



**“Working together
to make Europe
a safer Place”**

► **EuroSafe news**

EU-Injury Data Exchange: EC-leadership needed

The final report on the Joint Action on Injury Monitoring in Europe (JAMIE), carried out under the leadership of EuroSafe, has been published in October 2014. The report provides evidence of the feasibility of collecting core information on the causes and circumstances of injury events that lead to an emergency department visit. In the course of the three-years project, 26 countries were able to deliver injury data to the EU-Injury Data Base, which means twice as many countries as in the year 2010.

Given the proven feasibility of injury data collection in emergency departments, EuroSafe calls on the European Commission to initiate a binding arrangement for all member states and associated/ candidate countries to deliver hospital based injury data on a regular base. Such data exchange is essential for identifying priorities in health promotion and consumer protection policies and for benchmarking progress in programmes and measures taken in member states.

Number of injury reporting countries doubled

Over the past three years, the European Commission, member states and associated and candidate countries have jointly explored ways to improve EU-level exchange of injury data from emergency departments at hospitals. The overarching objective of JAMIE was to have by the end of 2014 in a great majority of MSs, at least in 22 participating countries, a common hospital

based surveillance system for injury prevention in operation which covers also key information on the external causes of injuries.

JAMIE resulted in a EU-wide consensus on IDB data quality requirements, including confidence intervals for IDB based national estimates of injury incidence rates. The great majority of MSs are now able to report IDB-data on a regular base. By now, 26 countries have designated national injury data administrators, who are well trained in the Community approach in injury surveillance and these 26 countries actually delivered data in the course of the project. This has also resulted into an increased use of IDB data for prevention purposes at national level.

JAMIE helped to establish in Europe an unique cross-sector injury information and reporting system. The European Injury Data Base makes it now possible to compare MSs and the level of safety regarding different risk groups, which creates stronger motivation for MSs to improve on their performance. JAMIE provided to the Commission as well as to the MSs the proper support structure and tools in order to make a difference in injury prevention and safety promotion and to initiate focused actions for safety promotion in response to the Council



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Recommendations for Injury Prevention (2007).

The way forward

The entire IDB system (its methodological basis, geographical coverage, data quality, organisational processes) has been considerably improved, and is therefore ready for starting the next phase, which is the political, technical, and legal consultation process with a view to include the IDB within European Statistical System, as part of the set of public health statistics.

For a successful implementation of injury data collection at minimum data set level in ALL Member States, it would be most advantageous to have a mandatory provision or binding agreement amongst health information authorities that such data should be collected and exchanged at EU-level on a regular basis. Given the fact that the majority of Member States are monitoring injuries, such an agreement would not create an additional burden for most of the countries.

However the collection of more elaborate information that includes details related to the involvement of consumer products, definitively requires additional resources for enhancing the capacity and infrastructures in health services to be able to collect and deliver such information in a sustainable manner. As consumer safety authorities are the main beneficiaries of such information, they should provide the proper co-financing mechanisms for making such information gathering possible in a cost-efficient manner.

More information:

<http://www.eurosafe.eu.com>



► EU news

EU-Consumer Policy: Legacy document

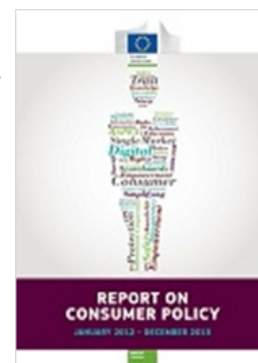
In a recently published legacy document Neven Mimica, Past Commissioner Consumer Affairs, presented his views on the achievements of the Commission over the past few years in shaping a true Single Market for consumers.

Indeed, the last five years have been a pivotal time for EU Consumer Policy. Amidst a severe economic crisis, the EU has managed to set and achieve challenging goals with a view to put consumers at the very heart of the Single Market, says Commissioner Mimica. The 2012 European Consumer Agenda presented a vision for consumer policy as part of the Europe 2020 strategy.

The Agenda set out the Commission's strategic vision of consumer policy for the years to come, underscoring the importance of stimulating consumer expenditure – 56% of EU GDP – to ensure that the demand side of the economy can play its part in bringing the EU out of the crisis. It announced a series of actions across different policy fields, to

strengthen consumer safety, enhance knowledge, adapt consumer rights to key economic and societal changes and increase the effectiveness of enforcement and redress mechanisms.

The Agenda identified the main challenges facing consumers and policy makers, in particular the need to improve product, service and food safety in an increasingly global environment and to address the sustainability of our consumption patterns and the effects of the crisis on consumers, notably the most vulnerable ones, in areas such as financial services and energy. The digital revolution, whilst presenting great opportunities for consumers, also poses challenges in terms of information overload and consumers' digital literacy and confidence, in a wider context where there is a



need to promote consumers' participation in the market through enhanced information and knowledge, notably of their rights. Those rights need to be adapted to key economic and societal changes and be respected in practice through more effective enforcement and redress mechanisms.

To this end the Agenda provided a structured framework: its main objectives translate into 62 concrete policy measures of which more than 80% were completed by end 2013. Alongside horizontal measures, such as the legislative proposals on consumer product safety and market surveillance or guidance on the implementation of the Consumer Rights Directive that entered into force in June 2014, many measures have been adopted that promote consumer interests in key sectors, particularly transport (new passenger rights legislation), telecoms (the Connected Continent proposals) and energy (various measures to empower consumers) as well as finance (such as the Payment Accounts and Mortgage Directives).

