010* Conference, organised under the auspices of the World Health Organisation (WHO) and co-sponsored by the UK Department of Health and the European Commission. Conference delegates discussed the tragic impact of injuries and violence which globally result in six millions deaths every year from road traffic injuries, assaults, drowning, burns, suicide and other causes. The conference also highlighted the financial and personal costs of injuries in the UK.

Dr Etienne Krug, Director, Violence and Injury Prevention and Disability, WHO, said at the conference: “Globally, injuries kill six million deaths per year which is more than all AIDS, tuberculosis and malaria deaths combined. Reducing injuries and their many consequences begins with people and governments recognising that prevention is possible. It is essential that our knowledge about effective prevention measures is disseminated around the world.”

UK figures

The World Safety Conference, revealed that the financial costs of injuries to the UK are now £36 billion/year. These new figures were released at the Conference by Ronan Lyons from Swansea University’s School of Medicine. He said that the enormous cost of injuries to British people and to the NHS show how important it is to invest appropriately in injury prevention, treatment and rehabilitation facilities and also in research to lessen this burden.

Mark Bellis, Head of WHO Collaborating Centre for Violence Prevention at Liverpool John Moores University and Chairman of the Safety 2010 conference, underlined that across the UK, the burden of ill health resulting from injuries, and especially violence, falls most heavily on the poorest communities: "Those living in the poorest fifth of the country are now five times more likely to be hospitalised as a result of violence than those living the wealthiest areas.”

Impact on victims and their families

The personal costs to individuals are also emotionally described by well-known figures from sports, entertainment and politics who talk about their personal experiences and views on injuries and violence in a new book, *Safety First*, launched at the conference.

The damage from just one incident can be life changing not just for the individual injured, but also for their family and friends.

In *Safety First - Stories and Key Figures on Violence, Injuries and their Prevention* celebrities tell their personal stories. In the booklet, Cherie Blair, as a leading human rights lawyer, argues that changing social attitudes, as well implementing new laws, can significantly reduce incidences of injuries and violence.

For more information and ordering *Safety First* booklet: info@safety2010.org.uk

New WHO Fact sheet on Falls

Globally, falls are a major public health problem. Almost half a million fatal falls occur each year, making it the second leading cause of unintentional injury death, after road traffic injuries. Though not fatal, approximately 37.3 million falls, severe enough to require medical attention, occur each year. Such falls are responsible for over 17 million DALYs (disability-adjusted life years) lost.

The largest morbidity occurs in people aged 65 years or older, young adults aged 15–29 years and children aged 15 years or younger. In addition, those individuals who fall and suffer a disability, particularly older people, are at a major risk for subsequent long-term care and institutionalization.

Risk groups

While all people who fall are at risk of injury, the age, gender and health of the individual can affect the type and severity of injury. Age is one of the key risk factors for falls. Older people have the highest risk of death or serious injury arising from a fall and the risk increases with age. This risk level is due to physical, sensory, and cognitive changes associated with ageing, in combination with environments that are not adapted for an ageing population.

Another high risk group is children. Childhood falls occur largely as a result of their evolving developmental stages, innate curiosity of their surroundings, and increasing levels of

independence that coincide with more challenging behaviours commonly referred to as 'risk taking'. While inadequate adult supervision is a commonly cited risk factor, the circumstances are often complex, interacting with poverty, sole parenthood, and particularly hazardous environments.

Other risk factors include occupations at elevated heights or other hazardous working conditions, alcohol or substance abuse, poor mobility, cognition, and vision, particularly among those living in an institution, such as a nursing home or chronic care facility, and unsafe environments, particularly for those with poor balance and limited vision.

Prevention

Fall prevention strategies should be comprehensive and multifaceted. They should support policies that create safer environments and reduce risk factors. They should promote engineering to remove the potential for falls, the training of health care providers on evidence-based prevention strategies; and the education of individuals and communities to build risk awareness.

For older individuals, fall prevention programmes can include a number of components to identify and modify risk, such as screening within living environments for risks for falls and clinical interventions to identify risk factors, such as medication review and modification, treatment of low blood pressure, Vitamin D and calcium supplementation, treatment of correctable visual impairment. Muscle strengthening and balance retraining have proven to be most effective in preventing serious fall injuries in older people.

For children, effective interventions include engineering modifications of nursery furniture, playground equipment, and other products and legislation for the use of window guards. Other promising prevention strategies include: use of guard rails/gates, home visitation programmes, mass public education campaigns, and training of individuals and communities in appropriate acute pediatric medical care should a fall occur.

More information: *http://www.who.int/mediacentre/factsheets/fs344/en/index.html*

► Child safety

Baby walkers

In a joint position statement, the European Child Safety Alliance and ANEC, the European organisation that represents consumer interests in the process of standardisation and certification, call for immediate action as to the risk of injuries to young children caused by baby walkers. In a press statement they express the need for a total ban of the product.

However, as long as baby walkers are still for sale on the European market, parents should make sure that safety barriers are installed in the house to prevent falls down stairs and access to dangerous places like e.g. the kitchen. In addition to that, awareness campaigns about the risks are necessary, as well as enforcement activities to make sure that baby walkers available on the European market are complying with the European standard EN 1273:2005. Health care providers are also called upon to educate parents about the risks, and to promote the many safer alternatives, such as stationary baby activity centres.

In many European countries, baby walkers are linked to more injuries than any other type of nursery equipment, causing an unacceptably high number of severe falls, burns and scalds and poisonings. European data shows that 90% of baby walker injuries are to the head, with over 30% causing brain injury.

Unfortunately most parents believe that the baby walker is a safe place to leave a child or they believe that this product will help a child learn to walk. Sadly, neither is true. Baby walkers may interfere with a child's ability to learn to walk while increasing the risk of injuries. The majority of these injuries are caused by falls, especially down stairs. The second largest risk is burns and scalds caused by the baby reaching dangerous items that were previously beyond reach (such as kettles or heaters). It is most often the face and chest area where children suffer burns and scalds while in baby walkers, leaving the scars for a lifetime

For a detailed look at patterns of baby walker injuries and recommended prevention measures, read the position statement and the background paper at: *www.childsafetyeurope.org* and *www.anec.eu/*

Progress report Child safety in the EU

The European Child Safety Alliance launched the final report of the Child Safety Action Plan initiative at the International Society for Child and Adolescent Injury Prevention (ISCAIP) seminar in Bristol (UK) on September 20.

The report highlighted the advances made by the 26 participating countries in the 6 years since the project's inception, including: development and implementation of national action plans to address child safety, development of baseline indicators and child safety report cards for 27 countries, and publication of a good practice guide summarising more than 50 effective measures to reduce childhood injuries.

The initiative proved that between diverse cultures there is great similarity in the issues and challenges related to child safety, and that the process and lessons are transferable to other countries looking to develop national action plans for child safety. The launch of the report at the ISCAIP seminar provided an opportunity to discuss with child injury prevention experts worldwide how the lessons learned with 29 countries in Europe may be helpful to move other countries' efforts forward in reducing child injuries.

More information:
http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l2europeanchildsafetyalliance.htm

Swimming Pool Safety – a need to act

As another pool season ends in the northern hemisphere, it is time to reflect that there are glaring shortcomings in critical areas of pool safety; areas where the most elementary regulation could save countless precious lives.

There are many different aspects to pool safety: water quality, pool maintenance, lifebelts, signage, the requirement for lifeguards…and so on. These are all important issues, but the simplest – and by far the greatest - contribution to pool safety could be made by restricting access to residential pools by young children – especially those in the high-risk 0-6 years age group.

Uniquely in the EU, France has enacted tough pool safety legislation, particularly as it relates to residential pools. The French have led the way with their Raffarin Law (December 2002) and the AFNOR standards of conformity. Punitive fines of up to € 45,000 can be imposed for non-compliance and for owning an 'unsafe' pool. The USA has also enthusiastically tackled the issue of pool safety, with most American states requiring an approved safety barrier to be installed where pools and young children are in close proximity.

