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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"

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Home injuries to be prioritized within child safety plans

The European Child Safety Alliance, a EuroSafe-programme, released *Child Safety Report Cards* for 31 countries. The Report Cards score countries on their level of adoption, implementation and enforcement of over 100 proven strategies and policies to prevent unintentional injury – good practices known to save children's lives. This is the third round of bi-annual report card assessments since 2007.

To date no country has adopted all the recommended safety measures. For all countries, there is ample room for improvement, particularly given the inequalities between countries with over 6 times difference in accident rates between countries with the highest and lowest rates:

- Only 13 countries (42%) have a national helmet law requiring use of a bicycle helmet while cycling, with seven of those laws coming into effect since the first report card assessments. However, only 8/13 report that the law is fully implemented and enforced.
- No country has a law requiring children to use a rear facing child passenger restraint to age 4, although this is normal practice in Sweden where child passenger deaths in this age group have been reduced to almost zero.
- Only 7 countries (23%) have a national law requiring barrier fencing for private pools, but in only one (France) is the law fully implemented and enforced and that law allows a choice of prevention measures of which barrier fencing is only one.
- Only 15 countries (48%) have a national law requiring child resistant packaging of medications and of those, three report the law is not fully implemented and enforced.
- Only 16 countries (52%) have a national law requiring environmental changes to prevent children from falling out of windows in buildings with more than one storey/level (e.g. window guards), but for over half of those the law only applies to new buildings or renovations.

Overall, countries had greater uptake of transport related policies than those related to the prevention of home injuries. As home injuries are a leading cause of child injury hospitalisations and emergency room visits, efforts to enhance the adoption, implementation and enforcement of proven policies to reduce drowning, falls, burns and scalds, poisonings and choking/ strangulation need to be given the same level of commitment and resourcing as transport related policies.

Investment in child injury prevention from relevant sectors at the national and European levels still is not commensurate with the size of the problem. Therefore, ensuring children's right to safety is key to raise the level of health, well being and growth for European children and society at large.

For more information: *http://www. childsafetyeurope.org/reportcards/*

► EU news

EU Health Programmes

In the run-up to the next EU-Health Programme (2014-2020), the Commission organised recently a high level conference on EU-Health Programmes, past and future. The conference has been organised jointly by the European Commission's Directorate-General for Health and Consumers and its Executive Agency for Health and Consumers (EAHC). On this occasion the results and success stories from the first and second Health Programmes were presented and on pre-selected topics discussions were facilitated for the future third programme which is currently under discussion at the Council and in the European Parliament.

Around 700 representatives registered, representing Member States and European institutions and health programmes' beneficiaries, and scientists and academics from EU participating in the Health Programme. The conference was also web broadcasted during the day.

Lessons learned

Although the number of successful projects that could be presented in plenary and workshops was limited, some lessons were drawn by the session moderators:

- The development and implementation of actions in the field of health information and health promotion require a longer time span than 3 years. Most of the successful projects took 10-15 years to develop and to become more sustainable;
- Sustainability remains a challenging issue, but there are successful examples of actions leading to new legislative initiatives (cross boarder health services) and possible uptake by EuroStat (ECHIM);
- The Health programme led to an increased involvement of a wide range of stakeholders beyond the health sector in health related actions which deserves further encouragement;
- Dissemination of programme results should be intensified, in particular by increased funding of capacity building efforts; and
- The focus should be a fewer number of actions in key priority areas bringing the largest added value for the EU and the Member States.

New programme

It is proposed that the new programme should focus on a limited number of key priority areas where the maximum EU-added value can be reached and ample evidence is available as to the cost effectiveness and the readiness for uptake of actions at local and country level.
The proposed programme 'Health for Growth 2014-2020' foreshadows priorities to be set in the following areas 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;
- increase access to medical expertise and information for specific conditions also beyond national borders and to develop shared solutions and guidelines to improve healthcare quality and patient safety in order to increase access to better and safer healthcare for EU citizens;
- identify, disseminate and promote the uptake 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 general opinion of participants was that the new programme is quite broadly defined and misses the connection with the previous programmes and priorities. Injury prevention is for instance not mentioned at all in the programme proposal at this stage. This is unfortunate, as injury prevention should be considered as an integral part of health services delivery and innovation of health care in order to reduce costs and improve that quality of services. For the next version of the programme proposal, injury prevention needs to be explicitly mentioned as essential component of child health promotion, promoting active and healthy ageing and policies for reducing inequalities in health in general. We should not forget that injuries are still the fourth leading cause of death in the EU and injury prevention measures have been widely proven to belong to the category of most cost-effective public health interventions!

For more information: *http://ec.europa.eu/health/programme/events/ev_20120503_en.htm*

A new European Consumers Agenda

While the EU has a substantial corpus of consumer law and the consumer dimension is an important part of many EU policies, a comprehensive framework is needed which also addresses imminent challenges such as those linked to the digitalisation of daily life, the desire to move towards more sustainable patterns of consumption, and the specific needs of vulnerable consumers.

The European Consumer Agenda, presented by the Commission in May 2012, aims to increase confidence by: reinforcing consumer safety; enhancing knowledge; stepping up enforcement and securing redress; aligning consumer rights and policies to changes in society and in the economy. It also presents a number of key actions to be implemented between now and 2014.

Four main objectives

The Consumer Agenda presents measures designed to achieve the objectives of the EU's growth strategy, Europe 2020. It builds on and complements other initiatives such as the EU Citizenship Report, the Single Market Act and the Digital Agenda for Europe. To this end, it is built around four main objectives designed to increase consumer confidence.

- Reinforcing consumer safety: for goods, services and food, strengthening the regulatory framework and making market surveillance more efficient.
- Enhancing knowledge: to cope with the increasing complexity of markets, where consumers need the right tools and information to understand everything from the real cost of consumer credit to finding the right place to complain. This is important for both consumers and traders, and the role of consumer organisations is key.
- Improving enforcement and securing redress, without which rights cannot exist in practice. This is all the more relevant given that the detriment suffered by European consumers incurred from problems causing complaint is estimated at about 0.4 % of EU GDP. The role of consumer enforcement networks is central.
- Aligning policy to societal change and making it relevant to daily life: to adapt consumer law to the digital age and tackle problems consumers face online; to factor in the needs of vulnerable consumers; to make sustainable choices easy.