The Commission's initiatives have been informed by strengthened evidence on the state of consumer conditions and markets in the EU, and developed in strong engagement with citizens as the Commission stepped up its communication and cooperation with stakeholders. At the same time, enforcement of existing rights and market surveillance remained an important priority.

Upon assuming office as Commissioner for Consumer Policy in July 2013, Commissioner Mimica set out three priorities within the framework provided by the Consumer Agenda:

- consolidation of legislation, in terms of both adoption and implementation,
- co-ordination between the stakeholders, and
- communication, especially to consumers.

Legislative proposals on product safety and medical devices have prepared the ground for ensuring better and more efficient protection of consumers against potential risks to their health and safety. Unfortunately, Council Presidency was not given a mandate to launch the informal trilogues due to differences in Member States' positions concerning the proposed mandatory indication of the country of origin. The package will therefore continue to be negotiated under the new legislature. New rules were adopted in the area of financial services and recent legislation on alternative and online dispute resolution aim to provide consumers with fast and affordable means of redress.

In parallel, intensified cooperation amongst EU enforcement authorities, facilitated by the Commission, has produced results in swiftly removing unsafe products from the market, improving traders' compliance through annual online "sweeps" of websites and leading to a first coordinated enforcement action in the field of "in-app" purchases in online games.

Consumers' access to quality information and assistance has continued to improve, through a number of awareness-raising campaigns, the development of innovative online tools and thanks to the network of European Consumer Centres.

Finally, the Commission has attached great importance in deepening and diversifying its cooperation with stakeholders, including consumer organisations as key multipliers, and international partners, with a special focus on the US and China.

More information:

http://ec.europa.eu/commission_2010-2014/mimica/docs/legacy_consumer_report_2010-2014.pdf

► WHO news

WHO-Europe: Rights to a safe and healthy adolescence



Every child should have every opportunity to live a healthy and meaningful life. To ensure this happens, the Member States in the WHO European Region have adopted a new strategy, titled “Investing in children: child and adolescent health strategy for Europe 2015–2020”.

The strategy recommends adopting a life-course approach that recognizes that adult health and illness are rooted in health and experiences in previous stages of the life-course. Targeted effort is needed to break the negative cycles in childhood and adolescence such as poor early childhood development and lack of support in growing through adolescence. This will enable children and young people to develop into healthy, happy and competent individuals who can make a positive contribution to their own health and to society.

Supporting adolescents to enjoy a happy and healthy transition into early adulthood is a key focus of the new WHO strategy for children and adolescents in the European Region. The determinants of adolescent health are now better understood. The social values and norms of the immediate family, peer groups and school environments may expose adolescents to risk, as well as protect them. Health literacy must be promoted from childhood through adolescence, so that future citizens of Europe have the skills to make informed decisions. The challenge for policy is to balance risk and protection in favour of well-being and away from behaviour that may undermine health.

WHO has mapped youth friendly service

delivery models, which can inspire countries to develop their own models, and Project Healthy Generation serves as an example of how to translate the abstract concept of youth-friendly health services into real action.

Health risks for adolescents in the Region

Injuries is one of the leading causes of mortality and morbidity among adolescents. One in ten adolescents have some form of mental ill health. By the age of 18, it is estimated that 9.6% of children and adolescents will have suffered sexual abuse and 22.9% physical abuse. In the European Region, 25 % of boys and 17 % of girls aged 15 drink alcoholic beverages at least once a week.

Being young is not always a healthy and happy time. Many suffer from depression, are victims of maltreatment or contract sexually transmitted infections or unplanned pregnancies. Youth friendly services are vital to help young people to a safe and healthy entry into adulthood by addressing the health and developmental needs of this age group.

Protecting adolescents from environmental risks

The WHO-report underlines that environmental determinants strongly affect child and adolescent health. WHO-Europe calls for country measures to ensure that children and adolescents:

- live in safe, healthy communities with access to safe environments in which to play and take part in physical activity;
- live in areas in which the air quality is monitored and measures are enacted to reduce levels of pollutants;
- have access in homes, pre-schools and schools to a regular supply of safe drinking-water, good sanitation and hygiene facilities; live in adequate housing with good cooking and food storage facilities;
- have access to good, affordable public transport; and
- benefit from measures to promote road safety and ensure car drivers' competence and fitness to drive.

A range of cost-effective interventions specific for the prevention of injury is available, the report says.

The best approaches ensure that safe, sustainable environments are developed through, for instance, a combination of legislative engineering for safer products and social marketing to reduce risk-taking behaviour.

More information: http://www.euro.who.int/data/assets/pdf_file/0010/253729/64wd12e_InvestCAHstrategy_140440.pdf?ua=1

► 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/12injurydata.htm>).

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



Injury data collection in Finland



For everyone working in the field of injury prevention and injury monitoring it is well understood that injuries are a major public health concern. Unfortunately this is not always as evident for those working outside this sector. As a consequence, injury prevention work often requires a strong injury advocacy component within its range of activities. This means informing relevant people such as professionals, decision-makers, citizens, of the situation and to create understanding of why preventing injuries is beneficial.

