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EuroSafe Alert

European Association for
Injury Prevention and Safety Promotion

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"Working together to make Europe a safer Place"

Contents

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Safety in Basketball - launch of Sports Task Force report

A three-years study by the EuroSafe - Safety in Sports Task Force confirms that it is possible to anchor injury prevention more strongly into the education and training of coaches as well as players and thus to increase the health benefits of playing basketball by decreasing injury risks. Coaches play a decisive role in translating the prevention evidence into practice and are the most important mediators for integrating safety aspects within current training and practices. The study report on the pilot has been launched in collaboration with FIBA-Europe, the European basketball federation.

The Issue

With an annual toll of over 720,000 injuries in EU-countries, basketball is a demanding sport. The total medical costs of basketball related injuries are estimated at up to 500 million euro a year, one third of these costs being related to knee injuries.

Quite some knowledge is available as to the appropriate training principles and protective measures, e.g. use of (external) ankle support, in order to reduce injury risks among basketball players.

However, the challenge is to enable clubs to invest means and capacity to implement such measures and to motivate coaches and athletes to bring these principles consistently into practice. Coaches play a key role in integrating safety aspects within current training and coaching practices.

European initiative

With this in mind, the Safety in Sports Network under the leadership of the Ruhr-University Bochum (GE), developed a set of measures and tools that has been proven to be effective and readily available for being taken up by the trainers, coaches and athletes. This has been done in collaboration with FIBA-Europe, the European basketball federation, and the Swedish and Slovak national basketball federations.

Experts from the two national federations critically reviewed a set of recommended practices and assessed their applicability and acceptability at local level. Each of the two federations produced a 'tailor-made' set of tools, coaching clinics and training seminars.

Results

The results of these pilots are most promising:

- Coaches in the two countries became more competent in directing their training practices towards training contents that are more effective in reducing injuries, in particular by including muscle strengthening and coordination exercises;

- Coaches found better opportunities to motivate their team members in appreciating and accepting the training practices offered;
- The players that participated in the pilots welcomed the inclusion of safety aspects in sports practice while this also contributed to enhancing their performance.

Both federations are confident that the pilots have helped to anchor injury prevention more strongly into their education and training curricula, to decrease injury risks and to make basketball an even more attractive type of sport.

Way ahead

The Safety in Sports Network advises national basketball federations to follow a more pro-active strategy as to the risk of injury and communicate with their members openly about the injury risks involved and necessary measures to be taken by clubs and individuals. All sustained injuries should be reported to trainers and coaches and should be systematically recorded at club and national level, in order to identify individual and situational risk factors, to monitor injury trends and to evaluate effects of measures taken.

All national associations should include an injury prevention module in their trainer education curriculums and designate an official staff member as the national 'safety promotion ambassador' within their federation.

FIBA-Europe, the European basketball federation, should play a key role in facilitating the transfer of the good practices developed by the Swedish and the Slovak Basketball Federations towards other countries in Europe. Such a pro-active approach will contribute to the positive image of the game and of organisations involved, and will help to attract new members.

The Safety in Sports Network will continue to promote safety in all types of sports and physical activities by initiating collaborative pilots and information campaigns. The pilot results are also of relevance for other ball sports and team sports and will be therefore shared with other relevant stakeholders.

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► EU news

EU-Health: Call for proposals

The 2012 Work Plan of the Health Programme adopted on 1 December 2011 has been published mid-December. It sets the annual priorities for implementation of EU Health Programme. Based on this decision, the Executive Agency for Health and Consumers (EAHC) has launched the calls for proposals for joint actions, operating grants, projects and conferences, to be financed from the 2012-budget.

The Executive Agency for Health and Consumers (EAHC) is entrusted by the European Commission to implement the Health Programme. This is mainly done through financing four types of different actions: projects, conferences, joint actions and operation grants. Those actions intend to have a special European dimension, meaning that a minimum of various partners of different European Countries have to be involved in the project plan. For more specific information please see the respective Programme actions.

For receiving a European grant projects generally have to contribute at least to one of the 3 main objectives of the Health Programme (2008-2013):

- to improve citizens' health security;
- to promote health, including the reduction of health inequalities;
- to generate and disseminate health information and knowledge.

The 2012 Work Plan gives more emphasis and resources to a focused cooperation with the Member States. The amount of € 8.950.000. will be dedicated to the funding of five joint actions. The indicative amount for

for the call for operating grants for non-governmental organisations or specialized networks active in the field of Public Health is € 4.400.000. euro. In comparison to 2011 the total indicative amount available for projects has increased and is € 13.171.820. euro. This call for proposals is seeking for very specific projects in eight different areas. Funds will also be made available for grants for conferences (800.000 euro). The final deadline for the submission of proposals is 9 March 2012.

More information:http://ec.europa.eu/eahc/health/index.html

Proposal for new EU-Health Programme

In November 2011, the European Commission adopted a proposal for the new EU-Health Programme, the "Health for Growth Programme", the third programme of EU action in the field of health for the years 2014-2020. The programme builds on the previous Health Programmes. The new programme, with a proposed budget of €446 million, aims to support and complement the work of Member States to achieve the following four objectives:

- Developing innovative and sustainable health systems;
- Increasing access to better and safer healthcare for citizens;
- Promoting health and preventing disease; and
- Protecting citizens from cross-border health threats.

Health for Growth

In the pre-amble of the proposal, the Commission repeats that health is not just a value in itself - it is also a driver for growth. Only a healthy population can achieve its full economic potential. The healthcare sector is also one of the largest in the EU: it accounts for approximately 10% of the EU's gross domestic product and employs one in ten workers, with a higher than average proportion of workers with tertiary-level education.

Health therefore plays an important role in the Europe 2020 agenda. Promoting good health is an integral part of the smart and inclusive growth objectives for Europe 2020. Keeping people healthy and active for longer has a positive impact on productivity and competitiveness.

The proposed programme aims to strengthen the links between economic growth and a healthy population to a greater extent than the previous programmes. Key goals, set out in the Europe 2020 hinge on increasing innovation in healthcare as reflected in flagship initiatives such as the Innovation Union and the Digital Agenda. As innovation in health has the potential to help reduce healthcare costs and improve the quality of care, many areas of the proposed Health for Growth Programme, such as health technology assessment (HTA), medical devices, clinical trials and medicinal products, as well as the European Innovation Partnership on Active and Healthy Ageing, aim to strengthen the link between technological innovation and its uptake and commercialisation; while fostering security, quality and efficiency of healthcare. Other initiatives focus on promoting the uptake and interoperability of e-Health solutions, to improve for example cross-border use of patient registers.