Australia and New Zealand also have strict regulation in place – with periodic home inspections by local authorities - ensuring that as much as possible is done to prevent drowning accidents in the family pool. Of course, legislation alone is not enough, but it makes a start by recognizing the need for something to be done. How much progress have we made in Europe? Other than France and a tweaking of the rules by Spain – absolutely none.

In the absence of legislation from state authorities, it is up to parents to recognise the risks that non-secure swimming pools pose and to take precautionary actions. Regrettably, parents all too often believe that they are infallible in the supervision of their children. They declare that they never let their offspring of their sight. They assert that at an early age they will teach them to swim. And anyway, their kids (they claim) are well behaved around the pool, and are never inquisitive, playful or careless enough to fall in. If all this were true, everything would be fine. Except that it isn't: depressing drowning statistics for young children tell a different story, with every child fatality an unimaginable tragedy for the family concerned.

Children have an innate desire for exploration and adventure. They have no fear and are not aware of the dangers which swimming pools pose. Consequently, as parents, we need to be vigilant at all times and to install barriers around our pools which physically prevent unauthorized access by young children. We then need to chivvy our political masters to enact legislation which requires *other* parents - who may be less safety-aware than we are - to do the same.

Lloyd Owens, Safe.T.First Pool Safety Ltd.
www.mysafepool.com.cy

Child safety initiative in Hungary

In Hungary every week an average of five children die because of avoidable accidents. Another 460+ children are admitted weekly to hospitals. Readers of this newsletter will not find these statistics surprising, but the general public in Hungary are unaware of the impact. A local NGO, United Way Hungary, aims to change this by raising awareness and helping prevent these accidents before they happen.

United Way Hungary is one of the few Hungarian NGOs focused on prevention. “We see preventing accidents in the home and in childcare institutions with an emphasis on Hungary’s socially disadvantaged regions as an urgent priority,” commented Program Director, Éva Vörös. “Families are not yet fully aware of the dangers in the home and we want raise awareness by mobilizing a multi-sector approach that results in sustainable solutions.”

United Way Hungary, a new member of EuroSafe, partners with Hungary’s National Institute of Child Health who authored the country’s Child Safety Action Plan. The evidence based expertise of the Institute combined with United Way’s access to the private and civil sectors is an effective partnership. The Institute’s Senior Councillor, Dr. Gabriella Páll, noted that, “United Way’s involvement represents the necessity for all sectors to combine resources so we can effectively meet our ten year goal of reducing avoidable accidents by 30 percent.”

As part of its proactive activities, United Way visits schools educating children and those that care for them on how to stay safe. Currently there is no safety education as part of Hungary’s national curriculum. Their extracurricular program combines innovative teaching techniques with data professionally collected by EuroSafe, Hungary’s National Institute of Child Health, UNICEF and WHO. Educational partners who are teaching the children use drama and experimental learning to reach the children and empower them on how to make good decisions about their safety. Effective education reaches not just the children but the teachers, school administrators and parents. United Way’s “safety school” will reach over 3 000 students and those that care for them by end of 2011. Their goal is to reach all children in Hungary with particular attention to disadvantaged areas. The result will have a lasting and positive effect on reducing accidents.

Also as part of their efforts, United Way will host a multi-sector conference on 25 November to raise awareness of this critical issue. Sponsored by Citibank, the bank represents the private sector’s interest in finding sustainable solutions to this problem. The conference is the first known opportunity in Hungary where individuals, the private and public sectors as well as the NGO community will gather to share ideas. The conference also supports Hungary’s 2011 EU Presidential focus on child safety as well as EuroSafe’s June 2011 International Child Safety Conference to be held in Budapest.

One major goal of the conference is to draft a joint resolution by all participating parties which will then be shared with state, regional, city, and other local municipalities as a guideline for children’s safety. United Way and Citibank will also present a safety award to an outstanding organization that is actively reducing avoidable accidents.

United Way Hungary was founded in 1991 and is part of a global network of United Ways in 47 countries. The NGO relies on a results-orientated model called Community Impact to *solve* community problems. Community Impact is not just about financial resources but about bringing together the time, talent, expertise and will of individuals, the private and public sectors as well as the NGO community in view of creating long-term, pro-active, sustainable solutions, including safer environments for children.

For more information:
eva.voros@unitedway.hu

► Consumer safety

EC-Product safety week

The European Commission is organising events under the umbrella of the 3rd International Product Safety Week in Brussels, from 1 to 3 December 2010. As in the past years, this week comprises a series of conferences and meetings bringing together a broad range of (non-food) consumer product safety professionals from around the world, representing regulators, businesses, consumer organisations, standard makers and test laboratories, academics etc.
On Wednesday 1 December a Stakeholder conference will be organised on the review of the EU General Product Safety Directive (2001/95/EC).

On Thursday 2 December a Meeting of the International Consumer Product Safety Caucus (ICPSC), *(partly open to stakeholders)*, will be organised in collaboration with the International Consumer Product Health and Safety Organisation (ICPHSO).

On Friday 3 December the Product Safety Forum of Europe (PROSAFE) will organise an international risk assessment seminar of EMARS II, a PROSAFE project on Enhancing Market Surveillance through Best Practice).

Linked to these events in Brussels, ICPHSO, the International Consumer Product Health and Safety Organisation is organising a Symposium on International Cooperation on Product Safety from 29 to 30 November 2010 in London. The symposium will focus on the evolution of product safety in the EU and how it could respond to future challenges. The conference will take stock of the product safety achievements in Europe during the last 20 years and then look in particular into the future of market surveillance, international cooperation and injury data use.

For further information:
http://ec.europa.eu/consumers/events/international_product_safety_week_en.htm

Signs and people with 'low vision'

A new study published by ANEC, the European organisation that represents consumer interests in the process of standardisation and certification, demonstrates that the interaction between size and contrast has to be taken into account in view of improving the visual accessibility of pictograms, symbols and text used in public places such as airports, metro stations and shopping centres. The study has been carried out by the University of Ghent (Belgium).

Background

In the countries of the EU, life expectancy continues to increase. As a consequence, the number of people with age-related low vision also increases. Problems such as macula related conditions etc are more and more frequent. At the same time, people are more mobile and continue to be mobile until a higher age. This older population will often have considerable purchasing power and is therefore likely to travel more for holidays making.

However, the layout of our built environment has become more and more complex with the use of more and more signs and signage in and around public areas and buildings for information, guidance, identification or warning purposes. And also to indicate directions to facilities such as toilets or information kiosks. This situation results in a growing number of mainly elderly people with low vision having difficulties in finding for example their way in public spaces. Despite the obvious need to care for the needs of people with low vision, no European standard nor regulation exist on the visual accessibility of signs and signage in public places.

Therefore, ANEC commissioned a study that primarily aimed to provide a critical overview of the national standards -if available- for signs and signage in the EU countries. This data was checked against the results of two experiments conducted for the study on identification and localization of signs.

Main results

A literature overview showed that within the EU, a large variability in standards for visual

accessibility exists. The overview focused on factors such as character height of text and symbols, foreground/background contrast, colour, reading distance, localisation, lighting and legibility. Existing guidelines for the size of signs in public spaces differ significantly over EU countries, ranging from 1.5 to 6% of the Critical Reading Distance (CRD), from which the information contained in letters or symbols must be readable for people with low vision. As far as contrast guidelines are concerned, inconsistencies in definitions and calculations of contrast have to be noted, although there is a general agreement on aiming at a maximal contrast for signage in public spaces.

Forty-two volunteers -40 persons with low vision and 2 control persons- participated in the practical part of this study. In a first experiment, they had to identify signs, with different sizes and contrast intensities, presented on the same location in their central visual field. In a second experiment, they had to search for a specific sign in a busy visual environment such as a railway station hall and identify it. Response accuracy and response time were measured.

The results with respect to size of the signs in general show that size of text and symbols on signs should be at least 5% of the Critical Reading Distance. Optimal –but not maximal- performance was observed when contrast intensity approached a value of 75% on the white-black axis. From this study, and in particular from the interaction between size and contrast, it is clear that these two factors cannot be seen independently from each other when proposing guidelines for visual accessibility in public spaces.