Five key sectors

The Agenda supports consumer interests in key sectors.

- Food: to ensure sustainability and safety.
- Energy: so that consumers can get the best value for money in the liberalised market and better manage their energy consumption.
- Financial: to protect consumers' financial interests and give them the tools to manage their finances.
- Transport: to adapt legislation to modern patterns of travel and to support sustainable mobility.
- Digital: with a view to tackling problems faced by consumers and ensuring their protection online.

For more information:
http://ec.europa.eu/consumers/strategy/index_en.htm#agenda

► WHO news

WHO-DG: priority for domestic violence

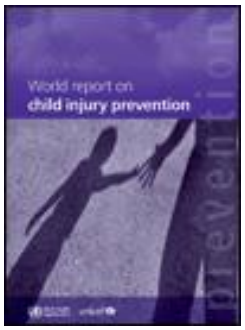
At the World Health Assembly in May, Dr Margaret Chan was appointed for a second five-year term as Director-General of WHO. In her acceptance speech, Dr Chan noted, "As part of my commitment to women, I will be giving more emphasis to the prevention of domestic violence."

Among her specific priorities for the next five years are chronic non-communicable diseases, mental health and disabilities. WHO reform was a key agenda item. Resolutions adopted included those on non-communicable diseases, social determinants of health, Millennium Development Goals, mass gatherings, and early marriages and young pregnancies.

The Sixty-fifth World Health Assembly concluded on 26 May in Geneva after adopting 21 resolutions and three decisions on a broad range of health issues. The six days of discussions involved nearly 3000 delegates, including health ministers and senior health officials from amongst the 194 WHO Member States, as well as representatives from civil society and other stakeholders.

More information: *http://apps.who.int/gb/*

WHO scales up child maltreatment prevention



Violence is an important public health issue in itself, directly affecting millions of individuals every year. For instance, WHO estimates cited in the UN Secretary General's Study on Violence Against Children state that nearly 53,000 children are murdered each year, and that the prevalence of forced sexual intercourse and other forms of sexual violence involving touch, among boys and girls under 18, is 73 million (or 7%) and 150 million (or 14%), respectively.

As part of the on going WHO Global Campaign for Violence Prevention, and as its contribution to follow up on the UN Secretary General's Study on Violence Against Children, WHO has scaled up its child maltreatment prevention activities.

To help meet the prevention challenges, WHO has collaborated with the International Society for Prevention of Child Abuse and Neglect (ISPCAN) in the development of Preventing child maltreatment: a guide *http://whqlibdoc.who.int/publications/ 2006/9241594365_eng.pdf* for taking action and generating evidence to assist countries to design and deliver programmes for the prevention of child maltreatment by parents and care givers. The guide provides technical advice for professionals working in governments, research institutes and NGOs on how to measure the extent of child maltreatment and its consequences; how to design, implement and evaluate prevention programmes, and on important considerations for detecting and responding to child maltreatment. The guide is a practical tool that will help governments implement the recommendations of the recently released United Nations Secretary General's Study on Violence Against Children.

WHO, ISPCAN and other partners are working intensively with a small number of selected countries to develop model prevention programmes built around the guide, and WHO Headquarters, Regional and Country Offices look forward to providing advice and technical support in response to requests for assistance more generally.

For more information: http://www.who.int/violence_injury_prevention/child/en/

WHO-Europe releases report on alcohol in the EU

The report *Alcohol in the European Union: consumption, harm and policy approaches* has been recently released by the WHO Regional Office for Europe. This new report uses information gathered in 2011 to update key indicators on alcohol consumption, health outcomes and action to reduce harm across the European Union (EU). It gives an overview of the latest research on effective alcohol policies, and includes data from the EU, Norway and Switzerland on alcohol consumption, harm and policy approaches. VIP staff in the regional office contributed a chapter entitled "Reducing injuries and death from alcohol-related road crashes."

Alcohol and road safety is one major chapter in the report and in the conclusions WHO-Europe proposes the following main points for action order to reduce the mortality, morbidity and economic loss due to drink–driving:

- for any country with a BAC limit above 0.5 g/litre, it would be beneficial to reduce the level to 0.5 g/litre;
- in those countries with a BAC limit of 0.5 g/litre, additional benefit could be gained by reducing it to 0.2 g/litre;
- the legal BAC level for novice and professional drivers should be reduced to 0.2 g/litre or less;
- coverage of testing for BAC levels should be improved; and
- enforcement can be enhanced by increasing the use of random breath-testing and by increasing the fear of being caught; evidence shows that drivers need to know that there is a real risk of being stopped and breath-tested at any time.

As with many of the other alcohol policy issues presented in the report, the key issue comes down to ensuring adequate implementation of what is known. Some countries have up-to-date alcohol-in-traffic laws and enforcement systems, and among countries with adequate measurement of BAC involvement, these countries do much better in holding down the number of crashes where alcohol is involved.

See for report: *http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf*

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

► Country update on Injury Surveillance

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

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

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

Injury surveillance in Portugal

In Portugal, the National Health Service (NHS) is responsible for providing health care to its ten and a half million inhabitants. Health service planning and regulation take largely place at the central level in the Ministry of Health (MoH) and its institutions, through its National Health Plan. The management of the NHS is devolved to the 5 health regions, Norte, Centro, Lisboa e Vale do Tejo, Alentejo and Algarve, and to the 2 autonomous regions, Açores and Madeira.

Primary care centres (377 at present) are the main pillar of the health system. The health administration board of each of these regions is accountable to the MoH and is responsible for strategic management of population health, supervision and control of hospitals, management of primary care/ NHS primary care centres, and implementation of national health policies taking into account regional needs. The NHS operates the 77 hospitals that have an Emergency Department (ED).

Injury awareness by both the public and health care providers has been reinforced by the adoption of the National Programme of Prevention of Injuries 2009-2016. This programme aims to reduce injuries and their impact on the population in general and especially on vulnerable groups as well as to ensure equitable access of injured persons to health care. It also highlights the need to collect, analyse and disseminate information on unintentional injuries through an integrated system of information. Results from the last Census in 2011 indicate that 15% of the population in Portugal belongs to the age group 0-14 years and about 19% is 65 years or over, while in 2001 these proportions were 16% and 16,5% respectively. This trend is expected to continue and certainly will have an impact on the annual number of injuries.