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

Therefore, the general objectives of the Health for Growth Programme are to work with Member States to encourage innovation in healthcare and increase the sustainability of health systems, to improve the health of the EU citizens and protect them from cross-border health threats.

Focus

The new programme focuses on four specific objectives with a strong potential for economic growth through better health:

- to develop common tools and mechanisms at EU level to address shortages of resources, both human and financial and to facilitate up-take of innovation in healthcare in order to contribute to innovative and sustainable health systems;
- to increase access to medical expertise and information for specific conditions also beyond national borders and to develop shared solutions and guidelines to improve healthcare quality and patient safety in or-

der to increase access to better and safer healthcare for EU citizens;

- to identify, disseminate and promote the up-take of validated best practices for cost-effective prevention measures by addressing the key risk factors, namely smoking, abuse of alcohol and obesity, as well as HIV/AIDS, with a focus on the cross border dimension, in order to prevent diseases and promote good health; and
- to develop common approaches and demonstrate their value for better preparedness and coordination in health emergencies in order to protect citizens from cross-border health threats.

The Programme builds on the results of the first Public Health Programme (2003-2008) and the second Health Programme (2008-2013), in line with the conclusions and recommendations made in the different evaluations and audits performed on these programmes. The new programme aims to focus on fewer actions of proven EU added value, that deliver concrete results and respond to identified needs or gaps. The programme seeks to improve the way Member States cooperate in the area of health and to provide leverage for reform of national health policies.

The new Health Programme is part of the EU's financial priorities for 2014-2020 (the EU Multiannual Financial Framework), which was announced by the European Commission in June. The proposal will now be discussed by the European Parliament and Council of Ministers, with a view to adoption by the end of 2013, to allow for the start in 2014. Negotiations on the Multiannual Financial Framework for the whole EU budget will continue in parallel.

More information: *http://ec.europa.eu/health/programme/policy/index_en.htm*

Proposal for new EU-Consumer Programme

In November 2011, the European Commission also adopted a proposal for a new Consumer Programme. The new programme will run from 2014-2020 with a budget of €197 million. Focus will be on fewer concrete actions that offer clear EU added-value.

The Consumer Programme will support EU consumer policy in the years to come. Its objective is to place consumers at the centre of the Single Market and empower them to participate actively in the market and make it work for them, particularly by:

- Enhancing product safety through effective market surveillance;
- Improving consumers' information, education and awareness of their rights;
- Consolidating consumer rights and strengthening effective redress, especially through alternative dispute resolution;
- Strengthening enforcement of rights cross-border.

Focus

The programme aims to build on the previous programme by focussing action on empowerment of the consumer through safety, information and education, rights and redress and enforcement actions. Actions will focus on:

- Monitoring and enforcing safety through EU-wide systems such as the EU rapid alert system for dangerous consumer products
- Information and education initiatives to make consumers, particularly young consumers, aware of their rights. This includes also the continuing development of the evidence base for better policy making at both EU and national level on consumer issues, with, for example, the Consumer Markets Scoreboard which maps out the markets that fail consumers in Europe;
- Delivering legislation aimed at enhancing consumer rights, for example the Consumer Credit Directive which ensures that consumers across Europe enjoy a common set of core rights, including the right to receive clear and comparable information before committing themselves financially;
- Enforcement action through "Sweeps" operations, which are co-ordinated by the European Commission and carried out simultaneously by national consumer enforcement authorities to see where consumer rights are being compromised or denied.

Expected results

The new Consumer Programme will support the general objective of future consumer policy placing the empowered consumer at the centre of the Single Market. European consumer policy supports and complements national policy by seeking to ensure that EU citizens can fully reap the benefits of the Single Market and that in so doing, their safety

and economic interests are properly protected:

- In the field of safety, actions at EU level and cooperation through the General Product Safety Directive (GPSD) network will deliver better results than a series of individual actions by Member States since it fills information gaps, including using information collected by other countries, and avoids disparities in the Single Market.
- Consumer market monitoring will help to identify weaknesses in national markets and Single Market obstacles that could be removed with reforms improving innovation and competition.
- Alternative Dispute Resolution will offer a cheap, rapid and easy way of getting redress throughout the EU, ensuring a level playing field. The development of a Union-wide on-line dispute resolution system will lead to a co-ordinated approach, creating economies of scales and synergies.
- Coordinated joint enforcement actions with the Consumer Protection Cooperation (CPC) Network of national enforcement authorities such as the 'sweeps' have revealed to be a very efficient way to tackle issues which have a cross-border EU dimension.

Leveraging the vast economic force of consumer expenditure (which represents 56% of EU GDP) is expected to make an important contribution to meeting the EU objective of reigniting growth.

More information: *http://ec.europa.eu/consumers/strategy/programmes_en.htm*

► WHO news

WHO-Europe: Health 2020 Strategy

At the autumn-session of the WHO Regional Committee for Europe, Member States reconfirmed the mandate of WHO-Europe to develop the new European health policy, Health 2020, and to accelerate progress towards achieving the European Region's health potential by 2020. By developing a new health policy for Europe, the WHO and its Member States aim to bring a focus on health to the fore in the debate on economic and social development in the fast changing European context.

Emerging trends

Increasing health inequities within and between countries, shrinking public service expenditures due to the financial crisis and a growing burden from non-communicable diseases, indicate an urgent need to promote and protect health, particularly for the most vulnerable segments of the population, and to ensure that appropriate care and support is available to those who are ill. The European Health 2020 policy will set out an action framework to accelerate attainment of better health and well-being for all, adaptable to the different realities that make up the WHO European Region.

Key questions to address

Health 2020 is intended to provide a unifying and overarching value-based policy framework for health development. It will bring together and interconnect new evidence and strengthens the coherence of existing knowledge and evidence on health and its determinants. It is designed to offer practical pathways for addressing current and emerging health challenges in the Region, appropriate governance solutions and effective interventions. It identifies how both health and well-being can be advanced, equitably sustained and measured through actions that create social cohesion, security, work-life balance, good health and good education.

Health 2020 aims to address a number of key questions:

- Which type of policies and interventions would make the biggest difference in the health and well-being of the people of the Region?
- How can Member States best use scarce resources to make measurable and equitable health gains?
- What opportunities and types of innovations hold the greatest promise?
- How can we accelerate action to reduce inequalities?
- How can the Regional Office and Member States join forces and work with partners in

the European Region on priorities for action within a unifying and coherent policy framework?