The simplest tool for justifying our ambition is to rely on statistical numbers and data. Although data and figures may be interpreted in many different ways, they still provide the

hardest evidence we actually can have. And we do have plenty of data to back up our plea for increased political attention for injury prevention.

The importance of the issue

In Finland, unintentional injuries are the 4th leading cause of death. Just this fact should be important enough to put injuries in comparison with other major public health concerns. Furthermore in the population between 1 and 45 years of age, unintentional injuries are leading cause of death. The sheer total numbers of deaths by unintentional injuries fall far behind the cardiovascular diseases and cancers which remain the main killers in particular in older age-groups. However, comparing the last years

of life rather than just the number of deaths, might provide a more correct picture. This kind of examination gives more weight to deaths in young ages and might be also useful in determining the total burden of disease.

In Finland unintentional injuries are causing the biggest number lost years of life until the age of 50. Cardiovascular diseases and cancers surpass them only after the age of 50 (see figure), while as for in-hospital treatments injuries have just recently surpassed cardiovascular diseases as a diagnosis group with the most patients annually.

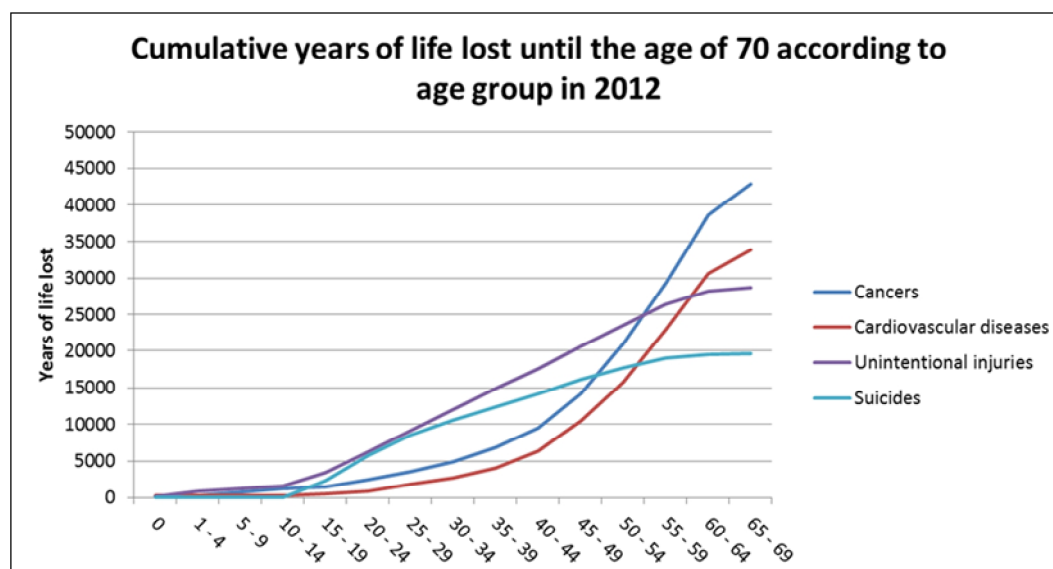
The importance of good data

Meaningful epidemiological work on any area or topic always needs high quality data to back it up. The Finnish injury monitoring is mainly based on general health care registers, such as cause of death statistics and hospital care register, and also on specialised statistics such as traffic accident statistics and occupational accident statistics.

well established in Finland. Some types of information such as that arising from accident investigations and various risk data sources should still be better linked with the official monitoring systems to better understand the related risks of injuries. As understanding the epidemiology of injuries is one challenge, there is also need of information of in risk factors, including life style changes, and protective factors such as traffic behaviour, the use of safety equipment or for example the fire safety measures in public buildings. Furthermore data on injury prevention policies and measures might be valuable to include in the analyses.

IDB and Finnish experience

International comparison of injury is another challenge. Mortality between different countries is easier to compare but especially the huge differences between national health care systems make comparison of hospital data hard. However attempts to do this are needed in order to understand the burden of



The benefit of specialised statistics is that they can answer questions such as why and how accidents happened, while common statistics and registers provide general statistics on the number and nature of injuries as they concentrate on the consequences rather than causes of injury events. The National Institute for Health and Welfare (THL), which is the national coordinating agency of injury prevention in Finland, mainly draws their estimates from the cause of death statistics and hospital care register, which together cover all deaths, hospitalisations and visits to specialised medical services as a consequence of an injury. This however excludes most visits in primary care, i.e. the family doctor, school nurses et cetera.

The epidemiological data on injuries are rather

injuries in various parts of Europe and to learn from experiences in addressing the issue.

In Finland, establishing a strong national data for injury surveillance has helped to create a better national understanding of injury situation and to promote the goals of injury prevention work. The ability to produce timely, accurate, reliable and dynamic statistics on injuries and their costs is the essential requirement to justify the need of national programmes and strategies as well as the need for local injury prevention projects. That was the main reason for Finland to join the Joint Action on Injury Monitoring in Europe and to provide data to the EU-Injury Database for Finland.