Injury data collection

Since 1986, Portugal participated in the EC-projects for collecting product related injury-data from EDs in a sample of public hospitals. These studies were coordinated by the national Consumer Safety Department. After the end of the consumer injury data collection programme, the Ministry of Health took over the coordination of the injury surveillance system ADELIA in 2002. ADELIA is now managed by the Portuguese National Institute of Health Doutor Ricardo Jorge – INSA and is based on data on home and leisure accidents (HLA) collected in a sample of emergency health units of the NHS.

The main objectives of the system ADELIA are to detect:

- Short-term trends: identify the frequency of HLA in general and the various types of injuries, as well as the characteristics of victims and the circumstances of injury events;
- Long-term trends: identify risk-prone situations, establishing a support base for developing and refining consumer protection regulations and enforcement based on evidence. Disseminate information and stimulate research.

Strategic health advisors, decision makers, Consumer Safety Department, me-

dia and university researchers are the main users of the data collected.

The sample of health units in ADELIA consists of a random selection of 6 hospitals and 15 Health Centres in the NHS. The recording of data is supported by a modular software application, Module ADELIA, which runs within the SINUS- and SONHO-programs of MoH. Data capture is done by the receptionist at the time of registration of the user, in accordance with instructions provided by INSA.

Module ADELIA consists of a dialog box, and collects information on the casualty, accident and its circumstances, as well as characteristics of the injury. The following fields are available in this module:

- Sex and Date of birth of the victim;
- Date and time of care in the emergency room;
- Date and time of injury;
- Location and activity of the injury, and
- Mechanism & Part of body injured.

Challenges

Recent changes in NHS hospital management structures in 2009 and the reorganization of primary care system has lead to a slowdown of notifications by the EDs. Due to these developments the sample had to be rebuilt. Also, now the JAMIE-methodology has been agreed at EU-level, some changes are required in the instructions and the codification scheme of the data, which changes are expected to be fully implemented in the year 2013.

Some results

In 2006, a proportion of 6.6 % of all hospital admissions, i.e. 72.152 cases, related to an injury, of which 9.556 were children up to the age of 19 years, 33,209 of adults between the 20-64 years and 29.387 of people with more than 65 years. Average stay in hospital was 9,5 days.

ADELIA collected 23.079 injury cases in 2006, 15.787 in 2007 and 15.697 in 2008 (number of ED and health centres participating varied). As for sex distribution In the years 2006-2008 data shows that in all group ages until 45 years men are more affected by injuries than women, but after 45 years the proportion of women exceeds that of males, which also is a reflection of demography.

As to the location (setting) of injury the majority of HLA-injuries happen at home (52,8% in 2006; 49,9% in 2007; 51,5% in 2008), in particular among children between 0-4 years (77,9% in 2006, 73,6% in 2007 and 77,3% in 2008) and those aged 75 or over (69,5% in 2006, 72,9% in 2007, 75,5% in 2008. It was also evident that young people are overrepresented in the category of injuries at school or in educational institutions as it is expected.

In the distribution by mechanism of injury, falls accounted for the majority of injury cases (67% in 2006, 70,9% in 2007 and 74,2% in 2008) and even higher proportions in the older age groups: 65-74 age group with 81,1% in 2006, 84,4% in 2007 and 87,1% in 2008 and the group of people aged 75 or over with 90,4% in 2006, 90,2% in 2007 and 92,3% in 2008.

Of all injuries registered in ADELIA in 2006, 2007, and 2008, 3,9%. 3,6% and 4,1% respectively, where admitted for further treatment.

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Injury surveillance in Sweden

In Sweden, every year almost 5 000 persons die as a result of an injury event, about 150 000 persons are discharged from hospitals for the same reason and approximately 600 000 individuals are treated as outpatients at hospitals. An unknown number of persons are treated in health care centers or by a general practitioner. As in most other European countries, injuries are in Sweden the killer number one among children and young adults. In the same age-group, injuries are also the most common reason for hospital admissions.

It is therefore very important to continue to invest in injury prevention and safety promotion. However, to be successful in injury prevention, it is essential to know how, when, where and why injuries occur. Sweden has nationwide population-based registers on fatalities, hospital discharges and Emergency Department-attendances. These registers are all based on ICD-10, which works quite well for monitoring injuries and their treatment, but not for prevention purposes as they lack detailed information on the causes and circumstances of injury events. In order to produce better information for prevention activities, both on national and European level, Sweden has joined the IDB network and takes part in the JAMIE-project.

Background

Sweden became a member of the European community in 1995, and in that very same year Sweden adopted the so-called EHLASS system, a European injury data exchange programme that focused on home and leisure accidents. However, quite soon quality controls revealed that collecting only home and leisure accidents resulted into deficiencies in data capture and into a high percentage of missing cases. To manage that problem it was decided to expand the scope of the system and to collect information on all injuries – both unintentional and intentional- and in line with the successor programme of EHLASS: the European Injury Data Base (IDB).

In 1999 an 'all-injury' data collection was started and at the same time IDB-Sweden became a formal part of the nationwide National Patient Register. This implies that the personal identification number could be added to the information on the injury event. Now IDB-Sweden can be linked to other registers, like the population register or the hospital discharge register.

Over the past few years, IDB-Sweden included a varying number of hospitals, between three and nine. Together these hospitals cover five to nine per cent of the entire population.

Current situation

IDB Sweden is managed by the Socialstyrelsen, the National Board of Health and Welfare (NBHW). The NBHW is the national office for collecting statistics in the health and social welfare sector. IDB-Sweden is built on the basis that the County Councils, who actually run the hospitals in the counties, are the owner of their injury data. The NBHW s a data-user who buys this information. When the data reach the NBHW, the quality is checked and the data is compiled into a national database. The staff of IDB Sweden consists of two full time employed data administrators who analyse and report on the injury statistics.