A few key principles have been affirmed in discussions and consultations so far. There is for instance a strong consensus on the principle that Health 2020 should address the wider government, including presidents and prime ministers, and call for a whole-of-government approach with messages that speak convincingly to other sectors and to the investments they need to make in health.

It has been also affirmed that more needs to be invested in prevention now. Not only does prevention "pay off" in the medium and long terms, even expensive investments in prevention may be worthwhile for other reasons than financial savings only.

Process

Health 2020 will be developed in the period leading up to the sixty-second session of the Regional Committee in September 2012. There are four basic process principles. The policy framework should being based on:

- strategic and anticipatory analyses of drivers, trends and the policy context related to health in the period to 2020;
- the best evidence of the causes of ill health and inequalities, public health concepts and effective solutions;
- consultations with a wide range of stakeholders, decision-makers, public health professionals, civil society and international agencies; and
- contribute to the creation of partnerships with countries to strengthen know-how and their capacity to address major policy and governance challenges.

More information: *http://www.euro.who.int/__data/assets/pdf_file/0007/147724/wd09E_Health2020_111332.pdf*

► Injury Data

Injury surveillance: experience and challenges in Nordic countries

The European Public Health Association (EUPHA)-section on Injury Prevention and Safety Promotion organised a one-day seminar on 'Health-based injury registration in the Nordic countries– experiences and challenges', as a satellite meeting to the annual EUPHA- conference in November, Copenhagen. The seminar was attended by 26 delegates from the Nordic countries, where injury data collection started to develop decades ago under the auspices of the Nordic Medico-Statistical Committee, NOMESCO. The majority of delegates had many years of experience in injury surveillance and in registering injuries in Emergency Departments (ED's) at hospitals. The seminar gave an opportunity to draw the lessons from decades of injury surveillance work in the Nordic region, as well as to develop a longer term perspective for the future.

Current status

In the seminar, the preliminary results of a survey among the five Nordic countries were presented. This was followed by individual country presentations and discussions looking into critical issues such as the added value of injury data for the wide range of policy stakeholders, cost-efficiency of data collection in ED's at hospitals, the quality of information provided and future perspectives of using information technology for more performing patient registers and for data linking.

The survey among the five Nordic countries, i.e the respective centres of excellence in injury data in Denmark, Finland, Iceland, Norway, and Sweden, indicates that, in spite of the many decades of exchange and collaboration among these countries, each Nordic country has developed its own mix of instruments for injury registration. Also different classification systems (ICD, NOMESCO, IDB, IDB-MDS and N-ICECI), and versions of classifications, are in use; there are large variations in data accuracy reported by countries and there are no harmonised data delivery formats available.

Therefore these countries have still a long way to go in unifying data reporting for European cross-comparisons and in sharing resources for increasing the cost-efficiency of such systems. The introduction of a Minimum Data Set for Injuries (MDS-I) as a common denominator for all, as the JAMIE-project intends to establish, countries is seen as a realistic solution for solving issues related to classification and data accuracy.

It was also apparent that in spite of the strong communalities in the socio-economic environments in the Nordic countries, there are slight but noticeable differences in way their health systems are organised and in particular financed, which makes the data they report not fully comparable. There is a need for data models that may adjust to differences in health care system variations across countries.

Lessons learned

In the presentations and discussions a number of conclusions were drawn as to the lessons learned. It is beyond doubt that the health sector provides unique access to cases that can provide important information on the causes and circumstances of injuries as well as their impact on individuals and society. The function of such surveillance systems is to assist in priority setting, risk assessment, cost assessment and risk communication initiatives. The prime user groups are health and accident insurers, government authorities (road safety/ safety at work/ consumer protection agencies), hospital management and safety promotion and injury prevention research organisations.

However the costs of collecting such information is borne by the health system, while other sectors seem to be rather contented with there own systems in spite of their biases. Therefore it is important to reduce the running costs of such systems as much as possible. Sweden, Denmark and Norway are therefore moving towards a 2-step system in line with the JAMIE-approach.

Major supporters and possible funders for data collection, should be found under authorities responsible for rod safety, consumer protection and safety in the workplace. The MDS-I provides them an entrance point to gathering of additional data on the basis of special modules developed for each of these policy sectors. ICT may provide opportunities for increased integration of injury data collection into patient information systems and for linkage with other emergency and police data systems.

Challenges

The participants supported the JAMIE-approach as being a most promising way to make injury data collection more sustainable for the future. There is however a misunderstanding by those who see the MDS-level as a too meagre data set and are used to more extended data collection efforts. It should however be clear that the JAMIE-MDS-I is only meant as to be the bare minimum data set: data collected at an lower level makes no sense at all. The JAMIE-MDS-I can always be expanded, and it is even recommended to do so.

For sustainable injury surveillance it is important to provide it a legal binding base and made mandatory in the framework of the EU Regulation on Community statistics on public health, which already identifies 'accidents and injuries' as one of the core health topics to be covered within this common framework. The JAMIE-project lays the ground for such a process of adopting a harmonised methodology for injury data collection in ED's in the European Region.

More information: http://www.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/l2whoiswhoexpertdirectory-.htm

► New section: Country update on Injury Surveillance

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

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

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

Injury monitoring in Lithuania

Lithuania is the largest of the three Baltic states. Lithuania has an estimated population of 3.2 million as of 2011, and its capital and largest city is Vilnius. On 11 March 1990, the year before the break-up of the Soviet Union, Lithuania became the first Soviet republic to declare independence. Prior to the global financial crisis of 2007–2010, Lithuania had one of the fastest growing economies in the European Union.

Health Information Centre of Institute of Hygiene (HIC IH) of Lithuania is responsible for health statistics, especially causes of deaths, health care and health resources statistics. HIC IH collects data using annual survey of health establishments (health care resources and some data on activities) and data from administrative data sources such as the Compulsory Health Insurance Fund information system (CHIF IS) managed by the State Patient Fund. CHIF IS covers data on hospital discharges, out-patient visits, and primary heath care visits. CHIF IS covers about 98% of hospital discharges, about 90% of outpatient visits, 100% of primary health care visits. HIC IH gets the copy of CHIF IS with recalculated personal ID numbers for statistical data calculations.

Current situation

In Lithuania there are 40 hospitals with a traumatology department at present. The Ministry of Health has a plan to reduce the number of traumatology departments to 12 trauma centres in big cities and county centres. Primary care is being provided by 2600 family physicians and other primary health care physicians (therapists and paediatricians) working in about 400 primary health care institutions. In 2010, totally about 286 000 cases of injuries were treated in hospitals, out-patient units of hospitals and in primary health care.