Despite the good quality of national data, there are a number of gaps to be filled. Currently the coverage on external causes of injuries is good on hospitalisations and visits to secondary care, but in primary care, where many of the first contacts take place before patients are referred for specialist treatment or f.i. in the case of sports injuries are treated by physiotherapists, the registration of external causes is not mandatory. This might result as a significant bias in morbidity figures derived from the emergency department services only as the minor injuries are missing from that data. On the one hand, this makes the international comparison within IDB extremely difficult, but on the other it reveals the national

needs to improve the data and also create better understanding of the differences in national health care data.

The mere existence of high quality data is not enough alone. New data tools such as indicators will be needed. Working in health information and injury surveillance in particular is like standing on a slippery slope: stopping new developments would not mean just being stationary but decline. Therefore the work on better injury data needs to continue for ever.

For more information contact Antti Impinen at antti.impinen@thl.fi

National Injury Conference, Italy



In May 2014, the Gaslini Centre for Health Education and Training (CISEF) hosted a two-days Injury prevention conference in "Villa Quartara", an impressive XV century villa in Genova. The conference had both a National and a European focus and presented progress of work in injury surveillance and child injury prevention. The Gaslini Institute children's hospital organised the conference through its educational centre with the scientific coordination of the Italian National Institute of Health - Environment and Trauma Unit - Department of Environment and Primary Prevention - and with the support of the Ministry of Health and its National Centre for Disease Control.

The results of both the SINIACA-IDB national project and the European JAMIE project were presented highlighting the achievements hospital based surveillance of injuries in Italy and its integration into the European Injury Database (IDB). The Italian injury surveillance system SINIACA, an acronym which stands for national information system on home injuries, was set up in compliance with the Italian regulation nr. 493 of December 1999. In this system other injury domains such as road traffic injuries are included in a comparable way with the IDB surveillance, and in line with the European Council Recommendation of May 31 2007 (2007/C 164/01) on injury prevention and safety promotion.

Conference participants were informed about the burden of injuries in Italy in comparison with other countries in Europe and highlighting home and leisure accidents, road traffic accidents, violence (aggression and self-harm) as major areas of concern. The operative procedures of the SINIACA system were presented which aim to integrate local injury surveillance system into the national overarching system in accordance with an harmonise methodology and classification structures.



Giuseppina Lecce, Ministry of Health Rome, and Wim Rogmans, EuroSafe, before opening of the conference.

Actually around 100 hospitals, representing all hospitals in the three major regions of Italy being Piedmont, Tuscany and Abruzzo, produce more than 130,000 records per year in the IDB format "All Injury" minimum data set (IDB-MDS) for emergency departments (ED) attendances. With respect to data in IDB-FDS (Full Data Set) format 32 hospitals distributed over 9 regions, i.e. Piedmont, Aosta Valley, Trent province, Liguria,

Emilia-Romagna, Umbria, Marche, Molise, Sardinia, produce around 42,000 records/year of home injuries; 13 hospitals in 4 regions, i.e. Piedmont, Liguria, Umbria and Sardinia, record around 16,000 cases/year of ED attendances caused by road traffic injuries; and 5 hospitals in 3 regions, i.e. Piedmont, Liguria, Emilia-Romagna, record around 1,600 cases/year of violence. Within these FDS hospitals a subsample of 12 hospitals also record the object, product or substance involved in injury delivering around 22,000 records/year.

The conference was in particular organised for staff members of the National Health Service who are active in the field of injury control and prevention. Delegates from the territorial units of the SINIACA-IDB project participated in the conference together with staff from the hospital emergency departments that register the external causes of injury in compliance with the IDB guidelines.

On the second day, the results of these surveillance efforts were presented with a view to address the issue of childhood injuries in Italy. Representatives of the Italian medical scientific societies in paediatrics and emergency medicine and from the Emergency Departments within the Italian network paediatric hospitals attended that meeting and discussed the development of evidence-based paediatric guidelines for injury prevention. At the end of the meeting it was decided to have in all paediatric hospitals in Italy a mandatory system for the collection of data on injuries treated in emergency departments of those hospitals.

More information: <http://www.iss.it/casa/index.php?lang=?lang=1&id=113&tipo=19>

► Consumer safety

Hazardous chemicals in products - The need for enhanced EU regulations

In a recently published report, ANEC - the European Consumer voice in standardisation - welcomes the commitment of the EU to strengthen its regulatory framework to address chemicals, particularly as regards chemicals in products. However, ANEC believes that the current provisions at the European level are insufficient and that there is no community approach to address chemicals in products in a systematic manner. A horizontal regulatory approach to address chemicals in products in a systematic way is dramatically needed.

In November 2013, the Council of the EU and the European Parliament agreed on the text of the 7th Environmental Action Programme - 'Living well, within the limits of our planet'. It identifies chemicals in products as an action point: *"The Union will also set out a comprehensive approach to minimising adverse effects of hazardous substances, including chemicals in products"*(point 50). It also states that it shall be ensured that by 2020 *"...risks for the environment and health, in particular in relation to children, associated with the use of hazardous substances, including chemicals in products, are assessed and minimised."*

To the opinion of ANEC, the present specific European regulatory provisions for chemicals in (consumer) products, particularly in articles, are insufficient, as they are either:

- inadequate because of serious restrictions - as in case of food contact materials where only plastics materials are comprehensively regulated; or missing clear limits (medical devices) or lack of a high level of protection (toys), or
- non-existent for many products consumers come into contact with, such as materials in contact with drinking water, products releasing emissions to the indoor air, clothing and other consumer textiles, child care articles, packaging, tattoo inks, personal protective equipment, furniture, sports and playground surfaces and equipment, car interiors, ...