At present, seven hospitals, based in four different counties, are reporting to IDB-Sweden. The coverage is now nine per cent of the adult population and seven per cent of the child population. The data is collected at emergency departments, where the circumstances of the injury event are reported either by the injured person or by an accompanying person. The administrative data and diagnosis is completed by the medical staff. The collected information is classified and coded by trained staffers before it once a year is being submitted to the National Board of Health and Welfare where the data is checked and uploaded into the national database IDB-Sweden.

Altogether, information on approximately 60,000 injury events will be reported in the 2012 database. The vision is that IDB-Sweden, together with injury data from the nationwide registers on cause of deaths and in- and outpatient treatment at hospi-

tals, will function as a representative national information system on injuries. To fulfil the vision the number of hospitals reporting IDB-data must be increased.

Data use

The statistics from IDB Sweden are used by a wide range of authorities, organisations, mass media and educational institutions. The government has used the IDB-statistics for consumer protection purposes– one example is the recent Swedish legislation that prohibits fire-crackers. For some national authorities, for example the Swedish Consumer Agency, the Swedish Contingencies Agency and the Swedish National Board of Housing, Building and Planning, IDB-Sweden is a most valuable information tool for their injury prevention work. As the participating hospitals own their data, they are also encouraged to use it for local injury prevention actions. Statistics from IDB-Sweden are also often used for raising public awareness and for media campaigns.

In conclusion

As IDB contains unique and detailed data on injury events it is very important to ensure that the data remains accurate and helps to produce national representative data. The financing of the existing system must be secured, as well as a further extension of the number IDB-reporting hospitals to guarantee representativity of the data.

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JAMIE Network meeting

The 2nd meeting of JAMIE-partners was held in Vienna on 10-11 May 2012. The meeting was hosted by KfV, the Austrian Road Safety Board, and attended by 24 participants from 18 countries. While the first meeting in September 2011 focussed on developing consensus on the JAMIE-methodology and -classification, the purpose of this meeting was to facilitate the implementation of JAMIE in the participating countries.

Sound methodology

The meeting concluded that the current JAMIE-IDB methodology is sound and ready for implementation in countries. The JAMIE-methodology is also in line with principles laid down in the European Statistics Code of Practice. It gives due consideration to key quality principles such as the relevance, accuracy and reliability of injury statistics produced through JAMIE, timeliness of reporting, coherence and comparability of data across regions and countries, and quality principles related to the product, i.e. the methodology and statistical procedures used.

The JAMIE-classifications for the Minimum Data Set (MDS) and for the Full Data Set (FDS) are also compatible with WHO-ICD-10, ICECI and NOMESCO. Although there are differences between these classifications, in their data elements and in codes, these classifications have a common structure. By using conversion tables it is possible to make the datasets to a large extent comparable. Transcoding software is available.

Data collection efforts and reporting

At present, 13 EU-countries are collecting injury data and we are working towards many more to start in 2013. This is a major challenge due to the recession and limited resources. But there are also challenges for the current 13 reporting countries in their developing genuine nation wide all-injury reporting systems. Some are operating only at regional level (GE-Brandenburg/

UK-Wales/ ES-Navarra), others are collecting cases that are admitted to hospital or that only relate to children.

The available data over the years 2009 and 2010 will be soon uploaded on the Commission's IDB-data base and made accessible through the HEIDI-wiki information and data interface. A new 'Injuries in Europe'-report will be launched in autumn.
Among the 26 countries collaborating in JAMIE, 16 have submitted an implementation plan for enhanced injury surveillance in their countries. The remaining countries are being assisted in their timely production of national implementation plans in line with the requirements. The minimum requirement is that each country shall deliver before the end of the project injury data over at least twelve months, covering 10% of all injury cases in a country OR data from at least 3 hospitals of which one is reporting the full JAMIE-data set (FDS). Each country shall report a minimum number of 10.000 cases, of which 3.000 at FDS level.

Partners presented existing infrastructures in their countries and challenges in implementing the JAMIE approach. It was confirmed that in almost all countries it would be feasible to provide soon complete data sets at MDS-level in a sustainable manner. The major challenge they saw in collecting data at FDS-level, as this is too often perceived by hospital staff as a major administrative burden. The national Ministries of Health could provide more moral support and financial incentives in order to motivate hospitals to include more specific information on the circumstances of accidents and injuries within patient registers.

Continued government support needed

It was underlined that the Joint Action is the result of a strong commitment expressed in 2010 by national governments of 22 EU/EFTA-countries to enhance national injury surveillance, in response to Council Recommendation on injury prevention and safety promotion and the invitation by Commissioners Vassiliou and Kuneva in 2009, calling for enhanced injury surveillance exchange in the European region.
It is evident that injury data is vital for developing effective injury prevention policies and actions. And the costs of injury data collections are only marginal in comparison to the direct and indirect costs of injuries to society at large. Therefore, the Ministries of Health in the MSs should ensure that the achievements in EU-wide injury data exchange are being harnessed through the JAMIE-joint action and consolidated in a sustainable national system and EU-level arrangement. The Regulation for Health Statistics provides a proper framework for such an arrangement.

It was also highlighted that injury surveillance should be included as a spearhead action for health information action. The proposed new health programme, 'Health for Growth', should profile more strongly the need for better health information, in particular on injuries.

For more information on JAMIE:
http://www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwFreeText/jamieprojectdocumentation.htm?OpenDocument&context=7B506D71199DF2AEC1257857003CC238

▶ Child safety

Commissioner Dalli supports Child Safety initiative

European Commissioner for Health and Consumer Policy, John Dalli, acknowledged in the press launch of the Report Cards on 11 June (see page 1 of this Alert-issue) the great burden of child injuries in the EU:

"I believe we must do everything we can to ensure the safety of the youngest and most vulnerable members of our society across Europe. This is why the EU Health programme supports initiatives to reduce accidents and injuries. Deaths caused as a result of childhood injury cause unimaginable suffering for the families left behind. The European Union and its Member States must cooperate and act to ensure the right of all children to safety. The uptake of evidenced based strategies shown in these report cards can help in improving child safety."