By now Lithuania has no special register or database on injuries and external causes. For statistical purposes data from CHIF IS is used. External causes in hospital discharge database are coded by ICD-10 on 4 digits level (one external cause code), since 1st April 2011 – ICD-10-AM 5 digits level (up to 3 external cause codes). This system allows to present inpatients data on external causes for IDB minimum data set for by now. In 2010 CHIF IS reported 60.707 hospital discharges due to injuries (S00-T98), of which 3316 transport accidents (5.5%), 37071 home and leisure injuries (61.1%), 2957 self-harm cases (4.9%) and 2368 assault (3.9 %). In 19.5% of cases the external cause is not coded.

Some information as to the number of visits in ED and number of cases of ED-treated injuries can be derived from the CHIF IS. External causes registered in out-patient care and in primary care services are not ICD-coded but only classified along 8

groups of external causes: 1-transport accident, 2-work place, 3-other public places, 4-home, 5-sports, 6-in educational institutions, 7-self-harm, 8-assault, 9-others. Coding of external causes for CHIF IS is mandatory. However, the quality of coding needs improvement: around 50% of the cases are being coded as unspecified or not coded at all.

By now discussions is going on introduction of external causes coding in emergency departments. The current software that is being used by CHIF IS needs to be upgraded next year which allows to change data items to be collected and to improve the functionality of the system.

National injury monitoring project

From August 2011, with financial support from the Structural Fund, Institute of Hygiene started the implementation of EU funded national project "Injury and Accident Monitoring System". The national project aims to create the national system of monitoring of injuries and accidents (trauma register), including as many data as possible for health policy planning, health care administration, public health, international data collection needs. It is carried out in close collaboration with the twelve main trauma centres and a national consultative group of stakeholders, i.e. data users, in the relevant governmental departments and agencies.

Ideally, this register should allow comprehensive data collection on pre-event causes, treatment as well as later stage consequences, i.e. disability. The use of personal ID is necessary for follow up the patient. According to the Law of Personal Data Protection in order to create the register with personal ID collection this register should be defined in the Law. The biggest challenge of the project will be the changing of the necessary Laws what sometimes could take years.

Monitoring system should cover at least the 12 main trauma centres (in-patient and emergency departments) in Lithuania. Ideally, the system should cover all hospitals. The duration of the project is 3 years. Implementation of Joint Action on Monitoring of Injuries in Europe (JAMIE) is closely connected with the implementation of national project "Injury and Accident Monitoring System".

Owing to the CHIF IS-system external cause data is available at least at minimum data set-level (MDS-I) for all hospitalised cases from 1st of June 2011. It is planned to have from 2013 MDS -level information available for all non-hospitalized patients treated in emergency departments in trauma-hospitals in Lithuania.

Possibly, Full Data Set (FDS-I) could be available only from 2014 when the national monitoring system of injuries and accidents will be implemented as a result of national project "Injury and Accident Monitoring System". FDS implementation is planned for 12 trauma centres in Lithuania, covering the biggest part of inpatients and out-patients emergency departments with injuries.

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HIGIENOS INSTITUTAS

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Main stakeholder organizations for injury monitoring in Lithuania

- Ministry of Health, Department of Public Health,
- Institute of Hygiene, Health Information Centre,
- Centre of Health Promotion and Diseases Prevention,
- State Non Food Products Inspectorate under the Ministry of Economy,
- Disability and Working Capacity Service under the Ministry of Social Security and Labour,
- Ministry of Interior, Department of Police, Traffic Police Service,
- The Lithuanian Road Administration under the Ministry of Transport and Communications

▶ Child safety

Swedish Child Safety Conference

The Swedish Child Safety Forum organised its first national conference in Karlstad (Sweden) on October 3-4. An initiative of the Swedish Child Safety Council, the conference was made possible and organized by the Swedish Civil Contingencies Agency. The aim for the conference was to establish a meeting place for those working with children and their safety at the local and regional level.

Programme

The conference started off with an annual meeting assembling the participating agencies within the Child Safety Council, who also contributed to the panel debate later that same day. The first day of the conference then continued with plenary presentations describing the field of child safety in Sweden and worldwide from a historical point of view; from effects and risks of socioeconomic inequity to methods of how to make children and youth more involved in strategic planning. A newly released prevention publication "Safety of children & youths" consisting of statistics and evidence based practices, was launched and distributed to the delegates in their capacity of child safety workers.

The second day of conference consisted of plenary presentations along with parallel sessions which included a wide range of perspectives such as a statistical update; home safety; safety in preschool and school; risk and environmental factors; leisure time safety; children's participation & involvement and young adults (15- 24 years). In relation to young adults, it has just recently come to Swedish authorities' attention that injuries are the leading and increasing cause of all deaths (65-75%) within the age group.

Annual meetings foreseen

The conference was attended by nearly 170 delegates, an impressive turnout for a newly established event. The evaluation indicated that the conference had been highly appreciated from the delegates and it was also said to meet a long felt need. In the evaluation the delegates also indicated that the Child Safety Council upcoming works towards preschool-/ safety were seen as a good initiative. Based on the positive feedback, it has been determined the Child Safety Forum will take place every other year, the next in Autumn 2013.

More information: daniel.carlsson@msb.se or visit the Swedish Civil Contingencies Agency´s website at www.msb.se

▶ Consumer safety

Safer child seats on the horizon

Younger children will be better protected when travelling by car following the adoption of a new regulation on child-restraint systems (CRS) by the UNECE (United Nations Economic Commission for Europe) Working Party on Secondary Safety RSP).

The new regulation (known as the “I-size regulation”) is the response of experts in UNECE to criticisms of the existing regulation for child car-seats from both Member States and consumers.

Work on the new regulation started in 2008. ANEC and Consumers International (CI) welcome the adoption of the new and more consumer friendly I-size regulation as it will offer greater safety to the youngest consumers. The new regulation requires the mandatory rear-facing transport of children up to 15 months of age, provides side impact protection and will help reduce misuse of the child seat”.

ANEC urges the World Forum for Harmonization of Vehicle Regulations to ensure implementation of the new regulation as early as January 2013.

More information: www.anec.eu

Fires ignited by cigarettes

Cigarettes left unattended are one of the leading causes of fatal fires in Europe. Evidence shows that the number of fatalities can be reduced by over 40% with the introduction of 'Reduced Ignition Propensity' (RIP) cigarettes. This means cigarettes which self extinguish when left unattended and which are thus less likely to cause fire. This safety measure is already in place in some countries globally (US, Canada, Australia), and in Finland since April 2010.