Conclusions

The study should be considered as the starting point for the formulation of guidelines, which could in time result in a European standard on the legibility of signs and signage in public buildings/for public procurement, where examples of good practice are given as an illustration. Further research should be carried out to assess the specific needs of people with low vision, given the considerable heterogeneity in this group with respect to visual acuity and visual field restrictions.

The place where the signs are situated also seems to play a role in increasing readability. It should be subject of further guidance as it happens sometimes that signs are large but appear to point into the sky or to a brick wall. The logic of following the signs along a route is also very important for visually impaired people, with enough continuous signage to help people navigate around routes

It should be reminded that safe and independent mobility in public places is a basic right, also for people with low vision.

Further information: *http://www.anec.eu/anec.asp?rd=77474&ref=07-01.01-01&lang=en*

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Call for Registration and Poster abstracts

http://www.eurosafe.eu.com

Dangerous Projectile Toys

Hampshire County Council Trading Standards Service brought a prosecution against a national discount chain after discovering archery and toy gun sets for sale in a retail shop in 2008, which failed to meet safety regulations. Suction cups detached from each of the darts and arrows supplied with the sets, at less than 90 Newtons, when tested in accordance with the European Standard for toy safety, EN71, each then fitted through the suction cups template, posing a potential choking hazard.

Bow and arrow set, which failed to meet toy safety regs

In 2009 the company was convicted, with fines and costs of more than £8,000 after admitting two offences under the Consumer Protection Act 1987.The company was quick to recall the products, after selling more than 38,000 sets in the UK. A European RAPEX alert was issued.

Potential suffocation hazard

Suction cups affixed to projectile toys are intended for securing the projectile to a surface. Sticking and unsticking projectiles leads to repeated stress at the interface between the suction cup an the projectile. Children often place the suction cup in or near their mouth to lick and/or moisten it so that it sticks better to the intended impact surface, it is foreseeable therefore that these suction cups could be swallowed, blocking the airway at the back of the mouth and upper throat and potentially causing suffocation or asphyxiation.

This case follows a similar conviction in 2008, brought by Hampshire County Council against a national distributor for supplying unsafe projectile toy guns. The company involved was given a three year conditional discharge and required to pay £1,000 costs.

In recent years there have been a number of child deaths in Sweden, the US and the UK caused by children above the age of three years choking on projectiles. In reaction to these deaths, the European Commission adopted Decision 2007/224/EC, in April 2007, which amongst other things increased the tension test for projectiles from 60 Newtons to 90 Newtons.

In 2010 the Trading Standards departments of Hampshire, Surrey and the Vale of Glamorgan, participated in a survey of projectile toys. 19 samples were purchased and subsequently tested. 58% of these samples failed to meet the essential safety requirements of The Toy (Safety) Regulations 1995. The "Perilous Projectiles -2010/11" survey is the latest in a series of 5 surveys carried out over the last 7 years by Hampshire Scientific Service. The summary report concluded "that a significant proportion of projectile toys available on the market still pose a potential hazard to children from excessive kinetic energy and the detachment of suction cups."

Foam darts, which failed to meet toy safety regulations

It is recommended that market surveillance authorities continue to monitor these products, especially from new importers or manufacturers.

More information: Hampshire County Council Trading Standards Service. Tom.penton@hants.gov.uk

Consumer code in Catalonia

agència catalana del consum — Generalitat de Catalunya

On 23 August 2010 the Consumer Code of Catalonia Act 22/2010, which brings together and systematises regulations for consumer issues, came into force. New features include *minimising unacceptable risk* in product safety and the introduction of the basic concept of risk as a general principle in the right to protection of health and safety. The Code also brings in other basic definitions for ensuring a balance between consumer protection and the interests of business in order to enable the internal market to operate properly: the concepts of *safe goods and services, risk* and *unacceptable risk*.

General safety requirements

The general safety requirement applies to goods or services which under conditions of normal or reasonably foreseeable use, including conditions of duration and, where appropriate, commissioning, installation and maintenance, shall present no risk or only minimal risks that are compatible with the good or service and considered acceptable as part of a high level of protection for people's health, safety and economic interests. As a general requirement, consumer goods and services should not involve any risk for consumer health or safety, except for ones that are usual or legally acceptable under normal or foreseeable conditions of use which should in turn be known to consumers. Access to information about the health and safety of persons with disabilities will be ensured in particular and Braille labelling of products, especially those affecting health and safety, is strongly recommended.

Role of Regional government

What will the Government do to guarantee this right to health and safety protection? Its agencies will identify and have withdrawn from the market any good or service which present unacceptable risks and will inform consumers, clarify responsibilities and if necessary prevent actions that are in breach of the regulations.

The general right of consumers to receive attention and information about the safe use of goods and services is emphasised. This means that compulsory labelling and packaging of products must include, apart from type, weight, etc., information about the risk entailed by using them and how to foresee, reduce and counteract the undesirable effects of incidents which, *in spite of the instructions,* may take place.

When unsafe goods or services have been sold, consumers must be immediately informed about the risk involved in using the unsafe good or service. This information will be provided through special announcements which will tell consumers about the risks of using the good or service as soon as possible. These goods or services will be withdrawn from the market. If consumers have already purchased them, the relevant measures will be taken to adapt the goods or services or replace them or refund the amount paid.

In the case of the provision of services which involve risks for the health or safety of consumers, the latter must be informed by a visible sign in the establishment or by giving them a leaflet.

The code also introduces *the precautionary principle*. Under this, and based on the acceptable risk to the health, safety or interests of consumers, the public authorities may act in a way that is proportionate to and consistent with the risk to reduce it, and precautionary measures will be maintained throughout the minimum time required to ensure the essential purpose for which they have been put in place.

For more information: *www.consum.cat* or *cec@consum.cat*

► Injury Data

EU wide action on injury data

A project proposal, submitted by EuroSafe in the framework of the EU-Health Programme, has been selected for co-funding by the European Commission for possible co-funding over the years 2011-2013. The proposed project, under the title Joint Action on Monitoring Injuries in the EU (JAMIE) aims at laying the grounds for a genuine EU-wide injury information system. JAMIE will elaborate and test the concepts and methods of the current IDB-system and assess the feasibility of EU-wide IDB-data collection, in accordance with the principles set up by the European Statistics Code of Practice.

Background

What information is available at European level, it tends to focus on fatal injuries, and so the policies do. However, deaths represent only a small part of the total injury spectrum. It should be acknowledged that hundreds more casualties due to accidents or violence are being treated in hospitals. Therefore it is important to enhance the reporting of injury cases: i.e. cases that lead to medical treatment in an hospital, either as out-patient or as in-patient.

It is obvious that the health sector provides the best setting for collecting information on all injuries that need medical observation and/or treatment in hospital.

Over the past years, the European

Commission stimulated several projects in view of EU-level exchange of injury data collected in accident and emergency departments at general hospitals. At present, fifteen Member States (MSs) have developed a monitoring system in hospitals, which provides the needed detailed information, in addition to existing health and accident statistics. This system, known as the European Injury Database (IDB), allows for deriving health status indicators as incidence rates of injuries in certain areas like home, school, sport and leisure activities, self-harm and interpersonal violence.The challenge today is to harness the lessons learned and to work towards an EU-wide exchange of injury data that is collected in accordance with a common methodology as to representativeness and reliability of the assessment of the injury severity and that includes all MSs in reporting injury data in a sustainable manner.

Ambition

Given current information needs and the available infrastructure in the health sector, EuroSafe and the IDB-network aim at having by 2015 a common hospital-based surveillance system for injury prevention in operation in all EU-Member States. Such a system should report on external causes of injuries due to accidents and violence as part of the Community Statistics on Public Health.

More specifically, EU-wide injury surveillance should:

- cover EU-Member States, including EEA and EU candidate countries and collect minimum level injury data in all hospitals;
- have in all countries at least one hospital serving as a reference hospital for collecting on routine base detailed data on external causes and the circumstances of the injury event, as well as the long term consequences;
- serve the needs of the main stakeholders (public health, consumer safety, safety practitioners) at EU as well at MS level;
- be mandatory by 2015 in the framework of the EU Regulation on health statistics, which will imply that from 01/01/2016 EuroStat should be in charge of the IDB database.