REACH does not compensate for these deficits because articles – particularly imported ones - are barely covered. Moreover, the process of restriction is laborious and related to comprehensive single substance risk assessments.



ANEC recommends the Commission to develop a systematic approach to address chemicals in products relevant for consumers. It should cover overarching principles and basic strategies for all kinds of products, identify priorities, elaborate on product specific requirements including information provision as well as monitoring and market surveillance. Consideration also needs to be given to a horizontal framework to be complemented by product specific implementing measures.

As a matter of highest priority ANEC wants requirements for the following product to be adopted:

- materials in contact with food, including printing inks, paper & board, metals & coatings, and strengthened requirements for ceramics;
- materials in contact with drinking water based on the "The European acceptance scheme for construction products in contact with drinking water (EAS)", proposed in 2005 ,and the subsequent harmonisation work initiated in 2007;
- products releasing emissions to the indoor air based on existing national legislation and the reports published under the "European Collaborative Action - Urban Air, Indoor Environment and Human Exposure";
- clothing and other consumer textiles – including generic exclusions of substances of high concern;
- toys aimed at a considerable strengthening of the inadequate chemical provisions of the Toy Safety Directive including e.g. a significant reduction of the CMR (Carcinogenic, Mutagenic and/or toxic to Reproduction) thresholds and addition of limits for substance categories not yet covered (such as colorants, monomers, nanomaterials, endocrine disrupting chemicals);
- child care articles based on (improved) requirements for toys adapted to the specific use and exposure situation of child use and care articles;
- packaging complementing current requirements for lead, cadmium, mercury and hexavalent chromium by e.g. excluding CMR chemicals;
- tattoo inks - using recommendations of the Council of Europe as a departure point to establish a stand-alone regulation or to broaden the Cosmetics Regulation.

The need to set additional chemical requirements for other product groups - such as medical devices, electrical and electronic products, personal protective equipment, furniture, sports/playground surfaces and equipment or products made from leather or paper - needs to be investigated.

More information: <http://www.anec.eu/attachments/ANEC-PT-2014-CEG-002.pdf>

► Child safety

European Standardization in support of child safety

CEN-CENELEC published the brochure, European Standardization in support of child safety. It gives an overview of the European standardisation activities that aim to contribute to improving the safety of products used by or with children, and includes information on recently-adopted standards, ongoing standards work and the technical bodies involved.

The safety of children is an absolute priority, not only for parents but for society as a whole. A wide variety of products may present potential hazards to children, for example while they are playing games or practising sports. Various household appliances that are commonly found in the domestic environment can also be potentially hazardous for children.

European Standards have an important role to

play in protecting children and preventing

accidents. In particular, they help to ensure that products used by or with children – including clothes, furniture, toys and playground equipment – are as safe as possible. As official European Standardization Organizations, CEN and CENELEC aim to ensure that their standards address all possible hazards that products may pose to their most vulnerable users.

CEN and CENELEC develop and adopt European Standards that support child safety under the following categories: toys; nursery products and furniture; child resistant products and protective devices; and playground and sports equipment for



children. The European Commission recognizes the important role played by European Standards in promoting the safety of children. It has issued numerous official requests (or 'Mandates') to CEN and CENELEC, asking them to carry out specific standardization activities.

While they are developing standards in support of child safety, CEN and CENELEC take full account of relevant legislation adopted by the European Union, including the Toy Safety Directive (2009/48/EC) and the General Product Safety Directive (2001/95/EC).

In addition to European Standards for specific products, CEN and CENELEC have also developed and published a guide on how to include child safety in standards (CEN-CENELEC Guide 14), which is intended as a tool for experts who are drafting European Standards and other standardization deliverables.

More information: <http://www.cencenelec.eu/News/Publications/Pages/default.aspx>

Toy Directive: is it effective?



According to Article 48 of Directive 2009/48/EC on the safety of toys, by 20 July 2014 and every five years there-

after, Member States have to send to the Commission a report on the application of the Directive. The Commission has to draw up and publish a summary of the national reports. For the purposes of drawing up the national report, the Commission has distributed a questionnaire to Member States.

Parallel to this process, ANEC recently published a position paper expressing its views concerning the safety of toys and the effectiveness of the Toy Safety Directive. Although the new Toy Safety Directive, which entered into force in July 2011, certainly brought improvements to toy safety in Europe, ANEC calls upon policy makers to take the health of children more seriously by significantly strengthening the chemical requirements for toys.

It has become clear that the significant shortcomings of the Directive, such as the lack of

adequate provisions to exclude exposure to CMR substances (Carcinogenic, Mutagenic and/or toxic to Reproduction) generally, and particularly in toys intended for use by children under 36 months or in mouth-actuated toys, can be solved only by a fundamental revision of the chemical requirements of the Directive. Such revision is unavoidable as it is unacceptable that the health of children should be 'played' with further.

Furthermore, ANEC urges that the Toy Safety Directive be amended to regulate impulse noise levels in toys, and to set the limit to what is allowed for adults in industry according to Directive 2003/10 /EEC. We see no safety based reason to expose children to higher levels than is allowed for adults.