Protecting citizens from fire hazard

Data from Member States covering 2003 to 2008 show that, in the EU, cigarette related fires cause more than 30,000 fires every year, with more than 1,000 deaths and over 4,000 injuries. The experience from Finland, where the number of victims of cigarette-ignited fires has fallen by 43%, suggests that nearly 500 lives could be saved in the EU every year.

As from 17th November 2011, once the new safety standard is published in the EU Official Journal all cigarettes sold in Europe will have to comply with these measures. It will be the role of the national authorities to enforce this new fire safety measure. Of course, there is no such thing as a safe cigarette, and, obviously, the safest thing is not to smoke at all. But if people choose to smoke then the new standard will require tobacco companies to make only reduced ignition propensity cigarettes, and potentially protect hundreds of citizens from this fire hazard.

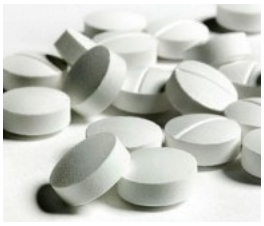
New safety standard

The change which is required under the new standard is about reducing ignition propensity, which is the ability of a cigarette left unattended to start a fire. Cigarette paper manufacturers have changed their paper production to insert two rings of thicker paper at two points along the cigarette. If the cigarette is left unattended the burning tobacco will hit one of these rings and should then self-extinguish, because the ring restricts the oxygen supply. A RIP cigarette cuts down the burning time, thus reducing the chance to ignite furniture, bedding or other material.

The new standard has been drawn up under the General Product Safety Directive, which obliges producers to place only safe products on the market. In 2008 the European Commission defined the safety requirements, following discussion with Member States, the tobacco and paper industries and NGOs, and then asked the European Committee for Standardisation (CEN) to develop the relevant standard, which national authorities will use to measure compliance with fire safety rules.

More information: *http://ec.europa.eu/dgs/health_consumer/dyna/enews/enews.cfm?al_id=1196*

Pack sizes of paracetamol and intentional overdoses



Paracetamol is commonly used in acts of intentional overdoses. In order to reduce acts of intentional overdoses involving paracetamol, legislation was introduced in the UK in 1998 to restrict pack sizes of paracetamol sold in pharmacies - max. 32 tablets- and non-pharmacy outlets -max. 16 tablets-, and in Ireland in 2001 -max. 24 and 12 tablets resp.-.

A study was carried out by a team under the leadership of the Centre for Suicide Research, Department of Psychiatry, University of Oxford, to examine whether pack size reductions resulted in smaller overdoses of paracetamol in Ireland compared to the UK. The study investigated the number of paracetamol tablets consumed in non-fatal overdoses resulting in hospital presentation between 2002 and 2007 recorded by the Multicentre Study of Self Harm in England and the National Registry of Deliberate Self Harm in Ireland.

Results

There were clear peaks in numbers of overdoses reflecting the maximum pack sizes in each respective country. There were also peaks at multiples of these pack sizes. The average number of tablets consumed in paracetamol overdoses did not differ significantly between the English (22 tablets) and the Irish sample (24 tablets). However the average number of packs used in overdose was greater in Ireland (2.63 packs) than in England (2.07 packs).

The study has shown that people who take paracetamol overdoses tend to consume

numbers of tablets related to available pack size. The difference in paracetamol pack size legislation between England and Ireland does not appear to have resulted in a major difference in size of overdoses. This is because more pack equivalents are taken in overdoses in Ireland, possibly reflecting differing enforcement of sales advice and differences in access to clinical services.

More information: *European Child and Adolescent Psychiatry, 10, 499-508.doi:10.1007/s00787-011-0210-4.*

► Adolescents & risk taking

Adolescent development and risk of injury: using developmental science to improve interventions

Worldwide, injury is a leading cause of adolescent death and disability and in most countries injuries are responsible for more adolescent deaths than all other causes combined. During adolescence, there is a complex interaction among physical, cognitive, and psychosocial developmental processes, culminating in increased novelty-seeking and risk-taking behaviour. At the same time, with growing autonomy, adolescents face the challenge of making decisions independently in situations that are new to them.

The health and criminal justice consequences of risk-taking behaviour become more serious as the decision-making environment expands to include access to automobiles, alcohol, drugs, and firearms. The confluence of pubertal development, psychosocial development, cognitive development, and neurodevelopment is the context for adolescent vulnerability to injury; as a result, an understanding of developmental processes must be integral to adolescent injury prevention programmes.

In a paper recently published in Injury Prevention Journal, Sara Johnson and Vanya Jones from the Johns Hopkins Bloomberg School of Public Health, Baltimore, provide an overview of developmental considerations for adolescent injury interventions based on developmental science, including research findings from behavioural neuroscience and psychology. They examine the role that typical developmental processes play in the way adolescents perceive and respond to risk and how this integrated body of developmental research adds to our understanding of how to do injury prevention with adolescents. They also highlight strategies to improve the translation of developmental research into adolescent injury prevention practice, focusing on graduated driver licensing to reduce road traffic injury.

The authors conclude that the interaction among neurological development, pubertal development, cognitive development, and the environment is most complex, as a result of which adolescence is a period of particular vulnerability to injury. The nature of brain growth and change in adolescence adds to mounting evidence from the behavioural sciences that adolescents are not older children or younger adults, but that their needs with respect to injury intervention are unique. Thus, we must examine the assumptions of injury prevention strategies with adolescents and redirect the injury prevention paradigm accordingly.

Injury prevention efforts with adolescents should focus on phasing in risk over time paralleling maturity. In addition, injury prevention inventions should seek to scaffold developmental vulnerabilities by focusing on peers, parents, and policymakers. Advances in developmental research can serve as the impetus for a new way of thinking about adolescents and risk behaviour. Adolescents' developmental need for novel experiences and drive to test the boundaries of their competence should not be the targets of intervention since they are unlikely to be modifiable. The challenge for injury prevention professionals is to create a system that takes development into account and shores up these vulnerabilities.

More information: *http://injuryprevention.bmj.com/content/17/1/50.full*

► Safety for seniors

European Year for Active Ageing and Solidarity between Generations

In 2012 we will celebrate the 10th Anniversary of the United Nations Action Plan on Ageing. 2012 will be also the European Year for Active Ageing (EY2012). The EY2012 will seek to:

- Promote active ageing in employment.
- Promote active ageing in the community through volunteering and caring.
- Promote healthy ageing and independent living.
- Enhance solidarity between generations in order to create a society for all ages.