Joint action

The JAMIE project will contribute to the realisation of this ambition by initiating actions that lay the grounds for a genuine EU-wide injury information system. By end of the action (end of 2013), in each of the EU-MSs a national IDB data administrator (“NDA”) shall be established and endorsed by the responsible national or regional authority. By the end of the action (end of 2013), in at least 23 countries at least one reference hospital shall be collecting IDB data, applying the full IDB coding of external causes.

JAMIE has been initiated by a consortium of centres of excellence in injury surveillance based in the EU region: the National Centre for Healthcare Audit and Inspection of the republic of Hungary, the National Health Information Centre in Slovakia, the Swansea University School of Medicine-Health information Research Unit in the UK. the Austrian Road Safety Board and the European Association for Injury Prevention and Safety Promotion (EuroSafe). The project will be implemented with a strong involvement of 23 national authorities and their designated competent bodies, participating either as associated partner.

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► Adolescents & risk taking

Young people’s views on risk

Evidence indicates that people new to the workplace are at a greater relative risk of work-related injury. Workers in the first few months with their employer have the highest rate of injury and on a yearly basis, the rate of injury to workers in the first 6 months is over twice that in workers who have been with their employers for at least a year, whether all workplace injury or reportable injury are taken into account.
The relatively high risk for new workers remains after allowing for occupations and hours of work. Other factors do not seem to explain the higher risk in workers new to their employers.

Experience and age are thought to be important factors affecting risk assessment: age

and a tendency to be to be distracted had an indirect effect on accident involvement. Previous experience of accidents and the consequences could also contribute to attitudes towards risk.

To survive in the workplace young people need to be able to identify hazards and carry out an assessment of whether that hazard has a potential to cause harm. It is therefore important to include health and safety education in schools. Part of this education is however a need to help young people become risk intelligent or “risk savvy”, that is risk aware not risk averse.

Survey

The EXPO 2010 event was organised by Lancashire Education Business Partnership (LEBP) to bring 3,000 year 9 students (13-14 years of age) to the college and find out more about training and employment opportunities. It was held on 27-28 January 2010 at Accrington and Rossendale College. This provided Institution of Occupational Safety and Health **(**IOSH) with a unique opportunity to make contact with a large cross section of young people from the North West of England and discover their attitudes to risk.

During the ten minute workshops young people had an opportunity to consider their attitudes to risk and were asked to write down “What does the word “risk” mean to you?” 705 young people answered the question. There were 308 males and 391 females, (6 participants did not tell us their gender). Students were also invited to take part in an interview about risk.

Results

Interestingly, 48% of participants equated risk just with danger. An additional 4% felt that it meant the need to stay away from activity. 7% acknowledged that although risk meant danger to them, it could be good or bad. 13% of definitions included the idea of choice or chance. 14% of participants equated risk with something daring or fun to do. There were no real differences in the responses according to gender although 2% more girls chose a definition that included choice or chance than boys.

The collection of definitions from 705 young people is interesting because, it tells us that over half of the young people equated risk just with danger, like:

'The word risk to me means that something is dangerous and it could harm you or someone else'; or
'You are putting your life in danger to do something'; or
'You could injure yourself or you could die doing it'.

Conclusions

The findings support previous research which highlighted that many children and indeed adults equate risk with just danger. Rather than viewing risk as just another word for danger, it seems to be more useful to see risk as a continuum where the consequences of some hazards are more severe than others. Willingness to take risks is an important life skill but it is equally important to be able to take a realistic view of the consequences of decisions made.

This is an important message for schools, because it reinforces the need to educate young people about being risk aware not risk averse. IOSH’s Workplace Hazard Awareness Course (WHAC) could be useful in this regard as it provides an opportunity to engage young people in discussions about hazards and risk.

Listening to what young people think about risk helps us learn the best way to tailor safety messages for them. It’s also good practice to involve young people in measures to keep them safe. Helping young people be “risk savvy” (risk aware not risk averse) is an important step in preparing them for their first experiences in the workplace. It is a first step in developing a risk intelligent society.

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► Safety for seniors

2012: European Year for Active Ageing

The European Commission has proposed that 2012 be designated as the "European Year for Active Ageing".

The initiative aims to help create better job opportunities and working conditions for the growing numbers of older people in Europe, help them take an active role in society and encourage healthy ageing. It comes as Europe's policymakers grapple with a steadily ageing population and its impacts on public services and finances. The European Parliament and Council are expected to endorse the initiative by the beginning of next year.

The EU is in a process of significant population ageing. From 2012, the European working-age population will start to shrink, while the over-60 population will continue to increase by about two million people a year. The strongest pressure is expected to occur during the period 2015-35 when the so-called baby-boom generation will enter retirement.

This presents challenges for sustainable public finances, in particular the financing of health care and pensions, and could weaken the solidarity between generations. But this view neglects the significant actual and potential contribution that older people - and the baby-boom cohorts in particular - can make to society.

The proposed European Year for Active Ageing is designed to serve as a framework for raising awareness, for identifying and disseminating good practice and, most importantly, for encouraging policymakers and stakeholders at all levels to promote active ageing. The aim is to invite these players to commit to specific action and goals in the run-up year 2011 so that tangible achievements can be presented during the European Year itself in 2012.

Active ageing includes creating more opportunities for older people to continue working, to stay healthy longer and to continue to contribute to society in other ways, for example through volunteering needs to be supported by a wide range of policies at all levels of governance. The EU has a role to play in areas such as employment, social protection and inclusion, public health, information society and transport, but the primary role is for national, regional and local governments, as well as civil society and the social partners.

European Partnership Initiative for Innovation (EPI)

The European initiative for an "Innovation Union" that has been recently launched by the European Commission helps create the supportive environment needed to promote healthy and active ageing and develop innovative solutions for our ageing population. The European Commission's "Innovation Union" sets out a strategic approach to innovation, driven by the highest political level. The Innovation Union will focus Europe's efforts - and co-operation with third countries - on challenges like climate change, energy and food security, health and an ageing population.

The Partnership Initiative also seeks to build synergies between what is done at European level and actions implemented at national/ local level, and will set a framework to encourage a wider range of stakeholders across the EU to work together on the promotion of active and healthy ageing, a key objective of the Europe 2020 Strategy and the theme of the recently announced European Year 2012 for Active Ageing. The EPI will seek to build bridges between research and market deployment and will promote user's involvement in research and development of solutions which target them.

In a press release, AGE Platform, a European network of around 150 organisations of and for people aged 50+, welcomes the joint initiative of Vice-President Kroes and Commissioner Dalli as it may pool efforts at EU and national level to develop both ICT and non ICT solutions to address the challenges faced by older people and support their full participation in society and the economy.

More information:
http://www.age-platform.eu/en

► Sport safety

Snow helmets

At the start of the new skiing season, EuroSafe launches a campaign promoting helmets wearing on slopes by issuing a policy briefing on snow helmets. This policy briefing is directed at policy makers responsible for sports, education and public health and for decision makers in winter sports businesses delivering products, services and facilities to sportsmen and women, both at national and at local level. It informs these audiences about injury risks on slopes and in particular about the role of snow helmets in reducing the severity of head injury.

EuroSafe calls upon governments and ski slope operators to make helmet wearing obligatory in order to reduce head injuries in skiing and snowboarding.

Background

Snow sports, in particular skiing and snowboarding, are very popular nowadays. These sports are being practised in Europe by several millions of people at all ages. People like snow sports because it makes great fun and it is healthy, relaxing and sociable. But certainly snow sports also hold a risk of injury due to an accident or to overexertion.

Fortunately, there are many possibilities to prevent injury, for instance by making sports infrastructures and equipment safer, by respecting the rules and by promoting proper exercise and training methods. It is evident that the best thing is to avoid that an accident or injury may happen. However, there is no sport without risks and therefore wearing protective gear like snow helmets is essential in view of reducing the severity head injuries, in case an accident occurs.