Finally, in the interest of legal certainty, ANEC deems it important that the Commission introduces specific requirements for visibility and legibility of warnings on toys (e.g. a minimum letter size), in order to enable Member States to enforce these requirements in a uniform way.

More information: <http://www.anec.eu/attachments/ANEC-CHILD-2014-G-064%20final.pdf>

► Sport safety

Youth and amateur sports



Every day, millions of amateurs in Europe enjoy sport activities on a wide range of places, from soccer and hockey fields to swimming pools and ice skating rinks. It's called playing, but sports activities are more than play. For youth, participation in athletics improves physical fitness, coordination, and self-discipline, and gives them valuable opportunities to learn teamwork. But sports activities can also result in injuries - some minor, some serious, and still others resulting in lifelong medical problems.

The Ruhr-Universität Bochum and ARAG Sportversicherung in Germany carried out a survey on sports injuries in German sports club between 1987 and 2012 with a view to identify focal areas for the development and implementation of prevention measures. The survey consisted of a continuous questionnaire-based injury monitoring of club sports injuries that have been reported by selected federal sports associations to the respective sports insurance agencies.

Since 1987, a sample of 200,884 sports injuries has been established. About two thirds of the injuries that were reported occurred in soccer, handball, basketball, and volleyball, although only one third of all sports

club members are registered in these team sports.

The rate of women's soccer injuries has risen from 7.5 to 15.6 %. Ankle injuries have decreased from 28.7 to 16.9 %. By contrast, the rate of knee injuries has increased from 18.4 to 20.3 %. Days of disability have dropped steadily since the 1990s. Inpatient hospital days have decreased from 10 to 5 days, whereas the share of injuries that needed surgery increased from 30 to 40 %.

The authors conclude that team ball sports shall be still a clear focal area for injury prevention, as participation and injury risk are highest in this group. While the prevention of ankle injuries seems to be developing in the right direction, knee injuries are increasing. As team ball sports become more popular among women, who are –as evidence shows- more prone to severe knee injuries, prevention programs should be tailored toward carefully selected segments and needs of these sports participants.

More information:

<http://www.sicherheitimsport.de/>

► Safety for seniors

Fall prevention: Cost-effective?

The economics of fall prevention have received increased interest from health policy makers and other stakeholders over the past years. In a national seminar on preventing falls in older people held in Leuven (BE) earlier this year, Lieven Annemans professor in health economics at the Ghent University demonstrated the potential cost saving that evidence based prevention measures could produce.

In the current health policy environment, programmes being effective is not sufficient for decisions on making such programmes wider available and being financed by health insurance system or governmental funding. Preventive programmes, just like any other interventions in healthcare must be assessed based on their cost-effectiveness. Policy makers are bound to make available only those interventions that offer an added health benefit to patients and come at a reasonable cost in proportion to the expected health gains.

This concept of cost-effectiveness is attracting more and more interest and has an increasing influence in decision-making about reimbursement of implementing such programmes. However, the level of required evidence varies widely between advisory bodies and decision makers. Health technology assessment (HTA) bodies such as the National Institute for Clinical Excellence (NICE) in the UK or the Belgian Health Care Knowledge Centre (KCE) require high methodological standards and expect results in the format of cost per quality-adjusted life year (QALY) gained. The QALY combines quality and quantity of life in one parameter and is theoretically the best approach to articulating health gains. Other decision-makers only consider costs and budget impacts, thereby missing an important part of the picture.

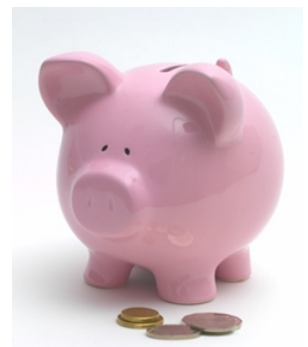
The cost-effectiveness of fall prevention has been studied relatively well. The results are however quite divergent and depend a lot on the target population and the modalities of the prevention programme itself. The Otago programme is a general practice programme of home based exercise to prevent falls in elderly women and has acquired a status of

best practice in falls prevention as the programme resulted in a reduction of the number of falls from 1.3 to 0.78 per year in elderly women at high risk for

falling due to muscle weakness. A study in Norway suggested that investment in the prevention programme addressed to all home-dwelling women of 80 years and older could be completely compensated by the reduced costs due to less falls: each € invested in the programme would return 1.85€ to the health care system within one year. These results are of course very compelling but it should be noted that the results of a trial in frail home-dwelling elderly never can be extrapolated to all women aged above 80. Moreover in a real life context programme adherence will be significant lower and thus drive down the health and economic benefits.

Yet another community fall prevention programme in the UK confirmed the excellent economic results in high risk patients. The mean difference in NHS and personal social service costs between the intervention group and the control group in that study was £-1,551 per patient over 1 year. The intervention group experienced on average 5.34 fewer falls over 12 months. The mean difference in QALYs was 0.070 in favour of the intervention group. One should note that the huge number of prevented falls points to the very high risk profile of the target population in that study.