Active Ageing is defined by the World Health Organization as the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It allows people to realise their potential for wellbeing throughout their lives and to participate in society according to their needs, desires and capabilities, while providing them with adequate protection, security and care when they need assistance.

It implies optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life. On the other hand, creating an intergenerational society needs awareness of each and every one about what she or he can do for the society of all ages, urgent adaptations of family policies and innovative solutions for new working careers which are life-cycle based.

Aims

Our entire society is going to have to adapt itself to the needs of its ageing population, but it will also have to tackle the new challenges faced by other age groups so that all generations will be able to continue supporting each other and living together in peace and solidarity. This means that stakeholders in government and private sector have to collectively review their policies and practices in regards to town planning, rural development, public transport, access to health care, family policy, education and training, social protection, employment, civic participation, leisure, etc.

Demographic change should be looked at as an opportunity, which can bring innovative solutions to many current economic and social challenges, but this will require a new assessment and reworking of several economic and social policies within society.

Empowering older people to age in good health and to contribute more actively to the labour market and to their communities will help cope with the socio-demographic challenges in a way that is fair and sustainable for all generations. Involving young people at early stages is necessary to get mutual inspiration and to raise awareness of the interdependence of the generations, e.g. in terms of pension systems.

The European Year is designed to serve as a framework for:

- raising awareness on the contribution that older people make to society and the important part that young people play for a holistic society;
- identifying and disseminating good practice;
- mobilising policymakers and relevant stakeholders at all levels to promote active ageing;
- calling for greater cooperation and solidarity between generations.

A wide range of stakeholders: national, regional and local authorities, employers and trade unions, the business sector, civil society organisations, researchers, etc. will be encouraged to use this opportunity to propose action to support active ageing in the field of: employment, social protection, family policies, education and training, health and social services, as well as housing, transport, leisure, and public infrastructures: *together we can help bring the necessary changes to achieve a society for all ages and to find innovative solutions that are sustainable and fair for all generations*.

More information: http://ec.europa.eu/social/ey2012.jsp

European Year for **Active Ageing** and **Solidarity between Generations 2012**

EU-Strategy for Action on Active Ageing

In its Europe 2020 flagship initiative Innovation Union, the European Commission put forward the concept of European Innovation Partnerships (EIP) to promote breakthroughs, to address societal challenges and gain competitive advantages (see also the July issue of Alert). It proposed to test the concept by launching a pilot partnership on active and healthy ageing, aiming to increase the average healthy lifespan of Europeans by 2 years, by the year 2020.

In November, the Steering Group on Active and Healthy Ageing published its recommendations as to the way forward in promoting innovation and coordinated partnership. The Strategic Implementation Plan (SIP) outlines a set of operational, effective and efficient strategic priority action areas to address the challenge of ageing through innovation. The priority action areas and individual actions in this document represent the consensus achieved by the Steering Group.

Vision

In its strategic document the Steering Group underlines that ageing, though one of the greatest societal challenges influencing the outlook of European economies and societies, should be considered an opportunity rather than a burden. It advocates a positive vision which values older people and their contribution to society, their empowerment to influence and benefit from user-centred innovation in active and healthy ageing. This involves changing people's perception of older individuals, beyond their predominant position in society as patients and recipients of benefits. They should also be considered in equal measure as empowered consumers and active participants of societies and labour markets bringing value to the economy and prosperity of the communities they live in.

Innovation

The Steering Group believes that the partnership should respond to the challenge of active and healthy ageing by harnessing innovation, testing new organisational frameworks, stimulating new forms of entrepreneurship and promoting new work practices.

Innovation, in all its forms – spanning across technology, process and social innovation – can be a crucial contributing factor to improving the health and well-being of citizens as well as the sustainability of care systems, and to enhancing Europe's global competitiveness and growth. Innovation in services and products for active and healthy ageing may require large investments and carries risks. If based on solutions which are effective, cost-efficient and evidence based it can bring multiple returns. Added value can be created through better outcomes for older people and increased work satisfaction of health professionals and care personnel, better quality of life and financial security of informal/family careers, as well as improved efficiency and increased productivity of health and social care systems.

Objective

The Partnership aims to increase by 2 the average number of healthy life years in the European Union by 2020, by securing a triple win for Europe:

- Improving the health status and quality of life of European citizens, with a particular focus on older people.
- Supporting the long-term sustainability and efficiency of health and social care systems.
- Enhancing the competitiveness of EU industry through an improved business environment providing the foundations for growth.

Priorities

Addressing the complex issue of active and healthy ageing requires comprehensive work on a broad scale. In order to determine the best way forward and focus on those innovative actions which deliver the highest impact, the Steering Group has structured the work needed in three pillars reflecting the 'life stages' of the older individual in relation to care processes: 1. prevention, screening and early diagnosis, 2. care and cure and 3. active ageing and independent living

Fundamental to Europe's search for a new paradigm on ageing is the need for health and care systems to move from a reactive and curative approach to disease – with a main focus on acute care - to proactive care based on health promotion, disease prevention, including older people vaccination and self-management. For the purpose of the EIP, the scope of health promotion and disease prevention concentrates mainly on older people.

This preventive approach is not only beneficial for patients but also offers promise in cost-containment and efficiency for health systems, as costly interventions and treatments can be avoided. In practice, however, this shift from curative to preventive investment has proved difficult to deliver, with only three per cent of current health expenditure in the EU invested in prevention and public health programmes.

Personal health management

There is emerging evidence that involving older people in their own care and engaging people in community initiatives as co-producers of health and wellbeing both improves quality of life and can reduce demand for health and social care services. Therefore the Steering Group strongly recommends to focus on innovation in personal health management through validated programmes and good practices for early diagnosis and preventive measures and health promotion.

This priority area aims to move forward innovation in prevention and early diagnosis and empowering citizens as a co-producer of his/her own health. This may include the development and deployment of ICT- enabled personal guidance systems and services that promote a healthy lifestyle, as well as organisational innovation, such as enabling regional/national pharmacists or other healthcare professionals and payers to play a more active role in prevention, to better use scarce healthcare resources.

Fall prevention

As one of the first initiatives to start with, the Steering Group advises to launch a EIP- Initiative on Falls Prevention with the aim to have in at least 10 European countries validated and operational programmes for early diagnosis and prevention of falls among older people in operation by the year 2015. These programmes should use innovation in organisation, delivery and business models, in risk registers, toolboxes and services. Good practices that result from this initiative should also be made available for replication in other regions. The action is expected to build on a network of actors involved in ongoing cooperation and on new common activities to develop/adapt guidelines and best practice sharing in falls prevention.