The facts

The EuroSafe policy briefing on snow helmets includes the following key messages:

- Snow sports hold a significant injury risk of injury. Children and young people are more at risk. There is no major difference in injury risks between snowboarders and skiers. More than 50% of all severe and fatal injuries in snow sports are related to the head.
- As other types of injuries are decreasing, such as knee injuries owing to better binding systems, head injuries in snow sports is taking a larger share in the total number of snow sport injuries.
- Snow sports helmets, if worn properly, will reduce the impact of a collision or crash and thus reduce the severity of injury outcome. The protective effect is estimated to be within a range of 21 to 45%.

Fortunately, helmet wearing rates are increasing: Germany, Austria and Switzerland are respectively reporting 40%, 63%, 76% helmet wearing rates now. Switzerland is even reporting a 95% helmet wearing rate among children.

Legislation

There is quite some controversy as to whether or not helmet wearing should be enforced by legislation, as it could discourage snow sports participants from practising their sports.

However, the high level of acceptance of helmet wearing also provide the right momentum for making helmet wearing obligatory in order to further reduce the severity of head injuries in snow sports.

As children are more at risk of head injuries than other age groups, helmet wearing for children to age 15 should be made obligatory in snow sports, at least in schools and in snow sport camps.

More information:
http://www.eurosafe.eu.com

► Suicide and self-harm

Deliberate Self Harm Ireland - Annual Report 2009

The eighth annual report from the National Registry of Deliberate Self Harm has been published by the National Suicide Research Foundation (NSRF) in Ireland. It is based on data collected on persons presenting to hospital emergency departments as a result of deliberate self harm in 2009 in the Republic of Ireland. The Registry had near complete coverage of the country's hospitals for the period 2002-2005 and since 2006, all general hospital and paediatric hospital emergency departments in the Republic of Ireland have contributed data to the Registry.

In 2009, the Registry recorded 11,966 presentations to hospital due to deliberate self harm nationally, involving 9,493 individuals. Taking the population into account, the age-standardised rate of individuals presenting to hospital following deliberate self harm in 2009 was 209 per 100,000, a significant 5% increase on the rate of 200 per 100,000 in 2008 and the third successive increase in the national rate of hospital-treated deliberate self harm.

Other key findings

Another other key finding in the report is that the male rate of deliberate self harm was, with 197 per 100,000, 10% higher than in 2008. This is the second successive major increase in self harm by men following an 11% increase in 2008. The most pronounced increase in the male self harm rate was the 21% increase in men aged 20-24 years. The female rate in 2009 was 222 per 100,000, virtually unchanged from the rate of 223 in 2008. As in previous years, the peak rate for women was in the 15-19 years age group, at approximately 635 per 100,000, whereas the peak rate among men was in 20-24 year-olds at 526 per 100,000.

Drug overdose was the commonest method of self harm, involved in 71% of all acts registered in 2009. Minor tranquillisers were the most common type of drug involved, accounting for 42% (approximately 3,500) of all intentional drug overdose presentations. Attempted hanging was involved in 5% of all deliberate self harm presentations (7% for men and 3% for women), 18% higher than in 2008.

Conclusions

The report concludes that the increase in deliberate self harm in Ireland intensifies the need for prevention and intervention programmes to be implemented at national level. Increased support should be provided for evidence-based prevention and mental health promotion programmes in line with priorities in the National Strategy for Action on Suicide Prevention (2005-2014).

The major increase in deliberate self harm among Irish men since 2007, in particular among young men, is likely to be associated with the recession in Ireland. These findings underline the need to increase awareness of mental health issues among the general public and professionals supporting people who are unemployed and experiencing financial difficulties.

In line with previous years, 41% of all deliberate self harm presentations involved alcohol. This findings underlines the need to increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control. It also appears that minor tranquillisers are by far the most common type of medication involved in intentional acts of drug overdose and this suggests that consideration be given to restricting access to minor tranquillisers

Finally it is recommended that minimum guidelines for the assessment of deliberate self harm patients should be implemented by the HSE in line with the guidelines of the National Institute of Clinical Excellence in the UK, in order to prevent inconsistencies in assessment and management of deliberate self harm patients across the region.

The Annual Report is available on the website of the National Suicide Research Foundation: http://www.nsrf.ie

Strangulation risks in youngsters

Improperly called 'choking game' in Anglophone countries or 'jeu du foulard' ('scarf game') in France, this practice, is far from being a game. It basically consists of external compression of the airway, either at the sternum or neck, either by hand (often in a group of youngsters) or with a rope or wire (performed in solo) with the intention to restrict oxygen flow to the brain (hypoxia) and to achieve a condition of euphoria ('getting high').

Children (from 5 years onwards) and adolescents, especially those in the age group of the 12-16 years, from all social classes and backgrounds, are at risk. When they try the 'choking game' in teams, alternatively by self-strangulating or by being strangulated, the main risks are brain injury after fainting and falling, or due to a cardiac arrest.

Those who practice on one's own are often only discovered after they died from accidental strangulation or hanging.

One should be alert when youngsters regularly play with a belt or a rope in unexpected place, when they frequently report recurrent and violent headaches, present 'ecchymoses' (marks of purple discoloration of the skin -bruises- due to passage of blood from ruptured blood vessels into subcutaneous tissue) on chest or around their neck, micro-hemorrhages in the eyes, amnesia, or show signs of mental confusion.

A survey in 2007 by the French IPSOS-research institute revealed that, in a sample of more than a 1 000 persons representative of the French population aged over 15 years, 6% of the parents who have heard of the "game" consider that their children might have practised it once. Out of these, 5% declare knowing children or adolescents who have been injured or died of this practice. Nearly half of those who practised or have seen others doing it, were not at all aware of the serious risks involved in such practices.

The APEAS (Association of victims' parents) organized an International Symposium on 3-4 December 2009, in Paris, at the Ministère de la Santé (NHS).

The presentations and conclusions from this seminar are now published. (L'Harmattan, ISBN 978-2-296-11260-5 (French) and 978-2-296-12292-5 (English).

More information (various languages): *http://www.jeudufoulard.com/*

u Violence prevention

WHO, in partnership with the London School of Hygiene and Tropical Medicine, launched its latest report on violence against women - *Preventing intimate partner and sexual violence against women: taking action and generating evidence -,* at the 10th Injury Prevention-World Conference in London.

This manual - developed with input from a globally representative panel of experts - aims to provide information for policy-makers and planners to develop programmes for preventing intimate partner and sexual violence against women.

Evidence base

The evidence-based prevention of intimate partner and sexual violence is still in its early days and much remains to be accomplished. At present, only one strategy has evidence supporting its effectiveness – and this only relates to intimate partner violence. The strategy in question is the use of school-based programmes to prevent violence within dating relationships. Evidence is, however, emerging of the effectiveness of a number of other strategies for preventing intimate partner and sexual violence, including microfinance programmes for women combined with gender-equality education; efforts to reduce access to and harmful use of alcohol; and changing social and cultural gender norms. Many more strategies appear to have potential, either on theoretical grounds or because they target known risk factors, but most of these have never been systematically implemented – let alone evaluated.

Public health role

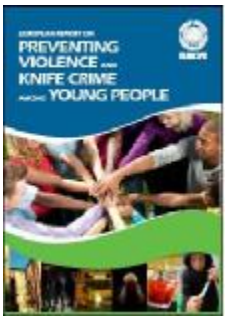
The public health approach to prevention taken in this document is intended to complement criminal justice-based approaches. The approach relies upon the use of population-based data to describe the problem, its impact and associated risk and protective factors, while drawing upon the scientific evidence for effective, promising and theoretically indicated prevention strategies. Part of the approach is also to ensure that all policies and programmes include in-built monitoring and evaluation mechanisms. At the same time, taking a life-course perspective will help to identify early risk factors and the best times to disrupt the developmental trajectories towards violent behaviour using a primary prevention approach. For successful primary prevention, early intervention is required that focuses on younger age groups.

No time to wait for action

Although pressing, the need for evidence and further research in all these areas in no way precludes taking action now to prevent both intimate partner violence and sexual violence. Those programmes that have evidence supporting their effectiveness should be implemented and, where necessary, adapted. Those that have shown promise or appear to have potential can also play an immediate role – provided strenuous efforts are made to incorporate at the outset rigorous outcome evaluations. It is only by taking action and generating evidence that intimate partner and sexual violence will be prevented and the field of evidence-based primary prevention of such violence will successfully mature.