Can similar results be reproduced in a more general elderly population? In an Australian study it was found that the cost per QALY of different fall prevention programmes targeting community dwelling elderly >65yrs varied between 44,000 AUS\$ and 165,000 AUS \$ per QALY. In Australia the societal willingness to pay threshold for a QALY is around 50,000 AUS\$ meaning that the majority of the studied programmes were above this threshold and therefore did not



show an acceptable cost-effectiveness ratio. Other authors have stressed the importance of patient characteristics, stating that only those entering with "falls in last year" will benefit from interventions, while all other subgroups do not experience this effect. Given the importance of the prevention modalities more and more studies do not just focus on the cost-effectiveness of fall prevention as such but compare different potential programmes addressing a same target population.

In conclusion, fall prevention has a high potential to be cost-effective, even cost saving

to the health care systems, but depending on the target population and the prevention modalities results may change enormously. Programmes directed to high risk populations and not being too individualized seem to be most promising.

More information: http://www.valpreventie.be/Portals/Valpreventie/Documenten/sympo-sia/3.Lieven_Annemans_Kosteneffectief.pdf

Exercise to prevent falls and fractures

Falls are the leading cause of fatal injuries among older people, but experts from across Europe argue they should not just be written off as an unavoidable consequence of ageing. Ageing experts who joined the EuroPean Network on Falls Prevention (ProFouND) are advising people 60 plus to increase their exercise to reduce the risk of potentially fatal trips and falls: 'boosting your activity levels and doing strength and balance exercises more than halves your chance of breaking a bone as a result of falling if you are over 60', according to experts from an international research group.

Older people who have a history of falls, take 4 or more medications, who have problems in walking, use a walking aid or have conditions such as a previous stroke, Parkinson's disease, dementia or arthritis are at increased risk of falls. Fear of falling, problems with continence, poor vision or strength and balance problems also heighten the risk.

The golden rule to prevent falls and strengthen bones is strength and balance. There are a number of options and perhaps Tai Chi exercises are the best known. But exercise programmes like the "Otago" and "FAME" programmes are also effective and widely available.

People with a history of falls or who has not



been very active should visit their GP for prescribed exercises, which can start at their particular level of ability and be built up as they get stronger. This might involve squats to strengthen leg muscles and standing on one leg to practice balancing, with weights being added to

improve bone density and muscle retention as they progress. These are things that everyone can do usually in their own home and make a world of difference.

The University of Manchester is leading ProFouND: the Prevention of Falls Network for Dissemination - a European Commission-funded network aiming to provide the best falls prevention advice to help prevent falls among older people across Europe. ProFouND is training exercise coaches across Europe to deliver training in their local regions and extend exercise programmes to reach some 84,000 older people by 2016. Exercise leaflets have been translated into 14 languages with six more languages to go. Together the partnership hopes to make a real difference improving activity levels in later life and keeping people out of hospital for longer.

A major challenge is to raise awareness among older people and care providers as for the need to tackle the issue of falls prevention. With that in mind the ProFouND developed a campaign guide as a practical resource to equip professionals with ideas

and examples to help them plan activities and tailor them to local communities and settings. It is meant to inspire older people organisations, family doctors, physiotherapists, and exercise trainers to start campaigning for better awareness of falls prevention, whether this is part of a regionally or nationally coordinated campaign - like Falls Awareness Week or International Older People's Day - or simply as a one-off event in local areas. The guide gives advice as for how to engage older people in falls prevention programmes, how to run local events and activities, the need to work in partnership and how to measure success in raising falls awareness.

Local events and activities can help to prevent falls in a number of ways. Firstly, and most importantly, they offer a way of overcoming one of the biggest barriers to effective falls prevention: the attitudes of older people. Local events offer a vital way of addressing these issues and bringing about the all-

important behaviour change needed to prevent falls. In addition to raising awareness, they break down some of the common barriers to accessing falls prevention services or interventions, and provide opportunities for older people to act on the information they have received. They might do this by enabling older people: to see the venue where regular classes take place; to meet the staff who run services or classes; to ask questions and raise concerns; and to try out particular classes or services and see how it may benefit them.

More information:

<http://profound.eu.com/profound-falls-awareness-campaign-ideas-pack-2014/>



► Vulnerable road users

Global Road Safety

In a major boost to the Decade of Action for Road Safety 2011-2020, Bloomberg Philanthropies has announced a US\$ 125 million donation which aims to reduce fatalities and injuries from road traffic crashes. This new funding will be targeted to cities where we can make the biggest difference, that have shown the strongest commitment to taking action, and that have the best ideas for making roads safer.

As Michael R. Bloomberg says, 'every life lost because of unsafe roads is a tragedy - and most of those tragedies could be avoided with better rules, better enforcement, and smarter infrastructure. City governments can be especially effective at putting those measures in place, because they are often able to move faster and more efficiently than other levels of government'. Bloomberg Philanthropies will help those cities work together to share effective strategies - so that even more lives can be saved.

More than 1.2 million people die and 20-50 million people are severely injured from road traffic crashes around the world every year, making road traffic injuries the ninth leading cause of preventable death. Unless urgent

action is taken, road traffic injuries will become the seventh leading cause of death by 2030. To combat this trend, select low- and middle-income cities and countries will be funded through this effort. At national level support will focus on strengthening road safety legislation and at city level on implementing proven road safety interventions in areas such as pedestrian and cyclist safety, combating drinking and driving and speeding, and encouraging the use of motorcycle helmets, seat-belts and child restraints.