Next steps

The Steering Group members commit – each within their respective remits and responsibilities - to implement the actions of the Plan and engage with relevant stakeholders. However, the implementation of the actions needs to extend far beyond those who have been active in the Partnership so far. The Steering Group therefore suggests that the European Commission defines and launches calls for commitment and to involve all interested parties in Action Groups. Based on support from the European Commission, such Action Groups should jointly carry out the selected actions and address specific barriers, seeking synergies wherever possible between different actions and avoiding creating silos. Mechanisms will be put in place to ensure that this Partnership on Active and Healthy Ageing and its Plan can be further developed following a strategic and sustainable approach.

The Steering Group therefore suggests that the Commission establishes a Conference of interested partners meeting at least once a year, widely representing the Partnership community. The Steering Group members intend to guarantee the continuity of the process until the new governance structure is set up.

The Steering Group also invites the European Commission as well as Member States and regional authorities to lay down the suitable institutional, policy, regulatory and funding frameworks in support of the partnership's goals. To this end, the European Commission is invited to respond to the Partnership's SIP by early 2012, and to present the SIP for discussion and endorsement to the European Parliament and the Council.

More information: http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=steering-group

► Suicide & self harm

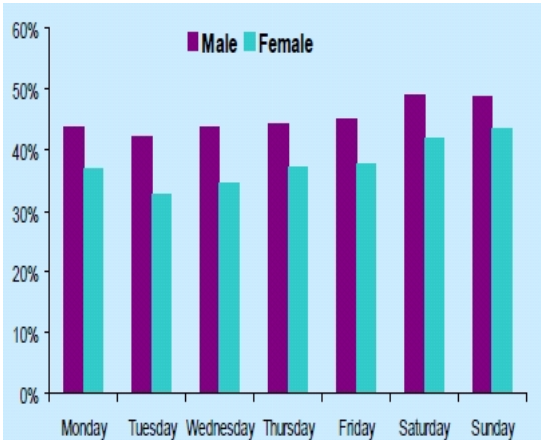
Alcohol and deliberate self harm

In 2010, the National Registry of Deliberate Self Harm (NRDSH) in Ireland showed a fourth successive increase in the national rate of hospital-treated deliberate self harm. In total, 11,966 presentations due to self harm were recorded, involving 9.630 individuals. Alcohol was involved in 41% of all self harm cases. Alcohol was significantly more common in men who engaged in deliberate self harm (44%) than in women who self harmed (37%). Alcohol is one of the factors underlying the pattern of self harm presentations by day of the week and time of day.

Time of the week

The Figure shows an increasing trend in involvement of alcohol with self harm during the week, starting on Tuesday with a peak on Saturday and Sunday, and with similar patterns for men and women. However, significantly higher proportions of alcohol involvement were found among men on all days of the week.

Figure Average percentage of self harm episodes involving alcohol by weekday (2003-2010)



The peak times for presentations with alcohol are between 8pm – 2am, which is a consistent pattern on all days of the week. In addition, there is a peak for female presentations in the early hours of Sunday and Monday mornings.

Young people

Alcohol involvement in self harm is prevalent among both young males and females with an increasing trend across the age groups. Sixteen percent of boys aged 10-14 years who engaged in self harm had used alcohol at the time of the self harm act which increased to 43.3% among young adult men aged 25-29 years. Among girls aged 10-14 years, 11.1% had used alcohol at the time of the self harm act and this increased to 39.2% among young adult women aged 25-29 years.

Conclusions

The findings underline the need to:

- Enhance health service capacity at specific times and to increase awareness of the negative effects of alcohol misuse and abuse, such as increased depressive feelings and reduced self-control.
- Intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age.
- Intensify national strategies to reduce access to alcohol.

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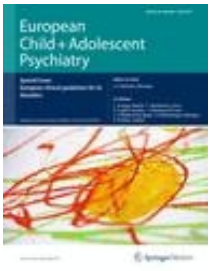
Stressful life events and deliberate self harm



Deliberate self harm is a significant problem among young people in European countries. There is evidence to suggest that both psychological characteristics and stressful life events may contribute to self harm in young people.

A study, by a team under the leadership of the Centre for Suicide Research, Department of Psychiatry, University of Oxford, examined the extent of the association between self harm and these factors among young people. Over 30,000 15 and 16 year olds took part in an anonymous questionnaire survey conducted in secondary schools in Ireland, Belgium, England, Hungary, The Netherlands, Norway and Australia.

Results

The study found that pupils with an increased severity of self harm history also had higher levels of depression, anxiety, impulsivity,

lower self esteem and had experienced more stressful life events. Being female, having experienced the suicide or self harm of others, having experienced physical or sexual abuse and having worries about sexual orientation all differentiated between pupils who engaged in one act of self harm from pupils who thought about self harm, without acting on it. Furthermore, female gender, higher depression, lower self esteem, having experienced the suicide or self harm of others and having been in trouble with the police all differentiated between pupils who engaged in multiple acts of self harm from pupils who engaged in just one act of self harm.

The study underlines that many psychological characteristics and stressful life events substantially increase the risk of self harm among young people and that some factors are more likely than others to be associated with increased risk.

More information: European Child and Adolescent Psychiatry, 10, 499-508. doi:10.1007/s00787-011-0210-4.

► Violence prevention

Why invest in Violence Prevention?

The WHO- Violence Prevention Alliance has launched a document, prepared by the Education Development Center Inc., USA, with contributions from members of the World Health Organization Violence Prevention Alliance, on the need for investing in violence prevention.

Violence affects a significant proportion of the population. It threatens the lives and physical and mental health of millions of people, overburdens health systems, undermines human capital formation, and slows economic and social development.

Alongside the deaths it causes are the significant consequences of non-fatal violence: injuries and disabilities, mental health and behavioural consequences, reproductive health consequences, other health consequences, and the impact of violence on the social fabric.

While violence affects people everywhere, those living in low- and middle-income countries are at substantially greater risk for most forms of violence, and over 90% of violent deaths occur in these countries.

Violence is predictable and therefore preventable. The World Health Organization (WHO) has identified strategies for evidence-based interventions to prevent interpersonal and self-directed violence: developing safe, stable, and nurturing relationships between children and their parents and caregivers; developing life skills in children and adolescents; reducing availability and harmful use of alcohol; reducing access to guns, knives and pesticides; promoting gender equality; changing cultural norms that support violence; and ensuring victim identification, care, and support. Most violence prevention programmes have yet to be systematically implemented and monitored for their impact in low- and middle-income countries where the problem is the largest and the potential prevention gains are the greatest.