More information:
http://www.who.int/violence_injury_prevention/violence/activities/intimate/en/index.html

Violence and knife crime among young people



At the 10th World Conference on Injury Prevention and Safety Promotion on Tuesday, 21 September 2010 in London, WHO-Europe launched a report on Violence and knife crime among young people. The report is the first comprehensive assessment of interpersonal violence and knife crime among young people in the 53 countries of the WHO European Region. It highlights interpersonal violence as the third leading cause of death and a leading cause of disability among people aged 10–29 years in the Region. This burden is unequally distributed, and 9 of 10 homicide deaths in the Region occur in low- and middle-income countries. Irrespective of country income, interpersonal violence disproportionately affects young people from deprived sections of society and males, who comprise 4 of 5 homicide deaths.

The report identifies numerous biological, social, cultural, economic and environmental factors that interact to increase young people's risk of being involved in violence and knife-related crime. Factors that can protect against violence developing among young people include good social skills, self-esteem, academic achievement, strong bonds with parents, positive peer groups, good attachment to school, community involvement and access to social support. Good evidence indicates that reducing risk factors and enhancing protective factors will reduce violence among young people. The experience accumulated by several countries in the Region and elsewhere shows that social policy and sustained and systematic approaches that address the underlying causes of violence can make countries in the Region much safer.

These make compelling arguments for advocating for increased investment in prevention and for mainstreaming objectives for preventing violence among young people into other areas of health and social policy.

For more information:
http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/violence-and-injuries/publications

('Preventing violence and knife crime among young people', by Dinesh Sethi, Karen Hughes, Mark Bellis, Francesco Mitis and Francesca Racioppi); ISBN: 978-928-900-2028)

▶ Vulnerable road users

Cost of Motor Vehicle Crashes

In a one-year period, the cost of medical care and productivity losses associated with injuries from motor vehicle crashes exceeded $99 billion – with the cost of direct medical care accounting for $17 billion, according to a study by the US-Centers of Disease Control (CDC), and the CDC's Division of Unintentional Injury Prevention within the National Center for Injury Prevention and Control. The total annual cost amounts to nearly $500 for each licensed driver in the United States. The one-year costs of fatal and non-fatal crash-related injuries totaled $70 billion (71 percent of total costs) for people riding in motor vehicles, such as cars and light trucks, $12 billion for motorcyclists, $10 billion for pedestrians, and $5 billion for bicyclists.

Severe risk groups

CDC researchers used 2005 data because, at the study time, it provided the most current source of national fatal and non-fatal injury and cost data from multiple sources. Every 10 seconds, someone in the United States is treated in an emergency department for crash-related injuries, and nearly 40,000 people die from these injuries each year. The study also found:

- Costs related to fatal motor vehicle-related injuries totaled $58 billion. The cost of non-fatal injuries resulting in hospitalization amounted to $28 billion, and the cost of injuries to people treated in emergency departments and released was $14 billion.
- More men were killed (70 percent) and injured (52 percent) in motor vehicle crashes than women. Injuries and deaths among men represented 74 percent ($74 billion) of all costs.
- Teens and young adults made up 28 percent of all fatal and nonfatal motor vehicle injuries and 31 percent of the costs ($31 billion). These young people represented only 14 percent of the U.S. population.
- Motorcyclists made up 6 percent of all fatalities and injuries but 12 percent of the costs, likely due to the severity of their injuries. Pedestrians, who have no protection when they are hit by vehicles and are also often severely injured, made up 5 percent of all injuries but 10 percent of total costs.

Prevention priorities

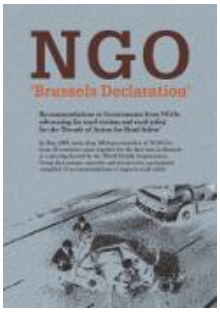
Motor vehicle crash injuries and deaths and the associated costs are preventable. CDC's Injury Center supports proven, effective strategies for prevention such as:

- Graduated driver licensing (GDL) policies: these laws allow new teen drivers to get experience on the road in lower-risk situations as they gain experience over time and are proven to reduce teen crashes. Strong GDL laws have been associated with up to 40 percent decreases in crashes among 16-year-old drivers.
- Child safety seat distribution and education programs: increased use of correctly installed and fitted child safety seats could help reduce the $3.6 billion annual bill for injuries to children, the cost number found in this study.
- Primary seat belt laws: these laws allow motorists to be stopped and cited for not wearing seat belts. Seat belts reduce the risk of death to those riding in the front seat by about half.
- Enhanced seat belt enforcement programs: Enhanced enforcement programs in which law enforcement officers focus on getting people to buckle up (e.g.: Click It or Ticket), are effective at increasing safety belt use and reducing deaths and injuries."
- Motorcycle and bicycle helmet laws: helmets can reduce the risk of death in a motorcycle crash by more than one-third and reduce the risk of brain injury by 69 percent.
- Sobriety checkpoints: these checkpoints, where drivers are stopped to assess their level of alcohol impairment, can reduce alcohol-related crash deaths by more than 20 percent.

For details on state-specific policies and a state-by-state policy comparison, visit http://www.iihs.org/laws/. CDC has also released a one-page fact sheet to help communities play an important role in reducing the human and economic toll of motor vehicle-related injuries by supporting prevention policies that have been shown to save lives and reduce costs. It provides information about cost-effective policies to improve child passenger safety, teen driver safety, reduce alcohol-impaired driving, and increase safety belt use.

For more information: http://www.informaworld.com/smpp/section?content=a926084087&fulltext=713240928

Road Traffic Victims



Among premature and preventable violent deaths and injuries – in Europe as well as worldwide - road deaths and injuries rank very high, including for children and young men, which makes action to stop this carnage especially urgent.

The publication in 2004 of the 'World report on road traffic injury prevention' by the World Health Organisation (WHO), has drawn attention to this hitherto neglected public health crisis, it was followed by various initiatives to help harness political will for action. Several UN resolutions have led to the declaration of the *Decade of Action for Road Safety 2011-2020,* for which a guiding Plan is being prepared by relevant organisations and institutions under the guidance of WHO.

Road safety NGO's

Many NGOs are working for years for road victims and safer roads with little or no funding or support, many set up as the result of governments failing to respond appropriately to the road death and injury toll and plight of road victims in their countries. In recognition of their role and work, the World Health Organisation regularly consults these NGOs advocating for road victims and road safety, including the European Transport Safety Council - ETSC, and the European Federation of Road Traffic Victims - FEVR.

NGO-Declaration

Coordinated by FEVR's president, these road safety NGOs recently compiled a document presenting 33 recommendations to Governments for the 'Decade of Action for Road Safety' - entitled NGO 'Brussels Declaration'. This Declaration, written by people with a unique expertise and interest, is a powerful and forward-looking document:

- governments are urged to give far greater priority to policies and infrastructure that would allow safe use for all modes of transport, in particular the benign, sustainable modes. A hierarchy on the road network should ensure that the rights and needs of vulnerable users and motorised traffic are equitably balanced. To calculate the true impact and cost of traffic danger, deaths and impact on health from pollution and sedentary life styles (obesity epidemic) should be added to the total societal burden of road death and injury toll.
- the NGOs also call on governments to provide adequate resources for research and enforcement, set up a sustainable financing mechanism for road safety, adopt global standards for traffic police and driver training and develop a life-long learning programme for all road users.
- NGOs underline that a serious post crash response is a vital component of effective road safety policy. They recommend that governments improve emergency services, ensure social, medical and legal care for victims, conduct thorough investigations of crashes to identify all causes and prevent their recurrence, and apply an effective legal response representing both a deterrent and justice for victims.
- Finally, they strongly recommend the establishment of national advocacy networks, consisting mainly of NGOs, official recognition and observance of the World Day of Remembrance, and the formation of a national Coalition Against Road Trauma as part of an international coalition, with the common aim of minimizing road trauma.