In 2010, Bloomberg Philanthropies committed US\$ 125 million in funding to ten countries that represented half of road traffic-related deaths globally, namely Brazil, Cambodia, China, Egypt, India, Kenya, Mexico, Russian Federation, Turkey and Viet Nam. Since Bloomberg Philanthropies began working on road safety in 2010, over 1.8 billion people have been covered by strengthened road safety laws, 65 million people have been exposed to hard-hitting media campaigns promoting road safety, close to 30,000 professionals have been trained on road safety tactics, and local governments have committed US\$ 225 million towards infrastructure improvements that will make roads safer.

With assistance from the world's leading experts in road safety, selected locations will establish a network of visionary municipal leaders who commit to implementing bold, new efforts to save lives and protect their citizens from injuries. The selected locations will be announced by January 2015.

More information:

http://www.who.int/violence_injury_prevention/road_traffic/en/

► Violence prevention

Child maltreatment: Action plan WHO-Europe

On 17 September 2014 the 64th session of the WHO Regional Committee for Europe adopted a resolution to implement the European child maltreatment prevention action plan 2015–2020. Health ministers from 53 countries gave support to implementing the Action Plan. The Action Plan raises concern that the prevalence, burden and costs from child maltreatment are very high. In the WHO European Region the prevalence ranges from 9.6% for sexual abuse, 22.9% for physical abuse to 29.1% for mental abuse. The Action Plan stresses that maltreatment and other adverse childhood experiences result in health-harming behaviour, poorer mental and physical health, and worse social and educational outcomes throughout the life-course for those affected.

The Action Plan sets a regional target to reduce child maltreatment and homicides by 20% by 2020. To achieve this, it has three objectives:

- make child maltreatment more visible by setting up information systems in Member States and publishing comprehensive reports on the incidence and prevalence of child maltreatment;
- strengthen governance for child maltreatment prevention by developing national plans involving multiple sectors; and
- reduce risks and consequences through prevention by strengthening health systems.

These prevention programmes include stopping corporal punishment, training parents in child rearing, nurse home visitation, hospital-based training of parents to prevent abusive head trauma, welfare support to high-risk families, teaching children to recognize child abuse, and training health care and other professionals in the early detection and response to protect children from harm and to rehabilitate them.

The Action Plan asks the WHO Regional Office for Europe to support Member States to advocate for child maltreatment prevention, develop national plans, provide tools for surveillance and prevention, and build health systems capacity. The resolution requests WHO to report on progress to the WHO Regional Committee for Europe in implementation at mid-term in 2018 and with a final report in 2021.

More information:

<http://www.euro.who.int/prevent-child-abuse>



► Suicide prevention

Suicide prevention: A global challenge

Suicide occurs all over the world and can take place at almost any age. More than 800 000 people die by suicide every year - around one person every 40 seconds, according to the first global report on suicide prevention, published World Health Organization. Some 75% of suicides occur in low- and middle-income countries. Globally, suicide rates are highest in people aged 70 years and over. In some countries, however, the highest rates are found among the young. Generally, more men die by suicide than women. In richer countries, three times as many men die by suicide than women. Men aged 50 years and over are particularly vulnerable.

Pesticide poisoning, hanging and firearms are among the most common methods of suicide globally. Evidence from Australia, Canada, Japan, New Zealand, the United States and a number of European countries reveals that limiting access to these means can help prevent people dying by suicide. Another key to reducing deaths by suicide is a commitment by national governments to the establishment and implementation of a coordinated plan of action. Currently, only 28 countries are known to have national suicide prevention strategies.

Suicides are preventable

Reducing access to means of suicide is one way to reduce deaths. Other effective measures include responsible reporting of suicide in the media, such as avoiding

language that sensationalizes suicide and avoiding explicit description of methods used, and early identification and management of mental and substance use disorders in communities and by health workers in particular.

Follow-up care by health workers through regular contact, including by phone or home visits, for people who have attempted suicide, together with provision of community support, are essential, because people who have already attempted suicide are at the greatest risk of trying again.

WHO recommends countries involve a range of government departments in developing a comprehensive coordinated response. High-level commitment is needed not just within the health sector, but also within education, employment, social welfare and judicial departments.

Global target

In the WHO Mental Health Action Plan 2013-2020, WHO Member States have committed themselves to work towards the global target of reducing the suicide rate in countries by 10% by 2020. WHO's Mental Health Gap Action Programme, launched in 2008, includes suicide prevention as a priority and provides evidence-based technical guidance to expand service provision in countries.

More information: <http://www.who.int/suicide/>

► AGENDA

2014

4 - 5 December in Munich, Germany

12th International Conference, Protection of children in cars

<http://www.tuev-sued.de/academy/conference-management/automobile-rail/protection-of-children-in-cars>

2015

18 - 19 November 2015 in Brasilia, Brazil

Second Global High-Level Conference on Road Safety

http://www.who.int/roadsafety/decade_of_action/en/

24 - 25 March 2015 in Bologna, Italy

European Falls Research Festival

<http://www.e-nofalls.eu/events/european-falls-research-festival.html>

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EuroSafe Secretariat

EuroSafe, PO Box 75169, 1070 AD Amsterdam
The Netherlands

Tel.: +31 20 5114513/ Fax: +31 20 5114510

E-mail: w.rogmans@eurosafe.eu.com