Watch video: http://ec.europa.eu/avservices/player/streaming.cfm?type=ebsvod&sid=204906

► Consumer safety

Latest RAPEX report

RAPEX, the EU- rapid alert system to keep EU consumers safe, has matured significantly since 2004, when the General Product Safety Directive was transposed into national law. The Commission estimates that Member States have spent up to 100 million € and employed up to 6000 inspectors to work on product safety enforcement. The report over the year 2011 highlights the achievements in market surveillance and product safety enforcement by national authorities, and results from specific projects.

All Member States participated in the RAPEX system by detecting and notifying new dangerous products and ensuring appropriate follow-up actions. The most active countries were Spain (189 notifications), Bulgaria (162 notifications), Hungary (155 notifications), Germany (130 notifications), and the United Kingdom (105 notifications). Notifications sent by these countries represent 47% of all notifications on products posing a serious risk sent via the system.

The report reveals that, although China remains – with more than half of the RAPEX notifications – the number one country for the number of notifications on products, there has been a decrease from 58% in 2010 to 54% in 2011. Dangerous products of European origin accounted for 293 notifications (19%), including 44 products of French origin (3%), 43 products of German origin (3%) and 32 products of Italian origin (2%). 15% were from other countries. 8% were of unknown origin. Compared to 23% in 2004, this category is decreasing steadily owing to better identification of country of origin.

Clothing and textiles were the most frequently notified products (423 notifications concerned suffocation and irritation risk), followed by toys (324 notifications mainly for choking risk), motor vehicles (171 notifications for risk of injury), electrical appliances (153 notifications for risk of electric shock) and cosmetics (104 notifications for chemical risk), which together account for 74% of all notifications on products posing a serious risk in 2011.

In the RAPEX report, the Commission expresses its intention to enhance the co-operation with third countries, in particular, bilaterally with China and trilaterally with the US and China and make progress on the co-operation with the US, Canada and Australia on an important work on pooling recall information under the auspices of OECD. It also wants to finalise proposals for a comprehensive legislative package on product safety and market surveillance and promote greater awareness among businesses of their obligations.

For more information: *http://ec.europa.eu/consumers/safety/news/index_en.htm*

Better product safety enforcement needed

Many consumers believe market surveillance in Europe will protect them from buying unsafe or dangerous products. But that is not true, says ANEC, the European consumer voice in standardisation, in a recently published policy statement: 'still too many unsafe products reach the European market, as can be seen from the RAPEX notifications to the European Commission'.

Market surveillance also means different things in different countries. Product safety may not be defined by central government as a priority, as was the case in the UK only a few years ago. These differences are important as market surveillance is the responsibility of Member States in Europe. It does not operate in a regulatory European framework. The individual Member States are responsible for resourcing and managing their

own market surveillance programme and enforcement authorities. That is the problem and this has been highlighted on many occasions by consumer interest groups as well as by the enforcement professionals themselves.

With proper implementation, ANEC believes that the New Legislative Framework provides the potential to achieve a real improvement for both the safety of consumers and the competitiveness of the European industry.
However, as demonstrated by the recent scandal of PIP breast implants, European safety legislation, based on the principles of the "New Approach" and CE Marking, still fails to provide consumers with the high safety levels they are entitled to expect.

Even when CE Marking is underpinned by the independent assessment of a notified body, such as in the case of breast implants, it cannot be a guarantee of a legal product (let alone a safe product) due to the variations in the quality of notified bodies. ANEC repeats its serious reservations about CE Marking, as CE Marking is often perceived as a safety mark.

Therefore, ANEC encourages the European Institutions to consider a strengthening of market surveillance in line with the calls for a European framework, to expedite their efforts to achieve a more effective system of surveillance and enforcement: the European legislators should take the opportunity provided by alignment of several New Approach Directives with the New Legislative Framework to ramp up the effectiveness of market surveillance.

For more information: *http://www.anec.eu/anec.asp?p=newsletter&ref=02-01*

► Adolescents & risk taking

Road safety: Action Kit for young people

In April this year, YOURS – Youth for Road Safety, a global youth-led organisation that acts to make the world's roads safe for young people - has officially launched the Youth and Road Safety Action Kit at the United Nations Road Safety Collaboration meeting in Washington DC, USA. This is a guide available for free to all young people around the world that aims to make road safety accessible to youth everywhere.

Targeting young people all over the world, the kit aims to introduce road safety in a concise, yet clear and appealing way. The first part focuses on the global road safety crisis: Why are young people at particular risk? How does speeding, distracted driving, alcohol and drug use, non-use of helmets and other risk factors contribute to road traffic injuries? The second part is a guide on how to get on board with a focus on planning and implementing road safety projects. The last part is a set of briefings on key actions and processes that can make projects successful: partnership building, community participation, networking, and fundraising.

The Youth and Road Safety Action Kit is an attractive youth friendly publication giving much needed attention to the global road safety threat facing young people. It provides a simple guide to inspire young people to get actively involved in road safety. Youth are the main victims of road crashes worldwide Each year 400,000 young people aged between 15-29 die on the world's roads and millions more are injured. This translates into more than 1000 young lives lost unnecessarily every day on the roads, making road crashes the number one killer of young people ahead of HIV/Aids, Tuberculosis, and Malaria.

In response to this crisis, many young people set out to become road safety activists, raising awareness of those around them and advocating their governments for more serious action. The global youth movement for road safety is gaining pace but there are still many who find road safety information inaccessible to them and a lot more passionate individuals who need guidance in getting started. This is precisely why the Youth and Road Safety Action Kit was written. It has been written by young people for young people. It is scientific yet appealing. As such, this Kit is the first of its kind in the world.

YOURS offers training on the content of the Kit for further development of young people around the world. The Kit has been pro-

duced with the support of Michelin, and the International Union for Health Promotion and Education (IUHPE), with the technical support of the Centres for Disease Control and Prevention (CDC), Division of Unintentional Injury Prevention.

For more information on YOURS: http://www.youthforroadsafety.org

► Safety for seniors

EU-Innovation platform for active and healthy ageing

Active and healthy ageing is a societal challenge shared by all European countries. It is also an opportunity for Europe to establish itself as a global leader, which is capable of providing innovative responses to this challenge. With the Innovation Union strategy the European Commission aims to enhance European competitiveness and tackle societal challenges through research and innovation. One way in which this is to be achieved is with Innovation Partnerships. The European Commission has identified active and healthy ageing as a major societal challenge common to all European countries, and an area which presents considerable potential for Europe to lead the world in providing innovative responses to this challenge. It is therefore creating a EU-Innovation platform for active and healthy ageing (EIP-AHA).