More information:
http://www.who.int/roadsafety/nongovernmental_network/en/index.html

World day of Remembrance for Road Traffic Victims - 21st November 2011

More information on:
http://www.wdor.org/

The third Sunday of November is the day on which the many millions killed and injured in road crashes throughout the world are being remembered, and pledges made for actions to prevent future needless deaths and suffering.

► Work safety

Economic incentives to improve safety at work

Newly published research by the European Agency for Safety and Health at Work (EU-OSHA) suggests that economic incentive schemes encouraging companies to invest in risk prevention are a cost-effective option for governments looking to cut the numbers of work-related accidents and illnesses. The EU-OSHA report on economic incentives was launched at a conference of the International Occupational Hygiene Association (IOHA) 'Health, Work and Social Responsibility' in Rome on 29 September 2010.

Good practices

Many EU Member States already offer various kinds of financial reward for businesses that invest in keeping their employees safe. These rewards range from lower insurance premiums, state subsidies and grants, through to tax breaks, and preferential terms for bank loans for the best-performing businesses.

Three out of 14 case studies highlighted in the project provided sufficient data to conduct a cost–benefit analysis. All three resulted in a positive payout ratio, ranging from 1.01 – 4.81 Euros return for every Euro invested. Quantitative criteria covered accident rates, sick leave, and general improvement in working conditions.

For example, an incentive scheme introduced in the German butchery sector in 2002 led to a 28% fall in reportable accidents over the following six years compared to a 16% fall in the sector as a whole. In total numbers this means there were about 1000 fewer accidents per year in incentivised companies.

Cost benefits

The report also shows that economic incentives can be effective in all Member States, regardless of wide differences in terms of their social security and accident insurance systems. As a result of the project, the Italian workers' compensation authority INAIL has developed a new incentive scheme which takes into account the experiences and good practice of other countries and therefore is based on the best available international knowledge. With a budget of over 60 million Euros the INAIL scheme is particularly targeting small and medium-sized enterprises and, according to expert estimations, could lead to a benefit of 180 million Euros at society level.

The new EU-OSHA report reflects a growing interest in economic incentives, as a means of motivating organisations to invest in occupational health and safety. There is increasing recognition that enforcement of regulations is not enough on its own, if the EU is to reach the target of a 25% reduction in workplace accidents, set out in its Community Strategy on Health and Safety.

The EU-OSHA report includes a review of existing research on economic incentives, an overview of government policy in the different EU Member States regarding reward schemes, and a collection of case studies giving details of how incentives have been used, in different European countries and across a wide range of sectors. The report evaluates the effectiveness of different incentive schemes, and identifies a number of success factors.

The report and a factsheet in 22 languages are available from the new web portal giving information on economic incentives:

http://osha.europa.eu/en/topics/economic-incentives

► Cross cutting issues

Social and Economic Cost of injuries in New Zealand

The New Zealand Accident Compensation Corporation (ACC) has recently concluded a study into the use of economic methods to inform injury prevention resource allocation decisions and a comparative cost analysis of all injuries and for each of the six injury priority areas in New Zealand. The current ACC-priorities are: Falls, Intentional self-harm and suicides, Motor vehicle traffic crashes, Drowning, Assaults, and Work-related injuries.

Cost elements included in the study

The following cost elements were included in the study:

- *Treatment and rehabilitation costs* refer to all the (out-of-pocket) payments made in relation to diagnosis, treatment and rehabilitation of injuries sustained by the population. Associated costs include transport, home modifications and ongoing assistance with impairment. These costs are paid by ACC through a variety of public and private funding arrangements.
- *Output and productivity costs* result from an individual not being able to work as a consequence of an injury. Loss of income (earnings to individuals and their friends and family, and loss of profit to employers) is the primary flow-on economic cost that can be measured. (This includes the productivity of those who work voluntarily or who are too young or old to earn taxable income.)
- *Human costs* from an injury or a premature death include the psychosocial effects of injury, psychological distress, impaired physical or mental health, pain and suffering. The 'costs' are often non-figurative and difficult to measure.

The human cost is derived by calculating, firstly, the DALYs incurred from premature mortality and from disability associated with the injury event. The second step is to place a dollar value on each DALY. The value used was NZ$150,000 per DALY. Justification for this is given in the detail of the report. In brief, the value of a life year is linked to the New Zealand official Transport Sector Value of Statistical Life (VoSL) – or Value of a Preventable Fatality (VPF) - which was derived from “willingness to pay” (WtP) surveys in the late 1980s. The original estimate has been adjusted upwards for subsequent increases in average ordinary-time earnings. The VoSL at June 2008 prices was NZ$3.352 million.

Estimates of the total social and economic costs

The table below summarises the results of the base case estimate of the total social and economic cost of injury to New Zealand by cost category, for 'all injuries' and each injury priority area respectively. All injuries include intentional and unintentional injuries. The numbers represent the cost of injury measured in New Zealand dollars at 2008 prices, excluding Goods and Services Tax (GST, which is equivalent to value added tax in Europe, and in 2008 was 12.5%).

The Table shows that the base case total social and economic cost of 'all injuries' was estimated to be NZ$9.677 million. The base case represents the middle cost estimate based upon a discount rate of 3% per annum, in 'real' terms, and a monetary value of the human cost based upon the New Zealand Official Value of Statistical Life used in the Transport Sector.

Summary Table of Injury Costs, by Cost Category and Priority Area. Base-case Estimate Using Official Transport Sector VPF, 3% Discount Rate, $ millions, June 2008 Prices (excl. GST)

Priority Area / Cost Category	Treatment and Rehabilitation	Output and Productivity Costs (Lost Economic Contribution)	Human Costs	Total Social and Economic Cost	% of Total Social and Economic Cost – All Injuries
Assault	$ 2.5	$ 49.5	$ 327.5	$ 379.6	4
Falls	$ 535.7	$ 270.8	$ 928.7	$,735.2	18
Drowning	$ 0.8	$ 48.2	$ 246.4	$ 295.5	3
Motor Vehicle	$ 253.5	$ 464.5	$ 1,477.0	$ 2,195.0	23
Suicide/Self-harm	$ 1.6	$ 380.1	$ 1,787.4	$ 2,169.1	22
Workplace	$ 349.5	$ 640.3	$ 357.8	$ 1,347.5	14
Subtotal – Six Priority Areas, $ Millions, (Excl. GST)	$ 1,144	$ 1,853	$ 5,125	$ 8,122	84
Estimated “Non-priority” Cost, $ Millions (Excl. GST)	$ 252	$ 217	$ 1,087	$ 1,555	16
All Injuries, $ Millions (Excl. GST)	$ 1,395	$ 2,070	$ 6,212	$ 9,677	100

Rank order of priority areas

The "rank order" of the different priority areas in terms of total cost is shown by comparing the percentages in the table. Motor Vehicle Traffic Crashes (MVTC) are first, followed by suicide, falls, and then workplace injuries.

The human cost component is influential in determining this rank order. It will be observed that workplace injuries, and also falls injuries, rank highly or relatively highly for the first two components, but less so for human costs, particularly for workplace injuries. This is because in 2006 the actual fatalities from workplace injuries were relatively low at 88 compared with approximately 500 from suicide, and 400 each for falls and motor vehicle injuries (the precise numbers are given in the report).

The relatively low ranking of falls in the final column has a different cause. Although fatalities are relatively high in number, these predominantly occur among the aged than do fatalities from other causes of injury. This means the number of life years lost because of falls-caused fatalities is a lot smaller and consequently the associated human cost is lower, than is the case for other causes of injury. A measure of human cost based on the value of a life rather than the value of a life year, or DALY, would see a considerably higher total cost for falls.

Other interesting findings included, the average age at death from falls is high, and average YLL relatively low. In contrast, MVTC, drowning, suicide and assaults, have considerably lower average ages at death, and significantly higher averages for YLL. The largest contribution to Total Years of Life Lost is made by suicide/intentional self-harm, followed by MVTC.