Why invest in violence prevention?

There are several moral, public health, societal, economic, and business reasons for investing in violence prevention. Specifically, violence prevention:

- Supports basic human rights;
- Reduces death and disease;
- Addresses underlying societal factors and so intersects with other ongoing initiatives that address macro-level factors;
- Can accelerate economic development;
- Can improve revenues.

WHO, CDC, and others have developed a substantial body of high-quality, science-based technical and normative guidance on how to better understand and prevent violence. Within this context, donor options for investment in violence prevention include:

- Direct prevention programming activities;
- Surveillance and data work;
- Research;
- Meetings;
- Coordination and secretariat functions.

The moral, health, and business reasons for scaling up investments in violence prevention are compelling. By reducing the inequities in prevention investments between violence and related conditions, donors can safeguard against the likelihood that health gains achieved through their investments in disease prevention will be erased by the subsequent violent victimization of those whose lives are saved.

More information: http://www.who.int/violenceprevention/en/

VIOLENCE PREVENTION ALLIANCE

GLOBAL CAMPAIGN FOR VIOLENCE PREVENTION
CAMPAGNE MONDIALE POUR LA PREVENTION DE LA VIOLENCE
VIOLENCE PREVENTION ALLIANCE / ALLIANCE POUR LA PREVENTION DE LA VIOLENCE

VPA 2012 Annual Meeting

The VPA 2012 Annual Meeting will take place in Munich, Germany 16-17 April 2012 and be hosted by the German Congress on Crime Prevention and the Annual International Forum on Crime Prevention. It will take place alongside their 2012 Congress in the International Congress Centre in Munich.

The Violence Prevention Alliance (VPA) was officially formed in January 2004 at the WHO-hosted *Milestones of a global campaign for violence prevention* meeting. The Milestones meeting reviewed the progress made in the first year following the 2002 launch of WHO's *World report on violence and health* (WRVH) and its subsequent Global Campaign for Violence Prevention (GCVP), and looked to the future to plan activities to be undertaken as part of the GCVP.

VPA is an opportunity for groups from all sectors (governmental, non-governmental and private) and levels (community, national, regional and international) to unite around a shared vision and approach to violence prevention that works both to address the root causes of violence and to improve services for victims. Under the umbrella of the GCVP, VPA participants intend to strengthen support for data-driven violence prevention programmes based on the public health approach and ecological framework outlined in the WRVH and to facilitate implementation of the WRVH recommendations.

Initial VPA efforts concentrate on interpersonal violence, while at the same time addressing its links with other forms of violence. Interpersonal violence alone causes a significant portion of worldwide violence-related deaths and disabilities, and its many subtypes are closely related to self-directed and collective violence. VPA participants are committed to adopting a public health approach to interpersonal violence prevention and to participating in consensus-determined activities to promote further adoption of this approach.

More information: http://www.who.int/violenceprevention/en/

► Work safety

Healthy Workplaces Summit

More than 200 top safety and health experts from around the world attended the 2011 European Summit on Safe Maintenance in Bilbao, Spain, on November 22-23. The summit marked the climax of the 2010-11 Healthy Workplaces Campaign on Safe Maintenance organised by the European Agency for Safety and Health (EU-OSHA).

The summit in Bilbao drew many distinguished politicians and experts from a variety of fields including the EU's Commissioner for Employment, Social Affairs and Inclusion, the Spanish Secretary of State for Employment and representatives from the Polish EU Presidency, the European Trade Union Confederation (ETUC) and Business Europe.

Challenges

One of the major barriers to improving workplace safety and health is lack of risk awareness. This is a particular problem for small organisations. According to the European Survey on New and Emerging Risks (ESENER), for the 12% of establishments that are not carrying out regular health and safety checks, the most frequently cited reason is that they are 'not necessary because we do not have major problems' (71%). As this reason is commonest among the smallest establishments, it raises the question of whether smaller enterprises are less likely to have major problems or whether they are less aware of OSH issues.

Organisations are unlikely to take action if they are unaware of risks in the workplace. Therefore, if the EU is to achieve its 2012 goal of reducing workplace accidents by a quarter, then it will need to significantly raise awareness of workplace risks, particularly in smaller organisations.

ESENER has highlighted that the most effective way of improving workplace safety and health is for employers to actively engage with their employees and the whole supply chain.

To this end, EU-OSHA's next Healthy Workplaces Campaign Working Together for Risk Prevention will focus on galvanising the support of employers, employees, their representatives and the whole supply chain and other stakeholders, to work together to reduce risks

in the workplace. Smaller enterprises will be particularly welcome to take part.

The social partners, from the EU level right down to individual organisations, need to become more strongly involved too. A vigorous culture of risk prevention should be encouraged in European workplaces, which means reaching out to even the smallest businesses, raising awareness and offering clear advice and guidance.

EU-OSHA's Healthy Workplaces Campaign is decentralised and is designed to help national authorities, companies, organisations, managers, workers and their representatives, and other stakeholders, to work together to enhance health and safety in the workplace. The Agency hopes that its partners will continue to show their support and join in the new campaign.

More information: http://osha.europa.eu/en/seminars

► AGENDA

2012

15 March in Birmingham, United Kingdom
Road Safety Seminar 2012: Practical Evaluation Skills
http://www.rospa.com/events/roadsafetyseminar/default.aspx

19-20 March in Copenhagen, Denmark
SPORTVISION2012: Volunteering, Fitness Doping, Financing & Health
http://www.sportvision2012.eu/home

21-23 May in Manchester, United Kingdom
2nd International wellbeing at work conference
http://www.hsl.gov.uk/health-and-safety-conferences/wellbeing-2nd-international-conference-2012/home.aspx/

22-27 May in Vilnius, Lithuania
12th WC on Environmental Health
http://www.ifeh2012.org/welcome

4-7 July in Bruges, Belgium
17th Annual Congress of the European College of Sport Science
http://www.ecss-congress.eu/2012/

1-4 October in Wellington, New Zealand
Safety 2012, 11th World Conference on Injury Prevention and Safety Promotion
http://www.conference.co.nz/worldsafety2012

18-19 October in Stockholm, Sweden
Fifth European Alcohol Policy Conference
http://www.eurocare.org/newsroom/upcoming_events

24-25 October in Vancouver, Canada
Third International Conference on Violence in the Health Sector
http://www.oudconsultancy.nl/vancouver/index.html

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