How does the AHA-partnership work?
A *Strategic Implementation Plan* (SIP) and *Operational Plan* (OP) was adopted on the 7th of November 2011 by the high level Steering Group, set up by the European Commission to assist with the launch and implementation of the pilot Partnership. The SIP sets out concrete measures to improve older citizens' lives, helping them to contribute to society, and reducing pressure on health and care systems - ultimately contributing to sustainable growth. Priority areas for actions are identified, including an Action on Falls Prevention.

On 29 February 2012, the *Commission adopted a Communication* on the European Innovation Partnership on Active and Healthy Ageing in support of the Strategic Implementation Plan. The European Commission and stakeholders (Member States, regions, industry, health and social care professionals, elderly and patient organisations,...) started to work together on making this plan a reality. The initial Invitation for Commitment was launched upon the adoption of the Commission Communication on the EIP Strategic Implementation Plan and closed on 3 June 2012. More than 300 commitments and in excess of 60 expressions of intent for reference sites were submitted.

Action group on Falls Prevention
The assessment of the applications that have been submitted is currently being carried out. The applicants fulfilling the conditions will constitute the founding members of the Action Group (formed for each Specific Action), and will develop the relevant governance structure and Action Plan. Future participants would have to specifically indicate their contribution to the Action Plan. It is planned to hold a first meeting of the Action Group on Falls Prevention in Brussels, early July. This first meeting will discuss the relevant governance structure, identify possible collaborations on specific activities and start developing the steps to arrive to the EIP targets.

For more information: *http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=home*

2012
EVERYONE HAS A ROLE TO PLAY!
European Year for Active Ageing and Solidarity between Generations 2012

Network for an Age-Friendly European Union

Using the opportunity offered by the European Innovation Partnership on Active and Health Ageing (EIP AHA), AGE Platform Europe has committed to set up and moderate an EU virtual forum on Age-Friendly Environments (AFE) to link stakeholders (public authorities, NGOs, service providers, industry, researchers) interested in the promotion of AFE at local, regional, national and EU level.

With its partners and virtual forum members, AGE will call on the European Commission to launch an EU Covenant on Demographic Change. The Covenant will seek to create the necessary political framework to bring together local and regional authorities across the EU who want to find smart and innovative solutions to support active and healthy ageing and develop age-friendly environments.

Once established the Covenant will encourage local and regional authorities across the EU to adopt WHO policy frameworks and guidance on AFE, to join the WHO network of cities that cooperate on age-friendly policies and to get actively involved in the EIP and relevant EU initiatives towards a more age-friendly EU.

As a WHO Global Network of Age-Friendly Cities and Communities Institutional Affiliate and cooperative partner of the Sub-Network on Healthy Ageing of the WHO European Healthy Cities Network, AGE will set up and moderate a discussion group with both networks and provide them with information on other EIP initiatives, relevant EU policy developments and EU funding opportunities to support synergies between WHO and EU initiatives supporting healthy ageing and to facilitate their involvement in EU policy processes and in EU projects.

For more information: *http://www.age-platform.eu/en/component/content/article/1457*

► Sport safety

Injuries in professional football

A recent study from the Oslo Sports Trauma Research Centre (OSTRC) revealed that the overall risk of acute match injury in Norwegian male professional football increased by 49% during the 6-season study period, although this increase was not fully consistent across teams.

As part of a continuous prospective injury surveillance system, all injuries sustained were recorded by the medical staff in each club. The present study includes data from 2002 throughout the 2007 season. Almost 500 000 hours of football activities and more than 2300 injuries were registered during this 6-year long study period.
An injury was registered if the player was unable to take fully part in football activity or match play at least one day beyond the day of injury. The player was considered injured until declared fit for full participation in training and available for match selection by the medical staff. A member of the club medical staff, in most cases the physiotherapist, performed the prospective injury registration.

Almost 50% increased match injury risk over time

The overall incidence of acute match injuries was 15.9 per 1 000 h (95% CI: 14.9 to 16.8), whereas the incidence of acute injuries during football training and other training was 1.9 (95% CI: 1.7 to 2.0) and 0.5 (95% CI: 0.3 to 0.6), respectively.

These figures correspond to an estimated total increase in match injury risk of 49% over the 6-year observation period. The researchers did not detect any change in the risk of training or overuse injuries or any difference between the preseason and competitive season.

Why this trend? This question still remains unanswered. Video analysis of high-risk injury situations and recorded injuries are needed to establish whether the increased risk of match injuries is the result of lax rule enforcement or more foul play.

This study was conducted by MD and PhD student John Bjørneboe, Roald Bahr and Thor Einar Andersen and published in the *Scandinavian Journal of Medicine and Science in Sports.*

Publication : http://www.klokavskade.no/upload/Publication/Bjørneboe_2012_SJMSS_Gradual%20increase%20in%20the%20risk%20of%20match%20injury%20in%20Norwegian%20male%20professional%20football.pdf

► Violence prevention

Global Campaign 2012-2020

The World Health Organization launched its Plan of Action for the Global Campaign for Violence Prevention (GCVP) for 2012 and following seven years. The Plan aims to unify the efforts of the main actors in international violence prevention and identify a focussed set of priorities for the field. It was developed in response to a need for a plan of action identified by hundreds of violence prevention experts who convened at the September 2011 Fifth Milestones in a Global Campaign for Violence Prevention Meeting in Cape Town, South Africa and the April 2012 Violence Prevention Alliance meeting in Munich, Germany.

The Plan of Action presents six national level goals towards which violence prevention efforts can be directed. The objective of the GCVP in the coming years will be to support the achievement of these goals in countries around the world.

The first two goals aim to prioritize violence prevention within the global public health agenda; the next three aim to build strong foundations for on-going violence prevention efforts; and the last aims to promote the implementation of evidence-informed violence prevention strategies which address parenting, life-skills, social norms, alcohol, the risks of firearm-related deaths and injuries, and services for victims. These strategies have the potential to prevent multiple types of violence.