Sensitivity Analysis

The results were subjected to a sensitivity analysis. The dollar value of a DALY was varied by increasing it in line with other higher and lower value VPF estimates reported in other New Zealand research on MVTC and Fire safety respectively. The percentages of total cost for the different priority areas did vary, but by relatively small amounts, and rank orderings were unchanged, except that for the highest value of a life year, suicide costs moved into first rank, ahead of MVTC.

The results were also tested for changes in the discount rate ranging from 0% up to 10%. Total cost was little affected by these variations, because of the methodology employed in the study, which saw an inverse relationship between the discount rate and cost assigned to a DALY trading against each other. The rank orderings of the priority areas were affected, however. Notably, higher discount rates, at 8% and 10%, moved falls into the highest ranking category. This is explained by deaths from falls being most prevalent among the elderly, which means the lost life years are less affected by increases in the discount rate because there is less of them subject to the higher discount.

The sensitivity analysis showed that while the cost estimates and rankings were responsive to changes in the parameters, these changes were not of sufficient size or unexpected to materially changed national priority settings.

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Well-being in Older People

The European Commission (EC) Directorate-General for Health and Consumers and the Spanish Ministry of Health and Social Affairs organised in June a Presidency-conference on "Mental health and well-being in older people- making it happen". Shortly after the conference the conclusions have been produced and can be accessed through web link mentioned at end of this section.

The issue

Mental heal health problems, including depression and other mood disorders, are among the most prevalent and serious health problems among older people, together with physical health problems, including neurodegenerative disorders, such as Alzheimer's disease and other forms of dementia. These different mental and physical health problems are often co-occurring in older individuals.

However, Europe's society and its health workforce is not yet always fully prepared to respond to current and future mental health needs of older people, by providing an adequate level of health promotion, preventive intervention and care and treatment to older

people, and by the support to informal carers, which they need and deserve.

Against the background of today's unmet needs, which without action might increase further in future, the conference underlined the right of older Europeans to enjoy a high level of health and well-being. It stressed that, in pursuing efforts to improve the health and well-being of older Europeans, policymakers, together with professionals, patients and informal carers, NGOs and older people themselves, should give greater priority to promoting mental health and well-being and to tackling mental health problems.

Unlocking and utilising the mental capital of the ageing population by ensuring a high level of mental health and wellbeing among its older population, and improving the situation of informal carers, will be essential for enabling the EU to promote the well-being of its peoples and for realising its economic and social policy objectives through a period of demographic change.

The conference supported a number of principles for building action to improve the mental health and wellbeing of older people:

- The strengthening of protective factors for ageing in good mental health and well-being, such as families and close interpersonal relations, active social inclusion and participation, intergenerational support and involvement in meaningful activities, and the reduction of risk factors for ageing in poor mental health, in particular, social isolation, poverty, violence and abuse;
- The need for intersectoral and interdisciplinary cooperation, in particular between the health and social sectors, and the importance of training for professionals working with older people on mental health issues, as well as the delivery of health and social services through community-based infrastructures;
- The empowerment of older people, for instance through the creation of Older People's Councils, and the recognition of the importance of self-help, peer support and informal care.

Key priorities

The conference identified a couple of key priorities, including:

- Mental health promotion in old age. A healthy lifestyle, safe living environment and meaningful, active participation in society and the community are important protective factors for mental health and well-being in older age. Support from families and peers plays a key role in promoting the mental health of older people by reducing loneliness and social isolation.
- Prevention of mental disorders and promotion of autonomy. Prevention of the most common mental disorders involves addressing the risk factors for mental health problems in old age, such as physical and sensory impairments, and improving help seeking, quality of services, early detection and intervention, when mental health problems are at risk of emerging.
- Older people in vulnerable situations. Older people from certain groups face a higher risk of mental health problems. This includes older women, persons with disabilities, those living in or at risk of poverty, experiencing chronic illness, suffering abuse and belonging to minority groups.
- Health systems for care and treatment. Primary health care, including nursing care and social services are primary access points for older people and should be used to proactively pursue the goal of improving mental health and well-being in older people.

Call for action

The conference invited the EC to mainstream the promotion of mental health and well-being of older people into its policies and initiatives on active, dignified and healthy ageing, on reducing health inequalities, on the European health workforce, on retirement and on promoting the rights of persons with disabilities, as well as its relevant policies and financial instruments, such as those on research, structural funds, the information society. The Commission is also urged to collect and disseminate good practices in promoting mental health and well-being of older people and to integrate issues related to the mental health and well-being of older people into the European Year of Active Ageing.

The conference invited MSs Governments to initiate a number of actions, among other things to build up health workforces which are able to respond to the mental health needs of older people in MSs with a reinforced focus on preventive measures and to carry out advocacy activities across sectors for the introduction and implementation of measures to strengthen the mental health of older people and promote their well being.

More information:
http://ec.europa.eu/health/mental_health/docs/ev_20100628_rep_en.pdf

Effective Measures in Injury Prevention (EMIP)

The EMIP database is an attempt to make it easier for decision makers (e.g. policy-makers and health professionals) to assess the level of evidence available for a particular measure or strategy. By browsing the database (http://www.eurosafe.eu.com/effectiveness), users have access to statements that provide evidence on prevention measures in injury prevention (e.g. legislation, education), background documents upon which these evidence statements are based and an indication on whether experts have judged the measure or strategy to have adequate evidence to be recommended as a good practice.

Definition of good practice

In the context of EMIP a good practice is defined as a measure or strategy that has been evaluated by experts as part of the EMIP assessment process and found to meet the following criteria:

- A preventive measure/intervention strategy that has been evaluated and found to be effective in reducing injuries (either through a systematic review or at least one rigorous evaluation) OR
- A preventive measure/intervention strategy where rigorous evaluation is difficult but expert opinion supports the practice and data suggest it is an effective strategy (e.g., use of personal floatation devices to prevent drowning) OR
- A preventive measure/intervention strategy where rigorous evaluation is difficult but expert opinion supports the practice and there is a clear link between the measure/strategy and reduced risk but a less clear link between the measure/strategy and reduced injuries (e.g., secure storage of poisonings) AND
- The preventive measure/intervention strategy in question has been implemented in a real world setting so that the practicality of the intervention has also been examined.

Scope

The scope of EMIP is all injuries (intentional and unintentional) and all ages. Information in the database is primarily based on existing reviews with a focus on systematic reviews. If high quality reviews are not available, other literature including original articles have been reviewed. Evidence statements are developed and reviewed by experts from the appropriate area of the injury field prior to being added to the database.

While EMIP is officially launched at the end of 2008, building and filling the database is a continuous process as new topics and new research becomes available. The topics covered in the initial launch include child safety, sport safety, vulnerable road users, and safety for seniors.

More information: emip@eurosafe.eu.com

► AGENDA

2010

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

24-26 November, Olomouc, Czech Republic
2nd Conference of HEPA Europe
Website: *http://mandh2010.upol.cz*

2011

7-9 April in Monaco
IOC World Conference on Prevention of Injury & Illness in Sport
Website: *http://www.ioc-preventionconference.org*

11-13 May in Danang, Vietnam
World Conference on Drowning Prevention 2011
http://www.worldconferenceondrowningprevention.org

16-17 June in Budapest, Hungary
3rd European Conference on Injury Prevention and Safety Promotion
http://www.eurosafe.eu.com

EuroSafe

the European Association for Injury Prevention and Safety Promotion

is the network of injury prevention champions dedicated

to making Europe a safer place

ARE you looking for opportunities to influence European policy developments relevant to injury prevention and safety promotion? **DO** you want to learn from other countries by bench marking your own policies and programmes with them? **DO** you want to increase the impact of your investments in safety promotion programmes by exchanging experiences with key experts in the field? **ARE** you looking for being engaged in collaborative projects and activities with other colleagues in Europe?

Together we can make a difference!

JOIN US by filling in the membership form

http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/l3howtobecomeamember.htm

or ***CONTACT US*** at

secretariat@eurosafe.eu.com

Sign up for WHO is WHO

The Who is Who expert directory is a networking tool for all involved in injury prevention and safety promotion. It is also an important tool for EuroSafe to be able to identify and invite experts in specific areas to participate in expert consultations around various EuroSafe activities and products.

http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/

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