The target audience for this Plan of Action is the global violence prevention community, including governments, United Nations and official development assistance agencies, philanthropic foundations, nongovernmental organizations and academic institutions.
WHO is encouraging these key actors to take every opportunity to:

- Provide feedback on this Plan of Action and efforts to implement it;
- Bring this Plan of Action to the attention of partners in national government;
- Use this Plan of Action as a template for national and local relevant plans and activities.

For more information: http://www.who.int/violenceprevention/en/index.html

► Vulnerable road users

The 2nd Global status report on road safety

WHO and its national and international partners are working on the launch of the 2nd Global status report on Road Safety, due this year. In 2009 WHO published the first *Global status report* on road safety for which it had gathered information from Member States using a standardized method in order to ensure that data collected were comparable. In that way, it provided the first assessment of the road safety situation at the global level, and revealed the gaps that exist in national road safety efforts

Road traffic injuries are a leading cause of death, killing nearly 1.3 million people annually.
To begin to address this problem, in 2004 the World Health Organization and the World Bank jointly launched the World report on road traffic injury prevention. This World Report outlined the major risks for road traffic injuries, and recommended a number of interventions that countries can implement to improve their road safety situation. However, until recently the extent of the road safety situation around the world was unclear. The report highlighted the following facts:

- Half all road traffic deaths are among "vulnerable road users" – motorcyclists;
- Cyclists and pedestrians; and
- Only 15% of countries have comprehensive legislation on the major risk factors to road safety.

The first *Global status report* generated considerable attention at national and international levels and has stimulated action on improving road safety in a number of Member States. In March 2010 the United Nations General Assembly adopted resolution 64/2552 which proclaimed the period 2011–2020 as the Decade of Action for Road Safety. The goal of the Decade is to stabilize and then reduce the forecast level of road traffic fatalities around the world by increasing activities.

conducted at national, regional and global levels. The resolution requested WHO and the United Nations Regional Commissions to coordinate the monitoring of the impact of the Decade of Action, and proposed the use of further *Global status reports* as a tool towards this end.

In 2011 WHO began to work on the second report. The objectives of this new *Global status report* are:

- To indicate the gaps in road safety nationally and thereby stimulate road safety activities;
- To describe the road safety situation in all Member States and assess changes that have occurred since the publication of the first *Global status report*;
- To serve as a baseline for monitoring activities relating to the Decade of Action for Road Safety at the national and international levels.

As with the first *Global status report*, national level data is being collected through the administration of a questionnaire. Data collection began in early 2011 and is being carried out in all WHO Member States that agreed to participate, working through WHO Regional and Country offices.

With a number of Member States developing action plans for the Decade and committing to the implementation of concrete actions, this second *Global status report* will serve as the baseline for monitoring national and international progress made towards the achievement of the objectives of the *Decade of Action for Road Safety 2011-2020.*

More information: *http://www.who.int/violence_injury_prevention/road_safety_status/en/index.html*

Public EC-Consultation on road traffic injuries

Recently the Commission launched a consolation on tacking serious road traffic safety. This consultation will provide input for the drafting of a strategy to reduce the severity of injuries caused by road traffic accidents. A questionnaire is published on the EC-website and relevant stakeholders have been invited to respond. The questionnaire addresses general issue related to road safety and more specific issues on how to improve the data available on victims of accidents and their collection at EU level, and on how to target some specific groups of road users.

Road safety strategies traditionally focus on reducing fatalities. Injuries, however, are overlooked too often, although they represent a major health problem. In 2010, about 1 500 000 people were injured on the roads of the European Union, at huge economic and human cost to society.

Reducing the number and the severity of road traffic injuries is one of the strategic objectives outlined in the Policy Orientation on Road Safety 2011-2020 and a priority for EU action. Accordingly, the Commission is developing a comprehensive strategy of action concerning road traffic injuries and emergency services, with the help of all relevant actors. Initially, it will seek to find a common understanding of definitions and concepts relating to casualties (in particular, the definition of serious and slight injuries), improve data collection and identify courses of action to improve prevention and intervention, including their socio-economic impact.

Based on feedback from the first stage of the proposed strategy, specific or tailor-made actions might be identified with a view to increasing the accuracy of existing databases on road injuries. Stakeholders may reply to this consultation via the Commission's online interactive policy-making tool. Contributions from citizens, organisations and public authorities are especially welcomed by the Commission.

For more information: *http://ec.europa.eu/yourvoice/ipm/forms/dispatch?form=RoadInjuries*

► Work safety

Healthy Workplaces Campaign

A *Healthy Workplaces Campaign 2012–13* '*Working together for risk prevention*' has been launched by the European Agency for Safety and Health at Work (EU-OSHA). It aims to encourage managers, workers and other stakeholders to join forces to improve safety and health in work places. The Campaign is co-ordinated by EU-OSHA and partners in the EU's 27 Member States.

The 2012–13 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 campaign focuses on: risk prevention; managing risks; encouraging top managers to actively engage in risk reduction; and encouraging workers, their representatives and other stakeholders to work with managers to reduce risks.

Central to the campaign are a range of materials that will further these goals. These include reports, practical guides, flyers, posters and DVDs. In addition, EU-OSHA will join forces with its partners and national focal points to promote the European Week for Safety and Health at Work, as well as helping to organise training seminars, conferences and exhibitions.

The campaign relies on a diverse range of partners and stakeholders, including governments and their agencies, employers, workers and businesses large and small. The previous campaign on Safe Maintenance drew on the help and support of more than 50 campaign partners. In March 2012, the Agency organised an EU partnership meeting to present its Campaign partnership-offer for this Campaign. At this meeting many organisations and companies expressed their wish to join this new Campaign.

For more information: *http://www.healthy-workplaces.eu/en/*

► Cross cutting issues

Safety 2012 World Conference

Recognizing the potential value of intersectoral liaison and collaboration, WHO is organizing the next event in the series of biannual World Conferences on Injury Prevention and Safety Promotion. These conferences play an important role, by facilitating the exchange of information and experiences throughout the world, in developing the professional level of injury prevention practice and by getting a growing number of professionals and stakeholders connected to the WHO-policies for violence and injury prevention. It especially aims at expanding the network of professionals involved in injury prevention and to offer training and skills building opportunities to those who entered the field just recently.

Conference theme

The next, eleventh, conference will be in New Zealand, October 2012. The overall theme for the 2012 World Conference on Injury Prevention and Safety Promotion is; "Connecting pathways for a vibrant and safer future". This theme has been selected as it reflects the intellectual and philosophic approach of the New Zealand injury prevention sector towards injury prevention. The theme is also consistent with the intent of the New Zealand Injury Prevention Strategy, and with the aspirations of the WHO Western-Pacific Region Framework for Action on Injury and Violence Prevention 2008-2013.

This theme provides a forum for exploring questions such as:

- How do we develop safer environments, yet retain vibrant communities and cities?
- How do we balance economic and social goals against injury prevention goals, and where is that balance?
- What are the pathways for developing a positive safety culture and how do we show their effectiveness?
- What are the pathways between compensation, treatment, rehabilitation, a return to active economic and social participation, and the prevention of re-injury?
- How do we better connect specific areas for injury prevention, such as road/water safety, violence/ falls prevention etc. to a more comprehensive focus?
- Is an injury-free future attainable?

These types of questions have been formulated into four sub-themes for discussion in the draft conference program, detailed below, along with a series of eleven topics and associated questions. The four sub-themes also provide a focal point for organizing the scientific program of each day of the conference. The four sub-themes are:

- Integrating Research, Policy and Practice
- Community and Business involvement
- Sustainability and Urban Design
- Diversity, People and Culture.

Read more: *http://www.conference.co.nz/worldsafety2012/home*

► AGENDA

2012

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

6 September in Brussels, Belgium
BESTPOINT Final Conference
http://www.bestpoint-project.eu/index.php?option=com_content&view= frontpage&Itemid=1

10 September in Leeds, United Kingdom
13th International Conference on Falls and *Postural Stability*
http://www.bgs.org.uk/index.php?option=com_content&view=article&id=1853& Itemid=807

26-28 September in Zagreb, Croatia
Child in the City 2012
http://www.childinthecity.com/page/6099

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

EuroSafe

the European Association for Injury Prevention and Safety Promotion

is the network of injury prevention champions dedicated

to making Europe a safer place

Together we can make a difference!

CONTACT US

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

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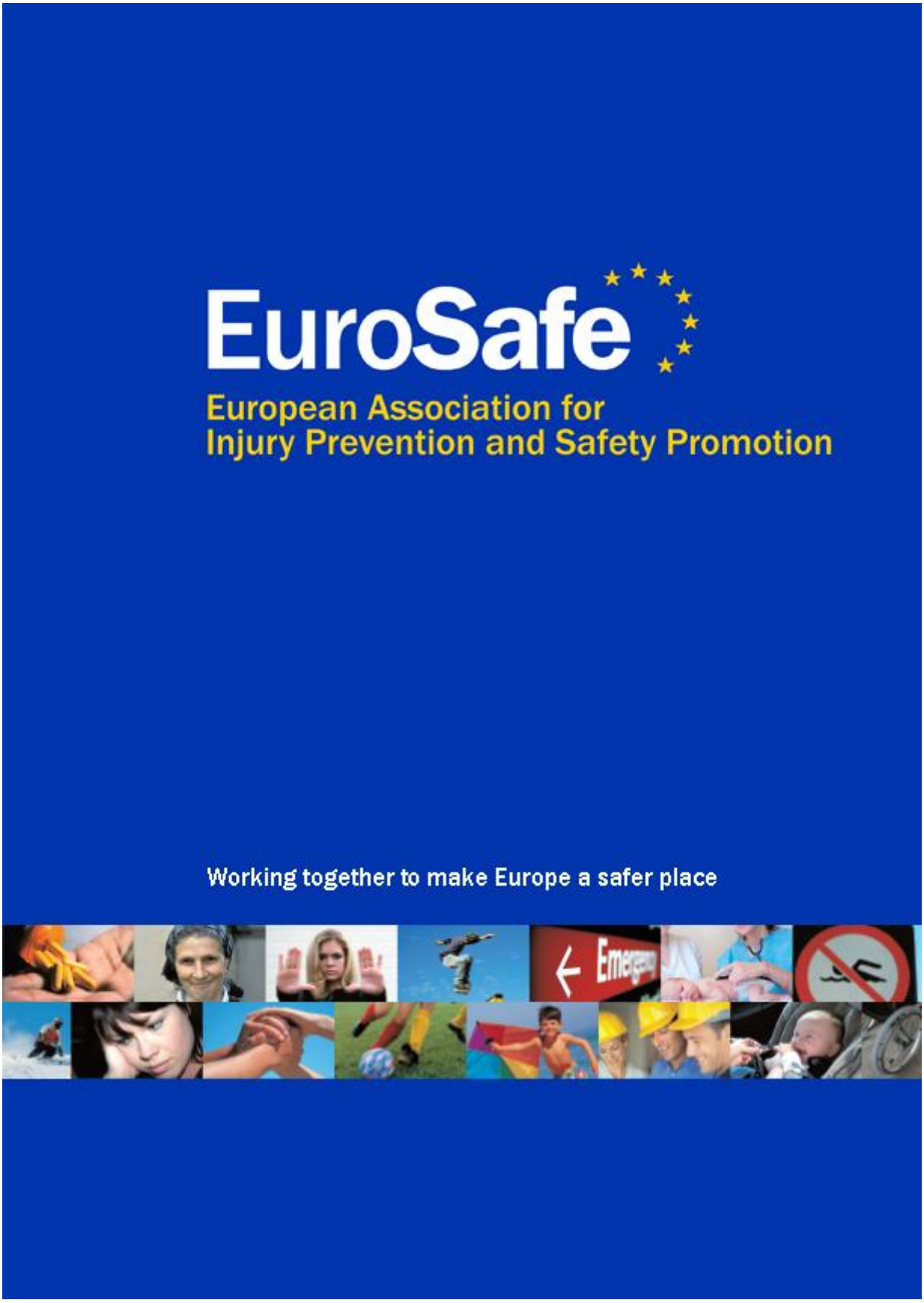

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